Down and Out?
The final report of St Mungo’s Call 4 Evidence: mental health and street homelessness
December 2009  |  Full Report

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St Mungo’s
Opening doors for homeless people
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Introduction

Charles Fraser CBE
Chief Executive, St Mungo’s

Over our 40 years of helping rough sleepers, at St Mungo’s we have come to realise that street homelessness is about much more than the simple lack of a home.

The statistics are stark. Our Happiness Matters peer research this year dug deep into the mental health experiences of homeless men and women, and found that a staggering 76% of interviewees who lived on the streets or in hostels, had some form of mental health problem – either diagnosed by a doctor (65%) or self identified (11%). Those with a diagnosed mental health problem turn to drugs or alcohol ‘because it is easier than coping with my life’. Our Client Needs Survey this year revealed that of our hostel clients who have slept rough, 69% have a mental health need (whether this mental health issue has been formally diagnosed or not) and 61% have both a mental health need and a substance use problem.

So really street homelessness is a health problem, that requires a dedicated response from the Department of Health. We all instinctively know street homelessness can cause mental health problems, and mental health problems can cause street homelessness – yet to us it seems health services and policy makers do not make that connection. Substance misuse is often masking mental illness, and services and policy makers need to respond better to this too.

We are delighted the Government has a target of ending rough sleeping by 2012 – but it needs to face the mental health problems of homeless people head on. Its strategy ‘No-One Left Out’, which underpinned its commitment, actually left out mental health - an area that was not given more than a passing mention. The draft New Horizons strategy, taking forward our nation’s mental health, barely mentions those with most complex or entrenched need, such as rough sleepers.

As part of our 40th anniversary we wanted to find out more. We initiated a Call for Evidence on Mental Health and Street Homelessness to cast the net wide, and draw together the views and experiences of the range of people who have an interest in the mental health of rough sleepers. The response we received demonstrated that we are not the only organisation that identifies these issues – the passion and commitment of those who submitted evidence was apparent. We received over 90 submissions, geographically spread across the UK and covering the voluntary sector concerned with mental health, substance use, housing and offending; the statutory sector covering health, social care and housing; and four Whitehall Departments, as well as the voices of homeless people themselves.

There was a resounding (and at times depressing) similarity in the problems identified - despite the wide range of expert contributors. Homeless individuals face exclusion from health services and support, because the complexity of their need does not match clinical criteria, or because mainstream services simply cannot provide specialist interventions. Projects to support positive occupation, which is so fundamental to people’s mental health recovery, are difficult to sustainably fund. Meanwhile people are crying out for more housing with a specific mental health remit – especially high support/complex needs projects. The evidence showed that there are many examples of good practice, and certainly many committed professionals – but overall there is a systematic failure to adequately meet the mental health needs of homeless people, which undermines the universal principles of the NHS.
The submission from the Department of Health unfortunately highlighted how far we have to go. It gives the responsibility to treat homeless people’s mental health problems to Primary Care Trusts. This Call for Evidence shows this is not working, with far too many people ending up on the streets, in hostels and in prison. Abdicating responsibility to the local level is proving inadequate to the extremity of need faced by rough sleepers – who by definition are not settled in geographic communities, and whose numbers are too small to be picked up by current needs assessments. And people with complex problems, such as dual diagnosis, are not getting an adequate service – making them even more likely to become tomorrow’s rough sleepers. Homeless people, and the people most vulnerable to homelessness, are falling through the gaps in service responses.

“Homeless people, and the people most vulnerable to homelessness, are falling through the gaps in service responses.”

St Mungo’s therefore calls upon the Government to take full account of homeless people’s mental health problems: responsibility for the most vulnerable in our society must lie at the top. The report that follows sets out a clear case for reform, using the range of evidence gathered that highlight the inadequacy of the current system of treatment, care and support. Policymakers need not be overwhelmed by ‘complexity’ – very often the solutions are simpler than the problems they address. What is required is the will to coordinate action effectively, and based on evidence of what is needed, and what works.

Only by concerted and effective action to meet the mental health needs of people who experience, or are most vulnerable to, street homelessness will the Government have a chance of meeting its own target of reducing rough sleeping to zero by 2012. We owe those who have been let down by mental health services nothing less.
Introduction

By Jacqui Thornton
Former Health Editor, the Sun, former health correspondent, Sunday Telegraph

One of the first articles I wrote as a cub reporter was a feature about supported living for people with mental health and learning difficulties. Twenty years on, although I have become a specialist health writer on national newspapers, covering mental health, I have never written about homelessness in any detail – until now.

Faced with lever arch files full of submissions from clinicians, outreach workers, Government departments, voluntary sector workers and more, I was chosen to write and edit this report to give the ‘outsiders’ impression, coming, on purpose, from a non-expert perspective. “Cut through the jargon,” I was told.

Certainly, at the outset, the subject is bewildering. Many of the contributors speak in a short hand that to the uninitiated is hard to understand. TWA's - Three Word Acronyms – are everywhere – CPA, PSA, HPU, NFA, RSU, let alone the four-word ones such as JSNAs, HMII, DATT and CMHT. At one stage I compiled my own mini-dictionary that I would constantly refer to. No wonder it’s difficult for a new employee, let alone a homeless person with mental health difficulties, to navigate the system.

Once I got past the new language, I saw the passion of many workers and former clients who want to improve things. As a journalist I look for ‘stories’: the vivid, heartfelt narratives that paint pictures to us all. Three stand out. There is Anne Milner; the community mental health nurse who assesses clients where they want to meet - under the pier, in parks and in supermarkets - in Bournemouth. She notes her frustration that the problems of so many of the people she sees could have been picked up by their GPs.

Then there’s Doug Musgrove, a former volunteer coordinator with St Mungo’s, who says people with serious mental health problems improve greatly when they have easily accessible healthcare, key worker support and stable housing, but without decent activities can regress so badly that they end up back in hospital. Again, there’s frustration that funding is not provided for this.

Finally there’s clinical psychologist Dr Suzanne Elliott, who reveals how the number of homeless people with mental health problems in Leicester has been reduced by a combination of joined up working and determination to follow good guidance. So why isn’t it happening elsewhere?

One consistent theme amongst workers on the ground is the depth and multiplicity of problems that homeless people with mental health issues face, often caused by traumatic events in their past. They are also clear that these are individuals who need to be treated as such, with tailored interventions. I share the optimism of some of the submitters about the Government’s Personalisation Agenda as a way of offering individualised care – if it can be afforded in the current economic climate.

At an ‘Outside In’ meeting of former St Mungo’s clients, I met Edwin, who has beaten drug problems to become an advocate for others, and has joined the Board of St Mungo’s. He summed up the point that ‘one size does not fit all’ by saying: “There’s no book on me.” Well Edwin, this report may not be a book – but I hope it will make commissioners and policy makers sit up and take notice, and go some way to solving the issues you and others so eloquently raise.
Methodology

St Mungo’s launched its Call for Evidence on April 1. By the closing date in June, it had received more than 90 submissions, from a variety of sectors: mental health organisations, homeless agencies, individual service users, campaigning groups, local authorities, PCTs, individual healthcare professionals, community groups, ex offender organisations and those for children. The authors were a mixture of service users, frontline workers, individuals and official responses. Although the majority were south east based, they came from all over England, covering cities such as Manchester, Sheffield, Brighton and Cambridge, but also Cornwall, Worthing and Hertfordshire. There were significant contributions from Scotland and Wales too.

Whitehall was well-represented, with contributions from the CLG, the Cabinet Office, DWP, and the Department of Health and, from across the river, the Mayor’s Office.

Most were written submissions directly answering St Mungo’s Call for Evidence in template form; others sent or added existing briefing and policy documents.

There were oral hearings – the St Mungo’s Parliamentary Committee, chaired by Sandra Gidley MP and attended by Doug Naysmith MP, and many interested parties in July; and a meeting of Outside In, St Mungo’s client group, in the same month. St Mungo’s held a Managers’ Away Day on the issue in June with 90 staff and supplied its five year Health Strategy. It also commissioned its peer-produced Happiness Matters Report specifically for the Call for Evidence.

All of this was analysed to produce this report.
Chapter 1

The Problem

The Government is currently broadening its approach to mental health in its draft New Horizons strategy, but crucially this does not yet directly address homelessness or people with complex needs. This must be challenged, as the only way the Government will succeed in its aim of reducing rough sleeping to zero by 2012 is to effectively tackle mental health issues in this population – not just the classic, psychiatrically defined illnesses but a wide spectrum of mental distress and disorders.

There are examples of good practice in the voluntary and the statutory sector, but these are patchy. Generally, statutory services are failing these individuals, allowing them to fall through gaps and excluding them because of their complex needs and substance use.

St Mungo’s, on reviewing the findings of this Call for Evidence, has come to believe the Department of Health must now take the lead on homelessness and, following a cross department audit, ensure these gaps in services, particularly regarding dual diagnosis services, are plugged. The Joint Strategic Needs Assessments are insufficient in ensuring homeless people’s needs are provided for because of their small numbers. More must be done to ensure the voices of the vulnerable are heard and acted upon.

1.1 Politics and Policy

Mental health policy is shifting: The Government’s New Horizons draft strategy concentrates on mental health and community wellbeing rather than a narrow focus on the ‘classic’ mental illnesses. There is a welcome recognition of the significance of working with people with personality disorders and people with substance dependency. It includes sections on prevention and on offenders’ mental health. Extraordinarily, the consultation document does not directly address homelessness or those with complex needs.

This is concerning for charities such as St Mungo’s, which fear that specialist work with vulnerable groups such as homeless people with mental health problems, and particularly rough sleepers, who are already being failed by the current system, are in danger of being further sidelined.

The Government aims to end rough sleeping by 2012 but its task is bigger than it imagines. Though ‘only’ around 500 people may sleep rough on any one night, over 3,400 different people slept rough in London alone last year. The only way it can succeed is to tackle these mental health issues head-on.

CHAIN data for London suggests that, against a backdrop of declining numbers of rough sleepers, the proportion of homeless people recorded with a mental health need has remained constant, at around one third. St Mungo’s and others believes that this figure is an underestimate, with many people with the ‘classic’ psychiatric illnesses in the homeless community remaining undiagnosed, often because of alcohol/drug use. Many others experience significant emotional and psychological disorders, notably personality disorders, and may not be diagnosed nor receiving treatment, and therefore not included in ‘official’ figures. A study at a St Mungo’s hostel in Lambeth, mainly for rough sleepers, by a clinical psychologist at Southampton University found levels of up to 65% of clients with personality disorders, around 40% with anxiety disorders, and 25% each with depressive disorder and/or PTSD.
St Mungo’s Call 4 Evidence Report

Homeless Link’s Survey of Needs and Provision 2009 (SNAP) suggests 43% of clients in an average homelessness project in England have mental health needs, and 59% have multiple needs. St Mungo’s Client Needs Survey this year identified 69% of hostel residents who have slept rough (a cohort of over 300) as having a mental health problem (diagnosed or undiagnosed), 37% displaying ‘challenging behaviour’ and 61% having a combination of mental health/substance issues issues.7 “Arguably, everyone who is homeless has a mental health problem by virtue of his/her homelessness,” says specialist nurse David Houghton. 8

Traditionally, the CLG has led on homelessness. The Department of Health puts the responsibility of treating homeless people with mental health problems in the hands of PCTs.9 The evidence shows there needs to be a new leadership and direction: if PCTs are providing treatment, then why do the majority of people on the streets and in Britain’s hostels and prisons continue to have mental health problems, which are often untreated? It is because statutory services are failing to reach many people.10

Clinical psychologist Dr Nick Maguire, from the University of Southampton, says: “The reason that numbers of people on the streets with a mental illness have remained high is because government policy and funding streams are addressing the wrong issue. Homelessness is not about housing — underlying, repeat/entrenched homelessness is associated with psychological problems and past trauma and antisocial behaviours.”11

Therefore, homelessness needs to be solved with mental health treatments, not just medication but also psychotherapy, and substance use treatment that can work with complex needs, backed up by appropriate supported housing and physical healthcare. As such, street homelessness is as much a health problem as a housing one and the Government needs to accept this. It also needs to take responsibility.12

Submitters say one of the biggest gaps for homeless people is where the CLG remit ends, and the Department of Health picks up. “There appears to be a huge gap in commissioning between Health and CLG,” says Dr Maguire. “There needs to be a more joined up approach between CLG,” echoes a specialist public health advisor.3 Neither can solve the problem of homelessness alone. The CLG and the Department of Health need to act together on this issue, and St Mungo’s believes the Department of Health should now rise to the challenge and take the lead.

St Mungo’s recommendations:
• The Government needs to act decisively to ensure nobody with a mental illness sleeps rough.
• There must be direct ministerial responsibility for health and homelessness within the Department of Health.
• The DH should lead a cross department initiative to address the mental health needs of homeless people.

1.2 Definition of mental illness

The psychiatric profession has traditionally focussed on the so-called ‘classic’ mental illnesses, in particular, severe and enduring mental illnesses such as schizophrenia and bipolar disorder. Many rough sleepers have experience of these conditions.

It has recently become increasingly evident, however, that ‘mental illness’ does not only relate to these conditions. Many others need some form of professional help but do not require, or do not respond to, traditional psychiatric treatment such as medication.

These people may have emotional and psychological disorders, such as severe depression and anxiety, post-traumatic stress disorder (PTSD) or personality disorder. They can exhibit their mental ill-health through behavioural patterns such as self-harm, self-neglect, antisocial behaviour, crime, and substance misuse, and are likely to respond to psychological therapies.

The medical model, which has traditionally been followed in mental health services, works on a ‘no diagnosis, no treatment basis.’ But many homeless people fail to get diagnosed because they do not fit into tightly defined categories of illness, so are excluded from treatment.14
For example, a patient may go to a GP with a mental disorder; he or she will get referred to a Community Mental Health Team, who may decide the symptoms do not fit their criteria for a diagnosis for treatment. The patient is then sent back to primary care, where he/she most probably will not be treated. Ultimately he/she may end up in prison or homeless with an undiagnosed condition.  

In secondary care, some individuals have such complex, multiple needs that a diagnosis is not always possible. They too are at risk of being excluded from treatment. Others are misdiagnosed and treated for more common conditions, such as anxiety and depression, when they actually have far deeper rooted psychological pathology.

A social model of mental health would see drugs and alcohol and poor mental health as different elements of an overall problem. “It is important that all forms of mental distress are recognised and addressed,” says Making Every Adult Matter, a coalition of Mind, Clinks, DrugScope and Homeless Link. “The acceptance of a wider, more inclusive definition of mental illness and mental health is very important,” says Connection at St Martin’s.

1.3 Gaps in Services

In the first quarter of this year, a ‘flow’ of over 400 new people were found sleeping rough in London, who had fallen through gaps in the statutory system designed to protect them.

Submissions highlight a number of ways in which statutory services are excluding people with complex needs, leading to this flow, which could be prevented if a thorough audit of these gaps was conducted and measures put in place to plug them.

The gaps exist vertically from Government to local level, where policy guidelines are not followed in practice. They also occur horizontally, both between local authorities, agencies and PCTs, and between commissioners within those individual services, which do not practice joined-up working.

Many homeless clients need different combinations of care, support and treatment, but these are commissioned separately, and the criteria for each component are different. Service users, whose problems may cross many boundaries, express surprise that there are so many professionals who want to help them, but that they often work at cross-purposes to each other.

What they want instead is a single point of contact who develops a care plan, with services going to them.

Illustrations of Good Working

Leeds Dual Diagnosis Project

highlighted by Jaime Delgadillo, St Anne’s Community Services

An innovative partnership has been set up between three services in Leeds with a joint working protocol; the Street Outreach team, Harm Reduction Services and the Assertive Outreach team. This came about after an audit found that 30 per cent of homeless people in Leeds had mental health problems and 21 per cent had combined substance misuse and mental health problems. The work is commissioned by Leeds PCT and managed by St Anne’s Community Services. Between September 2007 and August 2008, 503 people had been seen, 152 with significant mental health problems, 320 with substance misuse, and 102 with both.

There is friction over who pays for what; submitters complain funding is available from different sources such as housing, health or social services, leading to arguments about who pays; tasks are then overlooked, ignored, or passed on to others. “As one bureaucrat put it, off the record, ‘we love it when we hear ‘cross-departmental’, it means nobody is responsible”, says one submitter.

Major gaps exist in treatment services - especially for those with complex psychological disorders compounded by substance dependency; the ‘norm’ for street homeless people.

Recommendation:

• The DH must recognise the full breadth of mental health problems face by homeless people.
Some practical examples include:

- People who are obviously distressed go to a GP with a physical problem but are not treated for their mental health, because there are few services available for conditions such as personality disorder.  

- an individual may have a combination of needs that make them extremely vulnerable, but each single need may not reach the criteria for statutory services because they are assessed in isolation and so no service is forthcoming.

- GPs being unable to refer a distressed patient to mental health services because they won’t take people who use alcohol or drugs.

- People move from a hostel to permanent housing in another borough but care breaks down because agencies in different areas don’t work together.

- High risk young people are not receiving appropriate support because Child and Adolescent Mental Health Services end at aged 16 but the adult service does not start until 18.

- Residents who need basic skills training and a placement to access the labour market not getting appropriate support because supported housing and the DWP are not joined up.

- Hard to engage (or indeed other) clients miss two mental health or substance treatment appointments and are automatically discharged.

These gaps are often caused by ‘silo thinking’ by Government, agencies, individual professionals and commissioners. The phrase describes a narrowness of thinking and working, with professionals seeing their remit solely as the area they are working in, such as housing or mental health, placing boundaries around their work and not seeing the bigger picture. Few are working holistically, offering ‘wraparound care.’ “Individual services protect their own budgets rather than reducing overall costs, and responsibility is shunted around as fast as you can say ‘complex needs’.”

Interlinked working would ensure an integrated approach, but it would need co-ordinating around a common measure of success. At present, each service has its own targets. Integration is needed, not just between health services, but also between agencies and local authorities. Commissioners need to realise that, in regard to homeless people with mental health problems, they need to be acting as wide-ranging ‘problem solvers’. Physical ailments can generally be treated in isolation, but it is not as simple to ‘fix’ a homeless patient with complex needs. “Commissioning needs to recognise that people need to rebuild a life,” Ben Curran from Julian Housing writes.

A mapping exercise of the support system for people known to be at risk, and those with complex needs would identify systematic exclusions in services. Suggested areas for study would include the inability to work effectively with those below the threshold of diagnosis for severe mental illness, with complex needs, or with dual diagnosis; failures in co-operation, communication, and information transfer between agencies; and rigid practices.

The review should consider barriers to change and the way policy is co-ordinated across government departments, and barriers to local implementation. This exercise should define what principles are needed to underpin a new approach for a comprehensive safety net, and a clear implementation timetable.

Recommendations:

- The DH should lead a cross-governmental initiative – bringing health, housing and work together – which audits and addresses service gaps.

This audit should consider gaps within and between services. It should also consider how statutory mental health services and other services exclude rough sleepers and other people with complex needs.

- When designing services commissioners (and providers) should routinely and explicitly address how to include excluded groups (such as homeless people) who are not engaging with services.
Two areas of particular concern

Substance Use and Dual Diagnosis Services: The vast majority of submissions discuss how most homeless people with mental health issues use drugs and alcohol, which excludes them from services.

CHAIN data shows that 41% of rough sleepers on their register have a drugs problem, 49% have an alcohol problem, 35% have a mental health problem and - more importantly - a quarter of them have a combination of all three.38

The St Mungo’s Client Needs survey shows high figures too. The survey is across the full range of St Mungo’s accommodation and so covers both former rough sleepers and homeless people vulnerable to rough sleeping. Project and specialist workers have had an opportunity to more fully assess health issues, such as mental health problems. In this survey, 43% had alcohol problems, 46% drugs, 69% mental health problem and 46% had combined mental health and substance use problems. In one largely rough sleeper hostel in Lambeth, 62% had been drug dependent for more than five years.39

Substance use is largely secondary to mental health needs among homeless people – they often self-medicate to deal with their illness or disorders and to cope with life on the streets.40 This may mask their mental illness, making it less likely to be diagnosed and treated.41

Service users are very clear that mental distress leads to substance misuse, and that it’s the distress that needs treating first, through health services, not necessarily substance misuse.42 In some cases, people may get help with either their substance use or mental health problem - but not both.43 Instead they get pushed into drug/alcohol treatment by clinicians. This can happen even when they go to supposedly dual diagnosis services.44

At SU services, they may ask for help with their mental distress.45 A quarter of Happiness Matters interviewees had sought help for a mental health problem at a drug/alcohol service.46 But many substance misuse services do not routinely check out people’s mental health or work with mental health problems and vice versa so they fail to get adequate treatment.17 DrugScope says: “We should be equipping more drug service workers to deliver short low-intensity CBT-style interventions, with proper training and clinical supervision.”

Illustrations of Good Working

Wallich Clifford Community in Cardiff highlighted by DrugScope

The Wallich Clifford Community provides community houses for people with dual diagnosis – they adopted a policy in 2001 to allow drug use. With the exception of their Night Hostel, all projects will work with on site drug use and will distribute paraphernalia. Since then, there have had no evictions due to drug use no incidence of dealing, no reports of overdose and in 2006 reported that 64 per cent of residents entered treatment.

More worrying, is the ‘huge lack’ of effective dual diagnosis services for them, particularly for those who will not or cannot give up substance use.48 Bizarrely, even some dual diagnosis services insist on patients de-toxing first, before they will treat their mental health.49 There is a particular lack of services for people with alcohol problems. This is a key factor in them remaining on the streets, as their mental health remains undiagnosed and untreated.50

Typically, they ‘fall between two stools’, banned from both services because of their reluctance to give up alcohol or drugs, or are passed between each service because it is seen as the ‘other’s problem’; each does not want to deal with their complex needs.51

Services should not be allowed to simply shift responsibility back to the patient and say there is nothing they can do until he or she stops drinking or taking drugs.52 They should be designed to respond to people’s actual needs, not use substance use as an excuse to exclude.

DrugScope says progress on dual diagnosis services had been ‘slow and limited’ and added policy makers must recognise how prevalent it is and be ‘willing and equipped’ to deal with it.

Dual diagnosis needs to move from being a diagnosis of exclusion, to being accepted as a common feature of many who are street homeless. Rather than two separate strands of treatment, mental health and alcohol/substance use services should be integrated.53 PCTs need to be accountable for the lack of dual diagnosis services.54 Research projects are needed to provide evidence; it is possible to work effectively on mental health issues with people who use drugs/alcohol.
Recommendation:

- Integrated commissioning is vital – mental health treatment must never exclude people who take drugs or alcohol – dual diagnosis is common, and in homelessness is the norm.

Discharge from institutions

What happens when people with mental health problems – diagnosed and undiagnosed - leave institutions such as prison, the armed forces, long term stays in hospitals and even local authority care? These are predictable times when individuals are vulnerable to homelessness immediately or at a later stage, and much good practice guidance in this area already exists.

It is concerning that so many submitters cite these situations as causes of homelessness, indicating this guidance is being ignored. Guidance alone is not good enough, and a review of service gaps should recognise this.

Discharge and care arrangements from all these institutions should be looked into in depth, but particularly prisons.

Prisons - The Bradley review, published in April, emphasised the importance of mental health and social care services being involved at every stage of criminal justice; from arrest, through prosecution and the courts, to continued treatment and support after release from prison. The Bradley Review recommendations were welcomed and they should be acted upon, taking into account that many offenders have psychological and substance use issues rather than major psychiatric illnesses, so a new style of mental health treatment services are needed.

A high proportion of those in custody have mental health problems – 72% of male and 70% of female prisoners have two or more mental health problems. As many as 66% of them have a personality disorder, compared to 5.3% in the general population.

Of those with mental health problems, 43% have no fixed abode on the day of release. Furthermore, 8% of men and 10% of women are homeless when they enter custody, so it is unsurprising, though disappointing, that they leave with nowhere to go.

Submitters say offenders who were in supported housing or tenancies before incarceration lose them whilst inside, because of a lack of support or an inability to pay the rent. When they leave prison, they are often resettled with no support, let alone mental health treatment, which often leads to the same behaviour; i.e. re-offending, starting a vicious circle. More than a third of St Mungo’s clients have been in prison.

Those serving short sentences, of less than 12 months, are not subject to offender management on release. They are released with a discharge grant and often nothing else, and asked to fend for themselves.

Prisoners with mental health problems need a safe and supported accommodation route on discharge, and the local authority could become responsible for identifying accommodation before their release. Statutory homelessness assessments are not carried out in custody, but they should be.

Existing discharge protocols need to be enforced and offender housing advice schemes, such as those run by Revolving Door Agency at HMP Lewes and by St Mungo’s at a range of prisons and YOIs, should be extended.

Illustrations of Good Working

**Prison discharge co-ordinator, HMP Birmingham**

Highlighted by NACRO

Birmingham and Solihull mental health trust has located a prison discharge co-ordinator inside HMP Birmingham to improve communication and planning between prison and outside agencies for prisoners with mental health needs. This begins from the point of sentencing to release from prison, encouraging linked-up working across health, social and offender management care.
1.4 Social exclusion by numbers

In London more than 3,000 people sleep rough in a year; but borough by borough, the numbers may only reach double figures. This causes a difficulty, because it is at this local level that services are commissioned.

The evidence raises concern that local commissioners are not funding specialist schemes for those with mental health issues because they can only fill one or two places. Submitters say joint working between boroughs should be encouraged to maintain the funding of this important work.

Joined-up working is called for throughout most of the evidence and joint commissioning is seen as a good model to protect vulnerable groups which are small in number. The most obvious model is the Joint Strategic Needs Assessments, which began in 2008. This established the duty of local authorities and PCTs to identify the health needs of their local population.

The Government claims the assessments will enable services to be designed for people who are ‘currently under the radar in many PCTs.’ But submitters say the JSNA data set does not identify homeless people so the process must be monitored to ensure it takes homelessness and mental health into account.

St Mungo’s believes the JSNA mechanism is not sophisticated enough to pick up homeless people with mental health problems, let alone prioritise them. The only way to find data on homeless people by local authority area is for voluntary agencies to actively seek it out, and persuade the relevant authority to include it.

St Mungo’s efforts to provide evidence of homeless people in London’s needs have not been acknowledged by the PCT directors of public health who the Department of Health guidance says are responsible for devising JSNAs.

One such tool given as an example of good practice is The South West London and St George’s NHS Trust’s New Direction Index tool, which identifies residents not engaging with front line services resulting in chaotic lifestyles. This is one of the Cabinet Office’s 12 national Adults facing Chronic Exclusion pilots.

Recommendation:

• Commissioners and service providers would benefit from an indicator of multiplicity of need – so that multiply vulnerable people do not fall below individual service thresholds.

An audit of service gaps should include reviewing local commissioning and needs assessments.
Chapter 2

Healthcare

Homeless people’s health problems, particularly their mental health problems, need to be treated appropriately and effectively. This will, in turn, help them to accept and seek help for their housing and other issues, respond better to supported housing and prevent the ‘revolving door’ scenario of returning to homelessness.

However the evidence paints a picture of problematic access, plus a lack of effective treatment services, within primary care. There is a limited range of specialist mental health services that GPs can refer people to, particularly for Personality Disorder. When they can refer, exclusion is common because the patient does not fit rigid criteria for a diagnosis or they are rejected because they are using drugs/alcohol. These undiagnosed patients are sent back to GPs, who know that simple counselling is insufficient to treat the problem but psychotherapy is unavailable.

The evidence calls for better prevention and treatment in primary care, better physical and mental health outreach on the streets and in hostels by nurses and doctors, better dual diagnosis and personality disorder services, an increased willingness to section patients when needed and better acute care in hospitals. Overall, more holistic healthcare is needed, acknowledging complex need, taking into account multiple problems and diagnoses.

2.1 Holistic care

NHS health services are built around treating those who present with a single severe condition. Once this is diagnosed, they direct the patient down what they think is an appropriate ‘pathway’ and there is little room for acknowledging other problems or health issues.

But homeless people have complex, multiple problems. They might have a ‘cluster’ of physical and mental diagnoses, or one diagnosed and other, non-diagnosed issues.76

Wherever rough sleepers go for healthcare, staff should consider underlying mental health conditions, from substance dependency to psychosis, from depression to personality disorder. There needs to be much higher awareness in health and social care services that complex mental health problems, whether they predated rough sleeping or were the consequence of it, are the norm for homeless people.

Assessments of patients’ needs by clinicians should be holistic and not single issue.77 Specialised commissioning could also help. At a rough sleepers’ hostel in Lambeth, eight different commissioners enable the health interventions. St Mungo’s believes it probably has the best range of health provision within a hostel setting in the country, but these commissioning complexities mean this success is unlikely to be generally replicated.78
2.2 Primary Care

Access – The NHS Constitution 2009 promises that the health service provides ‘a comprehensive service, available to all, irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves.’

Like the rest of the population, GPs were the first port of call for the majority of homeless people. 59% of Happiness Matters interviewees had tried to get help for their mental health problem at a GP. But many are not receiving this ‘comprehensive service’. Homeless people are 40 times more likely not to be registered with a GP than the rest of the population, and three times more likely to have had no contact with a GP in the last year.

The myth persists that a patient can only be seen by a GP if they have an address: many doctors, gatekeepers and the homeless themselves still, wrongly, accept this notion. As one GP put it, ‘it is not that homeless people are hard to reach, it is that they are easy to ignore.’

This lack of access is significant as GPs are the gateway to the specialist mental health services. It is ‘crucial’ homeless people are registered; otherwise they present late with serious mental health problems - sometimes as late as 10 years after becoming homeless.

A homeless person may, of course, unintentionally self-exclude: a transient, chaotic lifestyle is often incompatible with primary care services which are based around office hours in surgery environments; they may find it difficult to keep appointments, attend meetings and comply with a regular medication schedule. They do not prioritise their health needs, and often ignore symptoms that the general population would rush to a GP with.

Crisis says: “These barriers mean that situations arise where a chat with a GP, which could have led to a referral, instead becomes an undiagnosed and neglected issue that may remain that way until the person comes into contact with an emergency service, such as A&E or the police.”

Once homeless people are registered, contributors urge primary care services to change their culture; they need to be more welcoming and accessible, with a greater range of opening hours and some form of drop-in, open access, as happens at Great Chapel Street, Westminster, and Manchester. Reception staff should be trained in how to deal with challenging behaviour or people with few social skills. NHS computer systems should be tailored to recognise that some people don’t have an address.

In areas with high levels of homelessness, there should be specialist, enhanced GP services, with primary care practitioners trained in identifying and meeting complex needs, and able to identify underlying mental health problems behind a screen of behavioural issues.

Illustrations of Good Working

The Quays Medical Centre, Hull highlighted by CLG and SCMH

Dr Mark Williamson has developed innovative working at the Quays, a unique surgery which provides general medical services, but also offers a service specifically for homeless people, those with drug and alcohol problems, asylum seekers and refugees, sex workers and patients with mental health problems and patients. It is a ‘good example’ of integrated primary and social care, according to SCMH, which successfully offers a range of approaches for a number of excluded groups.
Treatment

GPs must be better trained to spot the early warning signs of mental ill health amongst the general population, offer intervention and provide better mental health treatment generally within primary care.\(^9\) These early warning signs include substance use, suicidal feelings, self-harm, eating disorders, anxiety and depression, PTSD, and personality disorders. If mental distress is apparent but the patient is undiagnosed, they should be referred rapidly.\(^9\)

However, the evidence demonstrates a number of barriers to such good practice. Some GPs are unsupportive\(^9\); ten minute consultations are inadequate to spot potential problems,\(^9\) let alone draw out or deal with complex issues.\(^9\)

A CMHN, who has to pick up the pieces later on in the community, lays the blame at the door of primary care. She writes: "If they turn up here and I can assess it, why wasn’t it assessed in their own area? I do find this the saddest part, whereby someone has developed early psychosis and it hasn’t been spotted by their own GP and the person has effectively walked out on their family, their job."\(^9\)

When GPs do spot mental distress, there are complaints that they cannot effectively or easily get people into appropriate mental health services.\(^\) There is reasonable support for people with low level need, through Increasing Access to Psychological Therapies (IAPT), the Government’s programme to offer talking therapy to people with mild to moderate depression and anxiety in the general population. People with severe mental illness are referred on to psychiatric services though not necessarily accepted, if they use drugs or alcohol, or their symptoms are complex but diffuse.

People with moderate illness, for whom psychotherapy would be of ‘huge benefit,’ but IAPT would not be robust enough, often fall through gaps.\(^\) Psychological therapy, either in-house or referred on, is either non-existent, overlooked, subject to long waiting lists, not very good or refused on grounds of drink or drug use.\(^\)

People with low level but multiple complex needs are often not offered treatment for their mental health problems, nor are people with other combinations, such as mental health problems and learning disabilities.\(^\) Young people in particular are being failed.\(^\)

In physical health, whether a patient has a cold or cancer, the GP will treat him or her; the same should be true of mental health services – whatever the mental distress or illness, the patient should be offered effective treatment and/or referral by primary care mental health services.

In areas of high homelessness, specialist services should be integrated within primary care.\(^\) Mental health services could effectively be redefined and relocated in primary care environments such as GPs surgeries.

Recommendations:

- The DH should recognise that many people with lower and moderate mental health problems do not currently receive effective treatment from mental health services and this needs tackling.

  Mental health problems escalate and some people end up in hostels and prisons.

- People with mental health problems should receive good signposting - towards housing and mental health services - from their GP/other health contacts.
2.3 Mental health outreach

Two messages came out loud and clear in the evidence: firstly, doctors and nurses from primary and secondary care, and community mental health teams need to work in the community, in hostels and actually on the street, to reach those who avoid engagement and to carry out mental health assessments. Secondly, there should be more drop-in, problem-solving community centres with attractive facilities to encourage people to engage, again where assessments and treatment could take place.

Work on the streets by clinicians is far more effective with integrated dual diagnosis support, given the high levels of drug and alcohol use. Services need to allow for a long period of engagement to build trust with consistent personnel, ideally one to one. The approach could be ‘nudging rather than nannying’ towards helping agencies — ‘tea and sympathy alongside signposting.’

A recurring theme in the evidence is that services need to go to the client. Drop-in community centres in familiar locations can offer a variety of flexible services, where clinicians can offer a physical and mental health service on a regular basis. These centres should be capable of housing different agencies and services, which could each carry out physical and mental healthcare and assessments, give advice on issues such as housing, debt, the law and benefits, and offer drug services. They should have practical facilities such as showers, cheap food, and laundry services, too.

Illustrations of Good Working

Tyneside Cyrenians project highlighted by SCMH and Cabinet Office

The Cyrenians have converted some local houses in Newcastle into day centres for vulnerable people, on a one-stop shop model. Services include physical and mental health assessments paid for by PCT. The setting is attractive, service-user shaped and led. It runs social groups, housing and employment advice, laundry and food services. The team also has an assertive ‘search and outreach’ strategy with a unique style; workers know the places clients frequent and track them down so more engage.

Illustrations of Good Working

Mental Health Support Team for Homeless People, Nottingham highlighted by Becky Sayer, Nottingham Hostels Liaison Group

This voluntary sector team, part of Nottingham Hostels Liaison Group, views mental health ‘in its broadest sense.’ Workers talk about ‘mental health difficulties’ in an open way, and its literature for clients covers questions on panic attacks, stress, inability to cope, self harm and substance use. It promises regular contact with the same person, even if clients move accommodation. It aims for cross-channel communication between statutory and non-statutory bodies, and an active policy to identify gaps in service provision and feed this back.

They need to be open-door; so that if a support worker finds someone is asking for help on the street, they can be taken straight there and begin accessing treatment and services. To aid engagement, there should be no requirement for abstinence. Day Centres are popular with service users; the Happiness Matters report found 31% of questionnaire respondents wanted help for mental health problems in hostels or day centres.

The Department of Health says in its submission that Assertive Outreach Teams supported 19,900 people during March 2007-8, just below its 20,000 target. These are services that go out into the community (and are not to be confused with homeless agency rough sleeper similarly named outreach work.)
Submitters do not feel, however, that such figures are a cause for celebration, and press for increased provision, and more selective outreach, as services are ‘patchy.’

Lee Murphy, mental health manager at St Mungo’s, argues that the people seen by the DH’s AOTs are by and large either already within the system, identified by community mental health teams or having been discharged from inpatient care. This means clients where complex trauma, personality disorder or substance use issues are core, who are outside the system, are largely still excluded. This is why mental health workers need to operate within community centres, rough sleeper day centres and hostels.

2.4 Secondary mental health services

GPs refer people with serious mental health problems to secondary, specialist services, but often these are inappropriate or inadequate for homeless people with complex needs. Firstly, there are simply not enough services. “In London, psychiatric services are so saturated that in some cases, they are quite grateful if someone doesn’t engage – that is, goes away,” says the Women in Psychiatry Specialist Interest Group. This leads one submitter to suggest that patients are excluded to lessen the burden on overstretched statutory services.

Exclusion takes place in a number of ways. Mental health services assume a patient has stable accommodation and the ability or willingness to engage. Homeless people fit neither category. They are further excluded because they do not meet the diagnosis criteria for classic psychiatric definitions of mental illness. “Services have an unfortunate habit of pigeon holing people. When they don’t fit into a designated box, rather than making a new box that would accommodate their issues, they usually end up casting them aside,” says a nurse in a South Wales surgery.

Then there are the people who are denied treatment because they are drinking using drugs, as CMH teams see the substance use as the primary problem, when actually it may be masking their mental health problem. Or, services may think using drink or drugs will make treatment ineffective. “There is no acceptance that without a single drink, an alcoholic is unlikely to be able to sit still and be co-operative while he feels sick and has the shakes. Equally a heroin user who needs a fix will similarly not be able to answer questions about how he feels.”

All of these groups – people who don’t engage, those who use substances and those who don’t fit into a discrete diagnostic category – need to feel ‘safe and supported’ by mental health services. Instead they are often deemed unsuitable for treatment and simply passed back to primary care.

This ‘casting aside’ will only be improved if statutory mental health services broaden their definition of mental health, and become more flexible and understanding.

Assessments – Mental health assessments are carried out by psychiatrists and community mental health teams. Rapid referrals and informed assessments are needed so treatment can begin, but the evidence suggests the opposite happens.

People can be referred back and forth without an initial assessment ever happening, or multiple meetings. Others have so many ‘stepped’ referrals, going from the least qualified clinician upwards to get to the mental health expert who has the expertise to treat their complex multiple needs, that they disengage. Offices where assessments take place, such as CMHT offices, may be far from the city and town centres where homeless people are based, leading to missed appointments.

If the process takes too long, conditions can deteriorate until a more acute and difficult situation arises. In extreme cases, assessment can take two to three years, not months, and just getting into treatment can correspondingly take a long time.
It should not be acceptable that mental health services send people away without treatment because they do not fit with their criteria. There should be a needs-led, patient-centred mental health service that works with people whatever their presenting need, rather than leaving it to the voluntary sector to provide as best it can.

Sectioning

Many homeless people with mental health problems fear being sectioned and using the Mental Health Act is certainly not to be done lightly. However admission to hospital can be appropriate for some individuals.

But the percentage of homeless people admitted to hospital under section varies enormously from borough to borough and psychiatric team to psychiatric team. This seems to reflect variations in the degree to which different teams are willing to go on the streets themselves, and the availability of hospital beds, rather than variations in clinical need.

There should be a wider preparedness to section people from the streets, and more consistent sectioning across outreach teams. Indeed it is important not to wait too long before using the Mental Health Act – the result can be a poorer response to treatment and a more damaged individual.

Acute Care

Many homeless people with mental health problems go to A&E for physical and mental illness because of lack of access to primary care, or become inpatients after sectioning. Contributors describe a culture of hostility and ignorance by frontline medical staff in all areas.

One hospital says even psychiatric wards have to “prepare medical staff about what to expect when we admit a long-term rough sleeper. We have often had staff resistant to such admissions as they feel it’s a lifestyle choice.”

The staff do not see it as their role to treat homeless people, which undermines engagement with the patient and jeopardises the success of treatment. It is interesting that in the case of homeless people with a mental illness, the stigma attaches to the homelessness more than the mental illness.

These issues have their roots in prejudice and the misunderstanding of homeless people’s health needs, but also in the underfunding of acute mental health hospital services. There is a shortage of beds, leading to people being discharged too early. Homeless agency workers also say they want more crisis house provision, which is a cheaper route than sectioning and hospitalisation for those whose problems are escalating.

The problem of limited supply of places is that homeless people may go to the back of the queue; St Mungo’s has several cases of people asking for admission who were refused, and who then went on to attempt or succeed in committing suicide.

Senior NHS staff often fail to see the value of long admissions to facilitate compliance with treatment, and engagement with rehabilitation and recovery. People may be discharged quickly after a crisis with little follow on care or mental health input.

After the initial acute treatment, there needs to be therapeutic residential environments for people to live in for a duration determined by their recovery, not by funding priorities.
2.5 Personality Disorder

Up to 13% of the general population is believed to have a personality disorder, but the prevalence is much higher in rough sleepers and single homeless people. A recent survey at one of St Mungo’s hostels by a clinical psychologist from Southampton University confirmed these figures found levels of up to 65%.

PD carries more stigma than other disorders, and in the past it has either not been considered a mental illness at all, or has been seen as untreatable. Many people went undiagnosed.

The Department of Health’s 2003 report, Personality Disorder - No longer a diagnosis of exclusion recognised PD as a treatable condition. It placed a responsibility on statutory bodies to respond to the needs of people with PD. Earlier this year, NICE guidance recommended mental health trusts establish specialist PD services.

These positive moves do not appear to be reflected yet in commissioning decisions on the ground. Often there is insufficient demand at single borough level, so they are considered too costly, leaving a “huge unmet need in current service provision.” Almost all those with substance use issues are excluded from treatment and even specialist units are excluding some people with the disorder, leading one submitter to argue CMHTs should be ‘obliged’ to support people with PDs.

People with the diagnosis find it hard to find social care support, and are not considered to have priority need for accommodation. A nurse in a GP practice says: “PD is a convenient way of many services being allowed to say they do not have to provide services. Once labelled as having PD, many people have great problems accessing shared housing, hostels etc because of fears about their behaviour.”

The fact that there are such high levels of PD in the homeless population should impact on commissioning decisions, including housing allocation and mental healthcare services, and local strategies to address homelessness. PCTs should be talking to the voluntary sector because they successfully work with and house significant numbers of people with personality disorders.

Recommendations:

- The DH needs to recognise the extent to which its service problems lead to, and fail to help people away from, rough sleeping and show leadership in addressing this.
- As part of the mental health safety net for rough sleepers, there should be sufficient acute mental health provision.

Recommendation:

- We need direct recognition in local and national strategies, and commissioning, of the high incidence of personality disorder amongst rough sleepers and single homeless people.
Chapter 3
Social Care

Prevention of homelessness amongst people with mental health issues is central, particularly in the current economic climate. People with mental health problems need support, to varying degrees, to live their lives. This can be to maintain a tenancy, keep a job or safeguard family unity, to prevent losing their home. If they do become homeless, and end up on the streets, where their mental health will deteriorate, they need help from outreach teams working in a non-judgemental way, who can explain the options and ease the path to supportive, flexible accommodation.

This housing should suit the individual and offer the right level support hence a range is needed. It should not be time limited or subject to a particular outcome. Instead it should offer a therapeutic environment and be available for as long as that individual needs it.

Voluntary sector organisations, who have previously concentrated on housing provision and social rehabilitation, need to incorporate therapeutic working in their projects.

3.1 Tenancy Sustainment and Support

i) For those with established mental health problems and/or following homelessness

People with complex needs, mental health issues or who have been previously homeless (even all three) should not be denied the chance to have a tenancy if it is appropriate. At the same time, it must be recognised that many will need tenancy support. For some this will be for a long time, even permanently.

They may need help with practical living, paying bills, budgeting and other skills. They may need social support. Loneliness and having mental health issues can lead to them being more vulnerable to exploitation by others, as they may not be able to deal with problems as effectively. They may be targets for the take-over of their homes by crack or alcohol users or other squatters.

Tenancy support may appear expensive but it is cheaper and more effective to provide someone with support than it is for them to spiral downwards into homelessness or hospital. Crisis and others claim that without practical living support, vulnerable people will be pushing on a ‘revolving door’ of tenancy abandonment, recurring homelessness, social isolation, hospital admissions and contact with the criminal justice system.

Part of the care package for people with mental health problems needs to look at how much support they need to maintain a tenancy, including floating support.
ii) When symptoms first arise

When symptoms of mental health problems first arise, it can be a very frightening and confusing time. For someone living alone in a rented flat or house, it can be hard to sustain a tenancy, particularly if their job is affected and income reduced.\(^{151}\) When a tenant falls into arrears, or neighbours raise complaints due to unusual or anti-social behaviour, he or she is often evicted rather than any effort being made to work out why the tenant is in difficulty and prevent recurrence.

Submitters say increased tenancy support is crucial to prevent a first episode of homelessness.\(^{152}\) Local authority housing teams and community mental health nurses should work together when people are in danger of eviction. Some consider Floating Support could be offered by CMH nurses.\(^{153}\) Similar floating support, to sustain a job, or education, while experiencing mental health problems, should be available, to protect income and therefore tenancy.\(^{154}\)

A minority view was that private and local authority landlords should be more accountable. “The people who might notice something wrong which could lead to homelessness, are the people missing the payments for rent or mortgage such as the landlord and banks...yet those organisations are not concerned with recognizing or resolving mental health problems but with ensuring those payments are made. How those people could be better involved in helping in this area is an interesting point,” says the Queen’s Nursing Institute.\(^{155}\)

Another suggestion is that frontline housing workers and tenancy support workers, who come into contact with vulnerable people on a daily basis, should be trained in identifying early warning signs of mental health issues, and increased distress in those with known mental health issues, before they escalate.\(^{156}\)

Illustrations of Good Working

Protocol with housing department

CMHN Anne Milner has a protocol with the local housing department where, before any eviction, they check with her if the person has a mental illness so they can involve the care co-ordinator. If the person is not diagnosed, but housing officials have concerns, they refer Anne verbally and she assesses at the house. “Housing works with me and the resident to avoid an eviction. Not only has this saved the council a lot of money, it has saved vulnerable people becoming homeless,” she says.

ii) Family support

People often become homeless because of a breakdown in a relationship, such as with partner or a parent. Young adults in such situations might be seen by Child and Adolescent Mental Health Services, but critically there is a gap in services between CAMHS and the adult service. There must be better link between the two, to plug this gap which is failing 16-18-year-olds.\(^{157}\) It’s not just breakdown of families - young people leaving care are vulnerable too.\(^{158}\) The percentage of St Mungo’s residents who have been in care in the past has almost doubled from 6 – 11% in the last five years.\(^{159}\)

Family mediation services and other early interventions, which are not widely funded, can have significant prevention impact and should be prioritised, as well as floating support for the person at risk.\(^{160}\) Support for families and carers is also needed, especially after hours support, and particularly if the family member concerned has a personality disorder.\(^{161}\)

Local authorities may not want to fund such tenancy and family support but extensive prevention measures would be no more expensive for the Government overall than the current hospital stays after a crisis situation occurs.\(^{162}\)
The Mental Health Foundation argues in the current economic for the NHS “it may prove difficult to improve levels of support to rough sleepers...it makes it all the more important that early intervention and prevention become a key focus.” Provision of tenancy and family support will save costs later down the road.

iv) Signposting and First Aid

Frontline staff should be aware of how to inform vulnerable people where they can get support, particularly young people. There is currently a lack of understanding and proper awareness of mental health support amongst staff in non-medical services, such as housing. Mental health first aid training, which enables someone to assist the person until appropriate professional help is received or the crisis resolves, or a similar scheme, would be effective. Similarly, mental health professionals should be given awareness training about homelessness and housing advice options.

There are positive moves encouraging medical staff to become more aware of homelessness and mental health. In Nottingham, nursing students are trained by mental health service users with experience of homelessness as part of their course. St Mungo’s would like to see a system whereby trainee psychologists, psychotherapists and psychiatrists, as well as nurses and social workers, do clinical placements in services used by homeless people and people with complex needs.

Recommendation:
- Mental health, health and housing workers all need training that supports awareness of each other’s areas and knowledge set to enable good signposting.

3.2 Rough Sleeper teams and Street Outreach

The need for effective street outreach by homeless agencies to engage both new and entrenched rough sleepers and help move them into housing is articulated strongly in the majority of submissions.

There are two elements to street outreach: helping the ‘flow,’ people who are new to the streets, into accommodation, with quick intervention so their problems do not grow; and helping entrenched rough sleepers with mental health problems and complex needs, building relationships through time and effort. At least one member of the outreach team should have mental health expertise and all should have some knowledge.

Nowadays, most outreach teams in London also have a role in engaging vulnerable adults on the street who are begging, drinking and sex working, and this practice should become more widespread.

When teams do good outreach, targeting both ‘flow’ and entrenched rough sleepers, and when other services such as housing are in place, the models are proven. For example, this has been shown in Camden, where the number of rough sleepers was reduced from the 70s to fewer than 10 a night. This two-pronged approach should happen wherever there are rough sleepers, in all cities and boroughs across the UK.

Street outreach is commissioned by boroughs and is delivered by the voluntary sector, such as St Mungo’s, Thames Reach, CRI and Broadway. More recently St Mungo’s and others have been commissioned by Westminster City Council, which has the highest number of rough sleepers in any borough, to provide street outreach using this approach. This has the potential to have the same success in reducing numbers as St Mungo’s did in Camden. Its model involves intensive case management; staff trained in motivational work and is supported by psychologically informed reflective practice.
The system works because statutory services support it, and hostels/supported housing have become better in retaining clients. Both of these have happened because there is greater oversight and joined-up working by the CLG and local authorities.169

Of course, there has to be housing that people want to live in, more hostels that are able to take and work effectively with people with complex needs, including therapeutic projects and some intensively supported flats. “This is where St Mungo’s shines - our hostels by and large have regimes that are accepting of the complexity needed to retain this client group,” believes Adam Rees who runs outreach teams for St Mungo’s.

The nature of the street population has altered over the years. Since 1989, there has been a reduction in ex-Armed Services personnel and men with schizophrenia on the street, and an increase in those with opiate addictions, chaotic use of stimulant drugs and alcohol dependence.170

The Homeless Mentally Ill Initiative set up 20 years ago, created teams of mental health workers which carried out effective street outreach. They had their own ring fenced funds and accommodation projects which they could offer to rough sleepers. The teams are praised in submissions but there is an acknowledgement that since their inception, mental health and homelessness has changed, quite apart from the removal of the ring fence, so there is no new money for accommodation. This initiative is worthy of review.

If much success has been seen in recent years in developing good outreach/emergency response, one area is of growing concern. Of the 3,472 verified rough sleepers in London last year; 545 were from A8 and A2 backgrounds and 127 were 127 Eritreans.171 The Call for Evidence notes widespread concern about the increase in failed asylum seekers, refugees and eastern Europeans, who are not eligible for the hostel system or local authority housing and have no recourse to public funds. These people tend to present at psychiatric services with post traumatic stress disorder, adjustment disorders and hard to classify mixed syndromes.172

The Royal College of Psychiatrists writes: “Given that most trauma services will only consider someone for treatment if their social situation is stable and their immigration status is clearly decided, this group is often effectively excluded from effective treatment. This leaves both homelessness and mental health services with the complex and emotionally draining task of supporting them, often for years, while these matters are decided.”

St Mungo’s believes the government needs to clarify its welfare response to this growing group. An increasing proportion of them have complex problems to overcome.

Illustrations of Good Working
Homeless Mental Health Service, Leicester
highlighted by Dr Suzanne Elliott

Leicester has seen a remarkable reduction in homeless people with mental health problems on the streets, through a combination of targeted outreach and joined up working with housing and primary care. The service includes a Rethink funded support worker who follows a recovery model. It works closely with housing both in offering tenancy support but also in outreach directly with rough sleepers.

3.3 Housing

Due to the overwhelming evidence about the poor health of rough sleepers, housing itself is arguably no longer the main issue in street homelessness. Yet submitters say it is still highly significant, as the housing must exist, and be therapeutic and holistic, with mental health services and substance use treatment going to projects.
It should be based on 'need not speed' – that is, residents should be able to stay there as long as it is beneficial for them, not a set time period based on how long a commissioner will pay for assistance, such as the Supporting People model which pays for two years.\textsuperscript{173} The lack of move-on options can cause silt up - people remaining in housing longer than they need, and on the other hand funding pressures can force people to leave before they are ready.\textsuperscript{174} In terms of geography, homeless people want exactly what anyone else wants from a home - a safe building near facilities and support networks, not in a deprived large estate full of crime.\textsuperscript{175}

**Short term supported housing options**

Finding suitable 'first' accommodation can be challenging given the complex needs most rough sleepers and homeless people have. Most submitters accept the role of short term hostels for homeless people, but have concerns about their over-use for people with mental health problems, their size and the variable quality of some projects.\textsuperscript{176} As a result, a range is needed.

Hostels with onsite mental health, physical health and drug/alcohol treatment services are popular.\textsuperscript{177} Activity programmes in hostels are needed to allay boredom and prevent people resorting to drugs or alcohol. Flexibility and tolerance are important. Hostels should be able to use discretion, for example asking someone to leave for a few hours, for breaking a rule instead of evicting them.\textsuperscript{178} Key workers should build up positive relationships with clients, engendering trust and showing commitment.\textsuperscript{179}

The physical environment is important too; bright, open areas with good facilities are more likely to induce positive emotional wellbeing; having your own room is important for some.\textsuperscript{180} The £90m Hostels Capital Improvement Programme 2005- 2008, and the Places of Change Programme, helped 140 projects improve quality.\textsuperscript{181} However many more need to go through these physical and service improvements.

Larger hostels in themselves can be intimidating, especially for those who experience paranoia and those with low self esteem, or poor social skills.\textsuperscript{182} This can leave them vulnerable to exploitation and abuse, and increase the likelihood of substance misuse, which increase the risk of returning to the streets. Perhaps to avoid this, in an innovative locally-derived move, Glasgow has closed all of its large scale hostels.
Some submitters wanted to bypass hostels and move people straight from the street or from prison/hospital discharge into stable mental health accommodation or tenancies with support, but found shortages of supported housing hindered their ability to do this.

High support flats and intensive supported housing such as in the HMII model are welcomed, as well as more innovative solutions, such as supported lodgings. For example, St Mungo’s is working with the City of London Corporation to provide traditional B&B/lodgings for long term rough sleepers.

Longer term housing

When it comes to moving from a hostel to longer term housing, again there is no ‘one size fits all’ model. Submitters argue that different people with different mental health and other needs require different levels of support, so a range is needed.

Suggestions that work include semi-independent models with high levels of support within small shared units, single flats supported by a mental health worker and housing support workers or wardens on site. Shared group homes work well with women who have experienced domestic violence while self-contained units are recommended for chaotic people with personality disorders. Smaller projects are thought to work best for people with mental health issues, with perhaps as few as six beds.

Consideration must be given to people with dual diagnosis, who, according to DrugScope, have a higher risk of violence, non-compliance with treatment, repeated hospital visits, imprisonment and HIV. “It is essential that more housing providers are capable of accommodating and meeting the needs of this vulnerable group of people,” it says. Many submitters say housing should allow alcohol.

Illustrations of Good Working

Brent Dual Diagnosis

This project follows a harm reduction model and encourages, but does not demand abstinence. Its two sites provide 24 hour support to 11 tenants, integrating a psychotherapist and a substance use worker into the in-house support team. The majority of tenants have a long history of substance dependency, and enduring mental health problems, with many having been hospitalised for long periods. The project creates a community that considers their needs beyond medication and housing. Notable outcomes achieved include reduced hospital admissions, increased client move on and significant reduction in overall costs.

Move-On

Many formerly homeless people, like the population as a whole, have ambitions to become a tenant of their own property and there is no good reason why this goal cannot be achieved for many. It should not be assumed people can’t maintain a tenancy because they have complex needs. Agencies should not be under-ambitious. There again, some submitters challenge whether everyone could or should live in their own flat. In these situations, “accommodation has to allow for interdependent lives, not necessarily independent lives.” Again a range of options are needed.

St Mungo’s ‘Nowhere to Go’ survey 2007 showed that 42% of its residents deemed ready to move on were suitable for independent living in local authority housing, housing association properties or via private landlords. Unfortunately, 70% had nowhere to move on to. The same survey showed that half its ‘move-on’ residents needed medium or high supported accommodation as a next step, but half of those had no accommodation available.
Commissioners need to accept that long term medium and high support may be needed, sometimes even permanently; as a result more suitable accommodation with clinical, therapeutic, occupational services is required.

A shortage of suitable move-on accommodation is evident. "Move-on is a perennial problem. Even when (relatively) stabilized with the use of psychological therapies, individuals may not have been able to move to more appropriate accommodation," says a clinical psychologist. "Finding appropriate move-on accommodation for St Mungo’s residents is one of the biggest problems we face," adds Charles Fraser.

Submitters want more options to supportively house people directly from prison to prevent them rough sleeping. Others say they experience difficulties in moving hostel dwellers into next step accommodation. There are specific shortages of small units, providing intensive support for those with serious mental health problems, which can be expensive and challenging to commission; units for women, drinkers, and for people with substance use who continue using. DrugScope says: "There is an obvious need for housing projects to adopt a harm reduction model that allows drug use but doesn’t encourage or condone it, promoting safe practice and encouraging abstinence at the service users’ own pace."

People with high support needs are forced to go into large hostel accommodation because of a shortage of suitable places. For example, submissions from Leicester and London say there has been increase in long term placement of people in hostels with serious mental illness due to shortfall in supported accommodation.

There are a handful of dissenting voices to the ‘shortage’ view. In Scotland, there appears to be enough, but one submitter adds ‘complexity of needs is still an issue, as the service may only address mental health issues and nothing else, making progress unsustainable.’ Westminster City Council says there is a ‘good amount’ of housing provision for people with mental health difficulties. Interestingly, Westminster has the highest number of rough sleepers in the UK.

This scarcity of provision is creating higher thresholds to access housing and mental health treatment, with assessment by local authorities and PCTs acting as de facto tool for exclusion.

Commissioners may be reluctant to fund high support housing because of the lack of evidence of cost benefit. One submitter suggested piloting augmented housing support for homeless individuals at risk of relapse/re-admission, then measuring this against local hospital bed days to see if savings can be re-distributed to provide continued funding for augmented housing support.
Projects such as the Brent Dual Diagnosis, which follows a harm reduction model, have successfully shown how integrated, supported housing for those with multiple needs can be cost effective.

The Brent project is supported by commissioners, but generally the current commissioning environment is pushing in the wrong direction. Scarcity of provision is creating higher thresholds to access housing and mental health treatment, with assessment currently used by local authorities as a tool for exclusion.

The same agency that provides the housing - the local authority - also makes the assessment. The CLG should consider whether assessments should be done by a separate agency, removing the perverse incentive to allocate resources according to the capacity of the provider, rather than need. Independent assessment of needs would protect vulnerable adults.

3.5 Therapeutic Environments

Traditionally, agencies in the voluntary sector have been in the forefront of service provision for homeless people, working with a simple model of housing provision, social rehabilitation and sometimes onsite specialist mental health support. This specialist support has been limited recently, with cuts in Supporting People.

Shelter says in its document A Long Way From Home – mental distress and long term homelessness that onsite specialist mental health support is vital. “Mental health and psychotherapeutic services are less accessible and less effective when delivered as standard outpatient services.”

The evidence shows it is time to move on – and that in order to truly benefit people with complex needs, the voluntary sector’s housing projects must offer therapeutic interventions, with staff skilled in responding to people who suffer from anxiety, stress, depression, psychotic conditions and personality disorders.

Recommendations:

- Homeless people need access to appropriate supported housing.
- Access to high support housing that addresses complex needs is a clear service gap that must be addressed.
- The CLG should consider tasking local authorities with obtaining independent assessment of needs for higher/longer term housing to support those that require long term support towards recovery.

Illustrations of Good Working

Training in Mental Health Awareness for Frontline Staff

All St Mungo’s frontline staff take part in training called an Introduction to Mental Health and Complex Trauma. This raises participants’ working knowledge of the main mental health disorders, their management and treatment options. They also gain insight into the impact of a traumatic experience on an individual’s mental health and emotional wellbeing, and learn to identify and devise strategies to support clients and staff when working with the impact of trauma.
Therapeutic environments are planned in a way that makes them deliberately designed to help people’s well-being, rather than simply being based on a medical model. “The challenge is how therapeutic such agencies are prepared to become,” Dr Phillip Timms says.

**Talking therapy** - A number of interventions are useful – family therapy, therapeutic communities, behaviour-contingency programmes, CBT, psychodynamic psychotherapy, 12 steps programmes and generic counselling in context of supported housing.\(^1\) Newer programmes include therapeutic housing PIPEs – psychologically informed planned environments - where people feel safe to ‘find themselves.’\(^2\) But even the Government admits there are difficulties in accessing these specialist therapies. The CLG writes “there is some difficulty in accessing DBT (dialectical behavioural therapy) MBCT (Mindfulness based cognitive therapy) and ACT (Acceptance and Commitment Therapy).”\(^3\)

The Government is committed to widening access to therapy; the Comprehensive Spending Review 2007 allocated £173 million in 2010/11 to the IAPT programme.\(^4\) Its practitioners generally do not have the training to work with homeless people or people with more complex needs, and the therapy programme specifically excludes people who use drugs and alcohol. “As funding becomes more localised, we have a chance to create a ‘son of IAPT’ which focuses on people with more complex needs,” says St Mungo’s Head of Programmes Peter Cackersell.

St Mungo’s has been a particular advocate of psychotherapy, establishing Lifeworks, a project offering access to psychological therapies to socially excluded adults, one of the Government’s ACE pilots.\(^4\) Employees praised the initiative in submissions. “The take up has been excellent … clients are keen to address the underlying issues that have contributed to their situation,” says one.

**Recommendation:**
- Another significant service gap that urgently needs addressing is homeless people’s poor access to talking therapies.

**Illustrations of Good Working**

**Lifeworks** highlighted by the Cabinet Office

Lifeworks is a unique project offering homeless people in four London boroughs access to psychotherapists able to work with a whole spectrum of conditions. Crucially, people are not excluded for using drugs or alcohol, or because of particular diagnoses (or the lack of them). Since January 2008, 63 per cent of referrals have taken up a place in therapy. Three quarters are achieving positive outcomes, including taking up employment or training, renewing contact with families or having drug or alcohol treatment. The CLG praises the model for allowing for relapse and challenging behaviour, which can help reduce returns to the street.\(^4\)
Chapter 4

The Recovery Journey

The ‘Recovery Approach’ is an ethos first used to help patients in mental health services but has now been adopted in the homeless sector by St Mungo’s as the theory underpinning its work. It follows the principle that change in even the most damaged people is possible, and that everyone can aspire to transform their lives, and indeed can succeed.

This approach should be reflected in commissioning decisions; in how and where people live, in activities and training provided for them and in their attempts to find paid employment. Clients should be fully involved in decisions made about their own care plans and pathway, and be included in discussions on how care should be commissioned and delivered more widely. Having peer advocates and champions is extremely helpful. St Mungo’s believes the approach should be embedded across the sector, with all agencies employing this best practice.

4.1 Commissioning

It is misguided to believe that entrenched homeless people with complex mental health problems will never be able to change and improve their lives. St Mungo’s Peter Cockersell, an experienced psychotherapist, says: “People can and do ‘turn their lives around.’ This fundamental change in oneself is what we mean by recovery; the client becomes able to take charge of their own life in a mature way. They develop or regain the capacity to act in a socially appropriate and effective manner, to behave in a way that does not harm others and enables them to meet their own needs and to derive satisfaction, pleasure and happiness as a result of their achievements.”

This ‘Recovery Approach’ has won growing acceptance and indeed praise, and a commitment to it is usually a requirement when commissioning mental health services. St Mungo’s believes the same approach should apply when commissioning supported housing services too.

Commissioners should not specify inputs, such as the number of hours staff work, what sort must be employed, what forms must be filled in, how much time should be face-to-face, what types of intervention should be used, where they should take place. Nor should clients’ recovery be based on a medical model.

Instead commissioners should seek recovery-oriented outcomes, such as people directing their own care/life plan, entering socially valued occupation, regaining positive relationships, improving wellbeing and social functioning, and increasing satisfaction with life. This may involve psychotherapy, exercise, training and employment support and other holistic skills. St Mungo’s believes that if commissioners were to set outcomes like these, it would transform homeless people’s mental healthcare.
The programmes St Mungo’s has pioneered from pilot and charitable money now need stable funding. They should be taken on board by commissioners and embedded across the sector by other agencies: they have demonstrated that they can work with even the most damaged. St Mungo’s recommends recovery training for all mental health commissioners as part of the development of world-class commissioning.

### Recommendations:

- When designing services, commissioners and providers should specify the recovery-orientated outcomes the service should seek.
- Homeless service providers should fully adopt the principles of the recovery model, to ensure they are delivering the best possible help to their clients.

### Illustrations of Good Working

**Barnsbury Rd**

St Mungo’s Barnsbury Road in north London has a very good record of retaining clients and working with them towards successful move on. It has a successful Independent Living Programme providing structured activity with three different components – citizenship, food for health and wellbeing, and museum studies. Residents sign a Rehabilitation Contract on moving in, which requires them to be engaged in meaningful occupation two days a week. This is flexibly enforced, and there is an understanding that some clients are not ready for formal activity, and are not ready to be rehabilitated, but just need a place to be for a while.

### 4.2 Activity

For many homeless people with mental health difficulties, boredom is an issue, but paid employment is far from their grasp. Many turn to drugs or alcohol to fill time, but this gap can be better plugged by voluntary or social activity, which can give them purpose and friendships. It can also be a stepping stone to training and work down the line.

Indeed, socially valued occupation and activities are vital in the recovery journey, by increasing confidence, and self-esteem, building relationships and improving mental health. Suggested activities include art therapy, woodwork, Tai Chi, cooking, cleaning, helping run reception, minor repairs, and redecorating where they live. Sports, music, volunteering, working with animals, acting as mentors and selling the Big Issue are also mentioned.

Former service user and client champion Martyn Warr told the St Mungo’s Parliamentary Committee hearing about the Putting Down Roots programme. For £10 a day, homeless people do gardening work, planting up unkempt roundabouts. “People are engaged, they are doing a day’s work and they can’t drink with a spade in their hand,” he says. “They are tired at night, they feel they have done something, gained a feeling of empowerment. It’s beautiful and it’s highly addictive...who needs drugs when you have a trowel?”

But these types of activities are not universally provided. Service user Marsha Harlowe says: “I have found it hard to get information, you have to look hard for it.”

A difficulty for the voluntary sector is that there are no clear funding routes for ‘lower level’ activities such as gardening. Doug Musgrove, a former volunteer co-ordinator with St Mungo’s, argues that without activities, the progress made by health and support services may be reversed and high costs incurred – so any funding for activity would actually save the Treasury money long-term.
Mr Musgrove says: “*Clients arriving in the hostel progressed well as they were linked into mental health services, GP services and the support which key worker and staff were able to give. However, with no progress and opportunity in work, and very limited activity provision, a significant number would regress into isolation. All the good work achieved with them was lost. Sometimes the situation ended in a section with the client going into hospital. A robust activity ‘work’ provision is essential to give the client life purpose and interest.*”

David, now Lord Freud’s 2007 report *Reducing Dependency, Increasing Opportunity*, was cited as backing up the argument about cost-effectiveness, suggesting the government should fund more money for programmes that work with the furthest from the employment market. He argues this would also have benefits for the Treasury in the long run.

Benefits continue to be a major obstacle to people finding socially valued occupation; Jobseeker’s Allowance can be taken away if a claimant is not available to seek work, so any regular occupation could be counter-productive, although a certain amount of voluntary work is allowed. Regular voluntary working can also be considered to invalidate claims for incapacity and sickness benefit. The benefits system should not discourage activities being carried out.

### Recommendation:

- Socially valued occupation and activity should form part of all care plans and have a clear funding route, recognising them as a vital part of the recovery process and a key process towards employability.

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### Illustrations of Good Working

**Crisis Skylight Centres** highlighted by Crisis

Homeless people in east London and Newcastle have the opportunity to build on existing skills and learn new ones, regaining self-esteem and confidence at two Skylight Centres. Both are integrated and vibrant as they are open to the public. Workshops include art, woodwork, Tai Chi, and gardening. Crisis Skylight Cafes provide routes into work with structured training leading to recognised qualifications in food hygiene, customer care and health and safety. Crisis Changing Lives financial awards scheme awards applicants grants of up to £2,000 to access training, buy tools and equipment, help set up businesses, mentor and monitor results.

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### 4.3 Training

A small follow-up study of Broadway clients who had been successfully resettled found 80 per cent were in work, training, or doing voluntary activity (or a combination) and that half of them rated work or college as one of the best things in their lives.

Although these results are unusual, they show success can be achieved. Generally, however, people with mental health problems are still less likely to be in training than any other group of disabled people.

The evidence reveals many positive examples of good practice, with courses on offer leading to vocational qualifications, including computer skills, job skills, literacy, food hygiene, customer care, health and safety, music production and ear piercing courses. The problem does not appear to be paucity of ideas, rather scale of delivery.
There are two major complaints: the ‘very limited’ number of training, apprenticeships and work related activities on offer, in fact a ‘miserable dearth of occupation and activities’ and the lack of flexibility in offering these courses to people whose lives are still sometimes chaotic. As a result, there are calls for more opportunities and training, and better access to existing schemes.

Submitters find drop-in taster sessions more suitable than regimented schemes, or sessions gradually stepped up over time, such as Ready For Work, run by London Business Action on Homelessness. Trainers have to expect high dropout rates, with people dipping in and out. A positive outcome such as a qualification or certificate can increase the chances of participants finishing the course.

Crisis agrees there is not enough vocational training. Its ‘Changing Lives’ financial awards scheme gives successful applicants grants of up to £2,000 to access training, buy tools and equipment, help set up businesses, mentor and monitor results. “We have seen the remarkable effect that engaging people in creative and educational activities can have on their wellbeing and outlook on life. We believe these services should be more widely available across all areas of the country in addition to clinical mental health interventions.”

St Mungo’s Pathways to Employment, is an intensive, hostel based programme preparing hostel residents for work and learning. This comes out of charitable fundraising income that most organisations do not enjoy, and there is no government funding route, making it unrealistic for most voluntary agencies.

Closer towards the job market, more formal employment support programmes aimed at getting vulnerable adults ready to go to work by developing vocational and practical skills are vital. The problem is that these do not take into account the length of time or distance from the labour market of clients – and so become prohibitive to run, as providers are only paid for those who do get jobs and at a standard rate.

St Mungo’s thinks this is a new variation on the ‘inverse care law’ – at the moment, the further from the job market someone is, the less support the Government funds. This should be the other way round, and the most intensive support should be given to those who have to make the longest journey to achieve employment, such as people with mental health problems.

Commissioning structures should not just focus on getting a job as an outcome, as the current ‘payment by results’ and ‘one-size-fits-all’ approach does.

Recommendation:
• Specialist commissioning is required for back-to-work and activity schemes that meet the specific needs of former rough sleepers and single homeless people in recovery from mental health problems.

Illustrations of Good Working
Pathways to Employment highlighted by St Mungo’s

This intensive, onsite programme prepares hostel residents for work and learning at varying stages of recovery. Residents determine what skills they already have with their key worker as part of an ‘occupational health check’, write their own Pathways to Employment plan, detailing their aspirations and the steps they need to take to become ready for work. The client then receives regular support from a coaching specialist, who helps to break down the plan into manageable stages and provides encouragement and advice. Basic and key skills training are provided on site, five days a week. Finally, residents are helped to look for a job.
4.4 Work

In one of the Government’s submissions to the Call for Evidence, it says it wishes to extend the ‘expectation and aspiration’ of a job to excluded people, for whom working seems out of reach.237

People with mental health problems, a history of homelessness, substance dependence and offending, with perhaps low literacy and no recent work record, not surprisingly find it challenging to get jobs. 90% of St Mungo’s clients are not working, and 53% have not worked for more than five years.238

Homeless agency staff and clients themselves can have low expectations of the chances of paid working. One submitter singles out the psychiatric profession for criticism because they consider the goal of employment for their patients as a ‘dream’.239

But 62% of St Mungo’s clients say they would like to start work either now or at some point in the future. Currently, only 4% are doing paid work (full or part-time, or casual work) and a further 4% are doing voluntary work.

Practical issues include a lack of funds for going to interviews, lack of appropriate clothes, not having a correspondence address, CV gaps and the law obliging people to disclose their mental health diagnosis.240 Loss of housing and other benefits if successful is a problem.241

Stigma and prejudice from the world of work was frequently noted, with calls for bosses and the general population to be educated about the issues by ministers or other business leaders.242 Margaret Williams, a homelessness co-ordinator, writes: “There needs to be an acknowledgement that everyone has a part to play and mental health problems can and do affect us all.”243

A change in employment law is suggested to help people who were not necessarily effective profit makers have a place in the workplace and felt able to have a sense of dignity244 and giving employers greater funding and support if they take clients on.245

The BASW says well known businessmen should stand up and call for recovering drug addicts to be taken on and given a chance. John Varley, group chief executive of Barclays, who recently talked publically of the benefits to companies of taking on people previously homeless, and how mentoring, job coaching and training could help, is praised.

The St Mungo’s Parliamentary Committee heard about schemes such as the Mindful Employer, a voluntary, informal network of 525 employers and support organisations which encourages good practice in ensuring that employees and job applicants who declare mental health issues receive the right level of support.

More work experience placements co-ordinated by an agency would be a step forward.246 One submitter argues the priority should be getting people into work, then giving them support and on the job training once they are there - the ‘Place then train’ idea, using Individual Placement and Support schemes.247
4.5 Participation and Advocacy

Co-production is a model of practice in social care where a working partnership is developed between provider and service user. The Social Care Institute for Excellence describes it is ‘an active input by the people who use services as well as - or instead of - those who have traditionally provided them.’ This is effective in engaging groups where trust is an issue, as it is with many homeless people.

Many submitters make the point that clients should be involved in running their lives, their homes and their care/support plans to aid recovery. Their pride in their progress can be shared openly by using the Outcomes Star approach.

Further engagement could include drawing up their own crisis intervention plans, and giving clear indicators of when to act and a clear route for appropriate interventions. This is a positive, person-centred idea that support services can encourage.

Clients may want to help run projects and assist other users, acting as mentors or befrienders.

Successful schemes include Anti-Alc in Brighton, a user-led user involvement group which represents rough sleepers and dependent drinkers to the local authority and health trust, and the YMCA hostel in London for men aged 16-25 which offers mentors (who have previously been homeless) to new residents for the first few weeks of them arriving.

St Mungo’s applauds the DH Health Trainers scheme and looks forward to ex-rough sleepers and people with complex needs being trained in providing support and motivation to other clients to help them improve their health.

Recommendation:

- Homeless agencies, in accordance with the recovery approach, should enable the user experience to enhance their service provision and staff teams.

Illustrations of Good Working

Outcomes Star

The Outcomes Star – development of which was led by St Mungo’s - enables clients to work with their key worker to assess ‘soft’ outcomes, such as improvements in life skills, health and personal responsibility. It helps clients to feel they are moving onwards and upwards. It is now the leading outcome measurement tool in the homelessness sector and is also being adopted for use with other client groups. Central Government and an increasing number of London Local Authorities have also shown an interest in the Outcomes Star and now see the use of a ‘distance-travelled’ outcomes tool such as the Star as good practice.
4.6 Engagement

Former rough sleepers find it very hard to trust anyone but particularly strangers. These are people accustomed to broken relationships and loss. Many clients, especially those with personality disorders, have heightened sensitivity to people who affront them, born of years of being the objects of fear and contempt. They are quick to spot disdain by professionals supposedly there to help them; they usually respond by walking away, or not coming back.253

This is why frontline staff need to be flexible, tolerant, sensitive, responsive and non-judgemental, able to build up stable and consistent relationships, foster a sense of safety and an ability to progress in an effort to engage clients long term.

Commissioners need to engage homeless people with mental health problems too. Too often, services meet the needs of policy makers, commissioners and providers who frequently just need to prove they have ticked the right boxes, irrespective of whether the services have been designed to meet the needs of this population.254

Service users should have an active and participative role in service planning and delivery, with this integrated into commissioning more comprehensively. They should be included in discussions about the design of services at the outset, as well as asked for feedback afterwards.255 Rather than simply giving them a voice, they should be listened to.256

Survivors of the system should become champions and advocates for their peers,257 representing them on decision making bodies, with support provided where necessary for them to fulfil their representative roles.258

Nigel Fyles, from Manchester Drugs Service, says: “They should be involved in every step of the process of service commissioning, design and delivery, the monitoring process and what the outcomes should be...Until we put service users and their needs at the head of policy, we will not make any significant change.”

Recommendation:
• When designing services, commissioners and providers should routinely and explicitly address how to include excluded groups who are not engaging with services - by actively listening, early on, to potential clients.
Chapter 5
The Way Ahead: Making it Happen

The evidence shows that local authorities, PCTs and central Government are guilty of silo thinking and are still not working together effectively. As a result, homeless people with complex needs are on the streets. This lack of joined-up working is exacerbated by a lack of central leadership and a proposed new mental health strategy which does not mention homelessness.

The Government needs to concentrate on what worked in the past, such as the HMII, and look at innovative ways of working, such as the Scottish approach which has established a right to shelter.

These could include the proper provision of wraparound care. The Personalisation Agenda could be a great opportunity to offer people care and support when and where they need it, not at times and speeds suited to the commissioners.

Finally, there is a consensus amongst those on the ground on what works for this population group, but a lack of researched evidence. A strong evidence base is vital to persuade policy makers that approaches such as Recovery, no requirement for abstinence for mental health treatment, and client involvement not only work, but should be embedded.

5.1 Governance

Leadership from the centre

Lack of central vision, direction and leadership was a recurring theme in the evidence, with a significant proportion arguing for central government to produce some kind of national policy, standards or strategy on health and homelessness. This could include setting levels and access to care, and monitoring care improvements for homeless people.

A DrugScope internal briefing, submitted as evidence, says: “The failure to make sufficient progress on co-morbidity and complex need, both locally and nationally, is strongly suggestive of a lack of leadership, and some basic flaws and fissures in co-ordinating mechanisms and partnerships. There is plenty of good practice out there, but it is localised and dependent on local leadership.”

Central Government is criticised for not pushing prevention. “It is much harder to get off the streets than to avoid being there,” says the BASW. “Earlier intervention...will only come if central Government pushes it and agencies, including voluntary organisations, work together with service user organizations.”

The provision of psychological services should be directed by central Government but commissioned by local government, says another.

The Department of Health did produce, with the CLG, a good practice guide called Getting Through – Access to Mental Health Services for people who are homeless or living in temporary accommodation, in 2007; only three submitters mentioned it. One of them, Leicester’s Homeless Mental Health Service, has made spectacular progress, reducing its rough sleepers with mental health difficulties to just seven percent, with all of those in short term accommodation.
Rather than a good practice guide that is too easily put to one side, St Mungo’s believes the Government should issue national standards for homelessness and mental health, with strategic direction from the Department of Health. This would ensure clear criteria and expectations that all agencies with different responsibilities, such as PCTs and local authorities, should meet and work together.

These standards would need to be inclusive, not couched with criteria that serve to exclude. In other words, there should be a duty to respond to the needs of homeless people experiencing mental distress, not just for those who meet a distinct diagnosis.

5.2 What worked, and where

Homeless Mentally Ill Initiative

This initiative, which began in the 1990s, was initially based around four teams in London and was later extended to some other cities, with ring-fenced funding. Its promotion of the best of psychiatry, integrated health and housing, and community mental health teams working on the streets was successful and ‘significant’.

The specialist funding no longer exists, but some of the services continue, paid for out of mainstream budgets. However this diluted its success. “The removal of the money has resulted in services having to reduce their capacity, make workers redundant and thereby decreasing their ability to provide service for homeless people with mental health problems,” says Becky Sayer, from a Mental Health Support Team in Nottingham. Charles Fraser told the St Mungo’s Parliamentary Committee oral hearing that after 1991, the HMII ‘fragmented’ very quickly.

The HMII model - and successive initiatives such as the Care Services Improvement Partnership - should be reviewed to ensure that the needs of those homeless people with severe psychiatric illnesses are being met. It should be examined to see if it can be developed to include those who do not meet the diagnostic criteria of psychiatric illness, but rather the wider spectrum of mental distress.

Recommendation:

• The lessons of successes such as the collaboration between health and housing of the HMII should be revisited.

New Horizons

The Department of Health’s submission says it has a new approach to the mental health of the whole population, while still supporting the continuous transformation of specialist services, and addressing inequalities, including those affecting homeless people.

But the New Horizons consultation document does not recognise that mental health services are part of the exclusion process, nor does it specifically look at tackling mental health and homelessness (as it does with, e.g. offenders, ethnic minorities or the elderly).

As the draft document does not recognise the needs of homeless people, and how mental health services’ structure and way of working contribute to their exclusion, St Mungo’s does not see how it will help to tackle the problems of mental health and homelessness.

Recommendation:

• The Government should issue national standards for addressing mental health amongst homeless people.

• The New Horizons Strategy must explicitly recognise the needs of rough sleepers as a group which faces extreme exclusion, setting targets for such people with multiple needs.
Learning from Scotland

Scotland has adopted a problem-solving, inclusive approach to health and homelessness, and has acknowledged, and acted on, the link between the two.

Before 2003, Scotland, like England and Wales, had a duty to provide accommodation to people assessed as being unintentionally homeless and in priority need. But ‘intentionality’ works against people with a mental illness where their behaviour has been chaotic, unpredictable or antisocial. In such cases the safety net is actually withdrawn.268

In 2003, Scotland introduced legislation to give every homeless person a home and eliminate the idea of ‘priority need’ by 2012.269 This in effect ended the concept of ‘intentional homelessness’ and established a ‘right to shelter’. It also abolished Local Connection rules, so applications for housing were no longer referred back to the applicant’s previous home area.

These changes follow recommendations made by the Homelessness Task Force, a group set up in 1999 drawn from the voluntary sector, the local authority, registered social landlords, the Scottish Executive and Westminster government departments and agencies and academics.

The taskforce and the legislation ‘have improved the rights of the homeless, by seeing the issue as multi-faceted and this approach is embedded in legislation and policy’270 approves one submitter.

However, abolishing priority need by 2012 relies on there being enough affordable housing available, which is subject to mixed opinion. One submission makes it clear that there is evidence of an increase in rough sleeping recently in Glasgow due to difficulties in accessing emergency accommodation. Voluntary sector providers and service users report that people are being turned away by statutory services regardless of their new ‘rights’.271 Scottish legislation, changes to intentionality, locality, and priority need, the right to shelter and the homelessness task force should be considered as a potential benchmark by Westminster.

Social Exclusion

There are 30 Public Service Agreements aimed at reducing social exclusion amongst the most vulnerable adults. PSA 16 concerns access to, and maintenance of, settled accommodation and employment for four groups considered to be at risk of social exclusion.

These groups include adults in contact with secondary mental health, care leavers age 19, offenders under probation services and adults with learning disabilities known to councils.

Extraordinarily, single homeless people are not included. As the coalition group Making Every Adult Matter points out, PSA 16 is welcome but it fails to cover a core of people with multiple needs, such as homeless people with mental health problems.272

When the PSAs are reviewed in 2010, a social exclusion PSA is needed that covers homeless people with multiple needs, including those with mental health issues who are not in touch with secondary mental health services.273 This would be a valuable mechanism against which measurable targets could be set. This is an issue that affects most policy areas, has a high cost in cross-service budgets and is a root cause of a lot of social problems.

Recommendation:

- The Public Service Agreement 16 framework should be reviewed and to include people with complex needs, such as homeless people.

This will require an indicator of multiplicity of need.

5.3 Commissioning

Time Pressure and Personalisation

The Government’s ‘Personalisation Agenda’ promises that “every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings.”274 For homeless people with mental health problems, where a constant theme is ‘one size does not fit all,’ this choice and control could be extremely beneficial and is welcomed by contributors.275
A personal tailored package of support is important for people with complex needs. Support needs to last for a time period that suits their recovery, not that suits funding requirements. This time period can be extremely varied. Submitters disagree about the optimum length, but several say ‘the longer people stay in treatment, the longer the effects.’ One thought 10 year projects were needed for some vulnerable people.

But funding is often time limited and progress is often lost because of anxiety derived from pressure to move on, or because of a treatment ending prematurely because commissioners do not appreciate complex need.

Individualised budgets may be a way forward. Two ongoing pilots will hopefully provide a good evidence base for personalised support for homeless people, one in the City of London Corporation and another at the Coventry Road project in Newham, which is for adults with mental health problems who have experienced homelessness.

It is acknowledged that applying the Agenda will be challenging. One factor that does not sit easily with commissioners is there is no guarantee of universal success with the individuals in these projects. Commissioners like easily measurable, ‘hard’ outcomes, such as giving up drugs, but this are not always realistic for these clients, even when progress has been made. Outcomes must be personalised and devised in line with recovery and the patient/ client’s aspirations, and may often be ‘soft’ rather than ‘hard’.

Rather than dictating details on projects, commissioners should work with providers and service users to jointly define successful outcomes. Recovery should be seen as the goal, and client aspirations should drive targets rather than funding time limits or outputs. A client-centred practice requires much greater flexibility and for decisions to be taken on the basis of individual need.

**Wraparound care and working together**

‘Wraparound care,’ which meets the health, social and housing needs of individuals in a holistic way, is described as the best model to achieve successful outcomes for this group. But current commissioning structures, separate budgets for different services, and ‘silo thinking’ are a barrier to providing wrap around services.

Different funding streams lead to debate as to what constitutes care, support and treatment. This lack of agreement can make funding services very complicated, with organisations having to apply for multiple funding streams to continue providing a service. The streams come with different targets and monitoring expectations, which can place added pressure particularly on smaller organisations.

There is also rivalry and a tradition of working separately, particularly between the voluntary and statutory sector. As a snapshot example, Centrepoint reports a reluctance of mental health services to include housing workers in multi-disciplinary meetings, even though they are therapeutically trained.

To solve this, boundaries between care, support and treatment should be relaxed, with services from different sectors joining up and professionals from different disciplines working together, funding should be pooled, rather than fought over.

PCTs should co-commission with other agencies, such as Supporting People and Adult Social Care, to offer a holistic service. The de-ring fencing of SP funding may allow organisations to be more creative. The Government’s new ‘Total Place’ pilots will hopefully move this forward. IT systems need to be improved to enable this integration.

Smaller steps could be taken too. This report earlier suggested mental health services should be based in primary care; physical health should also be represented in mental health services too. There is no reason why a nurse should not offer routine screening for common physical problems of homeless people e.g. incontinence, diabetes in a mental health setting.

The CLG is an important player which agrees with integration. Its submission says: “Where there are high levels of complex need, primary care, social care and welfare and advice services should integrate and co-locate to provide a coherent service for chaotic and excluded people...the

**Recommendation:**
- Homeless people need access to appropriate support and treatment based on their need, rather than a commissioning requirement based on speed.

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*St Mungo’s Call 4 Evidence Report*
development of primary care models that include physical, psychological and social care help homeless people navigate services more easily and encourage engagement.”

A 2005 report from the Royal College of Psychiatrists noted that “areas with high rates of homelessness should appoint a lead clinician to ensure continuity of care across models and service boundaries.” This should be implemented, in conjunction with the appointment of a lead commissioner with an understanding of health/complexity to co-ordinate services. A five year homeless review, involving LAs, PCTs and the voluntary sector, to review the services on offer and to formulate such plans, should be introduced.

5.4 The Knowledge Gap

Responses to the Call for Evidence have been remarkably consistent in their analysis of the problems for this client group – lack of a diagnosis, a lack of treatment options for people using alcohol and drugs, and a lack of understanding of complex needs – and who is at risk – those with family breakdown, early childhood trauma, those who are dependent on substances, or who have been in some form of institutional care and lack life skills.

There is also a remarkable degree of consensus on what approaches work: - more inclusive definition of mental illness, changes in mental health treatment options, more therapeutically-oriented accommodation projects, more dual diagnosis services that offer treatment to people’s mental distress at the same time as or before drug/alcohol treatment, intensive support, tenancy sustainment, better discharge, long term supported housing, floating mental health support and better outreach, with the client treated as an individual and placed at the heart of every decision. Academic and clinical research on these agreed approaches is, however, woefully absent.

What is missing is researched solutions which focus on the issues this evidence raises – what actually works to help homeless people with mental health issues, what are the effective services, and why?

The evidence base needs to be broadened and the ‘knowledge gap’ on what services and treatments are most effective for people experiencing homelessness and mental health problems, needs to be plugged.

The DWP acknowledges the “need to identify if/how poor mental health triggers homelessness, and how the experience of homelessness worsens mental health. This could help to identify where/when resources be most cost effectively deployed.”

“We need a major investment in a research and policy initiative, targeting dual diagnosis and complex needs,” says DrugScope. Other topics to explore include psychological causes and maintenance factors in homelessness, the prevalence of mental disorders and the effectiveness of services.

When doing so, it must be remembered that classic research and data collection tends to exclude homeless people as they are hard to engage in a traditional way. Client-centred evidence is still disregarded in favour of randomized clinical trials and peer reviewed academic papers. These are both arguably mechanisms of exclusion, as relevant evidence is not produced.

Pilot services should be funded centrally in tandem with an academic and clinical research programme, backed up by better collection of data across the sector. “This would be an international first, and create significant knock-on benefits for both the academic institutions and clinical practice, and would be a true example of world-class commissioning.”

In terms of collecting data, there are some improvements. Homeless Link is undertaking a new project, supported by the Department of Health, to develop an audit tool to better evidence the health needs - physical and mental - of the homeless population by borough. Also, the new national indicators on mental health mean that housing status will now be collected, and reports on delayed discharge from hospital will acknowledge issues around the availability of supported housing.

Recommendation:

- The Department of Health should instigate academic, health economics and clinical research, based on comprehensive data collections, on successful services for homelessness and mental health.
Conclusion

On reading the individual responses of the Call for Evidence, one is struck by the empathy shown by many professionals working in this difficult field of homelessness and mental health, by their determination to do right by the vulnerable people they are working with, and by their frustration when they are not able to do so.

Complex needs require a holistic and determined response, but these workers on the ground know that helping even the most damaged off the streets and into health treatment and supported homes is possible.

They have solutions, they know what works; these initiatives might not be in a peer reviewed journal, but they exist. Indeed, good practice is in evidence in patches all around the country. Yet this is not being consistently integrated into commissioning decisions and government thinking.

St Mungo’s believes this Call for Evidence shows that some straightforward actions would transform the treatment of homeless people with mental health problems and prevent new arrivals to the streets – which may help the Government reach its 2012 target:

- the Government needs to act decisively to ensure nobody with a mental illness sleeps rough
- the Department of Health needs to show leadership and recognition of the extent to which its service problems lead to, and fail to help people away from, rough sleeping
- commissioners should routinely and explicitly address how to include excluded groups such as rough sleepers
- specialist commissioning is also required

The evidence clearly calls for central leadership and vision – and St Mungo’s believes the main responsibility for moving things forward now lies with the Department of Health, not CLG. The DH, with a minister directly responsible for homelessness, should lead the co-ordination of other relevant Departments and ensure an integrated strategy from the centre. With urgent action, the Government’s planned reduction of rough sleepers to zero by 2012 could still be achieved; without it, the plan will remain a pipedream.
**St Mungo’s Key Recommendations**

The Government:

1. **Government needs to act decisively to ensure nobody with a mental illness sleeps rough:**
   - The Government should issue national standards for addressing mental health amongst homeless people – recognising the full breadth of mental health problems faced by homeless people.
   - There should be direct ministerial responsibility for health and homelessness within the Department of Health.
   - The Public Sector Agreement 16 framework should be reviewed, and extended to include people with complex needs such as homeless people.

Department of Health:

2. **The Department of Health needs to show leadership and recognition of the extent to which its service problems lead to, and fail to help people away from, rough sleeping:**
   - The New Horizons mental health strategy must explicitly recognise the needs of rough sleepers as a group which face extreme exclusion, setting targets for such people with multiple needs.
   - The DH should recognise that many people with lower and moderate mental health problems do not currently receive an effective service from mental health services and that this needs tackling. Mental health problems escalate and some people end up in hostels and prisons.
   - The DH should lead co-ordination of effective (safety net) provision for the health of rough sleepers – with mental health provision within rough sleeper day centres and hostels, and sufficient acute hospital admission.
   - The DH should lead a cross departmental initiative – bringing health, housing and work together – which audits and addresses service gaps. (Lessons of successes such as the collaboration between housing and health of the Homeless Mentally Ill Initiative can be revisited.)
   - The DH should instigate academic, health economic and clinical research, based on comprehensive data collections, on successful service models for homelessness and mental health.
Local commissioners – local authorities, PCTs, etc:

3. When designing services, commissioners (and providers) should routinely and explicitly address how to include excluded groups who are not engaging with services and specify the recovery-orientated outcomes the service should seek:

- Integrated commissioning is vital - mental health treatment must never exclude people who take drugs or alcohol – dual diagnosis is common, and in homelessness is the norm.

- Commissioners and service providers would benefit from an indicator of multiplicity of need – so that multiply vulnerable people do not fall below individual service thresholds.

- Gaps in services must be addressed - homeless people need access to talking therapies and appropriate supported housing (in particular better access to high support housing addressing complex needs) and adequate hospital provision. Service provision should be based on need not speed.

- People with mental health problems should receive well supported sign-posting - towards housing and mental health services - from their GP/mental health or housing contacts. Mental health, health and housing workers all need training that supports this awareness and knowledge set.

4. Specialist commissioning is required:

- For back to work and activity schemes that meet the specific needs of former rough sleepers and single homeless people in recovery from mental health problems.

- We need direct recognition in local and national strategies and commissioning of the high incidence of personality disorder amongst rough sleepers and single homeless people.
CLG:
- The CLG should consider tasking local authorities with getting independent assessment of needs for higher/longer term housing to support those that require long term support towards recovery.

Homeless services providers:
- Should fully adopt the principles of the recovery model, to ensure they are delivering the best possible help to their clients.
Contributors

Written Submissions

3 Boroughs Homeless Team
Barbara Jane Rosnay Burke
BASW (British Association of Social Workers)
Beacon House
Brighton and Hove City Council
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Cambridgeshire and Peterborough NHS Foundation Trust
Camden and Islington Mental Health Foundation Trust
Cathedral Area Residents Group
Centrepoint
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City of London
Communities and Local Government
Clinks
Cornwall Health for Homeless
Cornwall Partnership NHS Trust
Counted In
Cricklewood Homeless Concern (CHC)
Off the Streets and into Work (OSW)
Crisis
Department Health, Southeast Region
Department of Health
DrugScope
Department of Work and Pensions
East London Housing Partnership
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Homeless Link
Homeless Psychology Service
IMPACT Training & Consultation Ltd
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London Borough of Hackney
Look Ahead
Making Every Adult Matter (MEAM)
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National Housing Federation
NSPCC
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Queen’s Nursing Institute
Revolving Doors Agency
Royal College of Psychiatrists
Royal College Psychiatrists WIPSIG (Women in Psychiatry Special Interest Group)
Sainsbury Centre for Mental Health
Salvation Army
Scottish Association for Mental Health
Sheffield City Council
Shelter
South London & Maudsley NHS Foundation Trust
Southampton University
St Anne’s Community Services
St Mungo’s
St Mungo’s managers – Managers Away Day
St Mungo’s clients - Happiness Matters peer research
START Team
Stonewall Housing
Thames Reach
The Connection, St Martin’s in the Field
The Mental Health Foundation
The Royal British Legion
Tom Gifford Project Manager, St Mungo’s Islington Mental Health Projects
TORFAEN YOUNG PEOPLES SUPPORT SERVICE
Turning Point, Hertsreach
Wayside Day Centre, Glasgow
Westminster City Council
Westminster Primary Care Trust
Wintercomfort for the Homeless
Worthing Churches Homeless Projects
Youth Access

Oral Evidence

St Mungo’s Parliamentary Committee

Dr Doug Naysmith MP, Health Select Committee Member
Sandra Gidley MP, Liberal Democrat Health Spokesperson
Charles Fraser CBE, Chief Executive, St Mungo’s
Linda Seymour, Head of Policy, Sainsbury’s Centre for Mental Health
Martyn Warr, Member of Outside In and Researcher for St Mungo’s ‘Happiness Matters’ report
Paul Plant, Director for Public Health, Department of Health
Rex Haigh, Clinical Advisor to the Personality Disorder Unit, Department of Health
Steve Shrubb, Director of the Mental Health Network, NHS Confederation
Dr Phil Timms, Consultation Psychiatrist, South London NHS Trust
Dr Nick Maguire, Deputy Director Cognitive Behaviour Therapy, Southampton University
Gary Lashko, Chief Executive, Cam-Gomm and Chair, Revolving Doors Agency

Outside In Focus Group Session
Footnotes

3 'Street to Home' annual report 2008/9, produced by Broadway. CHAIN annual figures show the number of people rough sleeping in London rose by 455 to 3,472 between April 2008 and March 2009
5 Making Every Adult Matter – a coalition of Mind, Clinks, DrugScope and Homeless Link; Broadway Support Needs data on Chain 2009
6 St Mungo’s Health Strategy for Homeless People 2008-2011
7 St Mungo’s Client Needs Survey 2009
8 Westminster PCT
9 Department of Health Inequalities Unit.
10 City of London Corporation
11 Dr Nick Maguire, clinical psychologist, deputy director postgraduate diploma in CBT, University of Southampton
12 Mental Health Support Team for Homeless People, (MHST) Nottingham.
13 Jane Cook, specialist public health advisor; Health Improvement Team and Health and Homeless Initiative
14 Sheffield City Council Housing Solutions Service; MHSTHP.
15 Women in Psychiatry Special Interest Group; St Mungo’s
16 Turning Point
17 Centrepoint
18 Sheffield City Council Housing Solutions Service
19 Connection at St Martin’s
20 ‘Street to Home’ quarterly report for London 1 January - 31 March 2009 Chain/Broadway. There were a total of 499 new people of whom 96 (19 per cent) were from the A8 countries - Poland, Lithuania, Estonia, Latvia, Slovenia, Slovakia, Hungary, Czech Republic – and so not in included in above statement referring to statutory protection
21 Centrepoint
22 Wayside Day Centre
23 Cricklewood Homeless Concern/Off the Streets and Into Work
24 Outside In focus group
25 IMPACT Training
26 St Mungo’s Managers’ Away Day
27 Sheffield City Council Housing Solutions Service
28 St Mungo’s
29 3 Boroughs Homeless Team
30 St Mungo’s
31 Centrepoint; SCMH; Mental Health Foundation
32 St Mungo’s
33 Wayside Day Centre; St Mungo’s
34 Jane Cook; specialist public health advisor; Health Improvement Team and Health and Homeless Initiative Hastings and Rother PCT; Queen’s Nursing Institute (Kate Tansley)
35 St Mungo’s
36 Julian Housing
37 DrugScope
38 Homeless Link
39 St Mungo’s Client Needs Survey 2009
40 Sheffield City Council Housing Solutions; Happiness Matters Report 2008; Martyn Warr; St Mungo's former client and Outside In member, witness in the oral evidence session held by St Mungo’s Parliamentary Committee

41 Wayside Day Centre
42 Happiness Matters Report 2009
43 Crisis
44 St Mungo’s
45 Happiness Matters report 2009
46 Happiness Matters report 2009
47 High Street Surgery, Swansea; St Mungo’s
48 3 Boroughs Homeless team; Manchester Drug Service; Cornwall Health for Homeless; Scottish Association for Mental Health; Brighton & Hove City Council
49 St Mungo’s
50 DrugScope; 3 Boroughs Homeless Team; SAMH; Sheffield City Council Housing Solutions; Counted In; Scottish Association of Mental Health
51 City of London Corporation; DrugScope; St Mungo’s; CLG; Look Ahead Housing and Care
52 Camden and Islington Mental Health FT
53 Health E1.
54 St Mungo’s Managers’ Away Day
55 Westminster PCT; Thames Reach; Jane Cook, specialist public health advisor; Health Improvement Team and Health and Homeless Initiative Hastings and Rother PCT; 3 Boroughs Homeless Team; MHSTHP; Sheffield City Council Housing Solutions Service; Health E1
56 Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice system http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PolicyAndGuidance/DH_098694
57 St Mungo’s
58 Prison Reform Trust
59 SCMH
60 Revolving Doors Agency
61 Ministry of Justice
62 St Mungo’s Client Needs Survey 2009
63 Revolving Doors Agency
64 SCMH
65 SCMH
66 Look Ahead Housing and Care; St Mungo’s
67 CLG
68 Homeless Link
69 St Mungo’s
70 Homeless Link
71 St Mungo’s
72 St Mungo’s
73 QNI
74 MEAM; Sheffield City Council Housing Solutions Service
75 DrugScope; Cabinet Office; St Mungo’s
76 SLAM NHS FT; 3 Boroughs Homeless team; Manchester Drug Service; Cornwall Health for Homeless
77 Wayside Day Centre
78 This hostel benefits from – an intermediate care pilot, a visiting GP service, a primary care team (3 Boroughs), the START mental health team and a drugs prescribing service, a palliative care scheme in partnership with Marie Curie, Lifeworks counselling. St Mungo’s specialist mental health and substance use workers alongside keyworkers, DAAT support for sex workers on crack and a range of charitably funded work and learning initiatives. Multiple PCT commissioners, SLAM the Cabinet Office ACE pilot (itself 5 funders), DH, Supporting People, DAAT and charitable funders are amongst the commissioning/funding routes.
80 Happiness Matters report 2009
81 Crisis submission
82 Women In Psychiatry Special Interest Group
83 Dr Reid, House of Commons 2008
84 CLG
85 Dr Phillip Timms, consultant psychiatrist at the South London & Maudsley NHS Trust and Honorary Senior Lecturer at King’s College London, witness in the oral evidence session held by St Mungo’s Parliamentary Committee
86 Crisis
87 Cornwall Health for Homeless; Charles Fraser, Chief Executive, St Mungo’s, witness in the oral evidence session held by St Mungo’s Parliamentary Committee
88 Counted In; Westminster PCT
89 Dr Phillip Timms, consultant psychiatrist at the South London & Maudsley NHS Trust and Honorary Senior Lecturer at King’s College London, witness in the oral evidence session held by St Mungo’s Parliamentary Committee
90 Turning Point; Women in Psychiatry Special Interest Group; CHC/OSW; Marsha Harlowe, service user We are checking she is ok with being attributed; DrugScope; Brighton and Hove City Council; IMPACT Training & Consultation Ltd
91 3 Boroughs Homeless Team
92 Christine Chapman, mental health worker, St Mungo’s
93 QNI (Anne Milner)
94 St Mungo’s; QNI (Anne Milner)
95 QNI (Anne Milner)
96 IMPACT Training & Consultation Ltd; St Mungo’s
97 QNI (Kate Tansley)
98 Shelter: A long way from home; 3 Boroughs Homeless team; Dr Nick Maguire, clinical psychologist, deputy director postgraduate diploma in CBT, University of Southampton; Sheffield City Council Housing Solutions Service
99 MEAM; St Mungo’s Managers’ Away Day
100 IMPACT Training & Consultation Ltd; SCMH
101 Women in Psychiatry Special Interest Group
102 Royal College of Psychiatrists; City of London Corporation; Julian Housing; Glasgow Street Services; Women in Psychiatry Special Interest Group; Turning Point; Sheffield City Council Housing Solutions Service; Look Ahead Housing and Care
103 City of London Corporation; Turning Point; Health E1; Wayside Day Centre; Connection at St Martins
104 Cambridgeshire and Peterborough NHS FT
105 CHC/OSW; Manchester Drug Service
106 Camden and Islington Mental Health FT
107 Crisis; Martyn Warr, former St Mungo’s client, member of Outside In, witness in the oral evidence session held by St Mungo’s Parliamentary Committee
108 Counted In
109 Camden and Islington Mental Health FT
110 City of London Corporation; QNI (Anne Milner)
111 Crisis; Connection at St Martin
112 Women In Psychiatry Specialist Interest Group
Dr Nick Maguire, clinical psychologist, deputy director postgraduate diploma in CBT, University of Southampton

SLAM NHS FT; Jane Cook, specialist public health advisor; Health Improvement Team and Health and Homeless Initiative Hastings and Rother PCT; St Mungo’s Managers’ Away Day

High Street Surgery, Swansea

Christine Chapman, mental health worker; St Mungo’s; Sheffield City Council Housing Solutions Service

High Street Surgery

Turning Point

SLAM NHS FT

Glasgow Street Services

Westminster City Council

St Mungo’s

SLAM NHS Trust

High Street Surgery

SLAM NHS Trust

Connection at St Martin’s; Focus Homeless Outreach Team; St Mungo’s Managers’ Away Day

St Mungo’s Managers’ Away Day

St Mungo’s

Cambridgeshire and Peterborough NHS FT; City of London Corporation

Crisis

Rethink

St Mungo’s Health Strategy 2008-11

Personality Disorder: No longer a diagnosis of exclusion - National Institute for Mental Health in England, 2003


St Mungo’s

Homeless Link

St Mungo’s

Look Ahead Housing and Care; MHST, Nottingham

MHST, Nottingham; High St Surgery, Swansea

High St Surgery, Swansea

Scottish Association for Mental Health; National Housing Federation

Christine Chapman, mental health worker; St Mungo’s; Cambridgeshire and Peterborough NHS FT

Crisis: Dean R & Craig T Pressure Points: Why people with mental health problems become homeless; Dr Nick Maguire, clinical psychologist, deputy director postgraduate diploma in CBT, University of Southampton; Christine Chapman, mental health worker; St Mungo’s

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198 SLAM NHS Trust; Julian Housing; Turning Point; Jane Cook, specialist public health advisor; Health Improvement Team and Health and Homeless Initiative Hastings and Rother PCT; Sheffield City Council Housing Solutions Service

199 Julian Housing

200 Sheffield City Council Housing Solutions Service

201 Homeless Link

202 MHSTHP

203 Islington BC.

204 Cambridgeshire and Peterborough NHS FT; DrugScope; MHSTHP

205 DrugScope

206 Homeless Mental Health Team, Leicester; Look Ahead Housing and Care

207 Scottish Association for Mental Health

208 Westminster City Council

209 Camden and Islington Mental Health FT

210 Shelter Good Practice briefing A Long Way From Home December 2008

211 RCP; IMPACT Training & Consultation Ltd

212 Homeless Mental Health Service, Leicester

213 Rex Haigh, Clinical Advisor to the Personality Disorder Unit, Department of Health, witness in the oral evidence session held by St Mungo’s Parliamentary Committee

214 CLG

215 DrugScope

216 St Mungo’s Lifeworks Report, 2009

217 Christine Chapman, mental health worker, St Mungo’s

218 Look Ahead Housing and Care; SCMH

219 SLAM

220 Worthing Churches Homeless Project; Charles Fraser, Chief Executive, St Mungo’s, witness in the oral evidence session held by St Mungo’s Parliamentary Committee

221 Martyn Warr, former St Mungo’s client, Outside In member; witness in the oral evidence session held by St Mungo’s Parliamentary Committee

222 Crisis

223 St Mungo’s

224 Worthing Churches Homeless Project

225 City of London Corporation.

226 Marsha Harlowe, service user

227 St Mungo’s Managers’ Away Day

228 St Mungo’s

229 Broadway Keeping Homes What Happens to Broadways Clients after resettlement http://www.broadwaylondon.org/ResearchInformation/Research/LongerTermOutcomes/HomelessLink

230 Work Learning Services, St Mungo’s; Counted In

231 Crisis; Look Ahead Housing and Care

232 Wayside Day Centre

233 Charles Fraser, Chief Executive, St Mungo’s, witness in the oral evidence session held by St Mungo’s Parliamentary Committee

234 Look Ahead Housing and Care

235 MHST, Nottingham

236 St Mungo’s

237 Cabinet Office

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279 St Mungo’s Managers’ Away Day
280 CLG; Look Ahead Housing and Care
281 Look Ahead Housing and Care
282 Look Ahead Housing and Care; BASW; Jane Cook, specialist public health advisor; Health Improvement Team and Health and Homeless Initiative Hastings and Rother PCT
283 MHSTHP, Nottingham
284 MHSTHP, Nottingham
285 Centrepoint
286 CHC/OSW; Homeless Link; Jane Cook, specialist public health advisor; Health Improvement Team and Health and Homeless Initiative Hastings and Rother PCT; Look Ahead Housing and Care
287 SLAM NHS FT
288 Look Ahead Housing and Care
289 3 Boroughs Homeless team; Wayside Day Centre
290 Tom Gifford, project manager; St Mungo’s
291 CLG; Health E1
292 RCP
293 Dr Phillip Timms, consultant psychiatrist at the South London & Maudsley NHS Trust and Honorary Senior Lecturer at King’s College London, witness in the oral evidence session held by St Mungo’s Parliamentary Committee
294 Jane Cook, specialist public health advisor; Health Improvement Team and Health and Homeless Initiative Hastings and Rother PCT
295 Dr Nick Maguire, clinical psychologist, deputy director postgraduate diploma in CBT, University of Southampton; Homeless Link
296 Mental Health Foundation
297 DrugScope
298 Dr Nick Maguire, clinical psychologist, deputy director postgraduate diploma in CBT, University of Southampton; RCP
299 St Mungo’s
We are London’s largest charity for homeless people and people whose complex needs mean they are at real risk of street homelessness. We provide over 100 accommodation and support services day in and day out.

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

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

By opening our doors, and our support services, we enable 1000s of homeless and vulnerable people to change their lives for good every year.