



STOP
the scandal

People with mental
ill health are stuck
sleeping rough

Stop the Scandal: the case for action
on mental health and rough sleeping
November 2016

St Mungo's
Ending homelessness
Rebuilding lives

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Acknowledgements

We are particularly grateful to the people with lived experience of homelessness and mental health problems who contributed to this report, including clients living in St Mungo's supported accommodation projects in Bristol and London and members of St Mungo's client involvement group Outside In.

With thanks to the health and homelessness professionals, commissioners, policy makers and researchers who shared their expertise, including:

Glenn Townsend, **Bristol CCG**; Dr Dean Eggitt, **British Medical Association**; Andy Bell and Amy Hardie, **Centre for Mental Health**; Claire Lilly, **Cotswold District Council**; Francesca Albanese, **Crisis**; Dr Ray Earwicker, **Department of Health**; Barney Wells, **EASL**; Darren Murinas, **Expert Citizens**; Helen Mathie, **Homeless Link**; Sarah Hart, **London Borough of Haringey**; Kath Dane, **London Borough of Tower Hamlets**; **London Homeless Health Programme**; Jacob Diggle, Russell Plunkett and Leila Woodhouse, **Mind**; Alex Bax, Stan Burrige and Elizabeth Clowes, **Pathway**; David Parker-Radford, **Queen's Nursing Institute**; Fran Busby, **START**; Robert White, **Westminster City Council**; and Dan Jones, **Westminster Joint Homelessness Team**.

Thank you to Manjur Jalil, policy and research volunteer at St Mungo's for all his work on our Freedom of Information request, and to Becky Rice at Accendo for support with research design.

A foreword from Outside In, the voice of St Mungo's clients

Outside In
The voice of St Mungo's clients



Each November, a service at the church at St Martin in the Fields marks the deaths of people who have been homeless. This year, 160 names were read aloud. Some statistics never fail to shock us.

When the Stop the Scandal campaign launched, we heard that four in 10 people sleeping rough have a mental health problem. This report looks closely at how we should respond, and uncovers new figures that show how far there is still to go.

There are stories underneath the statistics. Our experience is that people are treated poorly and often labelled, scapegoated and judged for sleeping rough. People see drink or drugs behind rough sleeping, but rarely think about mental health. Mental ill-health can affect anyone, but people sleeping rough face adverse weather conditions, fear and isolation that puts them at greater risk.

We want to pay tribute to the services, charities, volunteers and businesses that are already working to help people sleeping rough in bigger and smaller ways. It is important to appreciate what we already have, and not to cut resources where they are most needed.

But to stop this scandal, we have to go further. Outside In promotes client involvement in everything St Mungo's does, and the first step is to listen. This report listens to people who have slept rough in the past, hearing evidence from the horse's mouth.

No one should be stuck on the streets -everyone has the right to a home. But recovery is not just a roof. When people come inside they begin to reflect and may for the first time start learning how to manage their mental health. It is at this crucial time that support is most needed.

The government should do its homework, and it must take action to stop homelessness. We need to better understand homelessness and its root causes, and most of all we need urgent investment to make sure nobody is stuck sleeping rough with a mental health problem.

Outside In members, on behalf of clients at St Mungo's.

I. Executive Summary

In England, on any given night in autumn 2015, more than 3,500 people were sleeping rough.¹ The number of people sleeping rough in England has more than doubled since 2010.

In February 2016, St Mungo's published the first part of our Stop the Scandal investigation into mental health and rough sleeping. We were concerned by figures that showed a growing number of people sleeping rough experiencing problems with their mental health.

A review of the best available data recorded by street outreach professionals working with people sleeping rough showed that **four in 10 people who sleep rough need mental health support**. This rises to over half of UK nationals sleeping rough who need support for a mental health problem.²

People sleeping rough with a mental health problem tend to live on the streets for longer.

Poor mental health can be a barrier to engaging with services that can help people move off the street, and rough sleeping can be an obstacle to accessing mental health services.

Only 26 per cent of the homelessness professionals we surveyed for the first phase of our investigation thought that people sleeping rough in their area were able to access appropriate mental health services if they needed them.³

Poor access to mental health support keeps people trapped in dangerous circumstances on the streets. New research published by St Mungo's in October 2016, *Nowhere safe to stay*, exposed how harmful and dangerous sleeping rough can be. Interviews with 40 St Mungo's clients found that people were subject to violent attacks while sleeping rough. **129 people who were seen sleeping rough in London between April 2010 and March 2016 died within the same year they were seen on the street.**⁴

Rough sleeping is an emergency. **Access to mental health services saves lives**, both for people in an immediate mental health crisis and for people with an ongoing mental health problem stuck sleeping rough for months or years at risk of harm.

Looking at evidence from people with a history of rough sleeping and from services and commissioners across England, this report investigates how national and local government and the NHS can build effective services to put an end to the mental health crisis on our streets.

1.1 Local areas with the highest levels of rough sleeping are failing to commission targeted mental health services for people sleeping rough.

Despite the mental health inequalities faced by people sleeping rough, most local areas are not commissioning specialist, targeted mental health services.

Our Freedom of Information requests to commissioners in England revealed that **mental health services actively targeting people sleeping rough are commissioned in just a third (32 per cent) of the areas where 10 or more people are sleeping rough on any one night**.

In 68 per cent of areas with high levels of rough sleeping, local authorities and clinical commissioning groups (CCGs) did not identify locally commissioned mental health services actively targeting people sleeping rough.

¹ Department for Communities and Local Government (2016) *Rough Sleeping in England: autumn 2015* <https://www.gov.uk/government/statistics/rough-sleeping-in-england-autumn-2015>

² St Mungo's (2016) *Stop the Scandal: an investigation into mental health and rough sleeping* <http://www.mungos.org/documents/7021/7021.pdf>

³ Ibid.

⁴ St Mungo's (2016) *Nowhere safe to stay: the dangers of sleeping rough* <http://www.mungos.org/documents/7353/7353.pdf>

1.2 People come to the street with mental health problems, and rough sleeping further damages people's mental health.

Poor mental health is a cause and a consequence of sleeping rough. St Mungo's interviewed 21 people with recent experience of rough sleeping and mental health problems. The majority had problems with their mental health before they slept rough.

Almost everyone we interviewed told us their mental health deteriorated while they were street homeless. We heard about people sleeping rough while dealing with depression and anxiety, post-traumatic stress and bipolar disorder and while experiencing psychosis.

Eight of the 21 people we interviewed for this report told us about a time they had attempted or considered suicide.

1.3 People with mental health problems fall through gaps in legislation and local services

Gaps in the current homelessness legislation mean people often receive little help to avoid the dangers of sleeping rough. People at risk of sleeping rough, including people with mental health problems, are regularly found not to be in priority need and are offered little meaningful assistance.

People told us that they had contact with multiple services before, during and after the time they were sleeping rough. NHS services, as well as homelessness agencies, prison services and the police, have regular opportunities to intervene and make sure people have access to mental health support. Despite this, people are stuck sleeping rough with mental health problems.

1.4 Five principles developed by people with lived experience can transform services

Working with St Mungo's client involvement group Outside In to analyse data from our interviews, we developed five principles to inform how services working with people sleeping rough with a mental health problem are commissioned and delivered. Services must be:

- Accessible
- Attentive
- Understanding
- Caring
- Persistent

These principles are explored in detail in chapter seven of this report.

1.5 Specialist mental health services can provide effective treatment and support for people sleeping rough

Our Freedom of Information requests demonstrated that some specialist mental health services provide effective assessment, treatment, service coordination and referrals for people sleeping rough, but this is not available in all areas with high levels of rough sleeping.

Specialist services take responsibility for improving the mental health of people sleeping rough, whereas mainstream mental health services often fall short. We convened a panel of commissioners, policy makers, providers and health professionals with expertise in mental health and homelessness to discuss specialist services. The panel told us that siloed budgets and lack of understanding about rough sleeping are barriers to commissioning such services.

Commissioning and providing the right mental health services for people sleeping rough may be challenging, but the human and economic cost of leaving people stuck sleeping rough with a mental health problem is unacceptable.

1.6 Recommendations

- **Services** in every part of the country that come into contact with people sleeping rough with a mental health problem must adopt our five principles. There should be specialist homeless mental health services in all areas with the highest levels of rough sleeping and arrangements with mainstream teams in other areas so they can reach out to people on the streets.
- **National government** must meet its commitment to improve mental health services for homeless people and identify funding to build capacity in local areas. The ministerial working group on homelessness should produce a detailed plan for improving mental health services for homeless people as part of a national strategy to end rough sleeping.
- **Local councillors and commissioners** must take responsibility for ensuring everyone can access the mental health support they need and for ensuring they understand the case for specialist services. This applies to commissioners with responsibilities for homelessness, as well as those with responsibilities for mental health.
- **Health professionals**, including GPs and mental health practitioners, must take responsibility for ensuring they have a good working knowledge and understanding of homelessness and rough sleeping.

2. The policy context – mental health and rough sleeping in England

2.1. Towards parity of esteem

Mental health services in England were changed fundamentally by the shift away from large psychiatric institutions and the introduction of community care during the 1980s and 1990s. Decades later, providing effective care for people with mental health problems remains an important challenge for the NHS.

Recent governments have responded positively to long-standing efforts by mental health campaigners to raise the public profile of mental health and tackle stigma. In 2012, the Health and Social Care Act enshrined the principle of 'parity of esteem' into law, placing a duty on NHS England to work towards parity between mental and physical health.

The Coalition government commissioned the independent Mental Health Taskforce to make recommendations for transforming mental healthcare. The Taskforce report states that *"Every person with a mental health problem should be able to say: I have rapid access, within a guaranteed time, to effective, personalised care."*⁵

In February 2016, the government accepted the Taskforce's wide-ranging recommendations for the NHS and Whitehall departments. Prime Minister David Cameron announced an additional £1 billion of funding for mental health by 2021, acknowledging that *"For too long there hasn't been enough focus on mental health care in this country meaning too many have had to suffer in silence."*⁶

However, the Public Accounts Committee has sounded a note of caution about the government's public ambition to achieve parity of esteem. A recent report by the committee found that *"achieving parity of esteem between mental and physical health is a laudable ambition but pressure on the NHS budget will make it very difficult to achieve."*⁷

In 2014-15, the NHS spent £11.7 billion on mental health services, 12 per cent of its total budget. NHS England announced that clinical commissioning groups (CCGs) were expected to increase mental health spending in real terms in 2015-16. However, analysis by the King's Fund suggests that additional funding has not yet reached frontline mental health services in every area. In 2015-16, 40 per cent of mental health trusts, which provide 80 per cent of NHS mental health services, saw their operating income fall.⁸

2.2. A mental health crisis on our streets

It is troubling that there are still financial strains on the mental health system, especially when a mental health crisis is re-emerging on our streets. Across England, rough sleeping is rising. On any one night in autumn 2015, 3,569 people were sleeping rough, a figure that has risen by 102 per cent between 2010 and 2015.

Poor mental health among people sleeping rough is also on the rise. Four in 10 people sleeping rough need support for a mental health problem⁹ and, in London, the number of people sleeping rough with an identified mental health support need has risen from 711 in 2009-10 to 2,528 in 2015-16.¹⁰ There have been some improvements in recording, but these cannot account for much of this increase.

2.3. Government responses

In 1990, the Conservative government at the time responded to concerns about rising rough sleeping and the introduction of Care in the Community with the Homeless Mentally Ill Initiative (HMII). Launched by the Department of Health, HMII funded teams of specialist doctors, nurses and social workers, reaching out to people living on the streets in London who were unable or unwilling to access mainstream mental health services. A Department of Health evaluation of four clinician

⁵ The Five Year Forward View for Mental Health (2016) <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

⁶ <https://www.england.nhs.uk/mentalhealth/2016/02/15/fyfv-mh/>

⁷ House of Commons Committee of Public Accounts (2016) *Improving access to mental health services* <http://www.publications.parliament.uk/pa/cm201617/cmselect/cmpubacc/80/80.pdf>

⁸ The King's Fund (2016) *Trust finances raise concerns about the future of the Mental Health Taskforce recommendations* <https://www.kingsfund.org.uk/blog/2016/10/trust-finances-mental-health-taskforce>

⁹ St Mungo's (2016) *Stop the Scandal* <http://www.mungos.org/documents/7021/7021.pdf>

¹⁰ Data from the Combined Homelessness and Information Network (CHAIN), <https://data.london.gov.uk/dataset/chain-reports>

teams funded through the HMII was largely positive, finding that the initiative was successfully targeting people sleeping rough with severe mental health problems who had been failed by mental health services in the past.¹¹

Successive governments have also taken broader action on rough sleeping. In the 1990s, the Rough Sleepers Initiative funded hostels, outreach and advice to tackle rough sleeping in London, later rolling out the initiative to 36 areas across England. The 1997 Labour government's Rough Sleepers Unit set a target to reduce rough sleeping by two thirds in three years. This was achieved a year earlier than planned. In 2003, the Supporting People programme brought together funding for accommodation and interventions helping people identified as vulnerable to live independently, including people who had slept rough.

However, the level of funding available for these efforts had been declining. In 2009, the ringfence around Supporting People funding was removed. General reductions in funding for local authorities have led to an average 45 per cent reduction in spending on Supporting People services between 2009-10 and 2014-15.¹²

Despite their success, specialist homeless mental health teams have also experienced cuts in staff or resources. In London, specialist statutory teams covering Hammersmith and Fulham, Kensington and Chelsea, Islington and Hackney are no longer in operation.¹³

Recent governments have recognised the need to pay particular attention to the health needs of people who are homeless in order to tackle homelessness and reduce health inequalities. The most recent government mandate to the NHS states that homeless people should receive "high quality, integrated services that meet their health needs."¹⁴

In October 2016, the cross-departmental ministerial working group on homelessness committed "to drive action to tackle homelessness across government, including improving mental health services" and the Department for Communities and Local Government announced £10 million in Social Impact Bond funding to provide personalised support for people sleeping rough with complex needs.¹⁵

Our Stop the Scandal investigation series highlights the urgent need to deliver on these commitments and provides new evidence about how services can be most effective.

- ¹¹ Craig, T (1998) *Homelessness and Mental Health*. *Psychiatric Bulletin* 22 pp. 195-197 <http://pb.rcpsych.org/content/pbrpsych/22/4/195.full.pdf>
- ¹² National Audit Office (2014) *The impact of funding reductions on local authorities* <https://www.nao.org.uk/wp-content/uploads/2014/11/Impact-of-funding-reductions-on-local-authorities.pdf>
- ¹³ St Mungo's (2016) *Stop the Scandal* <http://www.mungos.org/documents/7021/7021.pdf>
- ¹⁴ Department of Health (2016) *The Government's mandate to NHS England 2016-17* <https://www.gov.uk/government/publications/nhs-mandate-2016-to-2017>
- ¹⁵ Department for Communities and Local Government (2016) *Homelessness Prevention Programme* <https://www.gov.uk/government/publications/homelessness-prevention-programme>

3. Gathering evidence on mental health and rough sleeping

To understand efforts by local commissioners to tackle the mental health crisis on our streets, we made 248 Freedom of Information requests to local authorities and clinical commissioning groups (CCGs) in areas with high levels of rough sleeping. Our requests asked about the mental health services targeted at people sleeping rough that are commissioned locally in each area.

Our new research also investigates how people experience mental health and mental illness while they are sleeping rough, and when, where and how they access support. During August and September 2016, we conducted 21 in-depth interviews with St Mungo's clients with a history of rough sleeping living in five London boroughs and in Bristol.

All the clients we interviewed had experience of mental health problems around the time they were sleeping rough. There was no requirement for interviewees to have a formal diagnosis or a mental health problem that pre-dated their time on the street.

The qualitative research was conducted by Catherine Glew at St Mungo's with support for research design from Becky Rice at Accendo and St Mungo's client involvement group Outside In.

Some of the topics we discussed during interviews had the potential to cause distress. All the clients we interviewed were in accommodation and being supported by St Mungo's at the time of their interview. Our sample was chosen so that clients could take part in the research safely. For this reason, we did not interview clients that were sleeping rough at the time of interview, though nearly all clients had slept rough within the last five years.

Demographic information was recorded for all 21 interview participants, eight female and 13 male. The majority of clients were between 25 and 54 years old, with one participant under 25 and two over 55 years old. 15 participants were White, and six were from BAME and other ethnic backgrounds.

Data from the Combined Homelessness and Information Network (CHAIN) database shows that 37 per cent of people sleeping rough in London are Central and Eastern European (CEE) nationals¹⁶, but only a limited number of people from CEE countries took part in our interviews. Two research participants told us they were from a Polish background and one of these interviews took place with an interpreter.

Our analysis is based on 18 complete interview transcripts and research notes from the other interviewees who did not consent to be recorded. We convened two expert panels to review our findings, involving members of St Mungo's client involvement group Outside In, as well as clinicians, commissioners, policy makers and service providers with expertise in mental health and homelessness.

We are grateful to everyone who contributed to this research. We would like particularly to thank our clients who were generous with their time and experience.

Please note that this report contains content that may cause distress. We have chosen to include this material because it reflects the lived experience of our clients.

¹⁶ Data from the Combined Homelessness and Information Network (CHAIN) <https://data.london.gov.uk/dataset/chain-reports>

4. Mapping specialist mental health services for people sleeping rough

4.1. Availability of specialist services

People sleeping rough can find it particularly hard to access treatment and support for mental health problems. Only 26 per cent of the homelessness professionals we surveyed for the first phase of our investigation thought that people sleeping rough in their area were able to access appropriate mental health services if they needed them.¹⁷

Our earlier research found that rough sleeping makes it harder to access mental health services due to stigma, difficulties getting an assessment or referral to secondary care, trouble keeping appointments while sleeping on the street, and a lack of services that will work with people facing multiple problems including drug and alcohol use.

To understand how local commissioners are responding, in June 2016 St Mungo's made requests for information under the Freedom of Information Act. Our requests asked commissioners to identify the services in their area which provide mental health assessment, support and treatment targeted at adults sleeping rough.

We made information requests to the 111 district and unitary authorities in England (including London Boroughs) where 10 or more people are sleeping rough on a typical night, based on annual homelessness data collected for DCLG.¹⁸

We also made requests to all county councils and clinical commissioning groups (CCGs) operating across the selected areas. Responsibility for homelessness commissioning can lie with housing or adult social services departments within English councils, and CCGs and local authorities have responsibilities for mental health commissioning.

In total, we made 248 requests and received responses from all but one local authority.

The data we received gives a detailed picture of the local commissioning landscape for mental health services that specialise in working with people sleeping rough. Data obtained through our request does not include information about services that are funded through central government programmes, including the DCLG Help for Single Homeless Fund (launched under the last government spending period), or those that are provided by local charities using voluntary income. Primary care services commissioned directly by NHS England, including some specialist homelessness GP practices, are also not included.

Our research shows that only 32 per cent of the areas where 10 or more people are sleeping rough on any one night commission mental health services actively targeting people sleeping rough.

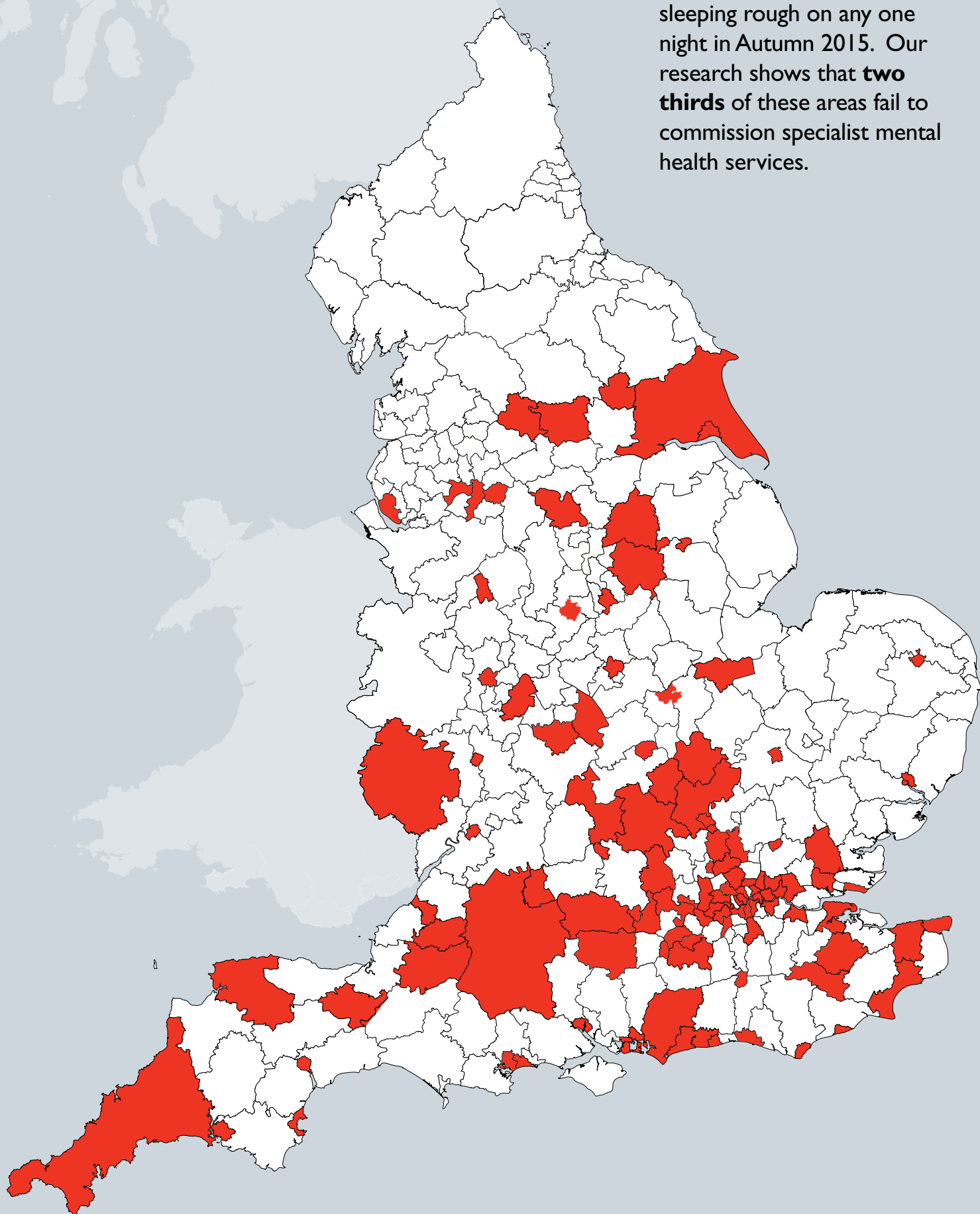
In 14 per cent of areas, services were commissioned by a local authority and in 28 per cent, they were commissioned by a CCG. 11 per cent of areas had services that were jointly commissioned or multiple services commissioned by councils and CCGs.

In 68 per cent of areas, commissioners did not identify mental health services actively targeting people sleeping rough. Some responses confirmed that they did not commission services of this type, while others included services that did not match the description or reported that the information was not held. One local authority did not respond to our information request.

¹⁷ St Mungo's (2016) *Stop the Scandal* <http://www.mungos.org/documents/7021/7021.pdf>

¹⁸ See <https://www.gov.uk/government/statistics/rough-sleeping-in-england-autumn-2015>

This map shows the areas with ten or more people sleeping rough on any one night in Autumn 2015. Our research shows that **two thirds** of these areas fail to commission specialist mental health services.



4.2. About specialist services

Within the 32 per cent of areas with a specialist service identified by commissioners, the level and type of support available to people sleeping rough varied greatly. We received details of services providing assessment, treatment, coordination, support and referrals to mainstream mental health services, but not all of these elements were present in each area where a service was commissioned.

In total, we received information about 31 mental health services targeting people sleeping rough that were locally commissioned in areas with high levels of rough sleeping.

These services were delivered by a range of providers, including NHS mental health trusts and voluntary sector organisations. They were based across a range of settings and took different approaches to working with people on the streets. Some worked on a flexible outreach model, meeting clients in various locations including on the street. Others offered drop-in sessions in homelessness GP practices, or in-reach into hostels or day centres.

CASE STUDY – Birmingham and Solihull Community Mental Health Team (CMHT) for homeless people

The CMHT for homeless people is a statutory city-wide mental health NHS service for service users who are homeless or threatened with homelessness. The CMHT provides assessment, diagnosis and treatment of mental health problems for people who are homeless, including those living in hostels or B&Bs, and patients who are not registered with a GP.

The service consists of a multidisciplinary team including a team manager, consultant psychiatrist, physician associate and specialist community psychiatric nurses. It is commissioned jointly by NHS Birmingham Cross City CCG, NHS Birmingham South Central CCG, NHS Sandwell & West Birmingham CCG and Solihull CCG.

A small number of services provided mental health treatment directly and were specifically designed to reach people sleeping rough and living in homelessness services. For example, in Birmingham a dedicated homelessness community mental health team provides assessment and treatment across the city.

A larger number of services work to assess people sleeping rough and broker access to local community or inpatient mental health services. Some services offer intensive care co-ordination, organising and managing care for their clients. Others are designed to signpost services rather than planning care for individuals.

CASE STUDY – Bristol Assertive Contact and Engagement (ACE) service

The ACE service works to improve access to mental health services for people with multiple and complex needs who find it difficult to access mainstream services, including people who are sleeping rough and people at risk of homelessness.

ACE employs engagement staff, a psychologist and two part-time therapists. The service operates through three hubs in Central and North, East and South of Bristol, allowing the service to reach the whole city. ACE staff also reach out into hostels and other community settings, facilitating open access and drop-in groups for clients. ACE takes referrals through a duty line staffed Monday to Friday and at weekends, accepting referrals from carers, services and concerned individuals as well as self-referrals.

The service was launched in April 2015 and is commissioned by Bristol CCG and managed by St Mungo's in partnership with One25.

CASE STUDY – London Borough of Tower Hamlets Rough Sleeper Outreach Service

Tower Hamlets Rough Sleeper Outreach Service aims to prevent reduce and prevent rough sleeping in the borough. This includes ensuring no one spends a second night on the street and individuals with a rough sleeping history do not become entrenched in a street lifestyle or return to rough sleeping after being accommodated.

The service employs a large team of outreach workers along with a full-time Approved Mental Health Practitioner (AMHP) who is seconded from the local Trust. The practitioner coordinates street-based mental health assessments and supports individuals to access and accept mental health treatment. The practitioner may also identify pathways into accommodation. The client group is mostly current rough sleepers but some work is carried out with former rough sleepers living in hostels. The AMHP attends mental health forums and network meetings to inform other mental health professionals about homelessness. She receives clinical supervision from the Community Mental Health Team from which she has been seconded.

The service is commissioned by the London Borough of Tower Hamlets as part of the borough's Housing Options and Assessment services.

Some services are commissioned to organise and conduct formal assessments under the Mental Health Act so that people sleeping rough can be assessed and admitted to inpatient mental health services.

Some FOI responses included services designed to meet the broader health needs of people who are homeless. These services include GP practices for people who are homeless, outreach or drop in services with nurses and mental health workers, and services provided by the voluntary sector that conduct overall health assessments and make referrals or advocate for clients to receive the health services they need. These services were only included in our analysis if they were specifically designed to meet mental as well as physical health needs.

CASE STUDY – Cornwall Health for Homeless

The Cornwall Health for Homeless service runs clinics in Truro, Penzance and Camborne for homeless people who experience difficulties in accessing medical care.

The service runs clinics on a drop-in basis. Many of the patients have alcohol or drug dependency as well as mental health problems, which requires a close working relationship between the medical team and Cornwall Drug and Alcohol Team, Addaction, Outlook Southwest and community mental health teams.

The medical team consists of three GPs, a nurse, a practice manager and two administration staff. The clinics provide advice and treatment for mental health, health promotion, dental care, foot care and housing solutions.

Cornwall Health for Homeless is commissioned by NHS Kernow Clinical Commissioning Group.

Responses from other areas included details of outreach teams working with rough sleepers to find them accommodation and services, including for their mental health. Outreach teams are commissioned by local councils in many areas with high levels of rough sleeping.

However, a national St Mungo's survey found that outreach teams were often unsuccessful in referring people sleeping rough to mainstream mental health services due to a lack of clinical authority.¹⁹ Commissioners and service providers told us that mainstream mental health services sometimes attach less weight to the opinion of street outreach workers who are not clinicians. Outreach services were not included in our analysis unless there was specific mental health expertise commissioned as part of the service.

In addition, mental health assertive outreach services were not included unless they specified people sleeping rough as a target group.

4.3. Commissioning specialist services

Our data indicates that specialist mental health services for people sleeping rough are more often commissioned by CCGs than local authorities. However, a small group of services with a mental health element were commissioned solely by councils within housing or homelessness teams.

Joint commissioning arrangements appear to be relatively uncommon – only seven services were identified as being commissioned jointly by health commissioners and local authorities.

4.4. Conclusion

Our research shows that in some areas where there are higher levels of rough sleeping, specialist mental health services for people sleeping rough are providing elements of assessment, treatment, coordination, support or referrals to mainstream mental health services. Some have input from doctors, nurses, social workers and have detailed expert knowledge of homelessness and rough sleeping. This expertise allows services to accurately assess people sleeping rough for mental health problems and make effective referrals or provide them with appropriate treatment. Specialist services also take responsibility for providing care and treatment to those who might otherwise be passed around multiple services.

However, our research also shows that these specialist services are not being commissioned in many areas with high levels of rough sleeping. We are concerned that people sleeping rough face barriers to accessing mainstream mental health services and that the absence of specialist teams leaves people who urgently need support without assessment or treatment, blocking their path to accommodation and keeping them stuck on the streets for longer.

In order to understand more about how people experience mental health and mental illness while they are sleeping rough, and when, where and how they access support, we also interviewed people who had experienced mental health problems and slept rough in the past. The findings are described in the next section of this report.

¹⁹ St Mungo's (2016) *Stop the Scandal* <http://www.mungos.org/documents/7021/7021.pdf>

5. Poor mental health as a cause and a consequence of sleeping rough

We interviewed 21 St Mungo's clients who had experienced mental health problems and slept rough in the past to understand how they came to sleep rough and how they viewed their own mental health before, during and after their time on the streets.

5.1. People start sleeping rough when tenancies and relationships break down

All but one of the clients we interviewed had slept rough within the past five years, and nine clients had slept rough in the 12 months prior to their interview. The majority of clients had slept rough more than once.

Most had slept rough in London, but we also interviewed clients who had slept rough in the South East, South West, North West and the East of England.

Some had slept rough for a few days in total. Others had been sleeping rough for five years or more. Data analysis published by St Mungo's in February 2016 showed that people sleeping rough with a mental health problem were around 50 per cent more likely to have spent over a year sleeping rough than those without a mental health problem.²⁰

Four interviewees first slept rough while they were under 18. One interviewee slept rough for the first time when she was twelve years old.

We interviewed clients about the events leading up to the time when they first slept rough. 14 slept rough after being forced to leave private rented accommodation, social housing or hostel accommodation. Nine spoke about problems with their partner, and six about problems with family members. Six clients said that drug or alcohol use contributed to them sleeping rough.

"I had the perfect woman, lovely flat, perfect job, then she left me, then it just all went downhill again. Just all went to hell. Homeless, prison, homeless, prison."

Male client

"I was evicted...I had so many letters from bailiffs, and then we start to get depressed, and everything is going slowly but surely down to the point where you are on the street."

Male client

"It was really bad domestic violence, really bad, he got arrested for attempted murder on me...I think me sleeping rough was through him. My mum or my sisters would put me up but they wouldn't put him up because obviously he used to beat me up."

Female client

"My foster parents abused me...and their son used to touch me, and that sort of thing, so I ran away from that."

Female client

People start sleeping rough when their connections with safe housing and supportive relationships break down. Mental health problems can play a role in these events: three times as many adults with mental health problems report debt or rent arrears, compared to those without mental health problems.²¹ Mental health problems may also create tension or cause harm within personal relationships.

"I was just sleeping at a boyfriend's house...he didn't really abuse me physically, he more abused me mentally because of my mental health, I hear voices and stuff. I got really, really bad anxiety issues. I used to think that I couldn't go anywhere without him."

Female client

²⁰ St Mungo's (2016) *Stop the Scandal* <http://www.mungos.org/documents/7021/7021.pdf>

²¹ Mind (2011) *Still in the Red: Update on debt and mental health* <http://www.mind.org.uk/media/273468/still-in-the-red.pdf?ctald=/about-us/our-policy-work/reports-and-guides/slices/debt/>

5.2. People sleep rough after leaving hostels, hospitals, prison and mental health inpatient services

Data analysis published previously by St Mungo's showed that a significant number of people with mental health problems were starting to sleep rough after leaving a service where they accessed treatment, care or support.²² Accounts from a number of clients we interviewed for this report supported these earlier findings.

Six interviewees said they had left hostels and slept rough. Three left prison, two were discharged from hospital wards and two left inpatient mental health services to sleep rough. One client left a women's refuge to sleep rough after her abusive partner found her address.

These examples are not a complete record of people's experiences. Some clients had slept rough so many times that we were not able to discuss each occasion during their interview. One client we interviewed said that he slept rough every time he left prison. He had been in prison a total of 37 times.

5.3. People experience problems with their mental health before they sleep rough

Our evidence shows that some people are coming onto the streets with existing mental health problems. Thirteen interviewees told us that they had problems with their mental health before they slept rough, and seven had a pre-existing mental health diagnosis. Some of the others had been sleeping rough over a long period and were unable to recall when their mental health had deteriorated.

"My mental health's been going on for all my life."
Female client

Nine interviewees said they had spoken to services or family about their mental health before they slept rough. However, some said they were not aware at the time that their mental health was causing problems, and others said they had difficulty asking for help.

5.4. People sleep rough while dealing with a range of different mental health problems

Table 1 shows the range of mental health problems clients discussed with us during interviews. Throughout our interviews, we heard about people sleeping rough while dealing with depression and anxiety, post-traumatic stress and bipolar disorder and while experiencing psychosis. Often, interviewees had experienced several mental health problems before, during and after they slept rough.

Table 1: Client descriptions of mental health experiences

Mental health experience	Number of clients
Depressed, low, empty	14
Considered or attempted suicide	8
Anxious, worried, panic	7
Psychosis, schizophrenia, hearing voices, hallucinations, paranoia	7
Emotional problems, anger, 'bottling up', 'breaking down', 'cracking up'	5
Bereavement, grief, loss	5
Personality disorders	5
Self-harm	3
Bipolar disorder, manic depression	2
ADHD	2
Post-traumatic stress	2

²² St Mungo's (2016) *Stop the Scandal* <http://www.mungos.org/documents/7021/7021.pdf>

Some interviewees spoke about their mental health experiences without using diagnosis labels, and others did not feel that a diagnosis they had been given fit their experience.

“Constantly I was always hearing voices, people calling me all the time...I thought it was normal because I always used to hear voices before but I did not realise it was an illness...Some people that told me in the past it was a spiritual thing travelling through you.”

Male client

“The crisis team...they don’t think it’s schizophrenia, it’s more likely to be [drug] induced. Yes, but it’s not...I still get it when I don’t smoke crack.”

Female client

Eight of the 21 people we interviewed for this report told us about a time they had attempted or considered suicide.



“I’d have hurt myself, I think, if I’d stayed out there anymore. I do get suicidal and I was on the limit of doing something to myself, know what I mean? I couldn’t take it no more.”

Female client

Recent research has shown that people who are homeless are over five times more likely to be hospitalised for a head injury than the general population.²³ Interviews conducted by a researcher with experience of homelessness and brain injury in Sheffield suggest that brain injury is often overlooked in people who are homeless.²⁴ Though brain injury was not covered in our interviews, under-diagnosis in

this area may further complicate efforts to assess and treat mental health problems.

5.5. People’s mental health deteriorates while they are sleeping rough

During the first part of our investigation, outreach and mental health professionals told us that people’s mental health deteriorated while they were sleeping rough. Nearly all the clients we interviewed for this report told us that sleeping rough had a negative impact on their mental health.

“My mental illness, being on the street and that, it didn’t help. I found it got a lot worse, and I was self-harming, I have suicidal tendencies, and it kind of heightened everything, you know? It was like me against the world.”

Female client

“It was very stressful. Very, very stressful. I couldn’t believe that I had to go through that again. I couldn’t believe that in this day and age, that it was still kind of happening like that, you know? I really did go into a very deep depression.”

Female client

Comments from these interviews demonstrate the high price people pay for sleeping rough, and the detrimental impact on their mental health and wellbeing.

Sleeping rough is extremely dangerous. Clients we interviewed had been physically and sexually assaulted while sleeping rough. Two reported being attacked by foxes. Interviewees experienced high levels of stress and often feared for their safety. This is consistent with findings from separate research involving interviews with 40 St Mungo’s clients who had previously slept rough, published in our recent report *Nowhere safe to stay: the dangers of sleeping rough*.²⁵

²³ McMillian, T. M. et al (2015) Head injury and mortality in the homeless. *Journal of Neurotrauma* 32(2) pp 116-119 <https://www.ncbi.nlm.nih.gov/pubmed/25010750>

²⁴ <https://thepsychologist.bps.org.uk/homelessness-and-brain>

²⁵ Available at <http://www.mungos.org/documents/7353/7353.pdf>

“I’ve had people piss on me, I’ve had people try to set me on fire, I’ve been kicked in the head, I’ve been sexually assaulted, I’ve been touched up.”

Male client

Some people we interviewed talked about their mental health deteriorating as they became unable to maintain their personal care and hygiene.

“When you’re neglecting the smallest things like eating and hygiene, they’re little things but they add up...you become dirty and more depressed.”

Male client

“It makes you like a wild animal. You stop caring.”

Male client

Interviewees talked about difficulties prioritising and managing their mental health while sleeping rough. Using mental health medication presented particular challenges.

“I was always on top of my medication, but many a time I’d have them stolen and things like that, you know?”

Female client

*“You can’t take mental health medication when you’re homeless, makes you too vulnerable. You’d be like a f**king cabbage, you’d get all your stuff robbed off you.”*

Male client

“Some of these medications make us sleep all day...people are vulnerable so it’s difficult.”

Male client

A number of interviewees told us they increased their substance use while sleeping rough. Many said they used alcohol and drugs to cope with poor mental health. Some said that substance use made their mental health worse.

“My head spills overboard, and I just get...depression. I use more, and I get drunk more.”

Female client

“It wasn’t until I started getting into heavy drugs that my mental health started to deteriorate...it went from being fine to dramatically going downhill over the space of a couple of years.”

Male client

Sleeping rough takes an emotional toll. When we asked how sleeping rough affected their mental health, clients said they felt humiliated, lost and hopeless:

“It made me feel degraded, almost, because...I knew a lot of people in the area, a lot of friends and that. I always felt as if I was hiding away from them.”

Male client

“My daughter, who is 24, must have found out about it and then came over...and she was with her friends and how humiliating for her.”

Female client

“I felt like my life was actually going nowhere at that point. No aim, no job, dad just passed away. Still feels like that now, but I’ve got somewhere to stay, so it’s a step on the ladder, as I see it. When I’m sleeping rough I don’t see no ladder to step on.”

Male client

“You know, I just felt like I’d lost everything I had.”

Male client

Sleeping rough left a lasting impact on the mental health of many clients we interviewed, even after they had moved into accommodation.

“You have to still deal with the anxiety that you’ve had, you know what I mean? It’s embedded...I think it’s just being looked at like shit all day, from people looking at you like shit.”

Male client

“I was very depressed. That kind of stuff was with me all through the time I spent [sleeping rough], and long afterwards.”

Female client

5.6. Conclusion

The clients we interviewed explained how existing problems with their mental health were made much worse by sleeping rough. Sleeping rough exposes people to extreme danger, causing further, long lasting harm.

In the next section we explore further evidence that rough sleeping makes it more difficult to access mental health services and that unaddressed mental health problems can obstruct efforts to help people move off the streets.

"I got abused as a kid"

"I just started rebelling"

First slept rough aged 16

"to get away from my dad"

Diagnosed with ADHD

Lost kids

Mental health "went to pot"

"every year I've been in prison"

Detox

In hospital with DVT

Moved into hostel

12 weeks later

"then they closed down and put me in a night shelter... I ended up ruining that"

Moved into hostel

On the streets for two years

Moved into second step housing

In hospital with DVT

July 2015

Sectioned "Suicidal"

In hospital
with deep vein
thrombosis

*"I'm always
in hospital"*

Moved
into
hostel

**Rehab
aged 20**

*"I had a
wicked time
at rehab"*

*"when my bloke gets out of prison, and
then I'm like in a woman's hostel and I end
up leaving it to be with him, and that's
just going on and on and on and on"*

**31 years
old now**

**Mental health
inpatient for 28 days**

*"I loved it, because it's
structured, and so you've
always got things to do"*

August 2015

Moved into
hostel

D's journey

As part of our research we asked clients to produce a timeline of events around the time they were sleeping rough. Clients colour coded their journeys to show **times their mental health suffered** and **improved**.

D's story is a complicated journey through rough sleeping and poor mental health. D was in contact with health, homelessness and criminal justice services during the time she slept rough. She was eventually detained under the Mental Health Act and received inpatient care, before moving back into a hostel.

6. Reaching people sleeping rough with mental health problems

Rough sleeping is harmful and creates barriers for people who need support. Understanding where people are already coming into contact with services before, during and after their time on the street should make it easier to take every available opportunity to resolve their homelessness.

Our experience of providing outreach services for people sleeping rough has informed our understanding of the services that work for people sleeping rough with mental health problems. During the first part of our Stop the Scandal investigation, we also conducted the largest ever national survey of street outreach professionals to gather perspectives from across England.

Our new research goes even further by asking people with direct experience of rough sleeping and mental health problems about their contact with services of different types. This person-centred data gives us a deeper understanding of how to build mental health services that rebuild lives.

6.1. People fall through the gaps in homelessness legislation

Gaps in the current homelessness legislation mean people often receive little help to avoid the dangers of sleeping rough. Under English homelessness law, local councils must secure settled accommodation for homeless households and individuals who meet defined priority need criteria. These criteria include people who are 'vulnerable' as a result of mental illness.

However, people at risk of sleeping rough, including people with mental health problems, are regularly found not to be in priority need and are offered little meaningful assistance. Our recent report *Nowhere safe to stay* highlighted how people ask councils for help but still end up sleeping rough.²⁶

6.2. People come into contact with multiple services while they are sleeping rough

The clients we interviewed told us that they were coming into contact with different types of services during the time they were sleeping rough. Nearly all interviewees told us that they had been in contact with rough sleeper outreach teams, which are well-established across London and Bristol.

A number of interviewees told us they were in contact with health services while they were sleeping rough. Almost half told us they had maintained contact with a GP. Seven told us about contact with hospitals, A&E or paramedics during the time they were sleeping rough, and three had been in contact with community mental health services at that time.

Eight interviewees had contact with day centres and seven with night shelters or No Second Night Out services.

The services that had opportunities to reach people sleeping rough were not always specialist homelessness or health services. Eleven interviewees reported contact with police, five had been in prison before or after they slept rough.

Most clients we interviewed had slept rough in cities. This level of service contact may not reflect the experience of people sleeping rough in rural and isolated locations. However, our interviewees' comments about how services worked for them can be applied across different contexts.

²⁶ St Mungo's (2016) *Nowhere safe to stay* <http://www.mungos.org/documents/7353/7353.pdf>

6.3. Health services have opportunities to support people sleeping rough with their mental health

We asked interviewees about their experiences of seeking and accessing support for their mental health through the NHS and via other routes. More than half of the clients we interviewed had approached their **GP** for support with their mental health, including medication and referrals to other services.

“She’s got me on the right pills. Take one of them, and I feel like a teenager again.”

Male client

“[I] had a doctors you could go and register, any doctor. So I was always on top of my medication.”

Female client

“When I left prison I came to see my doctor... then from there I was put under a mental health team.”

Male client

Interviewees particularly valued contact with their GP when they had developed a trusting relationship. Some who saw different doctors when they visited their GP said they found it difficult to open up about their mental health.

“Luckily, my doctor I’ve had for 25 years so he knows everything.”

Female client

“When I go to my GP, I see different doctors, I’ve not got one particular doctor... I tend to hold back a bit.”

Male client

“I could never just open up freely to them because I think, ‘He thinks I’m lying.’”

Male client

Several interviewees said that their GP was aware they were sleeping rough, but felt that GPs did not have the tools to help resolve their homelessness. Two mentioned their frustration that medical evidence from their GP was not accepted by local authorities as part of a homelessness application.

“What could he do for me? Just tell me to be careful.”

Male client

“They’d try and do whatever they can... I’m going back many years, and doctors didn’t really have a lot of say in those days... they knew but nothing was ever done.”

Female client

“My previous GP wrote a letter, it said, basically ‘This guy is vulnerable. He needs some help.’ They took no notice of that.”

Male client

Some clients we interviewed had accessed support from **community mental health services**. Interviewees reflected positively on this support when they felt services had taken time to listen and understand what kind of support would work for them.

“At first I was scared of them, very frightened... They’ve worked through thick and thin on my behalf... they’ve spent time with me, listening to me, telling to them what the experience I was having with the voices.”

Male client

“They’re alright... Breathing techniques and stuff, because I used to have panic attacks... I used to have one doctor, right, instead of teaching me anything he’d just be like, ‘When you’re having a panic attack, just take a diazepam.’”

Male client

Interviewees told us about times they were unable to access services or work with them effectively. Difficult or traumatic experiences affected interviewees' ability to interact constructively with services, leading to exclusion or delays in care.

“When you went to see a psychotherapist or whatever, one of those people, it’s hard to talk about things that are painful, and they kind of throw you in the deep end. . .if you’re not ready, I know a lot of people that kind of got lost in the system.”

Female client

“That was a psychiatrist. . . I was talking about bullies, and he said, ‘What do you want to do to bullies?’ and I said, ‘Kill them all’, and he wouldn’t see me again.”

Male client

When we spoke to specialist mental health professionals for the first part of our investigation, they told us that knowledge of the realities of homelessness are required to accurately assess the mental health of a person sleeping rough. Mental health professionals who are not homelessness specialists may not accurately identify mental health problems for people sleeping rough or understand their impact. For example, people who are sleeping rough as a result of delusional beliefs are sometimes repeatedly found to have the capacity to decide to sleep rough as a ‘lifestyle choice’.

The clients we interviewed who were using alcohol or drugs faced particular barriers to accessing mental health services. As part of our earlier research, 84 per cent of street outreach professionals surveyed said that mainstream mental health professionals are often unwilling to work with people sleeping rough who have substance use issues.²⁷

Mental health professionals may require people sleeping rough to reduce or cease substance use before working with them to address mental health problems. Interviewees told us they self-medicated by using alcohol and drugs to cope with symptoms of poor mental health, compounding their exclusion from services.

“I need a psychologist, or counselling or something. I’ve been asking for this for over a year, and still nothing. What is their excuse? It’s like, ‘Because you’re drinking.’”

Male client

Ten clients we interviewed for this report told us they had experience of **inpatient mental health services**. Seven had been detained under the Mental Health Act and four had been admitted voluntarily, including one client who had experienced both voluntary and involuntary admissions.

Several interviewees appreciated the well-structured care they had accessed as an inpatient. While some reflected that they had benefitted from their stay, others felt that their admission or detention in mental health services had prompted little improvement in their mental health.

“I loved it, because it’s structured, and so you’ve always got things to do.”

Female client

“When they admitted me I thought, ‘Yes. That’s a good start, I have the right people in the right places, I’ll get the support.’ It didn’t happen like that. . .I didn’t think they’d let me walk out after two days.”

Male client

“Hospital is not where I should have been. . .All this assessment has so far, I think, produced very little.”

Female client

²⁷ St Mungo's (2016) *Stop the Scandal* <http://www.mungos.org/documents/7021/7021.pdf>

Interviewees often spoke about being afraid during their time in inpatient mental health services.

“I was so frightened when I met other people... It was very scary, very frightening but at least the positive outcome of it was I got access to medication. That really helped me.”

Male client

“They threw me face-down on the bed if you didn’t take your medicine... all the nurses would come and twist you up, and sedate you. I came out of there worse, and it made me scared to speak about it even more, because if you speak about it, you don’t get out.”

Male client

“It wasn’t a bad experience. It was a bit scary sometimes because they were giving medication that I was hallucinating... You were cared for. Yes, the voices got less and it wasn’t so manic in there.”

Female client

“This psychotic, big bloke, they’d put him on lockdown. They didn’t realise I was sat in the TV room where he was- that was a tad scary.”

Female client

We asked interviewees whether they had visited **A&E or hospital** for any reason other than a mental health problem during the time they were sleeping rough. Seven talked about attending hospital for physical health problems, including abscesses, overdose and seizures. Most said that staff did not enquire about their mental health when they were in hospital.

Some interviewees told us that hospitals and mental health inpatient services had arranged accommodation for them when they were discharged. However, four clients we interviewed had been discharged from hospital to sleep rough, despite telling staff they had nowhere safe to stay.

“I’d finished my 28 day section... I tried to do voluntary, because I had nowhere to stay... There’s not enough space, isn’t it? So they’re only given to the sickest people in there.”

“Straight onto the road. I’m an adult. I was over eighteen, what can you do? Intentionally homeless, isn’t it?”

Male client

6.4. Other agencies are in regular contact with people sleeping rough and have opportunities to intervene to support them with their mental health

We asked interviewees about their interactions with other agencies while they were sleeping rough, and discussed what support they were offered for their mental health.

Nearly all the clients we interviewed had been in contact with **homeless outreach services**, including teams commissioned by local authorities and voluntary schemes. The majority valued the personal interaction they had with outreach workers.

“You’d have the vans that would come around, you know, with the sandwiches, and they’d sit and talk to you, and then people were nicer than the people in authority, really, because they actually genuinely seemed like they cared.”

Female client

“Relief, I think, is what I felt. I think I felt, ‘There’s someone out there who cares.’”

Male client

Outreach teams with no clinical input are not always equipped to address the mental health needs of people sleeping rough. Street outreach professionals have told us that they are often unsuccessful in referring people sleeping rough with a suspected mental health problem into mental health services, and in their experience mainstream mental health services give less weight to the opinions of staff who are not medical professionals.

Interviewees said that outreach workers had helped link them with other types of services, including accommodation and physical healthcare.

“They were concerned, but it didn’t solve my problem. I don’t know if they tried, but they came and talked, and said they would do this, they would do that... You need a roof over your head, and that wasn’t forthcoming.”

Female client

“The outreach, they come and they go and assist people on the street, and then give them an appointment to come and see them in the clinic, you know? Like, two nurses come, and just tell people to come there.”

Male client

Many of the clients we interviewed had contact with **the police** during their time sleeping rough, and in some cases had been taken to a place of safety by police under section 136 of the Mental Health Act.²⁸ Several told us about positive experiences, where police supported them in a mental health crisis.

“I got section 136-ed a couple of times, but I got released the next day, or the day after... the police are alright, they treat you like victims... When you’re ill they’re alright, because they understand you’re ill.”

Male client

“I broke down in the police station. They didn’t know if I was lying, telling the truth, if I really was distressed or if I wasn’t... It was fine, they took me to the hospital and they’d done their bit.”

Male client

“I got a cuddle from the police officer... They were really good and dealt with the situation really well to be honest.”

Female client

However, more general comments about police attitudes to homelessness were less positive. Interviewees were critical in cases where they felt police were unsupportive and did not make efforts to address their homelessness or mental health problems.

“They don’t care do they, coppers won’t. All they would do is wake you up in the morning, and that was it. They’d say, ‘Wake up’, and that was it. No, they don’t talk to you about nothing.”

Male client

“They said, ‘You have to clear the street,’ I said, ‘I have nowhere to go.’ So they took me to the cell... there was no other support. I just stayed there the night and the next, as soon as it was daybreak, I was out again.”

Female client

Five interviewees told us they had been in **prison**. For some, prison offered an opportunity to work on their mental health in a way that was not possible while sleeping rough, although not all client experiences of prison were positive.

²⁸ For more information about the Mental Health Act (1983), see <https://www.mind.org.uk/media/7505/the-mind-guide-to-the-mental-health-act-1983-2012.pdf>

“If I go to prison, obviously, because I don’t have the same amount of access to drugs and alcohol like I do outside, you know, that’s when I tend to seek out therapy and, treatment groups and courses and stuff. You know, I get my head into things.”

Male client

“They don’t know much, they just treat you like a number. You’re just a number to them.”

Female client

6.5. Conclusion

People who sleep rough are coming into contact with a wide range of services during their time on the street. However, when we asked interviewees whether people sleeping rough could access support for their mental health if they needed it, most told us it was difficult. Without adequate mental health support, people can struggle to escape street homelessness. Mental health problems make it harder for people to engage with support services.

“It’s a hard question to answer, ‘How are you feeling?’ If you answer truthfully you’d probably be in tears in seconds or you could be in a fit of rage.”

Male client

In the first stage of our Stop the Scandal investigation, street outreach workers told us that sometimes they are unable to engage properly with people sleeping rough for months or years due to mental health problems.

If services are not equipped to seize every opportunity to support people away from rough sleeping and towards better mental health, people can stay stuck in dangerous circumstances on the streets.

Migration, mental health and rough sleeping

People who have migrated to the UK and end up sleeping rough face additional challenges accessing effective mental health support. In London, 59 per cent of people sleeping rough during 2015/16 were non-UK nationals.²⁹

For some people, language can be a barrier to approaching services for support. Language and cultural differences can affect how people understand and express their own mental health, and how their mental health is perceived by services.

“There was a language barrier, I didn’t speak English at all. I didn’t have anyone to talk to.”

Male client

Where people are not able to receive some welfare benefits or housing support in the UK due to their migration status, the best available support for their mental health may be in their country of origin. Arranging mental health treatment for people sleeping rough can be complicated and involve dealing with a number of additional agencies in the UK and abroad, including embassies and local services.

Some people migrating to the UK have experienced extreme trauma and need immediate support for their mental health. The mental health charity Mind has produced guidance on commissioning mental health services for vulnerable adult migrants.³⁰

²⁹ Data from the Combined Homelessness and Information Network (CHAIN) <https://data.london.gov.uk/dataset/chain-reports>

³⁰ See http://www.mind.org.uk/media/3168649/vulnerable-migrants_2015_mindweb.pdf

7. Five service principles that can rebuild lives

Everyone sleeping rough should be able to access effective support for their mental health. Listening to people who have slept rough in the past can help us understand how services can work for people who are stuck on the streets dealing with poor mental health.

7.1. Five principles for services to adopt

During the interviews we asked clients what was important to them during their contact with different types of services. Working with St Mungo's client involvement group Outside In to analyse data from our interviews, we developed five principles to inform how services working with people sleeping rough with a mental health problem are commissioned and delivered.

These principles should apply to all services that have contact with people sleeping rough with a mental health problem, including health, criminal justice, homelessness and other outreach services.

Accessible

- **Services are genuinely accessible to people sleeping rough.** This means rejecting stigma and developing ways of working with people who are living in unsafe, unpredictable circumstances that can make keeping appointments difficult.
- **Services are available immediately in a crisis** and respond urgently when people sleeping rough are in acute distress, including when people are at risk of harming themselves, being harmed, or harming others.
- **Services continue to work with people as they move on from street homelessness** and are in a better position to focus on their mental health. Support for common mental health problems like anxiety and depression is actively offered to people who have slept rough in the past.
- **Services are designed to support people with complex needs,** including drug and alcohol use, to address mental health problems.

“Particularly with rough sleepers, your life’s so up and down, that keeping appointments and stuff like that is quite difficult.”
Male client

“If you’re not there at a certain time, then you miss out, and, you know, it’s hard.”
Female client

*“‘I’ll see you in two days’ time.’ Where are you going to be in two days? You’re going to probably be swinging from a f***ing lamppost somewhere. A lot of that mental breakdown is emergency there and then.”*
Male client

“They don’t know how to deal with someone that’s just a little bit depressed, or a little bit anxious... Unless you’re hearing voices and licking the window, there’s nothing wrong with you. So you have to be proper crazy before they’ll give you any help.”
Male client

Attentive

- **Services have the time and skills to listen to people**, including people who have multiple problems or find it difficult to discuss their own mental health.

“The doctors took a while to discover what was wrong with me because maybe I wasn’t giving them the right information. Mentally I was not even capable of giving the doctor the right information.”

Male client

“I’m not sure, having gone through the process, that people are actually listening to you.”

Female client

Understanding

- **Services and commissioners actively work to understand homelessness**, and assess the mental health needs of rough sleepers in their area.
- **Services have staff that have the necessary expertise and lived experience** of homelessness and mental health problems.
- **Services find ways of working with complex situations and challenging behaviour**, rather than discharging patients for poor engagement. Services understand that people may be dealing with problems with their housing, income, physical health and substance use as well as mental health problems.
- **Services can work with people whose first language is not English.**

“There’s people here that have been down the road of drugs, drink, homeless, you know, and they’ve come out the other side, so there is that little glimmer of hope. Knowing that, oh, that person has got through it. Maybe I can, you know?”

Female client

“There’s nothing worse than someone going, ‘Oh, we know how you feel,’ and they’ve never been through that...it’s like being patronised.”

Female client

“We’re all human still. People think that we’re just crazy but they’re not, they just need a bit of help... We’ve still got hearts, know what I mean?”

Female client

Caring

- **Services can build trust and personal relationships** with people who have experienced multiple trauma and rejection. Kindness is a quality that is felt to be important in interactions with services but is often missing.³¹

“My doctor, I’ve known him for a little while now. I’d have no qualms about telling him how I feel now and telling him that I need help. The thing is, I’ve got a relationship with him now.”

Female client

*“You’d tell [the GP], you know, what the problem was and he’d just look at you as if to go, ‘Yes, alright’... You know he didn’t f***king believe a word you were saying.”*

Male client

Persistent

- **Services are assertive** and reach out to people sleeping rough with information and support.
- **Services do not give up** on people, even if making progress is difficult.

“The service is there but unless somebody approaches them and directs them, I don’t think the majority of them have access.”

Male client

“You shouldn’t just give up on someone because you look at them and you think, ‘Oh, well they’ve been doing it for years’, because it’s not necessarily like that. Maybe they’ve adapted to that way of life because they haven’t had any help or anything, but there is room for improvement. There always is, there always will be.”

Female client

“Just got to keep trying, like the outreach workers, I suppose, should keep going back to the same person. Just keep going back and offering it until they are ready. It’s just a struggle every day... If you’re there at that time they’ll bite your hand off.”

Male client

Evidence from our research shows that people sleeping rough have contact with the NHS and a variety of other services. Mental health services, homelessness services, criminal justice services and the broader NHS are all part of a system that interacts with people sleeping rough and must take every opportunity to support better mental health and work together for the benefit of the individual.

Achieving this whole person approach is likely to require at least one individual or service to have a complete overview of the whole system to avoid passing clients around services and asking them to repeat their story time and again.

³¹ Fulfilling Lives (2016) *The importance of kindness* <http://mcnevaluation.co.uk/the-importance-of-kindness/>

7.2. Recognising housing as a vital part of the mental health system

As part of our interviews, we asked clients what had helped them most with their mental health. Many clients told us that accommodation had the most important impact on their mental health, giving them safety, security and space to seek support and manage their treatment.

“If the council had housed me properly, that would’ve changed my whole life...I was a seventeen-year-old kid and deserved a chance.”

Male client

“Having a roof over my head. Not sleeping rough. There is nothing to compare with it.”

Female client

The majority of clients told us that staff in their supported housing service would be their first port of call in a mental health crisis. The availability of housing services equipped to support people’s mental health is vital for people who have slept rough.

However, staff in supported housing told us that clients in many areas can still struggle to access support for their mental health when they are housed. According to a recent St Mungo’s survey, only 16 per cent of staff in our accommodation services reported that NHS mental health services in their area met the needs of our clients. The majority of staff reported that the availability of NHS mental health services for their clients had decreased in the last twelve months.³²

To fulfil our five principles, the mental health system must become better integrated with housing and support services and must recognise the importance of housing for prevention and recovery.

7.3. Conclusion

The service principles we have identified require commissioners to take the time to understand rough sleeping in their area, and call for services to have the skills and time to respond to individual situations that can be challenging. In a climate where commissioners and services are regularly required to do more for less, embedding these principles will require leadership and commitment.

However, the human and economic cost of failing to provide the right mental health support is too great to ignore. A 2010 study by the Department of Health (DH) found that people who are homeless attend A&E five times more often than the local average, and their hospital treatment costs are four times higher.³³

³² St Mungo’s (2016) *Stop the Scandal: can people living in homelessness accommodation access mental health services?* <http://www.mungos.org/documents/7143/7143.pdf>

³³ Department of Health Office of the Chief Analyst (2010) *Healthcare for single homeless people* <http://www.qni.org.uk/docs/healthcare%20for%20single%20homeless%20people%20NHS.pdf>

8. The case for specialist homeless mental health services

Our new research has revealed a lack of locally commissioned mental health services that target people sleeping rough. At the same time we have heard that poor mental health is both a cause and consequence of street homelessness, and that existing services are often unable or unwilling to help address mental health problems for people sleeping rough.

Commissioning specialist services can be an effective way to meet our five principles and take responsibility for a group of people who might otherwise be passed around multiple services without access to effective care.

Given the overwhelming evidence that mental health problems disproportionately affect people who are homeless, it is a scandal that so few areas have locally commissioned services designed to meet the mental health needs of people sleeping rough.

We explored the reasons for the lack of specialist services with an expert group of homelessness and mental health commissioners, service providers and policy makers.

Insufficient funding is seen as a significant factor that prevents commissioners from offering mental health services that can be used effectively by people sleeping rough. Our expert group agreed that the service principles we have identified should be the standard expected in the mental health system in all areas. However, they raised concerns about the resources required to embed these principles.

Despite years of debate about integration, services are often described as working in funding silos. It is particularly difficult for commissioners operating with limited budgets to spend on services that may accrue savings to different parts of the public sector. Where councils do continue to invest in services to reduce rough sleeping, including providing mental health support, the NHS, the police and the criminal justice system are likely to benefit from the reduced demand on their services. Despite the obvious benefits, our FOI

research has revealed that partnership working between commissioners in different sectors remains very limited, at least in relation to people sleeping rough.

The expert group also felt our evidence was an example of a wider shortfall in the mental health system for people with common mental health problems like depression and anxiety. The introduction of the Improving Access to Psychological Therapies (IAPT) programme was an attempt to address this problem. However, IAPT has so far struggled to deliver benefits for people with multiple and complex needs, including homelessness and substance use problems.³⁴

For people sleeping rough, there is perhaps a more obvious solution to this problem. Throughout our research into mental health and rough sleeping, we have heard how starting with the basics of a safe place to stay, having enough food, good personal hygiene and someone to talk to are crucial for improving an individual's mental health and preventing problems from getting worse.

A lack of understanding and expertise in homelessness is another reason for the shortage of specialist mental health services. The expert group, which included health professionals, told us that GP training in mental health is insufficient and training in homelessness is non-existent.³⁵ Poor understanding of the particular experiences endured by people sleeping rough also lead to unhelpful attitudes and a reluctance to work with people who present challenging behaviour or appear less willing to engage, even if they are seriously unwell.

Providing the right mental health services for people sleeping rough is evidently challenging, but it is a scandal that people are stuck on the streets, or return to rough sleeping on numerous occasions, because they cannot access the right support for their mental health. The human cost is unacceptable, and the economic cost considerable.

³⁴ The We Need to Talk coalition (2013) *We still need to talk: A report on access to psychological therapies* http://www.mind.org.uk/media/494424/we-still-need-to-talk_report.pdf

³⁵ Research from the mental health charity Mind found that less than half (46%) of trainee GPs undertook a training placement in a mental health setting, and the only option available was based in hospital rather than primary care. For more information, see <http://www.mind.org.uk/media/5063246/find-the-words-report-better-equipped-better-care.pdf>

“If you are depressed then you are screwed. If you are not depressed, you will get depressed.”

Male client

Government has estimated that homelessness costs local government, health and criminal justice services up to £1 billion per year. Most of the additional costs of homelessness to the public purse are attributed to people who are sleeping rough and in hostels with multiple needs.³⁶ Providing effective services for people sleeping rough with mental health problems could generate savings as well as alleviating individual suffering.

The final section of this report summarises our recommendations for the development of these services and describes the role that must be played by national government, local commissioners and health professionals.

³⁶ Department for Communities and Local Government (2012) *Evidence review of the costs of homelessness* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/7596/2200485.pdf

9. Recommendations

Services

- Services in every part of the country that come into contact with people sleeping rough with a mental health problem should adopt our five principles. These services, regardless of their area of expertise, must be:
 - Accessible
 - Attentive
 - Understanding
 - Caring
 - Persistent
- All areas should identify individual leads within NHS mental health services with responsibility for supporting people sleeping rough to access effective treatment and support.
- There should be specialist homeless mental health services in all areas with the highest levels of rough sleeping.

National government

St Mungo's *Stop the Scandal* campaign is calling for the Prime Minister to lead a new strategy to end rough sleeping. As part of this, the government must meet its commitment to improve mental health services for homeless people and invest in specialist homelessness mental health support.

We hope that the funding for social impact bonds to turn around the lives of the most entrenched rough sleepers is a helpful start. Those delivering the support will be paid for outcomes including engagement with mental health services. This has the potential to improve partnership working between existing services and increase the availability of specialist homeless mental health services. However, the funding will only be available in five to ten areas of the country and is time limited. It is important that there are reforms that deliver lasting changes that reach people wherever they are sleeping rough.

- The Prime Minister should lead a new strategy to end rough sleeping, including funding to help local areas deliver specialist homeless mental health services.
- The ministerial working group on homelessness should produce a detailed plan for improving mental health services for homeless people, including steps it will take to ensure specialist homeless mental health services are available in all areas with the highest levels of rough sleeping.
- The Department for Communities and Local Government should continue to support efforts to improve the homelessness legislation via the Homelessness Reduction Bill and fund its implementation.
- The Department of Health should work with NHS England to ensure planned improvements to community mental health services including crisis care – stemming from the Mental Health Taskforce report – take into account the needs of people sleeping rough.
- Government ministers should instruct research bodies to prioritise research into effective mental health treatment for people with multiple needs.

Local councillors and commissioners

Local councillors and commissioners must take responsibility for measuring, understanding and meeting the health needs of people who are homeless.³⁷ This includes taking steps to ensure that everyone can access the mental health support they need. This applies to commissioners with responsibilities for homelessness, as well as those with responsibilities for mental health.

- Local areas should assess the quality and accessibility of mental health support for people sleeping rough in their area, taking account of the whole system.
- Local areas should ensure that there is a clear service offer for people who struggle to access mainstream mental health services, including specific provision for people sleeping rough. This offer should identify a service or individual with the responsibility for ensuring that people receive effective treatment and support.
- Local commissioners should ensure the mental health system is integrated with housing and support services and the system adopts all five principles set out in this report in order to provide effective assessment, support and treatment for people sleeping rough with mental health problems.
- Local areas should provide supported accommodation with a specific mental health focus, integrated into NHS pathways.
- Local areas should produce a plan to prevent homelessness when people are discharged from mental health inpatient services. This could mean ensuring homelessness services are involved as part of discharge planning to prevent hospital discharges to the street.

Health professionals

Health professionals, including GPs and mental health practitioners, must take responsibility for ensuring they have a good working knowledge and understanding of homelessness and rough sleeping.

- Organisations responsible for education, training and workforce development in the health sector should ensure training on homelessness is readily available to all health professionals and consider including it in the core curriculum.
- Health professionals should seek opportunities to work alongside people with lived experience of homelessness.
- Health service managers should review the way data on the housing needs of patients is recorded and make improvements if necessary.

³⁷ St Mungo's Homeless Health Matters campaign asked Health and Wellbeing Boards to commit to measuring, understanding and meeting the health needs of people who are homeless by signing our *Charter for Homeless Health*. 44 Health and Wellbeing Boards in England have signed the Charter. For more information, see: <http://www.mungos.org/hwbinfo>

Appendix

List of district authorities, unitary authorities and London Boroughs in England with ten or more people sleeping rough on one night in autumn 2015.

Source: Department for Communities and Local Government³⁸

Arun	Dartford	Luton	Southwark
Aylesbury Vale	Derby	Maidstone	Spelthorne
Barking and Dagenham	Ealing	Manchester	St Albans
Barnet	East Riding of Yorkshire	Medway	Stoke-on-Trent
Basildon	Eastbourne	Mendip	Surrey Heath
Basingstoke and Deane	Exeter	Milton Keynes	Swindon
Bassetlaw	Gloucester	Newark and Sherwood	Tameside
Bath and North East Somerset	Greenwich	Newham	Taunton Deane
Bedford	Guildford	North Devon	Thanet
Birmingham	Hackney	Northampton	Torbay
Bournemouth	Haringey	Norwich	Tower Hamlets
Bradford	Harlow	Nottingham	Tunbridge Wells
Brent	Hastings	Oxford	Waltham Forest
Brighton and Hove	Havant	Peterborough	Wandsworth
Bristol	Havering	Plymouth	Warwick
Cambridge	Herefordshire	Poole	Watford
Camden	Hertsmere	Portsmouth	Welwyn Hatfield
Canterbury	Hillingdon	Reading	West Berkshire
Central Bedfordshire	Hounslow	Redbridge	Westminster
Chelmsford	Ipswich	Richmond upon Thames	Wiltshire
Cherwell	Kensington and Chelsea	Rugby	Windsor and Maidenhead
Chichester	Kingston upon Hull, City of	Rushmoor	Woking
City of London	Kingston upon Thames	Salford	Wokingham
Corby	Lambeth	Sheffield	Wolverhampton
Cornwall	Leeds	Shepway	Worcester
Crawley	Leicester	Slough	Worthing
Croydon	Lincoln	Southampton	Wycombe
	Liverpool	Southend-on-Sea	York

³⁸ <https://www.gov.uk/government/collections/homelessness-statistics#rough-sleeping>

Lead author: Catherine Glew, with Beatrice Orchard

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For more information contact:

St Mungo's, Fifth Floor,
3 Thomas More Square, London E1W 1YW

Tel: 020 3856 6000 Fax: 020 3856 6001

www.mungos.org

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