

Good practice: briefing

A long way from home

Mental distress and long-term homelessness

Introduction

The prevalence of mental health needs among those experiencing homelessness and the difficulties they face when attempting to access mainstream mental health services are well documented.¹

Shelter's research shows that people with mental health problems are at a greater risk of experiencing long-term, damaging homelessness. This continues to occur despite recent changes in policy and the introduction of high-profile reports and practice guidelines.

From April to October 2007, Shelter conducted in-depth, semi-structured interviews with 22 people at low-threshold homelessness services² in Westminster, Doncaster, Liverpool and Manchester. All service users had experienced long-term homelessness and suffered from mental health problems, from chronic or severe to the more 'common' mental health problems, such as depression, anxiety, and stress. Key findings included the following:

- Despite positive changes within service provision, many of the barriers to accessing mental health support remain, and are a continuing challenge to the development of good practice.
- Emergency, temporary, and supported accommodation schemes tend to be generic services, housing a mix of individuals with differing needs. Hostel workers can lack the relevant knowledge and skills necessary to support fully those suffering from mental distress. This can lead to exclusion from hostels and create additional problems for the service user.
- Drug and alcohol problems were common among interviewees, who reported that primary-care practitioners were often reluctant to refer them to psychiatric services. This can hinder recovery and exacerbate current mental distress.

This briefing collates the key issues raised during the interviews. It identifies good practice for those working with people who have been homeless for a long time and have mental health support needs. The briefing also examines how to prevent long-term homelessness by working effectively with people experiencing mental distress.

¹ For further information see: Randall, G, Britton, J, Brown, S, and Craig, T, *Getting through: access to mental health services for people who are homeless or living in temporary or insecure accommodation*, Department of Health (DoH), Communities and Local Government (CLG) and Care Service Improvement Partnership (CSIP), 2006.

² This term is used to describe services that are easily accessible or do not stipulate specific support needs or referral criteria. They tend to be drop-in style services.

Policy context

Historically, national mental health policy has focused on severe and enduring mental illness and has excluded personality disorders. Mainstream mental health services have, therefore, developed accordingly.³ Consequently, homeless people with intermediate- or lower-level mental health needs, and those who have received a formal or informal diagnosis of a personality disorder, have traditionally experienced the greatest difficulties in accessing appropriate accommodation, treatment, psychological therapies, and day-to-day support. Most homeless people experiencing common mental health problems are limited to primary-care interventions, and the prescription of anti-depressant medication.

In recent years, government departments have responded to the mental health needs of those experiencing homelessness with a number of initiatives. In 1990, the Homeless Mentally Ill Initiative (HMI) was launched by the Department of Health (DoH) in response to the high number of mentally ill people sleeping rough on the streets of London. Following this, and in response to the difficulties that many homeless people face in attempting to access primary healthcare, homeless Personal Medical Services (PMS) schemes were developed across the UK.⁴ Recent government guidance⁵ has recognised the need to develop services that address some of the more complex mental health needs of those experiencing homelessness. The guidance places an expectation on mental health services to take a lead in developing integrated support provision which is inclusive of both dual diagnosis⁶ and personality disorders, reducing the number of people who are moved between, or excluded from, services.

Other government documents describe the ways in which health and social care should be more closely linked.⁷ This interest is furthered in a practical capacity through initiatives such as the Hostels Capital Improvement Programme (HCIP). One aim

of the HCIP is to develop hostel provision that better addresses residents' health, training and employment needs. Another current initiative, the Adults Facing Chronic Exclusion (ACE) pilots, cuts across a range of service areas including health, mental health and homelessness.

This increased strategic interest in complex needs has been underpinned by the introduction of a planning and commissioning framework for services relating to the health needs of people who are homeless or living in temporary or insecure accommodation. The framework provides guidelines for the joint planning and commissioning of health, social care and housing services. The aim is to develop the means to coordinate service delivery, address current gaps in service provision, and improve health and housing outcomes for vulnerable adults.⁸ This document and the *Homelessness Code of Guidance for Local Authorities*⁹ places an expectation on local authorities to outline clear service pathways within health, social care, and housing, in revised homelessness strategies.

The removal of the ring fence on Supporting People funding and the implementation of local area agreements could provide a further opportunity for local authorities to pool funding streams (including those from Communities and Local Government (CLG) and DoH), and develop more flexible solutions to meet locally defined needs in the areas of health, housing and homelessness.

Key findings

The study group

Shelter's interviewees experienced a range of mental health needs – from depression, stress and anxiety, to schizophrenia, psychosis and personality disorders. A high proportion of the interviewees identified additional support needs, including drug and alcohol problems, a history of offending, and physical disability or illness. People's mental health

3 The Mental Health Act 2007 has introduced changes to the definition of mental disorder and the criteria for detention with the removal of the 'treatability test'. Both amendments have implications for people diagnosed with a personality disorder.

4 PMS schemes provide flexible core primary health services to homeless people, some of which also offer specialist mental health services and psychological therapies.

5 For example: DoH, *Mental health policy implementation guide: dual diagnosis good practice guide*, 2002; National Institute for Mental Health in England, *Personality disorder: no longer a diagnosis of exclusion, policy implementation guidance for the development of services for people with personality disorder*, 2003.

6 Dual diagnosis is a term used to describe the co-existence of both mental health problems and drug/alcohol use.

7 HM Government, *Reaching out: an action plan on social exclusion*, 2006; Office of the Deputy Prime Minister (ODPM), *Sustainable communities: settled homes; changing lives*, 2005; DoH, *Our health, our care, our say: a new direction for commissioning services*, 2006.

8 CLG, *Framework for planning and commissioning of services related to the health needs of people who are homeless or living in temporary or insecure accommodation*, 2007.

9 Department of Communities and Local Government (DCLG), *Homelessness Code of Guidance for Local Authorities*, 2006.

and support needs were interconnected with a range of personal experiences. These experiences commonly included: local authority care; violence; harassment; abuse or neglect; bereavement; relationship breakdown; and problematic family relationships.

Losing tenancies

Tenancy loss through eviction or abandonment is a recurring issue for people with mental health needs. Losing a tenancy can be devastating. Life on the streets, or in temporary and/or insecure accommodation, can exacerbate existing mental health problems. This limits a person's ability to access and maintain accommodation, while compounding their experiences of social exclusion, hopelessness and powerlessness.

Accessing mental health services and receiving a diagnosis can lead to increased support provision for both obtaining and maintaining a tenancy. However, the people we spoke to only accessed treatment and support after they had experienced a crisis and lost their tenancy.

Assessment and intervention

Service users expressed frustration at the difficulties they experienced when trying to access mental health assessments, treatment, and support. These included a lack of response to people with common mental health problems and those who were actively using drugs or alcohol. Lengthy referral processes were also a problem. They reported that GPs acted as a source of information on, and referral into, psychiatric services, but in some cases they also acted as a gatekeeper by rationing limited resources.

Service users found that their drug or alcohol problems became worse without mental health treatment or emotional support and as a result of unwanted side effects from prescribed medication. Others used substances in an attempt to find some form of emotional relief or escape.

Those who had been referred to mental health services found that accessing an assessment was a very lengthy process. Many found that difficulties and delays led to further deterioration of their mental health, which often occurred alongside crisis situations involving the accrual of debt and rent arrears, relationship breakdown, eviction, or abandoned tenancies.

Broken links

While hospitalisation and acute inpatient care can provide a pathway into the assessment process and statutory mental health services, it does not always provide the holistic assessment of need that homeless people require. Service users described instances where they were discharged before they felt ready to leave. Some were discharged back to the street or with a referral to attend a local homelessness service. Others felt that once they were discharged support was either inconsistent, or reduced and withdrawn against their wishes. Few service users were discharged with a formal treatment plan.

Someone to talk to

Traumatic events, such as relationship breakdowns or loss of specialised support, can play a large part in the deterioration of mental health. Such deterioration can then lead to the loss of a tenancy. Fifty per cent of Shelter's interviewees stated that they would like to be provided with long-term counselling. Psychological therapies, such as counselling, are viewed as a tool that could provide alternative coping mechanisms and aid the service user when settling into a tenancy. Those who did have access to such therapies emphasised their value, in particular therapies operating on an informal or drop-in basis.

Unhealthy hostels

Hostels tend to be a generic service, housing a variety of people with widely differing needs. Vulnerable and emotionally damaged people experiencing mental distress share hostels with a range of other people, many of whom have similarly entrenched patterns of behaviour. Shelter's interviewees explained how hostels can provide an environment where abusive behaviour compounds mental distress and the experience of victimisation. Most service users felt that hostel staff lacked strong mental health skills and were occasionally unaware of the deterioration in some residents' mental health until they had reached crisis point.

The levels of stress, depression and anxiety experienced by service users increased when they felt unsupported or disconnected from the support process. Such disconnection can lead to increased feelings of insecurity, hopelessness and powerlessness. Without appropriate supervision and support, front-line workers can find themselves without the tools to manage 'challenging' behaviour.

Service users reported being excluded from all, or most, hostels and emergency access services, which reinforced previous feelings of rejection and abandonment.

Hostel regimes can have a negative impact on mental wellbeing. In particular, hostel regimes can be too loosely structured, or too strictly structured with time-limited placements, which can result in feelings of insecurity. Subsequently, this can create feelings of deep confusion and distress for service users.

Vulnerability and moving on

All interviewees discussed a fear of moving on to independent tenancies, and of what would happen to them 'after homelessness'. Some had experiences of being repeatedly moved on to inappropriate accommodation, often located in undesirable areas with poor access to the local infrastructure. Others reported being left with little, or no, support, which for some led to heightened mental distress, exploitation by local residents, increased drug or alcohol use, tenancy breakdown, and eviction.

Interviewees described how housing providers had turned away those who had additional support needs, particularly ongoing drug and alcohol dependencies, those without a local connection, and people with a history of rent arrears. Local authorities do not always consider people with mental health problems to be vulnerable and in priority need under the homelessness legislation, meaning that such people are not owed an ongoing housing duty. For this group, the alternative accommodation on offer in the private rented sector is extremely difficult to access, insecure, and inadequately supported.

Supported accommodation?

Key workers or mental health practitioners do not always provide support at a level that meets people's needs. Some interviewees found that support was tapered and time-limited. In addition, people experienced a high turnover of support workers, limiting their opportunity to develop trusting and stable relationships.

Eight interviewees stated that they would like to live in some form of supported housing, ranging from sheltered accommodation to 24-hour supported housing. There was a desire among service users for independent living space combined with support or company when required. However, in some areas, the provision of supported housing schemes is insufficient; those who are deemed eligible for

supported accommodation are unable to access it when necessary. Of those service users that Shelter interviewed, at least two people's homelessness could have been prevented if supported accommodation had been available before they reached crisis point.

Service users who secured supported housing stated that their accommodation was not suitable. They felt that the housing schemes were not properly managed and they did not receive adequate support, creating an unstable living environment, and the potential for tenancies to fail.

Services without substance

Drug and alcohol problems were prevalent among those interviewed. Substance use can exacerbate mental health problems and, equally, mental distress can exacerbate substance use. However, service users found that primary care practitioners were often reluctant to refer them on to psychiatric services. Those who were able to access both mental health and drug and alcohol treatment services reported a lack of coordination between the two agencies.

There are few providers of specialist mental health supported housing who will accept referrals for people who continue to use substances, and some service users found that their referrals had been blocked. Housing providers often operate drug-free referral policies, and where referrals are accepted, the health and support agencies previously involved frequently withdraw contact in light of the support offered by the housing provider.

Housing is a vital aspect of any healthcare plan. Service users strongly feel that if they are able to access secure and stable accommodation, they would stand a better chance of stabilising their drug and alcohol use, and therefore managing their mental health needs.

Personality disorders

Personality disorders are common among people experiencing long-term homelessness. Research suggests that approximately two-thirds of street homeless people meet the diagnosable criteria for a personality disorder, yet only one in ten of those will have a formal diagnosis.¹⁰ People with personality disorders are more likely to experience other mental health problems and have multiple complex needs relating to housing, relationships, and drug/alcohol use.

¹⁰ Middleton R, *Brokering reality: a review of service provision in Leeds for homeless people with personality disorder/complex needs*, Community Links, 2008.

Homeless people with personality disorders experience particular difficulties in accessing services. Two of Shelter's interviewees have been diagnosed with a personality disorder, and have previously experienced complex trauma. However, neither had been able to access psychological therapies or long-term statutory mental health support. Instead, their support has largely been provided by homelessness services.

A diagnosis of personality disorder can be given to people who services find too challenging to work with. Formal or informal, the label of having a personality disorder can carry significant stigma. Whether such a label is an accurate reflection of someone's mental health needs or not, services can be reluctant to accept people labelled in this way and this can have detrimental consequences for homeless service users.

Managing expectations

Service users experienced a high degree of inconsistency in the type of service allocated and the level of communication and support that they received. This can have an acute impact on the individual, due to the recurring theme of experiencing rejection, loss, and problematic relationships initially developed during their formative years. When practitioners are not clear about what their services can offer and what they can reasonably expect to achieve, people can very quickly become disillusioned with the whole process, reinforcing negative beliefs about themselves and 'the system'.

Developing good practice

In the absence of appropriate and timely support, mental distress can contribute to a cycle of failed tenancies and long-term homelessness. The consequences of homelessness and bad housing can be devastating. Therefore, it is in everyone's best interests to develop good practice within services that address the needs of this vulnerable group.

This section identifies good practice for those working with people experiencing mental distress and long-term homelessness, and how long-term homelessness can be prevented through multi-agency partnerships and effective provision of support to service users.

Preventing tenancy loss

Local authorities and social landlords have a vital role to play in preventing people from losing their tenancies and averting long-term homelessness.

It is crucial that front-line workers identify housing problems while providing referral pathways to a range of support interventions. Social housing providers can achieve this by developing the following measures:

- a vulnerable people protocol: a multi-agency protocol and staff training package that provides indicators for vulnerability (including loss of income, debt, rent arrears, experiences of harassment or antisocial behaviour, and episodes of stress or mental ill health), and procedures for providing timely information, advice and support to prevent tenancy loss
- jointly agreed and quickly accessible structured channels for communication and multi-agency working with external agencies, including voluntary and statutory mental health support services
- joint training of housing officers and mental health practitioners in the relationship between both mental health and housing problems
- employment of a mental health practitioner to provide support and advocacy services to tenants
- employment of an internal housing benefit liaison officer to speed up the application process, deal with delays or difficulties, and prevent rent arrears from accruing.

If implemented and monitored, formal mechanisms for multi-agency working can be effective tools for preventing homelessness. For example, it is good practice for hospitals to produce and implement admission and discharge protocols for homeless people or people threatened with homelessness. Government guidance advises that post-discharge care plans and protocols should be developed, and specialist discharge workers or mental health advocates should be employed to assess and address housing needs prior to discharge.¹¹ However, developments have been slow across the UK, and greater emphasis must be placed on implementing this guidance.

GP surgeries, day centres, and other publicly accessible areas could provide housing and benefits advice for those who are not in receipt of, or who may not qualify for, mental health services. Such advice is already delivered in these settings but provision is inconsistent.

Accessible mental health services

There is a distinct need for the further development of flexible services that address a wide range of mental health needs. Health services must make homeless

¹¹ CLG and DoH, *Hospital admission and discharge: people who are homeless or living in temporary or insecure accommodation*, 2006.

people a priority group, taking into consideration the full complexity of their needs (including drug and alcohol use, and personality disorders).

Access to counselling and psychological therapies remains inconsistent. On the whole, patients can access counselling through their GP, but waiting times can be lengthy, being in excess of 12 months in some areas. The structure of traditional psychological therapies are not focused towards meeting the needs of multiply excluded people with frequently chaotic lifestyles.

Recent reports on the provision of psychological therapies¹² have led to a commitment by the Government to increase access to cognitive behavioural therapies (CBT) for people with mild to moderate mental health problems.¹³ This is unlikely to benefit homeless people who find it more difficult to access standard primary healthcare settings. The Government must identify additional funding to enable the roll-out of psychological therapies to homeless people. This is more likely to be achieved if shared outcomes can be developed, for example by reducing accident and emergency admissions, psychiatric inpatient admissions, and evictions.

Improving health in hostels

Accommodation services would benefit from the further development of on-site specialist mental health support. Mental health and psychotherapeutic services are less accessible and less effective when delivered as standard outpatient services. Intensive therapeutic support provided on site can assist people with even the most complex mental health and addiction-related support needs to access positive pathways out of homelessness.

Crises, relapses and repeat evictions/homelessness have a significant effect on service users and the front-line practitioners who work with them. Increased availability of CBT and other cognitive therapies benefits homeless people and also front-line homelessness workers, particularly those trained to operate with a CBT perspective. Those working in hostels should receive structured mental health training, support and supervision. Partnerships should be developed to provide front-line workers with access to advice and guidance from specialist workers.

Shelter believes that the development of the provision of mental health services within accommodation-based projects is essential.

Homelessness applications

When deciding whether or not the local authority owes a homelessness duty to the applicant, a local authority must assess whether the applicant is homeless or threatened with homelessness, eligible for assistance, in priority need, intentionally homeless, and has a local connection. This can cause problems because people experiencing mental distress are not always considered to be in priority need. Also, if their mental health issues led to the applicant abandoning their tenancy, or to the accrual of rent arrears, they may be considered intentionally homeless, and would not be owed a homelessness duty under the relevant legislation.

Shelter recommends the provision of interim accommodation and support for all those experiencing homelessness while a more complete assessment of their needs is made.

Applying for housing

Standard housing allocation does not work well for homeless people with mental health problems and complex needs. Once housed, consideration is not always given to their reduced ability to deal with difficulties relating to their tenancies. Losing a tenancy can have serious consequences, because individuals can face difficulties obtaining social housing in the future due to eligibility issues, being low priority, or lack of a local connection to the area.

Social housing is a finite resource that has been vastly diminished in many local authority areas. In the absence of alternatives, people with support needs are often housed in harder-to-let properties. In these circumstances, people are set up to fail in their tenancies. Therefore, there is a real and urgent need to examine alternative models of supported housing schemes that successfully utilise the private rented sector.

Shelter recognises that housing providers need to take into account the limitations of their allocation schemes towards those suffering mental health problems. They also need to ensure that multi-agency working is in place to provide tenants with appropriate support. Renewed clarity on reconnections guidance and assessment of the ways in which reconnections criteria are employed in local authority areas are also needed to promote consistent practice towards this very vulnerable group.

¹² For more information see: Bird A, *We need to talk: the case for psychological therapy on the NHS*, 2006; Mental Health Foundation and London School of Economics and Political Science (LSE), *The depression report: a new deal for depression and anxiety disorders*, 2006.

¹³ DoH Improving Access to Psychological Therapies (IAPT) Programme.

Supported accommodation

In order to tackle long-term homelessness for people with mental health problems, there needs to be an increase in the range of supported housing options available. Such schemes have typically developed around the 'core and cluster' model.¹⁴ Shelter recommends that these schemes are made available to people who have mental health needs and are continuing substance users, and people without formal mental health diagnoses. Schemes should cover both low-to-medium and medium-to-high support needs.

Shelter emphasises the importance of expanding the range and provision of supported accommodation services and urges local authorities, in consultation with a wide range of local voluntary and statutory agencies and service user groups, to fully investigate the level of need in their area. This is particularly imperative in light of the removal of the Supporting People ring fence, and the development of local area agreements.

Dual diagnosis services

Substance use was prevalent among those interviewed by Shelter and presented significant barriers to accessing treatment, housing and support. Specialist dual diagnosis services have been developed in some areas, but provision remains variable. Therefore, it is vitally important that development of dual diagnosis services continues and that access to, and coordination of, support is greatly improved.

Shelter recommends that drug and alcohol agencies should make mental health a core part of their service provision, and that mental health services should ensure that substance use is not used as an exclusionary measure in the rationing of their resources. Drug and alcohol services are in an ideal position to assess people's mental health needs and refer clients on to mental health services or, where appropriate, provide lower-level mental health support as part of an integrated treatment package.

Treatment services, mental health support services, and housing services should develop formal partnerships with each other. This would ensure that service users receive a more coordinated approach to assessment and referral processes, allowing services to take a more holistic approach to support provision. Additionally, developing joint assessments between treatment and mental health services would reduce the need for multiple assessments.

Personality disorder services

There is a high level of unmet need among people who meet the diagnosable criteria of a personality disorder. However, service structures have traditionally developed in such a way that the person has to fit the support provision rather than services being developed to meet the individual needs of the person. This approach leaves many people multiply excluded from the support they require. In addition, in most areas, the move towards brief interventions and time-limited support poses particular problems for this group, who require a consistent and coordinated approach to meeting their needs.

Shelter supports the 'mainstreaming' of personality disorder services within existing mental health, housing, and support services, along with the development of specialist personality disorder services.

Shelter is concerned that despite recent policy guidance and the development of specific initiatives, the range of mental health provision that those experiencing homelessness need is still unavailable in most cases. Until the mental health needs of multiply excluded groups is made a priority within services, very little will change and people's pathways out of long-term homelessness will remain fraught with difficulties.

Further information

Community Links Personality Disorder Accommodation Service

Ray Middleton, Manager
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Chapel Allerton District Centre
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Dual diagnosis services

Tracy Lundie, Manager
Midway Services
Turning Point Scotland
54 Govan Road
Glasgow G51 1JL
E-mail: tracylundie@turningpointscotland.com

Homeless PMS Services

Great Chapel Street Medical Centre
13 Great Chapel Street
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¹⁴ A 'core and cluster' model has semi-independent, self-contained units with on-site support and recreational facilities.

Recommendations

- Measures should be taken to ensure early identification of housing problems. Partnership and multi-agency working, appropriate skill training, and the employment of a mental health practitioner by a local authority or registered social landlord can ensure necessary support intervention.
- Local authorities should review advice and advocacy services available in their areas, and develop outreach services according to need.
- Local primary and secondary mental health services need to be reviewed, and the capacity of statutory community mental health services to respond to homeless people in a range of settings should be evaluated. Access to mainstream primary-healthcare services must be improved, and homeless PMS schemes should be expanded according to local need.
- Mental health services should be delivered within accommodation-based projects, specifically within hostels where differing regimes can adversely affect people's mental health.
- Front-line workers in hostels should receive structured mental health training, support and supervision, with access to advice and guidance from specialist services, allowing them to provide more in-depth support to the service users.
- Housing allocation policies should be amended so that they work better for homeless people with mental health problems and complex needs.
- Long-term supported housing schemes should be developed so that they offer both independent living space and on-site support.
- There should be development of increased levels of training, supervision and support of practitioners within existing services and across sectors.
- A coordinated, multi-agency network approach to housing and supporting homeless people with a personality disorder should be taken, along with an increase in the provision of psychological therapies.

Shelter, the housing and homelessness charity

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