The mental health needs of Nottingham's homeless population: *an exploratory research study*

Final Report

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Rough sleeping and homelessness have risen sharply in Nottingham in the past couple of years, reflecting nationwide trends. The relationship between health and homelessness has also increasingly been recognised, establishing homeless people as the concern of the CCG and NHS services.

The overarching aim of the study is *'to explore and understand the mental health needs of Nottingham's homeless population to inform how Nottingham City CCG can best work with local partners to better meet these needs.'*

The study comprised four overlapping phases:

Phase 1: Understanding the population. This phase of the research drew on primary research and secondary sources to profile the mental health needs of Nottingham's homeless population. In total, 167 people with a recent experience of homelessness (currently or in the past 6 months) were surveyed by the study team between February and May 2017. Survey fieldwork was conducted in a range of generic homelessness services. No specialist mental health services were included so as not to skew the results towards people with mental health issues.

Phase 2: Understanding the citizen story. This phase of the research comprised in-depth interviews with homeless people with mental ill health in Nottingham. The qualitative interviews with 37 homeless people with mental health needs were conducted in a smaller number of homelessness services, purposely targeted to maximise the diversity of the sample.

Phase 3: Understanding the stakeholder perspective. Through a series of interviews with local stakeholders this phase explored professionals' experiences of homeless people with mental ill health. Interviews were conducted with 23 stakeholders working at a strategic/policy, managerial, and front-line level in a range of organisations across the NHS, Local Authority and voluntary sector.

Phase 4: Learning from good practice. This phase involved a review of good practice to identify lessons that might be transferable to the Nottingham context.

The terms 'homelessness' and 'mental health' are used variably and loosely so it is important to clarify our terms for the purposes of this study:

- Homelessness. We adopted the legal definition of homelessness as set out in the Housing (Homeless Persons) Act 1977.

- Mental Health. An inclusive definition of mental ill health was employed, which ranges from mental disorder through to poor mental wellbeing. However, the survey was designed to ensure we could distinguish different types and severity of mental ill health.

Prevalence of mental ill health amongst homeless people in Nottingham (Chapter 2)

A number of previous studies have identified high levels of mental ill health amongst homeless people. Mental ill health was prevalent amongst respondents to our survey in Nottingham, with three quarters indicating that they had experienced mental health issues. In addition, one in five respondents had been detained under the Mental Health Act at some point in their life. More broadly, mental health issues were associated with lower wellbeing amongst our survey sample.

The mental health needs and conditions of homeless people in Nottingham (Chapter 3)

Homeless people in Nottingham are significantly more likely to have been diagnosed with all mental health conditions than the general population. Exploring respondents' mental health diagnoses in more detail reveals a picture of multiple mental health needs. Depression and anxiety were the most common mental disorders, and they were frequently diagnosed alongside other, more severe, conditions. Within our survey sample, almost two thirds of respondents with mental health issues (almost half of all respondents) had a diagnosis of a severe mental health condition (i.e. a condition other than depression and/or anxiety).

A number of broad patterns emerged relating to the onset and triggering of mental health issues amongst the homeless people interviewed for this study:

- Long-term mental health issues. Many respondents had experienced mental health issues - although not always diagnosed as such - for numerous years, often since childhood or adolescence.

- Mental health issues were typically triggered by a specific event, or ongoing trauma rather than developing independently of life experiences, and/or;

- Pre-existing but managed mental health issues were further exacerbated, or brought to crisis, by life events including stress, trauma and homelessness.

The association between mental health issues and adverse experiences in childhood signals a critical intervention opportunity. The coincidence between mental health issues and homelessness and other poor outcomes in adulthood, such as substance misuse and offending, points to a potential need for upstream preventative measures.

Housing situations and experiences (Chapter 4)

Understanding how and why people become homeless and their subsequent homelessness trajectories provides insight into their wider needs. The survey data show that the most common reason for respondents with mental ill health to have first become homeless was a relationship breakdown with their parents. Respondents with mental health issues were more likely to experience enduring homelessness.

Insights from the qualitative interviews offer a more in-depth and nuanced account of the causes and triggers of participants' homelessness. There were often considerably more complex factors at play and long chains of life events behind the single reasons captured in the survey responses. In a small number of cases, respondents had become homeless because of problems with their mental health. A number of triggers for homelessness emerged including leaving prison, leaving care, domestic violence and issues with the asylum system.

Homelessness repeated itself, as most participants lacked a secure family unit to offer a home and safety net when things went wrong; and as complex and severe needs were not

met with appropriate support. Nearly all of the people we spoke to had been 'stuck' in the temporary accommodation system for years - moving in and out with only brief spells of relative stability. It is vital for future interventions to take into account the features of these homelessness pathways, and the reasons for participants' homelessness.

Mental ill health: cause or consequence of homelessness? (Chapter 5)

The relationship between homelessness and mental ill health is complex. In some cases there may be a clear linear trajectory from mental ill health to homelessness, or vice versa. Often, however, there is no clear direction of causation but, rather, a mutually reinforcing relationship which is often mediated by other needs and experiences, in particular drug or alcohol abuse. It is absolutely clear that homelessness has a detrimental impact on mental health and wellbeing and can exacerbate existing conditions. With few exceptions, respondents had some form of mental health issue prior to their first episode of homelessness. However, the experience of homelessness can bring people to the point of mental health crisis.

Some of the key themes which emerged were that:

- A mental health crisis resulting in detention under the Mental Health Act presents a homelessness risk.

- Drug and alcohol use and mental ill health are usually deeply interlinked, and sometimes rooted in the same traumatic experience, and it is difficult for people with dual diagnosis to disentangle them in order to address them separately or sequentially.

- Mental ill health and homelessness (and drug or alcohol abuse) are rarely the only challenges faced by this population. This leads on to discussion of multiple, complex needs.

Additional support needs (Chapter 6)

Homeless people with mental ill health might be more accurately described as having 'multiple or complex needs' or as a population facing 'multiple exclusion homelessness.' Our findings concur with the results of other studies of 'multiple exclusion homelessness' that find a high degree of overlap between experiences of homelessness and other domains of social exclusion (including mental ill health). They conclude that multiple exclusion homelessness is often positively associated with adverse life experiences particularly childhood deprivation and trauma.

We undertook logistic regression analysis of survey data and found that, within our model, homeless people were:

- 11 times more likely to have a mental health diagnosis if they had spent time in prison.

- Six times more likely to have a mental health diagnosis if they had physical health issues.

- Six times more likely to have a mental health diagnosis if they had experienced domestic violence.

- Four times more likely to have a mental health diagnosis if they were aged under 25.

The qualitative interviews strongly mirror the results from the regression model. It is rare for mental ill health and housing problems to be the only issues facing this population group. These findings suggest that certain sub-groups of homeless people may be particularly at risk of mental ill health. This has important implications for service commissioning and delivery. It presents opportunities for targeting intervention and preventative work.

Understanding multiple exclusion homelessness: the distinctiveness of the client group (Chapter 7)

Distinct features of homelessness - multiple exclusion homelessness in particular - influence access to support services and people's capacity to engage. Our research highlights some of the distinctive features of homelessness, or characteristics of homeless people with complex needs:

- Daily survival is a challenge for homeless people and represents a set of priorities that most housed people don't have. As a result, mental health is not always prioritised.

- There can be a very small window to effect change that is incompatible with the slow process of accessing many services (e.g. waiting lists).

- The family circumstances of homeless people with complex needs are often chaotic, conflictual, or insecure. This means that family and friends may not represent the safe, supportive, stable environment that it does for others.

- Homeless people's previous experiences of support services often results in a lack of trust of others and/or a strong sense of self-reliance.

- This is a particularly transient population.

- Progress, and recovery can be slow.

- Low self-esteem, or feelings of hopelessness are common.

Patterns of service use and engagement (Chapter 8)

The majority (over half) of homeless people with mental ill health who feel they need support or treatment, are accessing services. However, one in five respondents were receiving no support or treatment, but required it. Prescribed medication was the most common treatment, followed by help from general health providers. The following themes emerged from the research:

- A wide range of mental health services were being accessed by homeless people in Nottingham.

- The majority of respondents were also in contact with non-mental health services.

- The majority of respondents had been prescribed or offered a prescription for medication.

- No significant issues emerged with regard to accessing GPs.

- A small but important minority of respondents first received mental health support (any, or the first beneficial support) while in prison.

- The support and treatment interviewees received after a mental health crisis - i.e. suicide attempt, hospital admission, hospital or police detention under the Mental Health Act - was very variable.

- Support or treatment from mental health services in Nottingham, was sporadic, uneven, and did not always align with respondents' needs.

- There was some evidence of inappropriate use of services by interviewees. This included asking professionals to detain them under the Mental Health Act.

Homeless people's experiences of mental health services (Chapter 9)

Survey responses suggest that only just over one-quarter reported receiving support or treatment that met their needs. This is not a surprise. After all, it is for this reason that

Nottingham City CCG commissioned this study. The key reasons why homeless people were unable to access the support they required were:

- not having mental health needs acknowledged;
- falling between service thresholds;
- dual diagnosis;
- waiting lists;
- inappropriate or 'dead-end' referrals.

Respondents' experience of the support and treatment they received was diverse. The support and treatment itself was generally welcomed and respondents derived some benefit from it. There was a general willingness amongst respondents to engage with statutory and voluntary sector mental health services. A number of services that stakeholders singled out were working particularly well. These were the Primary Care Mental Health Service, several specific GP surgeries, a CPN to the homelessness health team and Opportunity Nottingham. However, very few respondents had received comprehensive, effective, and consistent support throughout their mental health journey.

Homeless people's service preferences (Chapter 10)

Stemming from their experiences, respondents had their own ideas and suggestions about what might improve mental health services in the City. Key preferences were:

- the help of an 'advocate' or 'navigator' to access and negotiate services;
- access to mental health support at known and trusted services;
- improved communication and advertising methods;
- more 'holistic' mental health support which would be part of a wider package and would also include help with securing housing;
- to feel like they were being 'listened to' and 'cared about';
- to see more immediate-response, crisis services;
- support from someone who had been through the same experience ('formalised peer support');
- more training to improve health professionals' knowledge of homelessness;
- more continuity in services and staff (to avoid having to re-tell their story);
- longer-term, ongoing and more intensive support for mental health.

Barriers to meeting the mental health needs of Nottingham's homeless population (Chapter 11)

Our research highlights the key barriers facing homeless people, and the services working with them, in meeting mental health and associated needs. There was broad consensus across stakeholders that over the last two decades mental health, homelessness and other support services had been cut in Nottingham. The national programme of austerity has affected service provision in the City. Barriers to meeting needs also operate at the individual, organisational, and structural levels, although these are not mutually exclusive. Some of the main barriers identified were:

- insecure and inappropriate housing;
- thresholds for services as a barrier to access;
- 'silo' commissioning and delivery: (not) taking responsibility;
- inflexible service models: fitting square pegs in round holes;
- professional knowledge and training;
- limited services able to work with people with complex needs;
- inadequate linkages and pathways through support and treatment.

Learning from Good Practice (Chapter 12)

The Big Lottery Funded 'Fulfilling Lives' programme, and the individual projects funded within that programme (of which Opportunity Nottingham is one) provide excellent examples of good practice in working with people with complex needs.

There are a number of common themes amongst those identified as potentially representing good practice:

- common single assessments;
- direct access services;
- peer support;
- having dedicated mental health workers within homelessness services;
- intensive support and key working;
- promoting partnership working;
- co-creation, design and delivery of services;
- strengths-based models which focus on facilitating people to see their own strengths.

Conclusions and recommendations (Chapter 13)

The results from this study confirm the need to consider homeless people as a specific group in the development of mental health commissioning strategy and in service delivery across sectors.

A key conclusion from this study is that 'homeless people with mental ill health' are a population that could accurately be described as having multiple and complex needs.

There does not appear to be a significant cohort of homeless people with mental health issues in the City who are completely unknown to health services. This offers important opportunities for engagement. There have also been some positive developments locally, including:

- The newly commissioned Primary Care Mental Health Team.
- The addition of the CPN to the Homeless Healthcare Team.
- Opportunity Nottingham's successful bid to the Big Lottery's Fulfilling Lives programme for a seven year project for people with complex needs that started in 2015 (a partnership, with Framework the lead delivery partner).
- As the study was drawing to a close, local partners were scoping out the potential for a Housing First approach in the City.

Despite these more positive findings, the results from the study were clear that the needs of homeless people with mental ill health are not currently being met in the City. Very few of the homeless people participating in the study were receiving appropriate, consistent support or treatment that met their needs. Issues relating to the accessibility of services were particularly prominent and very few current services are targeted at (or able to work with) people with complex needs. Issues related to the supply and appropriateness of supported accommodation for homeless people with mental health issues (and complex needs) is leaving many living in inadequate temporary accommodation that undermines recovery and, in some cases, exacerbates or engenders mental health crises.

These challenges are not unique to Nottingham and there is good practice elsewhere that local agencies can learn from, to help them design and commission provision that will better meet needs. Drawing on the findings presented in the report and the good practice review, we make a series of recommendations, that, if actioned, have the potential to significantly improve homeless people's access to, and the effectiveness of, mental health and related support and treatment.

Recommendations

Key Principles

1. **System wide response**. The mental health needs of homeless people within Nottingham cannot be met by any one service. The interconnections between issues relating to housing, mental health and wider support needs mean that a range of services will need to co-ordinate their response. This may result in the integration of services and budgets. It is vital that there are clear pathways of support, particularly at points of transition (e.g. hospital discharge, leaving prison, care leavers).

2. **Services founded on awareness of complex needs, and histories of citizens.** All commissioners and providers of support will need to ensure that they are aware of the particular difficulties faced by homeless people with mental health and other complex

needs. This will include the need to ensure that staff receive training to deliver services based on Trauma Informed Principles. It will also include the need to recognise the diversity of experiences within this group (e.g. domestic violence, BME, no recourse to public funds). It also requires shifts in culture and processes to better accommodate people who are homeless through flexible, less conditional and more inclusive delivery models (i.e. rather than, or in addition to commissioning new services).

3. **Early intervention**. The aim must be that all citizens receive the support they need in order to prevent homelessness amongst people with mental health issues (and all citizens more generally). In order to do this, there is a need to ensure that interventions take place at the earliest possible opportunity (i.e. in childhood or early adulthood). Homelessness exacerbates mental health issues so we need to do everything possible to prevent people with mental health issues reaching this point. This is needed to prevent the human cost of those who experience mental ill health and homelessness but also to prevent the financial cost to public services.

4. **Long-term commitment to change**. An awareness of the client group and their complex support needs requires a long-term commitment to change across all sectors (Housing, Health and others). There is a need to (re)design services around long-term, intensive and non-time limited support so that staff can better meet needs and spend time building clients' trust. Long-term commitment to change also involves learning from and incorporating good practice from projects/models found to work effectively with people with complex needs. These could include peer support, common single assessments, intensive support and key working, partnership working, co-creation and delivery of services and strengths-based models.

5. **Coordinated approach for people with complex needs (proactive broker / advisor / navigator)**. The sustained involvement with service users that comes with intensive support and key working are crucial for effective treatment. There is a need to provide support to individuals in navigating often complex and fragmented systems, and in turn, helping to increase this group's engagement with healthcare services. This approach would also include a central assessment and information point where client data can be shared with other service providers (removing the need for multiple assessments and ensuring that service users do not have to tell their story to different agencies several times). It is important to place the person at the centre of this system, i.e. the person gives permission for their information to be shared across agencies.

Introduction

<div align="right">1</div>

This report is the final output from an exploratory research study that sought to understand the mental health needs of homeless people in the city of Nottingham. The study was commissioned by NHS Nottingham City Clinical Commissioning Group ('the CCG') and was undertaken by a team at the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University.

1.1. Rationale for the study

Rough sleeping and homelessness have risen sharply in Nottingham in the past couple of years, reflecting nationwide trends. Meanwhile local services have been reporting an increase in clients with mental ill health, dual diagnosis and complex needs and there were concerns locally that the mental health needs of the homeless population are not being met adequately.

Official homelessness and rough sleeper statistics do not gather information about health needs, and health statistics rarely record housing status, but all research evidence indicates high prevalence of mental ill health amongst the homeless population. Mental ill health is both a cause and a consequence of homelessness, sometimes forming a mutually reinforcing cycle, although often mediated by other needs, in particular drug or alcohol dependency. Evidence also suggests that homeless people's use of health services tends to be unplanned, costly, and that their health needs go unmet.

The relationship between health and homelessness has also increasingly been recognised, establishing homeless people as the concern of the CCG and NHS services. For example, the City's joint Health and Wellbeing Strategy, and the mental health strategy, Wellness in Mind, both recognise housing inequality as a key determinant of health outcomes.[1] The Health and Wellbeing strategy also notes the increased risk of mental health issues amongst homeless people. Strategically, local agencies may have to identify and respond to the needs of this particular client group if local objectives, targets and priorities are to be met. Improving mental health - and reducing the proportion of people with poor mental health by 10 per cent by 2020 - is a key objective of The Nottingham Plan, for example,[2] and the local Health and Wellbeing strategy identifies mental health as an early intervention priority. As a result, the issue was raised with the Mental Health sub group of the Health and Wellbeing Board, prompting Public Health to suggest this to the CCG as a theme for

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[1] Happier, Healthier Lives: Nottingham City Joint Health and Wellbeing Strategy, 2016 – 2020, http://committee.nottinghamcity.gov.uk/documents/s46431/Enc.%201%20for%20Health%20and%20Wellbeing%20Strategy%20Update.pdf and Wellness in mind- The Nottingham Adult Mental Health and Well-being Strategy http://committee.nottinghamcity.gov.uk/Data/Health%20and%20Wellbeing%20Board/20130828/Agenda/Wellness_in_mind%20-%2057580.pdf
[2] Nottingham Plan to 2020, http://www.onenottingham.org.uk/?page_id=4198

research. In addition, people who are homeless are specifically mentioned within the Equality Delivery System for the NHS.[3] Recognising, acknowledging and wanting to respond to these issues, the CCG commissioned this study to inform how they can work with local partners to better meet the needs of homeless people with mental ill health in the City, and to support the development of effective commissioning strategies to meet the needs of this population and to promote and support appropriate and timely mental health service uptake.

The study was being conducted at the same time as a number of relevant local reviews, including a review of the Mental Health pathway, and a strategic commissioning review of housing related support.

1.2. Homelessness in Nottingham

The research was conducted at a time when homelessness in Nottingham was increasing, reflecting national homelessness trends.[4]

In particular, there has been a significant increase in rough sleeping, and use of bed and breakfast accommodation to temporarily house statutory homeless people (i.e. those people whom the local authority owes a statutory housing obligation - see section 1.7 below). During 2016/17, Nottingham City Council accepted 492 households as being homeless and in priority need.[5]

In relation to **rough sleeping**, for example:

- There was a 150 per cent rise in rough sleeping between 2016 and 2017. Nottingham now has the same rate of rough sleeping per 1000 people as London.[6]

- In 2016, the street outreach team found 510 people sleeping rough in Nottingham. The team had already found 226 people sleeping rough in the first three months of 2017 - almost as many as they found in the whole of 2014.[7]

- A second winter shelter was opened during the winter of 2016/17 to meet demand.

There has also been an **increase in the use of bed and breakfast hostels to** accommodate homeless people**. This type of accommodation is used by local authorities as a last resort. It therefore reflects a rise in statutory homelessness beyond the capacity of the local authority's housing options. In 2001, the government established a 'bed and breakfast unit' to tackle the number of homeless people then accommodated in this type of provision, with a target to significantly reduce the number of households in B&B accommodation. Nottingham successfully reduced

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[3] NHS (2013) A refreshed Equality Delivery System for the NHS, https://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf
[4] Fitzpatrick, S et al. (2017) *The Homelessness Monitor: England 2017.* London: Crisis. Available from: https://www.crisis.org.uk/media/236823/homelessness_monitor_england_2017.pdf
[5] MHCLG (2018) Live table 784, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/667204/Table_784_201709.xlsx
[6] See the 2017 Nottingham Insight Review into homelessness. Available from: https://www.nottinghaminsight.org.uk/themes/health-and-wellbeing/behavioural-factors-and-wider-determinants-of-health/homelessness-2017/
[7] Figures from - *Responding to Homelessness in Nottingham: Stakeholder Workshop*, 29th March 2017. Available from: http://www.nottinghamcity.gov.uk/media/456588/focus-on-homelessness-2017.ppt x

their B&B placement to zero for over a decade. However, this has steadily increased since 2015. The Nottingham Insight Review into homelessness[8] reports that:

- There were 804 placements in bed and breakfast hotels in 2016/17.

- In 2016/17 there was an average of 73 total placements in B&B accommodation per month. This compares to an average of 26 total placements in 2015-16.

- At the beginning of August 2017 there were 105 households in B&B accommodation in Nottingham.

- The average length of a stay in a B&B has also increased.

Another relevant contextual factor is the **changing role of the private rented sector** as both a cause of, and solution to homelessness. With dwindling social housing stock,[9] the private rented sector is increasingly the only housing option for low income households, including those who are homeless. Local authorities are increasingly relying on this tenure to fulfil their statutory obligations towards homeless people. Yet this is an insecure and largely unregulated tenure. Specifically:

- Most private rented tenancy agreements are 'Assured Shorthold Tenancies' (ASTs) and can be terminated by the landlord with two months' notice and by the tenant with one month's notice. No reason needs to be provided for ending the tenancy. There has been a dramatic increase in the number of people presenting to local authorities as homeless who cite the reason for their homelessness as the ending of their AST (43 per cent of homeless presentations in 2016/17 compared to 25 per cent in 2015/16, and 18 per cent in 2011). At a national level, the ending of ASTs has been largely responsible for the growth in homeless acceptances in the past five years.[10] The rise in the ending of ASTs as a reason for homelessness coincided with changes (reductions) in the amount of Housing Benefit people in the private rented sector could receive and commentators suggest this has prompted some landlords to give notice to benefit claimants renting from them.[11] Other research shows that private landlords are increasingly reluctant to rent to benefit claimants because of welfare reform changes.[12]

- The private rented sector is increasingly being used to accommodate households deemed to be homeless. Since the introduction of the Localism Act in 2011 local authorities in England have been allowed to meet their obligations under the homelessness legislation by accessing housing in the private rented sector for people to whom they owe the main housing duty. Wider homelessness preventative work and efforts to help people resolve homelessness by local authorities and the voluntary sector increasingly focus on accessing private rented housing. In general, this sector is insecure (see bullet point directly above).

[8] See the 2017 Nottingham Insight Review into homelessness. Available from: https://www.nottinghaminsight.org.uk/themes/health-and-wellbeing/behavioural-factors-and-wider-determinants-of-health/homelessness-2017/
[9] Partly as a result of the 'right to buy' policy, which allows some council tenants to buy their homes at a discount, but combined with historic restrictions on local authority building.
[10] Fitzpatrick, S et al. (2017) *The Homelessness Monitor: England 2017.* London: Crisis. Available from: https://www.crisis.org.uk/media/236823/homelessness_monitor_england_2017.pdf
[11] Cole, I. *et al* (2014) *The impact of recent reforms to Local Housing Allowances: summary of key findings.* London: DWP. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/329902/rr874-lha-impact-of-recent-reforms-summary.pdf
[12] Reeve, K. *et al* (2016) *Home: no less will do - homeless people's access to the private rented sector.* London: Crisis. Available from: https://www.crisis.org.uk/media/237166/home_no_less_will_do_crisis.pdf

- New legislation and government policies are predicted to increase demand on services. For example, the Homelessness Reduction Act 2017 increases the duties of local authorities to assess, prevent and relieve homelessness. Local authorities are concerned that the resource associated with the new legislation will not be sufficient to meet demands.[13] Also, most of the financial impact of welfare reforms (83 per cent) announced in 2015 will be felt during or after 2017/18.[14] Nottingham City will be one of the 10 per cent of local authorities most affected by these welfare reforms.[15]

1.3. An overview of the research

The overarching aim of the study is *'to explore and understand the mental health needs of Nottingham's homeless population to inform how Nottingham City CCG can best work with local partners to better meet these needs.'*

The study comprised four overlapping phases:

- *Phase 1: Understanding the population.* This phase of the research drew on primary research and secondary sources to profile the mental health needs of Nottingham's homeless population, assess the prevalence of mental ill health amongst this population, measure well-being, and ascertain patterns of service use. Given the dearth of comprehensive, robust secondary data about the prevalence and nature of mental ill health amongst the homeless population, the study team conducted a survey of homeless people in Nottingham to generate this information (see 1.4 below).

- *Phase 2: Understanding the citizen story.* This phase of the research comprised in-depth interviews with homeless people with mental ill health in Nottingham in an effort to gain a detailed understanding of their needs and experiences, and any barriers to accessing appropriate, effective services (see 1.5 below).

- *Phase 3: Understanding the stakeholder perspective.* Through a series of interviews with local stakeholders this phase explored professionals' experiences of working with, and commissioning services for homeless people with mental ill health and the challenges of meeting the mental health needs of this population group (see 1.5 below).

- *Phase 4: Learning from good practice.* This phase involved a review of good practice to identify lessons that might be transferable to the Nottingham context and could help shape the recommendations to flow from the study. Bibliographic and web-based searches were conducted, using key words, and this generated a long list of sources including evaluation reports, press reports, academic articles, organisation/service webpages, and policy and strategy documents citing good practice examples. Each source was reviewed for relevance and a short list was generated. Information about each source was recorded (the client group, service provided, key outcomes, evaluation and such like) into a pro forma. These pro formas were then reviewed in detail once the headline findings from the study emerged, in an effort to identify good practice lessons that were relevant to the particular issues in Nottingham City.

[13] Messih, J. (2017) Homelessness Reduction Act: is the funding sufficient?, Inside Housing, https://www.insidehousing.co.uk/insight/insight/homelessness-reduction-act-is-the-funding-sufficient-53650

[14] Beatty, C. and Fothergill, S. (2016) *The uneven impact of Welfare Reform: The financial losses to places and people.* Sheffield: CRESR, Sheffield Hallam University. Available from: https://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/welfare-reform-2016_1.pdf

[15] Ibid.

In the next sections we provide more detail about the survey and the qualitative phases of the research.

1.4. The survey of homeless people in Nottingham

In total, 167 people with a recent experience of homelessness (currently or in the past 6 months) were surveyed by the study team between February and May 2017.[16] Survey questions covered different aspects of mental health, wellbeing, housing and homelessness situations, access to and experience of using different services. To our knowledge, this represents the most detailed survey of mental health and homelessness conducted in England.

Survey fieldwork was conducted in a range of generic homelessness services including hostels, night shelters, temporary supported housing schemes, refuges, day centres, Housing Aid, and through outreach workers. No specialist mental health services were included so as not to skew the results towards people with mental health issues.

No distinction was made for sampling purposes between those who were and who were not owed the main housing duty (see 1.7 below for definition of 'being owed the main housing duty'). Survey participants were, however, recruited through services working primarily with single homeless people,[17] and so the sample is focused on this group. This reflects Nottingham City CCG's original emphasis for the study. However, the definition of homelessness employed, and the approach to sampling, did not preclude the participation of families in the study. Reflecting commissioning boundaries, only people currently within the Nottingham City boundary were included.

Most surveys were conducted face-to-face although some respondents chose to self-complete with guidance and checking from a member of the study team. A small number of surveys were conducted in the respondent's first language by, or with, the assistance of a staff member with the relevant language skills. Eleven surveys were self-completed without the presence of a researcher where it was not appropriate for the team to visit in person during the course of the survey.

All survey respondents were given a £5 'Love2Shop' voucher to thank them for participating in the research. Responses were entered into an SPSS database.

The survey sample

The majority (68 per cent) of survey respondents were male, while 30 per cent were female, one per cent (two people) were transgender and one person identified as 'other' gender.[18]

The age profile of respondents is presented in Table 1.1 and shows that people in all age groups were represented in the sample. This reflects the sampling strategy

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[16] There are 'missing' responses against some questions and so the total number of responses to each question was sometimes fewer than 167. This occurs when respondents prefer not to answer a question, when they terminate the survey before it is complete, or where a survey/partial survey is withdrawn because of concerns about data quality. In addition, some questions were only asked of certain 'sub groups' (e.g. those indicating mental ill health, or those who had used services). For these reasons the results presented in this report are sometimes based on a sample of less than 167. The total number is always stated.

[17] In the context of homelessness 'single' refers to people without dependent children rather than people who are not in a relationship.

[18] Concerted efforts were made to ensure that around 30 per cent of respondents were female so that women were adequately, although not equally, represented in the sample. There are no reliable statistics about the proportion of women in the total homeless population so we do not know how representative this is. Nevertheless, our concern was to ensure adequate representation of women in the sample.

employed by the study team. The age profile of survey respondents was monitored throughout to ensure the views and experiences of all age groups were represented.[19]

Table 1.1: Age profile of survey respondents

	no.	%
Under 25	28	18
25 to 34	49	31
35 to 49	55	34
50+	28	18
Total	160	100

Survey respondents' 'current housing situation' is presented in Figure 1.1 and shows that the majority were currently resident in hostels. Respondents' current housing situation reflected the study team's approach to recruiting participants - i.e. many sites of recruitment were accommodation providers.

Figure 1.1: Where did you sleep last night?
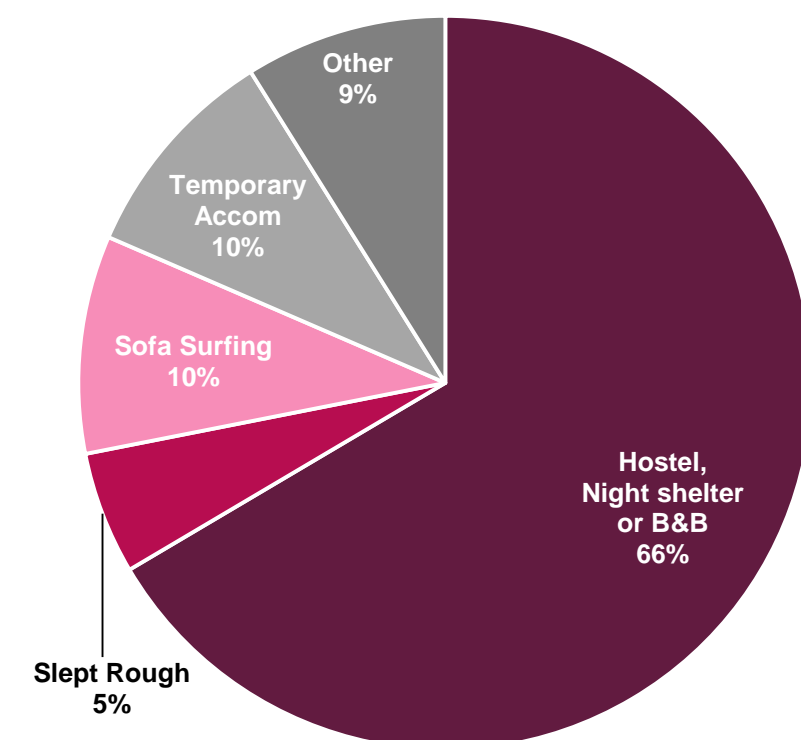
n=167

1.5. Qualitative interviews with homeless people

In-depth interviews were conducted with 37 homeless people with mental health issues between May and September 2017. All participants in the interview sample

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[19] Although no targeted or remedial efforts were required to achieve this.

were homeless[20] at the time of interview and met our inclusive definition of mental ill health, ranging from mental disorder to poor mental wellbeing. As with the survey sampling criteria, only people currently within the Nottingham City boundary were included. No other exclusion criteria were employed. However, reflecting the original aims of the study, and the types of services through which interview (and survey) respondents were recruited, none had dependent children (although several had children in the care of others).

The sample was monitored to ensure inclusion of the following groups:

- People with and without a diagnosis of a mental health condition (but who identify as having mental health issues).

- Statutory and non-statutory homeless people (see 1.7 for definitions).

- People with experience of being detained under the Mental Health Act.

- People with some experience of rough sleeping.

- A range of age groups.

- People of different minority ethnic backgrounds.

- Women - women are underrepresented in homelessness services so targeted efforts are often required to ensure representation within homelessness research.

- People with a range of different mental health issues, from severe mental illness (enduring, psychotic conditions), to more common conditions such as depression and anxiety, to more general poor wellbeing.

Participants were recruited through the survey[21] and through the organisations that had participated in the survey and other housing services in contact with people with mental ill health (to ensure certain groups and experiences were represented in the sample). The latter recruitment strategy relied on staff within services to identify people who met the criteria of being homeless and having mental health issues.

The study team employed a flexible interview tool that allowed the respondent to guide aspects of the discussion, prompted by the interviewer. Interviews took a 'biographical' approach, talking through respondents' housing and health pathways since their childhood. The interview did not always follow such a linear path - nor was that necessary - but it provided a framework for the discussion. Each interview, in terms of content, coverage and duration, was different but all provided in-depth insight into the lives, experiences and challenges facing homeless people with mental health issues.

All respondents were given a £10 'Love2Shop' voucher to thank them for their time. All interviews were recorded, subject to consent (only one respondent refused), and transcribed. Transcripts were then coded thematically using NVivo 11 but each individual transcript was also analysed whole as a 'biography'.

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[20] We employed the legal definition of homelessness that states that someone is homeless if they have no accommodation available for their occupation that they are entitled to occupy and that it is reasonable to expect them to occupy. Anyone in temporary accommodation (hostels, interim supported housing and such like) would be classed as homelessness under this definition.
[21] The survey included a question asking respondents if they would be interested in being interviewed in more detail and, if so, to provide contact details.

The sample of homeless people with mental ill health

The qualitative interviews with 37 homeless people with mental health needs were conducted in a smaller number of homelessness services, purposely targeted to meet a range of criteria in our sampling strategy. Respondents' current housing situations therefore reflected this recruitment strategy. Interview respondents were currently living in mixed sex hostels for single homeless people over the age of 18; supported accommodation for young single homeless people aged 16-25; supported housing as part of the statutory mental health pathway; a supported accommodation service for single homeless women; and rough sleeping.

The majority of the interview sample identified as male (57 per cent or 21 people), while 43 per cent (or 16 people) identified as female.[22] The age profile of the interview respondents is shown in Table 1.2 below. Most interview respondents were between the ages of 35 to 49 (43 per cent), followed by aged 50 and above (24 per cent), 25 to 34 years (22 per cent), and lastly, under 25 years (11 per cent). We ensured that all age groups were represented in the interview sample. The study team also attempted to include a mix of respondents from a range of ethnic backgrounds. 68 per cent of the interview sample identified as White British, while 32 per cent identified as being from non-White British groups including Kurdish, Indian, Black-White African, Black, White Black Caribbean, Black African, Black British, Syrian, Thai, Chinese, Mixed or other ethnic group, and Mixed.

Table 1.2: Age profile of interview respondents

	no.
Under 25	4
25 to 34	8
35 to 49	16
50+	9
Total	37

All respondents have been given appropriate pseudonyms for the purposes of reporting. Minor details of their circumstances have sometimes been changed to protect anonymity.

1.6. Qualitative interviews with stakeholders

Interviews were conducted with 23 stakeholders working at a strategic/policy, managerial, and front-line level in a range of organisations across the NHS (commissioning and provider), Local Authority (housing, social care, and public health) and voluntary sector. Interviews were conducted with strategic and policy leads for relevant fields, stakeholders working with or managing services for specific client groups (e.g. people with mental health issues, younger people, people with dual diagnosis, and people complex needs), and with both clinical and non-clinical staff. An initial list of relevant contacts was drawn up in conjunction with the project steering group but respondents often suggested other stakeholders to add to this list.

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[22] As in the survey, concerted efforts were made to ensure that women were well represented in the interview sample (above 30 per cent at the minimum).

Most (21) interviews were conducted on the telephone while two were conducted face-to-face.[23] Some interviews were recorded and transcribed, while notes were taken in others.

Where stakeholders are quoted in the report, sufficient information is provided so the reader has some sense of the field in which the respondent works, but to protect confidentiality we have used relatively generic identifiers.

1.7. Definitions

The terms 'homelessness' and 'mental health' are used variably and loosely so it is important to clarify our terms for the purposes of this study. These definitions informed our criteria for inclusion/participation in the research.

Homelessness

The legal definition of homelessness states that someone is homeless if they have no accommodation available for their occupation that they are entitled to occupy and that it is reasonable to expect them to occupy.[24] We considered this to be useful as a broad working definition of homelessness for the purposes of this study. It includes people sleeping rough, squatting, staying in temporary accommodation (hostels, B&Bs, interim supported housing, night shelters) as well as those in other, more 'hidden' temporary housing situations such as staying with friends and family ('sofa surfing').

Local Authorities have a statutory duty to accommodate people who meet the legal definition of homelessness, *and* who are assessed as being 'in priority need' (which includes families with dependent children and can also include people with a range of vulnerabilities, such as mental ill health), *and* who have a local connection to the area, *and* who have not made themselves intentionally homeless. This is properly known as being **'owed the main housing duty'.** People who meet these criteria are sometimes referred to as **'statutory homeless'** people.

Mental health

An inclusive definition of mental ill health was employed, which ranges from mental disorder through to poor mental wellbeing. The increasing emphasis on prevention within mental health policy prompts an approach capable of identifying people who are at risk of developing mental health issues (perhaps shown by very poor levels of wellbeing) but who may not currently have a diagnosable condition. In addition, we know that homeless people with mental health issues do not always access the services they need and may, therefore, suffer mental ill health but not have been diagnosed as such.

It is important, however, that the results do distinguish between different forms and levels of mental health and wellbeing. Much homelessness research makes no distinction between mental health and wellbeing, or between diagnosed (or diagnosable) and undiagnosed conditions. Studies frequently find very high levels of (self-reported) 'mental ill health' but it is rarely clear what this means. The survey was therefore designed to ensure we can distinguish different types and severity of mental ill health.

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[23] The majority of stakeholder interviews were conducted over the telephone to save time and resource but a small number of interviews were conducted face-to-face where this activity could be carried out on the same day as interviews with homeless respondents.
[24] As set out in the Housing (Homeless Persons) Act 1977.

1.8. The Report

This report draws together and integrates the full findings from each phase of the study. It is accompanied by a shorter, more accessible, report that summarises each chapter and presents selected illustrative evidence from this more comprehensive output.

Drawing heavily on the survey results, but supplemented by qualitative evidence, Chapters 2 and 3 draw conclusions about the prevalence of mental ill health within the homeless population, and the specific mental health conditions that homeless people report. Some qualitative insights are also provided about the triggers and experiences of mental ill health amongst this population. Chapter 4 focuses on housing situations, in particular seeking to understand the triggers and underlying causes of homelessness. Chapters 5 and 6 explore the complex interplay between mental health, homelessness, and other support needs, including drug and alcohol abuse. This brings us to a point where it is clear that we are discussing a population with multiple and complex needs. Chapter 7, therefore, summarises the distinct characteristics of this client group, greater understanding of which might inform positive service development to better meet their needs. This chapter also provides useful context for the discussion which follows in chapters 8 to 10. These chapters focus on homeless people's pattern of service use (Chapter 8), experiences of support and treatment (Chapter 9) and their stated support preferences (Chapter 10). Chapter 11 then draws the key findings from the preceding chapters together to draw conclusions about the key barriers to meeting the needs of homeless people with mental health issues in Nottingham. In Chapter 12 we present useful and relevant insights from the review of good practice, with the aim of highlighting initiatives that might address some of the key barriers. The report rounds off with recommendations for service development.

Prevalence of mental ill health amongst homeless people in Nottingham

<div style="text-align: right">2</div>

A number of studies have identified high levels of mental ill health amongst homeless people.[25] A systematic review of academic research from Western Europe and North America found a higher prevalence of mental health issues among homeless people than within the general population.[26] In particular, the systematic review noted high levels of 'major mental disorders' such as 'psychotic illness' and 'personality disorder'. This review identified considerable variation across different contexts, concluding that 'service planning should not rely on our summary estimates but commission local surveys of morbidity to quantify mental health needs'.[27] Similarly, a survey of over two thousand homeless people by Homeless Link in 2014, one of the largest in the UK, found that a number of severe mental health conditions are at least twice as common amongst homeless people when compared to the general population.[28]

However, most homelessness surveys/studies include only a very limited number of questions about mental health and these are often non-specific. For example, some surveys simply asked respondents whether they had mental health issues with no further scrutiny or clarification. At the same time, studies, evidence and data about mental health rarely gather sufficient information about people's housing status to extrapolate data specifically for those who are homeless. In addition, national surveys such as the Homeless Link study are not able to reflect the specific profile and needs of homeless people with mental ill health in Nottingham.[29] Some local research has been conducted that identifies high levels of mental ill health amongst homelessness service users but such evidence is limited.[30] Taken together, this suggests that there was a need for the type of local survey recommended by Fazel et al. in their systematic review (quoted above).

A number of secondary data sources were reviewed prior to our survey. The most notable was the Mental Health Services Data Set (MHSDS) which contains

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[25] For example: Rees, S. (2009) *Mental Ill Health in the Adult Single Homeless Population: A review of the literature.* Public Health Resource Unit. London: Crisis; Homeless Link (2015) *Support for single homeless people in England;* Homeless Link (2015) *Annual Review*; St Mungo's (2016) *Stop the Scandal: an investigation into mental health and rough sleeping*; Reeve, K. (2011) *The hidden truth about homelessness,* London: Crisis.

[26] Fazel, S. et al (2008) The prevalence of mental disorders among the homeless in Western Countries: Systematic review and meta regression analysis. *PLoS medicine,* 5 (12), pp. 1670-1681.

[27] Ibid, p.1676

[28] Homeless Link (2014) *The Unhealthy State of Homelessness. Health audit results 2014.* London: Homeless Link.

[29] Fitzpatrick, S et al. (2017) *The Homelessness Monitor: England 2017.* London: Crisis. Available from: https://www.crisis.org.uk/media/236823/homelessness_monitor_england_2017.pdf

[30] Framework (2014) *Mental Health and Substance Misuse Problems Experienced by Residents of Framework in Nottingham.*

anonymised record-level data for all people who are in contact with mental health, learning disabilities or autism spectrum disorder services. It includes an accommodation status code of 'homeless' which provides some data on the number of people using statutory mental health services who are considered homeless. In April 2017, two per cent of people within the MHSDS for Nottingham City CCG had their accommodation status recorded as being homeless.[31] However, only two-thirds (68 per cent) of people had an accommodation status documented within the dataset. This means that a direct comparison with the general population is not possible but does suggest that people who were homeless were over-represented within mental health treatment services.

Recognising the weaknesses of existing evidence and datasets, a key objective of this study was to assess the scale and nature of mental ill health amongst the homeless population in Nottingham City. In this chapter we present results on the prevalence of mental ill health and in Chapter 3 we explore the nature of respondents' mental health issues in more detail. Where possible we draw on secondary data sources to benchmark our survey findings.

2.1.   Prevalence of mental ill health

Mental ill health was prevalent amongst respondents to our survey in Nottingham, with **three quarters indicating that they had experienced mental health issues.**[32] This included respondents who 'self-reported' (i.e. agreed with the statement 'I have mental health issues'), and/or indicated that they had been diagnosed with a specific condition,[33] and/or reported having been detained under the Mental Health Act. Taking each of these overlapping indicators of mental ill health separately:

- 62 per cent of respondents agreed with the statement 'I have mental health issues.'

- 74 per cent of respondents had been told by a doctor or health professional that they have at least one of a list of specified mental health conditions (taken as a proxy for a formal diagnosis) either in the past 12 months, or more than 12 months ago. This concurs with monitoring data from a local homelessness service showing that, in 2014, 75 per cent of 159 residents had a mental health diagnosis.[34]

- 19 per cent of respondents had been detained under the Mental Health Act at some point in their life.

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[31] This included the following codes: Homeless - Rough Sleeper, Homeless - Squatting, Homeless - Night Shelt. Emerg/DA Hostel, Homeless-Sofa Surfing (friends' floors), Homeless-Placed in Temp accom. by LA, Homeless-Stay Family/Friends as Guest, Homeless - Other

[32] It is difficult to accurately benchmark this figure. Although there are studies assessing the prevalence of mental health amongst homeless people each uses a slightly different sample (e.g. rough sleepers, or people in temporary accommodation) or different measures of mental ill health and so results are too affected by these factors to provide meaningful comparators.

[33] Respondents were asked the question 'Has a doctor or health professional ever told you that you have any of the following conditions?' and presented with a list of mental health conditions as follows: depression; anxiety disorder or phobia; dual diagnosis; personality disorder; psychosis (including schizophrenia and bipolar disorder); PTSD; ADHD; and eating disorder. We use this as a proxy for having a diagnosed mental health issue, while recognising that some respondents may have been told verbally they may have a condition without a formal diagnosis. Respondents were also asked if a health professional had ever told them they have a learning disability or difficulty, or had autism but we report on these separately. If respondents indicating a learning disability or difficulty, or autism were included in the cohort of respondents with mental ill health the figures change very little as most of these respondents also indicated a mental health issue.

[34] Framework (2014) Mental Health and Substance Misuse Problems Experienced by Residents of Framework in Nottingham.

We can see here that the proportion of respondents indicating a diagnosed mental health condition is *higher* than the proportion self-reporting mental health issues. In total, 15 per cent of respondents reported a diagnosed condition but did not agree that 'I have mental health issues' (See Table 2.1). This is likely to include some respondents who have an historic diagnosis but no longer have mental ill health. Thus, while we can confidently say that 74 per cent of homeless people in Nottingham *have experienced* mental ill health, this figure may slightly over-estimate the proportion of those *currently* experiencing mental ill health. If we remove all respondents who report a diagnosis but *do not* agree that 'I have mental health issues', this figure falls to 59 per cent, although this is likely to under-estimate the proportion of respondents currently experiencing mental health issues.[35]

Table 2.1: Self-reported mental health issues and diagnosis

	%
Self-reported mental health issues AND diagnosis	59
Self-reported mental health issues and NO diagnosis	4
No self-reported mental health issues but diagnosis of MH condition	15
No self-reported mental health issues and no diagnosis of MH condition	21

n=163

If we consider further the interaction between self-reported mental health, and diagnosis by medical professionals we find that only a small number of respondents (4 per cent) self-reporting mental health issues did not have a diagnosis (Table 2.1). This is encouraging. It suggests that the **majority of homeless people with mental ill health in Nottingham have, at some point, accessed health professionals and had their mental health issues acknowledged, assessed and diagnosed.** Qualitative interviews with homeless people issue a note of caution, however, and suggest that a slightly more nuanced analysis of diagnoses may be required. We will see in Chapter 10.2 that some interview respondents struggled to have their mental health needs recognised or felt that their mental health issues were more severe than their diagnosis.

Never the less, there is no evidence of a sizeable cohort of homeless people with mental health issues who are unknown to health services. This provides opportunities for engagement, at least, and development of appropriate intervention.

2.2. Detention under the Mental Health Act

Respondents were asked if they had ever been detained under the Mental Health Act (sometimes referred to as 'being sectioned'). The results are presented in Figure 2.1 and show that **nearly one in five respondents (19 per cent) had been detained under the Mental Health Act.** Four per cent of all respondents (or one in five of all those who reported having been detained) reported being detained under this legislation in the previous year. This is much higher than is found among the general population. In 2016/17, detention rates were estimated to be 83.2 per 100,000 population for males and 76.1 per 100,000 population females.[36] Direct comparison with the Nottingham survey should be treated with caution but suggests that detention of homeless people under the Mental Health Act was around 50 times more common than amongst the general population.

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[35] In some cases respondents may have an active diagnosis but not accept that diagnosis, or may have a diagnosis of a common mental disorder and not consider that this constitutes having mental ill health.
[36] NHS Digital (2017) *Mental Health Act Statistics, Annual Figures: 2016-17, Experimental statistics.* Available from: https://digital.nhs.uk/catalogue/PUB30105

It is worth noting that the survey did not distinguish between being detained in hospital for treatment/assessment and being detained by the police under Section 136 for up to 24 hours. However, when in-depth interview respondents talked about 'being sectioned' they were always referring to hospital detention. In one case a respondent referred to being sectioned 'by the police', making a point of distinguishing this from a hospital detention. On this basis, it is likely that the vast majority of survey respondents who reported being detained under the Mental Health Act were referring to hospital detention. Although very high, these rates of detention also concur with evidence from other studies of homelessness ('multiple exclusion homelessness' in particular, which, we will see in subsequent chapters, accurately describes many respondents in this study). In one robust study, based on a large scale survey, 29 per cent of the homeless people surveyed in 'low threshold' support services reported having been 'admitted to hospital because of a mental health issue'.[37] This is likely to include voluntary admissions as well as detentions (hence the even higher figure) but we can see the very high proportion who have been hospitalised.

In the course of conducting the qualitative interviews we also encountered homeless people with mental health issues who have made concerted (but failed) efforts to be detained under the Mental Health Act, believing that this would provide a route through which their mental health needs would be addressed (see Chapters 8.5 and 9.4).

Figure 2.1: Have you ever been detained under the Mental Health Act?

Don't know
1%

Yes - in the last 12 months
4%

Yes - more than 12 months ago
15%

No
80%
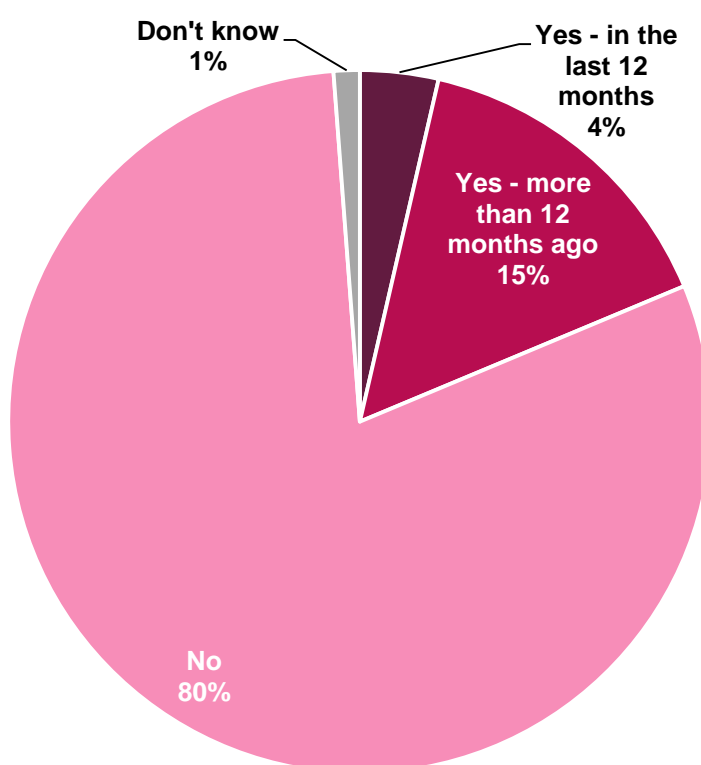
n=166

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[37] Fitzpatrick, S., Bramley, G. and Johnson, S. (2013) *Pathways into Multiple Exclusion Homelessness in Seven UK Cities*. *Urban Studies*, 50 (1), pp. 148-168.

2.3. Wellbeing

This study employs an inclusive definition of mental ill health (see Chapter 1) that encompasses wellbeing and wider health. It is important not to conflate poor mental wellbeing with mental health conditions. People with diagnosed mental health conditions can and do experience positive mental wellbeing. But health and wellbeing can have a mutually reinforcing relationship. As noted in the Nottingham Adult Mental Health and Well-being Strategy, 'Poor mental wellbeing does not necessarily lead to mental health problems, but when they are unbalanced our mental health is at risk'.[38]

In the context of homelessness, this approach may be particularly relevant. The in-depth interviews suggest that some homeless people have extremely poor wellbeing, including feelings of hopelessness, low self-esteem, and worthlessness - often arising from their experience of homelessness, or from the events that led to becoming homeless. Poor wellbeing appeared to have a detrimental effect on the lives of these respondents which was comparable to the respondents with diagnosed conditions. The distinction between poor wellbeing and mental ill health was also blurred in some cases. In addition, the increasing emphasis on prevention within mental health policy may demand more attention to wellbeing. People displaying very poor wellbeing - like those we have already interviewed - may be at risk of developing mental health issues.

The Short Warwick Edinburgh scale (SWEMWBS)[39] is a useful and widely used measure of mental wellbeing. This scale gives a score between seven (lowest mental wellbeing) and 35 (highest mental wellbeing) and was incorporated into the survey of homeless people in Nottingham. The results are presented in Figure 2.2 and show that wellbeing scores were in the full range from seven (five respondents) to 35 (three respondents).

Overall, wellbeing scores were relatively low. The mean score for the full sample was 19.4, compared with 23.6 for England and 24.8 for Nottingham.[40] The 75th percentile score for the sample was 22.3. This means that more than three-quarters of the homeless people surveyed had a mental wellbeing score which was below average. A significant minority of respondents had very low SWEMWBS scores with one third of the sample scoring below 17. It should also be noted that 20 per cent of survey respondents recorded scores higher than the national mean average.

Average wellbeing scores for Nottingham are broadly in line with the national average. Using the longer Warwick Edinburgh Wellbeing Measure, the 2016 Nottingham City Council Citizens survey of over 2,000 residents found very slightly higher levels of wellbeing amongst the general population of Nottingham compared with the national average, while the same survey in 2015 found scores that were very slightly lower.

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[38] Nottingham Clinical Commissioning Group, Nottinghamshire Healthcare Trust & Nottingham City Council (2013) *Nottingham Adult Mental Health and Well-being Strategy*, p.7. Available from: http://committee.nottinghamcity.gov.uk/Data/Health%20and%20Wellbeing%20Board/20130828/Agenda/Wellness_in_mind%20-%2057580.pdf

[39] Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS) © NHS Health Scotland, University of Warwick and University of Edinburgh, 2008, all rights reserved.

[40] SWEMWBS figures for England from 2011: ONS (2013) *Personal Well-being in the UK, 2012/13*. Figure for Nottingham supplied by Nottingham City Council from Nottingham Citizen Survey, https://www.nottinghaminsight.org.uk/d/186692

Figure 2.2: Mental Wellbeing scores (Short Warwick Edinburgh metric)

n=162
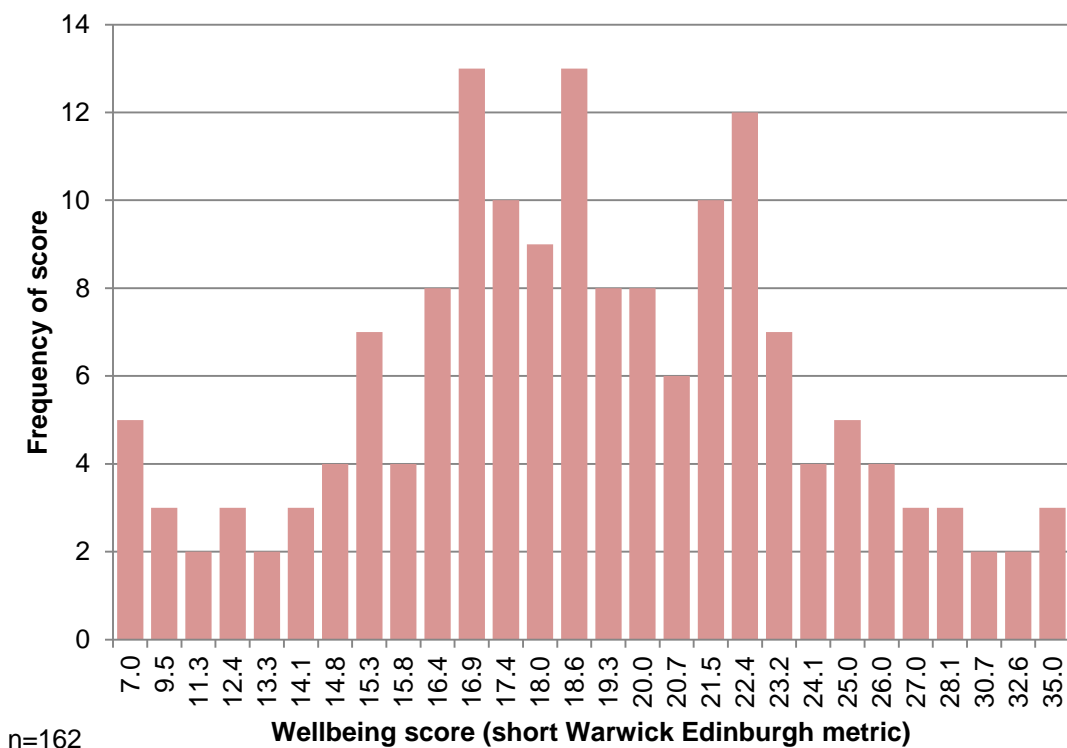
Figure 2.3: Life satisfaction scores[41]

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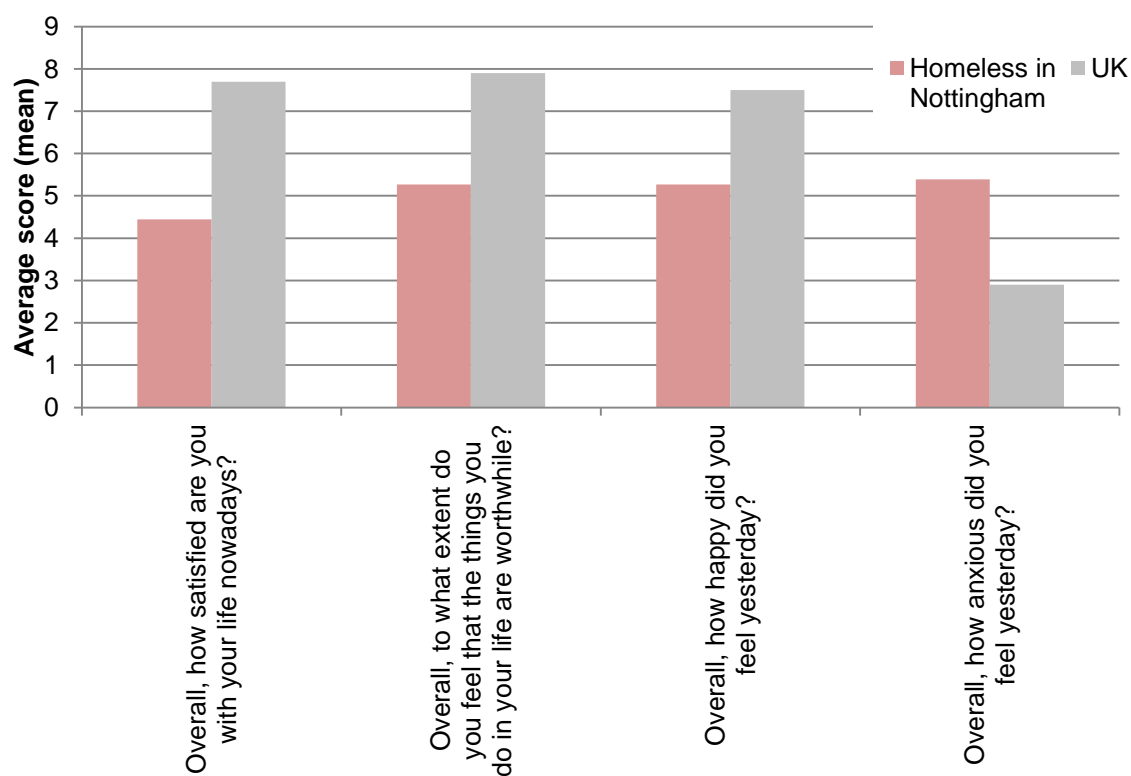
[41] n=163-165 for homeless sample. UK figures for 2016/17 taken from the Annual Population Survey as reported by: ONS (2017) *Personal Well-being in the UK, 2016/17.* Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/july2016tojune2017/pdf

Using a different measure of wellbeing, a similar picture emerges. Figure 2.3 shows average scores for four standard questions used by the Office for National Statistics (ONS) to measure wellbeing. These results suggest that homeless people in Nottingham have lower levels of life satisfaction, of self-worth, are less happy and have higher levels of anxiety than the general population. For example, overall life satisfaction was an average of 4.4 for our sample compared to 7.5 for the national population while levels of anxiety were rated at an average of 5.4 for homeless people in Nottingham compared to 3.0 for the national population.

There is evidence of a strong association between mental ill health and low wellbeing. Amongst our survey sample, mental health issues [42] are associated with lower wellbeing as measured by both the SWEMBWS and the ONS. For example:

- The mean SWEMBWS score for those with mental health issues was 18.2 compared to 22.8 for respondents without mental health issues.[43]

- 82 per cent of all respondents with lower than average SWEMBWS scores had mental health issues and those with the lowest scores (below 15.8) all reported mental health issues.

- The average ONS score for overall life satisfaction was 3.9 for those with mental health issues compared to 6.0 for all other respondents, while the average score for anxiety was 5.8 for those with mental health issues compared to 4.2 for all other respondents.

It is also worth acknowledging those respondents to our survey who did not report having a mental health issue (diagnosed or self-reported) but had low wellbeing (as measured in their SWEMBWS scores). This applied to 18 per cent of all survey respondents with lower than average scores, and 15 per cent of the full survey sample. Although a minority, these respondents may form an important cohort - people who, perhaps, would benefit from intervention, or may be at risk of deteriorating mental health, or who have mental health issues that are not recognised.

2.4. Conclusion

This chapter has provided an overview of the prevalence of mental ill health amongst Nottingham City's homelessness population. The results are clear that, in line with other studies, homeless people in Nottingham are very likely to have mental ill health, and display significantly higher than average rates of mental illness and poor wellbeing.

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[42] Respondents defined as 'with mental health issues' are those who agreed with the statement 'I have mental health issues' AND/OR reported that a doctor or health professional had told them they had at least one of the specific conditions listed AND/OR had been detained under the Mental Health Act.
[43] n=123 and n=40 respectively.

The mental health needs and conditions of homeless people in Nottingham

<div style="text-align:right">**3**</div>

In Chapter 2 we concluded from our survey results that homeless people - in Nottingham as elsewhere - have significant mental health needs and are far more likely to experience mental ill health than the general population. We saw that almost three-quarters had received a mental health diagnosis at some point, with the majority having received their diagnosis more than 12 months before the survey was conducted.

Exploring respondents' mental health diagnoses in more detail reveals a picture of multiple mental health needs. In this chapter we explore these needs in greater depth, looking at respondents' specific conditions and diagnoses, drawing on both survey and qualitative data from homelessness service users and staff working within mental health and housing/homelessness services in Nottingham City.

After providing a descriptive overview of the survey findings, the chapter paints a broad picture of people's experiences and trajectories (or 'pathways') of mental health. Respondents' stories trace the onset of their mental health needs; how (or if) these needs were triggered or exacerbated by life events; and how (or if) these needs were acknowledged and addressed by respondents and/or any support services (see Chapters 8 and 9). Respondents' mental health was often closely entwined with their housing situations, as well as other life experiences and needs. These relationships are explored in Chapter 5.

3.1. Mental health conditions and diagnoses

Survey respondents were asked the question 'Has a doctor or health professional ever told you that you have any of the following conditions?' and were presented with a list of mental health issues. The results are outlined in Figure 3.1 and show that the most common diagnoses were:

- Depression (61 per cent of the full sample, or 80 per cent of all those with diagnosed mental health issues);

- Anxiety disorder or phobia (43 per cent of the full sample, or 55 per cent of those with diagnosed mental health issues).

However, a significant minority of respondents had received diagnoses of:

- Personality disorder (17 per cent; or 21 per cent of those with diagnosed mental ill health);

- Psychotic conditions, including schizophrenia and bipolar disorder (15 per cent, or 19 per cent of those with diagnosed mental ill health);

- Post-traumatic stress disorder (15 per cent, or 18 per cent of those with diagnosed mental ill health);

- Dual diagnosis (24 per cent or 31 per cent of those with diagnosed mental ill health).

We see in Section 3.3 that although depression and anxiety were the most common mental disorders, they were frequently diagnosed alongside other, more severe, conditions (see Figure 3.4). Most respondents had received their diagnosis more than 12 months ago although a sizeable proportion had been diagnosed more recently (see Figure 3.2).

In addition, respondents were asked if a doctor or health professional had ever told them they have a learning disability or difficulty, or if they have Autism/Asperger's syndrome. In total, 18 per cent reported having a learning difficulty or disability[44] and two per cent indicated a diagnosis of Autism or Asperger's syndrome.

There was significant overlap between those reporting a learning disability/difficulty and/or Autism/Asperger's, and those reporting a diagnosed mental health condition. Only three of the 24 respondents who reported having a learning disability/difficulty and/or Autism/Asperger's did not also report a diagnosed mental health condition.

Figure 3.1: Has a doctor or health professional ever told you that you have any of the following conditions? (All respondents)

Depression, 61%

Anxiety disorder or phobia, 43%

Dual diagnosis, 24%

Personality disorder, 17%

Psychosis, 15%

PTSD, 15%

ADHD 7%

Eating disorder 7%

n=152 to 158

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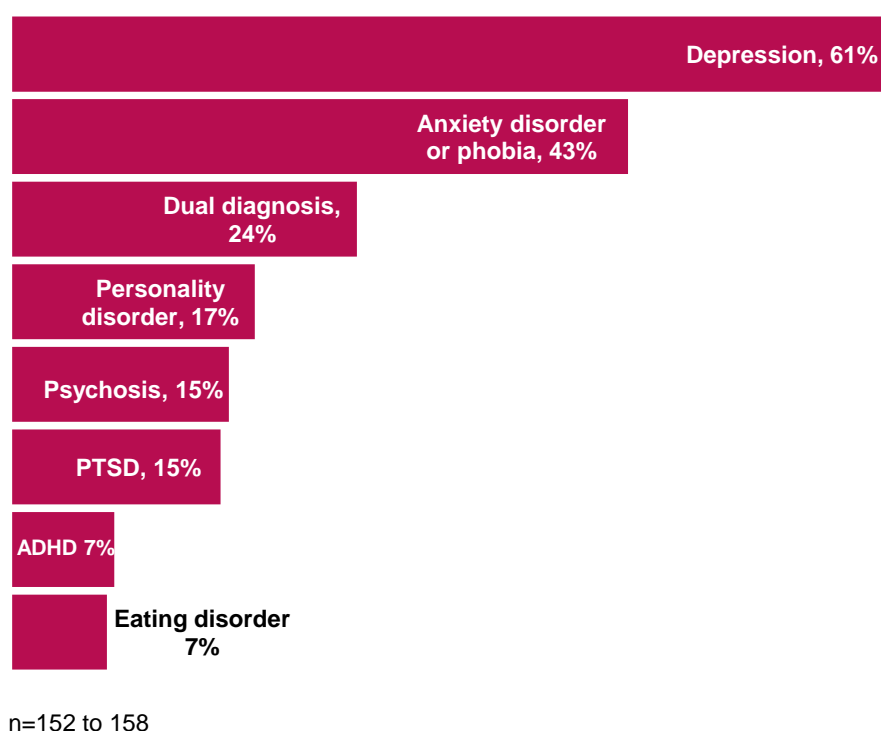
[44] It should be noted that this is much higher than the general population and is likely to include a range of issues which were perceived by respondents as a 'learning difficulty or disability'. These could include ADHD, dyslexia, and other difficulties. These are distinct from a formal intellectual disability diagnosis.

Figure 3.2: Has a doctor or health professional ever told you that you have any of the following conditions? (all respondents)
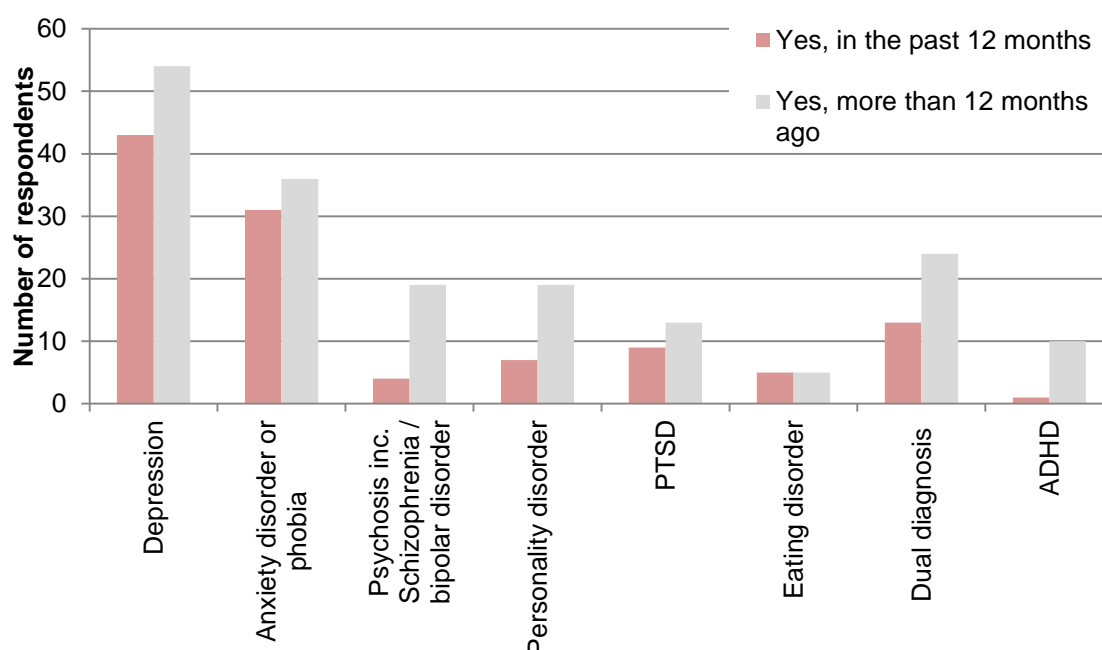
n=152 to 158

Comparing the results from our survey with what is known about the prevalence of different mental health conditions in the general population suggests that **homeless people in Nottingham are significantly more likely to have been diagnosed with all mental health conditions than the general population.** The Adult Psychiatric Morbidity Survey 2014 represents the largest survey of mental health and wellbeing. It did not include homeless people and so provides a useful national comparator. It found that:

> *One adult in six (17.0%) had a Common Mental Disorder… Other disorders were rarer, for example psychotic disorder and autism each affected about one adult in a hundred. Bipolar disorder…traits [were found] in about one adult in fifty. Signs of drug dependence were evident in one adult in thirty, with a similar level found for probable alcohol dependence.*[45]

Common Mental Disorders (CMD) is an umbrella term combining 'different types of depression and anxiety. They cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition.'[46] Our survey of homeless people in Nottingham found that 66 per cent had been diagnosed with *either* depression *or* anxiety disorders at some point. No directly comparable national statistics are available but 16 per cent of adults currently had symptoms of CMD in 2014.[47]

Statistics on local rates of mental disorders are not particularly robust making it very difficult to benchmark our survey results against the local population with any accuracy. In addition, local recording of mental health conditions is reported to vary widely. In 2015/16, the prevalence of depression was recorded as 8.6 per cent of

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[45] Appleby et al (2016) *Mental Health and Wellbeing in England: Adult Psychiatric Morbidity Survey 2014.* Available at: http://content.digital.nhs.uk/catalogue/PUB21748
[46] p38, Ibid
[47] Appleby et al (2016) *Mental Health and Wellbeing in England: Adult Psychiatric Morbidity Survey 2014.* Available at: http://content.digital.nhs.uk/catalogue/PUB21748

adults within Nottingham City CCG area.[48] The prevalence of Psychosis was found to be 1.0 per cent. These figures are much lower than rates of mental disorders found amongst our survey sample (61 per cent and 15 per cent respectively).

The high rates of mental illness indicated by our survey are not a surprise. Precise and reliable statistics on the nature and extent of mental ill health amongst homeless people may be limited but all available evidence concurs that rates of mental ill health are significantly higher amongst homeless people than is found in the wider population. Department of Health analysis in 2011, for example, concluded that 'people who are homeless have 40–50 times higher rates of mental health problems than the general population.'[49] Homeless Link, meanwhile, concluded in 2014 that 'serious' diagnosed mental health problems are at least twice as common amongst homeless people as the general population.[50]

Our survey results alone do not, therefore, suggest *unusually* high prevalence of mental ill health amongst Nottingham's homeless population compared to homeless people elsewhere. They are, for example, in line with the Department of Health (2011) analysis mentioned above. However, comparing our survey results to the results of a large survey of homeless people conducted by the charity Homeless Link in 2014[51] suggests that the range of mental health conditions may be more prevalent amongst the homeless population of Nottingham when compared to other studies of homeless people.[52] The Homeless Link survey found the following prevalence of diagnosed mental health conditions:[53]

- Post-traumatic stress disorder (PTSD) - seven per cent. Respondents to the Nottingham survey were more than twice as likely to report diagnosed PTSD (15 per cent).

- Dual diagnosis - 12 per cent. Again respondents to the Nottingham survey were twice as likely to report dual diagnosis (24 per cent).

- Schizophrenia or Bipolar disorder - 12 per cent. The Nottingham survey had marginally higher rates (15 per cent).

- Personality disorder - 7 per cent. The Nottingham survey found 17 per cent of respondents had been diagnosed with this condition.

- Depression - 36 per cent. This is much lower than the proportion of respondents in Nottingham reporting diagnosed depression (at 61 per cent). Homeless Link did find that 67 per cent of respondents 'felt depressed' and 73 per cent 'often felt stressed'. Similarly, in a longitudinal study of multiple exclusion homelessness, 79 per cent of respondents 'had a period in life when very anxious or depressed'.[54]

It is worth reflecting further on the final point above - that rates of *self-assessment* of common mental conditions in other studies are similar to rates of *diagnosis* in our

[48] NHS England (2017) *Quality and Outcomes Framework 2016-17*. Recorded disease prevalence, achievements and exceptions, Clinical Commissioning Group (CCG) level. Available at: http://digital.nhs.uk/media/33578/QOF-2016-17-Prevalence-achievements-and-exceptions-at-CCG-level/default/qof-1617-prev-ach-exc-ccg

[49] HM Government (2011) *No health without mental health: A cross-government mental health outcomes strategy for people of all ages.* London: Department of Health and Social Care: p.43.

[50] Homeless Link (2014) *The Unhealthy State of Homelessness*: *Health audit results.* London: Homeless Link.

[51] The Homeless Link survey had 2,590 respondents between 2012 and 2014 from across England.

[52] Where possible, the Nottingham survey used the same question as the Homeless Link survey so we could benchmark the results.

[53] Homeless Link (2014) The Unhealthy State of Homelessness: Health audit results 2014. London: Homeless Link. Available at: http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf

[54] McDonagh, T. (2011) *Tackling homelessness and exclusion*: *Understanding complex lives.* York: JRF.

survey (there were no corresponding self-assessment rates for more severe mental health conditions in the other surveys cited). It raises the possibility that our higher figures, potentially across all conditions, could reflect better access to GPs/diagnosis in Nottingham, rather than higher actual rates of mental disorders. Other evidence lends some support to this. We saw in Chapter 2, for example, that very few of the survey respondents who self-reported mental health issues, did not also have a formal diagnosis, and we will see in Chapter 7 that most respondents were engaged with a formal support provider. The study team were surprised by these results. It is well documented in national studies that homeless people, for example, encounter difficulties accessing (e.g. registering for) GPs.[55] Yet, in Nottingham, this did not emerge as a significant issue (see Chapter 8 for more detail). This might be explained by the fact that out of the 54 CCG member GP practices in Nottingham City, 21 practices provide enhanced services for homeless people (known as the 'Homeless Service – Single Action Tender').

This study did not generate longitudinal data but some of the stakeholders interviewed reported having noted an increase in mental health issues amongst their homeless clients. For example:

> *We can evidence that the level of complexity of mental illness in the general homeless population has increased, so it's perhaps less clear cut in the family cohort but in the singles population there is evidence that the complexity has increased and we've got lots of people who have a mental health diagnosis. (Local authority housing/homelessness department)*

> *I've been shocked by how mentally unwell people are that we're picking up on the homeless scene that have either fallen through the net or the response of stat services is terrible… we've had people that have, just no-one doing anything and it's how unwell does someone have to be? (Homelessness day centre)*

Where people could rationalise why this might be the case, underpinning factors included a reduction in services that help support people with their mental health and/or to stay in their accommodation, the use of (previously) legal highs such as Spice or Mamba, and an ageing population of people who were heavy drug users in the 1990s.

3.2. Multiple mental health needs

Exploring respondents' mental health diagnoses in more detail reveals **a picture of multiple mental health needs**. The majority of respondents with a mental health diagnosis reported having more than one diagnosed condition. This may provide a partial explanation for the prevalence of mental health diagnoses found in the last section. Almost three-quarters (73 per cent) of respondents with a diagnosed mental health issue reported having received more than one diagnosis. Just less than half (45 per cent) reported three or more different mental health diagnoses (See Figure 3.3).

It was rare for respondents to have only one diagnosis. As reported above, depression and anxiety were the most common diagnoses but most also had a more severe condition. Figure 3.4 provides details on the combinations of mental health diagnoses. It shows that almost **two thirds** (**63 per cent) of respondents with mental health issues had a diagnosis of a severe mental health condition** (i.e. a

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[55] See, for example, Gorton, S. Manero, E. and Cochane, C. (2004) *Listening to Homeless People: Involving homeless people in evaluating health services*. London: Groundswell UK and Health Link.

condition other than depression and/or anxiety). This means that almost half (46 per cent) of all survey respondents had a diagnosis of a severe mental health condition.

Figure 3.3: Number of Mental Health Diagnoses (respondents with a mental health diagnosis only)
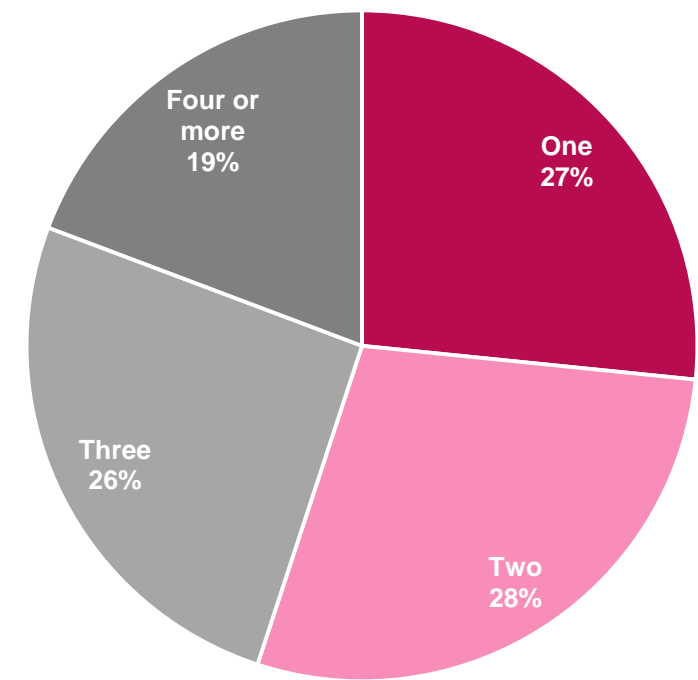
n=109

Figure 3.4: Combinations of mental health diagnoses (respondents with a mental health diagnosis only)

Depression and/or anxiety 37%

Other combination of two or more diagnoses 55%

One diagnosis - not depression or anxiety 8%
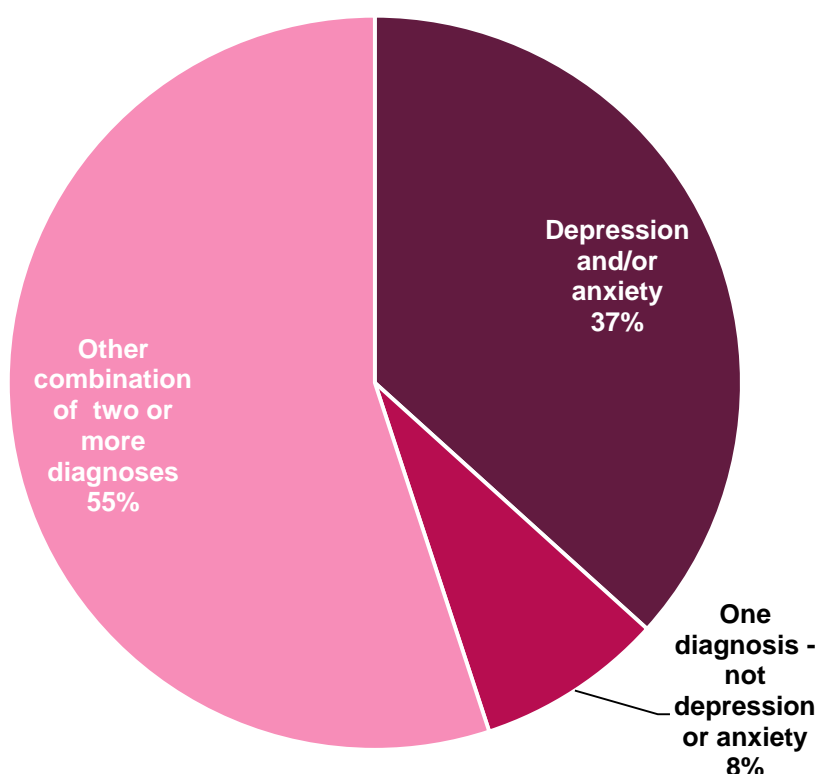
n=109

The qualitative interviews provide additional evidence of the multiplicity of mental health issues amongst this population. Many interviewees talked about having depression and anxiety alongside other conditions such as PTSD, psychosis and personality disorder, with self-harming, eating disorders and dual diagnosis also relatively common. Respondents described points in time where the combination of their mental health issues, often in addition to other needs and circumstances, had led to crisis scenarios such as overdosing or being detained under the Mental Health Act. Mick, for instance, had been diagnosed with passive schizophrenia but also recognised himself as depressed, especially at certain times in his life. Others described how they experienced different mental health conditions at different stages of their life:

Interviewer (I): How old were you when you first started developing these problems?

Respondent (R): Seven years old when I first got diagnosed with ADHD.

I: What about the psychosis and depression?

R: I've had that on and off really since I was young (Scott, aged 20).

R: I was diagnosed with psychosis but that was later.

I: At what age were you diagnosed with schizophrenia?

R: 17 (Stephen, aged 35).

As well as a multiplicity of mental health issues there was also a multiplicity of other support needs (social exclusion, trauma, drug and alcohol misuse and domestic violence) in the respondent sample and this is explored in Chapter 5.

3.3. Mental health trajectories

Each individual's mental health trajectory is complex and unique to their personal history and circumstances. However, a number of **broad patterns emerged relating to the onset and triggering of mental health issues** amongst the homeless people interviewed for this study:

- **Long-term mental health issues**. Many respondents had experienced mental health issues - although not always diagnosed as such - for numerous years, often since childhood or adolescence.

- **Mental health issues were typically triggered by a specific event, or ongoing trauma rather** than developing independently of life experiences, AND/OR;

- **Pre-existing but managed mental health issues were further exacerbated, or brought to crisis, by life events** including stress, trauma and homelessness.

If we explore respondents' mental health trajectories in more detail we can see these broad patterns illustrated.

It was common for interview respondents to trace their mental health issues to a time before they first became homeless, often in childhood or adolescence. Many, therefore, had a **long history of mental ill health**, albeit fluctuating in severity and manageability. Not all had been diagnosed with mental health conditions at that time and some only recognised their history with hindsight. Nicole (aged 28), for example, explained that *'I think it [mental ill health] started from a very young age but I didn't know.'* Mick, meanwhile, had suffered a breakdown before he realised that he had mental health issues and was eventually diagnosed with schizophrenia 15 years ago. Before that, Mick had felt unwell but had little understanding about what he was experiencing:

> *I: Did you have any idea that there was something going on before that [diagnosis]?*
>
> *R: No I don't think I did. I didn't understand I was going through a mental breakdown, all I knew was I was going to pieces and I couldn't control myself (Mick, aged 47).*

Respondents' mental health, as seen on a continuum or trajectory, can be understood as fluctuating or, as some respondents described, 'up and down'. Certain events and experiences acted as 'triggers' and often led to difficult feelings and behaviours.

> *R: Emotions, you can be quite scared, put me into shock a little bit as well, just like if I have a nervous breakdown.*
> *I: How often does that happen?*
> *R: […] I don't know how it happens; it just comes on and off (Stephen, aged 35).*

> *I've always been depressed but I go through dips where I'm severely depressed (Rosie, aged 29).*

> *I: So the trauma of the events that you experienced four years ago, that feels very much still…*
> *R: I relive it every day; it takes over my life (Arnold, aged 36).*

Like Arnold, **respondents generally traced the onset of their mental health issue(s) to particular life experiences.** For some this was a very specific event such as a violent personal assault, relationship breakdown, bereavement, or

traumatic experience associated with life as a refugee. For others it was ongoing trauma, including prolonged sexual abuse, domestic violence or severe neglect. Dara, a refugee who had been living in England for 16 years, for example, said his mental health issues (depression and schizophrenia) developed following the death of his close friend/flatmate. Subsequently his mental health deteriorated and Dara was Sectioned and prescribed medication.

> *I was happy yeah. I come here, I had my full time, permanent job, [and] then my friend get cancer and died, he was 28 years old, we used to live together and I get mental illness (Dara, aged 33).*

The onset of mental health issues was similar for Marwa, a refugee who had been diagnosed with PTSD and depression brought on by the death of her brothers in her country of origin. Derek, meanwhile, traced his depression and anxiety to the sudden breakdown of his marriage and the heavy drinking that followed. Despite being in the army for a considerable length of time, Derek described how his relationship breakdown was the first time he had experienced mental health issues. Other respondents similarly linked the onset of their mental health issues to the loss of important relationships and the sense of isolation that ensued.

> *I: Could you tell me a bit about how going through that experience leading from the break up affected your mental health?*
>
> *R: Well I became so depressed I didn't want to do owt, some days I wouldn't get out of bed all day, I couldn't face anything. It makes you feel like you're useless.*
>
> *I: Was that your first experience of feeling like that? Was there anything in your life before that occurring when you felt like that?*
>
> *R: No it was the first time I felt like that (Derek, aged 55).*

> *I never drank when I was bringing my kids up but they started leaving home […] I got depression big time (Judy, aged 47).*

> *Very first time [was] 15 years ago when I had the mental breakdown; I finished a relationship and things didn't go as well. I cracked up, I was drinking and taking medication on top and I couldn't cope no more, just went to pieces (Mick, aged 47).*

For a larger cohort of respondents, the onset of mental health issues was attributed to ongoing trauma, often in childhood:

> *Well when I was young I had got depression, anxiety […] what me mum and dad did to me, they wouldn't let me in the house and that (Jimmy, aged 53).*

> *I've had it for years, from what mum's done, what my ex-partner's done, I've been sexually abused as a child, been forced into prostitution (Michelle, aged 36).*

> *I think it started from a very young age but I didn't know, feeling neglected, I practically raised myself from a young kid (Nicole, aged 28).*

Leona (aged 26), similarly, traced the beginnings of her mental health issues to racial abuse and bullying in childhood and adolescence. Amongst those who attributed their mental health issues to events later in life, domestic violence often featured as a factor. This was true, for example, of Collette:

You start to see that it's [domestic violence] destroying every aspect of your life and I was getting quite suicidal and overdosed on a couple of occasions whilst I was with him […] I think for many years I had mental health problems and when my daughter fell pregnant and left home, I'd been on my own for quite a number of years and I felt totally lost […] When I met X I felt I could hide in his world […] I fell very quickly into a relationship with a man I didn't know that well but I was vulnerable and not very strong in my mental health and abusing a lot of Diazepam […] so I wasn't in a good place when I met him (Collette, aged 50).

We see from Collette's articulation of her deteriorating mental health, that respondents' mental health trajectories were not always clear-cut, or linear, and they could not always pinpoint 'causality'. For many, a complicated combination of factors led to periods of mental ill health of fluctuating severity. In Collette's case this included her daughter leaving home, isolation, a violent relationship and abusing prescription drugs. Other respondents described a 'build-up' or an accumulation of trauma and stressful life events. Despite fragile mental health, for example, Jasmine remained stable following the breakdown of her relationship but deteriorated when denied access to her step-son:

When I was with my ex it was fine. Just after we split up it was okay, but then she stopped me seeing my step-son in July last year and my mental health went down from there and I ended up starting self-harming again and that carried on till I moved in here in July, then I stopped for two months and when I ended up in the hotels[56] *I started again (Jasmine, aged 28).*

An accumulation of traumatic life events is also evident in Judy's mental health trajectory. Judy, aged 47, first became homeless eight years ago as a result of being evicted after falling into rent arrears. At the point of eviction, Judy described her mental health as 'bad' ('*I was self-harming and everything […] it was bad'*). Before this point, Judy lived in a house with her children but when they left home she began to feel isolated and depressed and started drinking heavily. Judy also revealed that she had been raped around the same time resulting in PTSD. She has also been diagnosed with depression. At the time of her interview Judy was living in a large mixed hostel where she felt at risk and was worried that her attacker was living nearby. Judy was not receiving any counselling for her depression or PTSD and said that she largely coped with it on her own or by 'blocking it out' (the interviewer also noticed self-harm marks on her arms).

We see in both Collette and Jasmine's stories how **pre-existing, but manageable, mental health issues are brought to crisis by stressful events.** In both cases, underlying mental health issues were exacerbated, and quickly shifted from manageable to problematic (in Jasmine's case, including a suicide attempt). Collette *'think[s] that for many years I had mental health problems'* but her health only began to deteriorate when her daughter left home, and she then met a violent partner. Jasmine, too, had managed depression for many years, until her mental health crisis was triggered by emotional distress.

When discussing the onset of their mental health issues, respondents frequently referenced periods of drug or alcohol misuse. Drugs and alcohol were sometimes used to mediate the effects of other difficulties (the relationship between mental ill health and substance abuse is explored in more detail in Chapter 5) but were also cited by a small number of respondents as the 'cause' of their mental health issues. After a relationship breakdown and the death of her brother, Jess used drugs to help 'numb the pain' but she also pinpointed this as the start of her mental health issues,

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[56] Provided as temporary accommodation by the local authority.

as did Rosie. Although both were also dealing with issues that might affect mental health, they believe the key trigger was drug abuse:

> *Instead of dealing with it I didn't, and my brother passed away at the same time so it was just easier to use the drugs and that's where all the mental health issues came from (Jess, aged 35).*

> *I: So do you pinpoint anywhere where you think your problems started or got out of control?*

> *R: Started taking the MDMA really, definitely. When I look at my problems it [mental ill health] all boils down to drug use (Rosie, aged 29).*

Common across all interviews – regardless of when the onset of mental health issues occurred – was a history of traumatic and difficult life events and personal circumstances that laid people open to mental health issues and homelessness. This was also evident from the survey results. A considerable proportion of survey respondents indicated a number of other support needs other than homelessness, including physical health issues, dependencies, self-harming behaviour, institutional backgrounds and experience of domestic violence (see Chapter 6). Respondents with mental health issues were much more likely to have spent time in an institution (with the exception of the armed forces) than those without mental health issues, for instance. Like in the general homeless population, our sample (both survey and interview) therefore contained a high concentration of vulnerable people with support needs who had a heightened vulnerability to adverse economic and social conditions. The data shows multiple - and often inter-related - causes of mental health issues. In some cases, they were already present before the initial period of homelessness and sometimes contributed to homelessness itself; in others, they materialised after - and because of - homelessness and its associated stressors. What was clear was that homelessness exacerbated existing mental health issues as the living situation added new layers of stress and insecurity. We revisit these complex interrelationships, and the multiple needs our respondents presented with, in subsequent chapters.

3.4. Conclusion

The identification of some of the causal factors of mental health issues amongst this population, in both the quantitative and qualitative data, provides insight into where the need for intervention lies. The association between mental health issues and adverse experiences in childhood signals a critical intervention opportunity. The coincidence between mental health issues and homelessness and other poor outcomes in adulthood, such as substance misuse and offending, points to a potential need for upstream preventative measures. The prevalence of problematic childhood experiences amongst those with multiple and complex needs points to a need for more improved understanding within children and family services of routes in to multiple exclusion homelessness and more targeted work with children who are experiencing issues that may relate to later homelessness.

Housing situations and experiences

<div style="text-align:right">4</div>

This chapter focuses on the housing situations and experiences of homeless people with mental ill health in Nottingham, paying particular attention to the circumstances leading to homelessness. Understanding how and why people become homeless, and their subsequent homelessness trajectories, provides insight into their wider needs, beyond mental health.

4.1. Reasons for homelessness

The survey data show that the most common reason for respondents with mental ill health to have first become homeless was a relationship breakdown with their parents (see Table 4.1).[57] In the vast majority of these cases (27/34 or 79 per cent), survey respondents indicated that their parents had explicitly asked them to leave. This concurs with local evidence about causes of homelessness amongst the wider homeless population.[58] Table 4.1 also shows that separation from a partner and escaping abuse from a partner were two other common ways in which survey respondents first became homeless. In total, 14 per cent of survey respondents with mental ill health became homeless escaping abuse.[59]

Insights from the qualitative interviews offer a more in-depth and nuanced account of the causes and triggers of participants' homelessness. There were often considerably more complex factors at play and long chains of life events behind the single reasons captured in the survey responses. Still, interview responses on their own only offer a partial explanation of the reasons behind an individual's homelessness. Poverty, especially childhood poverty, has been underlined as central to the generation of homelessness in recent analyses of UK datasets[60] - this confirms that homelessness is concentrated within the most disadvantaged sections of the community who lack the social and financial 'equity' to endure a personal crisis without becoming homeless. In other words, and as other commentators have argued, structural variables such as poverty, housing shortages and unemployment create the context within which homelessness will occur; and that people with personal problems are most vulnerable to. The 'reasons' for homelessness that follow are not straightforward or singular; neither do they pertain to a straight

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[57] It is important to note that we do not know whether these respondents had mental health issues at the point they first became homeless.
[58] See for example Nottinghamshire Homeless Watch Findings, 2015.
[59] Once the data for respondents without mental health is broken down by 'reason for homelessness' the numbers are too small to draw any meaningful conclusions.
[60] Bramley, G. and Fitzpatrick, S. (2018) Homelessness in the UK: who is most at risk? *Housing Studies*, 33 (1), pp. 96-116.

'either/or' between structural or personal causes but are often a complex interplay between the two. In nearly all cases, family and other key relationships - argued to be an important 'buffer' to homelessness - were estranged or severed. Relationship breakdown was both a direct and indirect cause of homelessness, in that divorce, separation or leaving the parental home immediately led to homelessness; but indirectly, in that the option of returning to the family home (after an eviction, for instance) was absent for most respondents. In the remainder of this section we discuss in more detail the main reasons why interview respondents became homeless.

Table 4.1: Thinking about the first time you became homeless, why did you leave the accommodation you were in?

	No.	%
relationship breakdown with parents	34	28
separation from partner	21	17
to escape abuse from partner	10	8
sentenced to prison	8	7
to escape abuse from someone other than a partner	7	6
entitlement to Home Office housing ended	5	4
evicted/repossessed for arrears	4	3
'abandoned' a tenancy	4	3
leaving LA care	4	3
evicted for anti-social behaviour	4	3
given notice to quit by a private landlord	3	2
went into hospital	2	2
Other	17	14
Total	123	100

Mental health and traumatic life events

In a small number of cases, respondents had become homeless because of their mental health where they had either left accommodation, or were asked to leave by other members of the household or their landlord, as a result of deteriorating mental health or had no accommodation to return to after a stay in hospital (this is explored further in Chapter 5.1). These personal circumstances, while not always the main or direct trigger of homelessness, evidently increased respondents' vulnerability to homelessness. For a number of respondents, however, it was clear that mental ill health was the principal factor. Arnold, for instance, developed depression, anxiety and PTSD following the deaths of two close family members and a friend all in a short period of time. He could no longer stay in (or even re-enter) the family home due to the painful trauma it triggered, so Arnold initially slept rough, then moved around B&Bs, and was currently staying in a hostel. Eleanor was admitted to the mental health ward of Highbury hospital after a traumatic assault and was staying at specialist temporary accommodation at the time of interview. Andy was asked to leave his family home after his mother was diagnosed with dementia and Andy's mental health issues and drinking meant the situation became difficult to manage.

Leaving prison

There is evidence that some respondents had become homeless following release from prison or Approved Premises with no move-on accommodation in place. Ross, aged 37, explains what happened after he was given a notice to quit by the Approved Premises he stayed in after release from prison:

> Probation didn't help whatsoever, they hindered; they put obstacles in my way at every turn. My hostel key worker did admit that she failed me cos she couldn't find me a move on address and my case was quite rare. I've got no local connection to Nottingham, that's what made it more difficult for me. So they escorted me off the premises and I took my tent and my bag and camped (Ross, aged 37)

Other respondents had been referred to specialist mental health units following their release and had subsequently moved into temporary accommodation after their time there (for example, Johnston). Some participants (for example, Gavin) stayed with friends for short periods of time (until relations became strained or 'it didn't work out') and then moved on to current situations in temporary accommodation. Factors that are known to expose people to the risk of homelessness were also often in play here, such as drug or alcohol misuse, an unstable childhood, and a lack of family support.

Gavin, aged 66, first became homeless in the 1990s following release from prison. As Gavin explained, *I'd been in prison a few times, when you're getting out you go and see various people but they can't fix you up with accommodation […] so you're still homeless when you get out'*. Leading up to his first experience of homelessness, Gavin had spent his childhood and young adulthood in various forms of instability - he had been involved in offending behaviour from a young age; had moved around different cities a lot as a child; and lived with different family members when growing up. He no longer sustained any form of contact with his mother *('I lost contact with my mother, she went to Plymouth and I've lost touch with her for quite a few years now')*. Donald, aged 58, has a similar background and pattern of offending behaviour. Having been abused as a child by his biological and foster families, Donald turned to crime at a young age and served three lengthy prison sentences in adulthood. He was moved into temporary accommodation following release from his most recent sentence.

Leaving care

A small number of survey and interview respondents first became homeless after leaving (or running away from) local authority care. Stephen, for instance, after spending his childhood moving between foster care and children's homes, moved to mental health supported housing after leaving care. At the time of interview he was living in a supported housing service which was part of Nottingham City's statutory mental health pathway. Before this he was housed in specialist accommodation. Stephen had previously spent a short period of time temporarily staying with friends and sleeping rough (until the police found him).

Relationship breakdown and separation

Relationship breakdown with parents and separation from a partner were the two most common reasons for homelessness amongst survey respondents. These reasons also emerged prominently among interview respondents in combination with other contributory structural and personal circumstances. Ray, Nicole and Jasmine's stories are illustrative of this point.

Ray, aged 53, first became homeless when he was 50 years old, when his relationship broke down with his ex-partner (and mother of his children) after they moved to Newcastle. Ray travelled back to Nottingham (where he lived before) with his 17 year old son but they were not made an accommodation offer by the Council due to him being deemed as having access to some form of accommodation (they were intermittently sleeping at his brother's house in between sleeping rough in a tent). This accommodation was far from ideal as Ray explained:

> Brothers and sisters live down here, but the family's not as close as what it used to be, X is the only close brother I've got but he's going through difficulties, drinks a lot. (Ray aged 53)

The loss of his relationship with his mother when she passed away was also a key contributing factor to Ray's homelessness and signalled the loss of a safety net. Ray lived with his mother until he was 38 and started his own family and she had provided support for him during other adverse life events (where he might have otherwise become homeless):

> I lived with me mum till I was 38. I've never been on me own till I became homeless […] I was in a special needs school to help me and that, keep me secure and safe, I came out of this place and all I relied on was me mam […] I got sentenced eight years […] but she stood by me even then and when I came out back again with my mum. (Ray aged 53)

Nicole first became homeless when she was 23 years old. Her mum - who she was living with at the time - decided to move cities and Nicole wanted to stay in Nottingham so she moved in with a family friend. Things did not work out and Nicole was forced to make a quick exit:

> I went to stay with a family friend, was paying rent, was doing everything as we agreed. One day I think he just got a bit erratic, a bit unreasonable and decided to kick me out, he packed all my things for me, I didn't get a chance to pack my things or even know where it was and the next thing I know I'm standing outside with bags surrounding me and that was the first day I experienced being homeless. (Nicole aged 23)

Jasmine also became homeless due to the breakdown of a relationship. She moved to Nottingham from another UK city (where she lived with her ex-partner) and at first slept temporarily on a sofa at a friend's house. Jasmine was subsequently asked to leave after her mental health deteriorated and she took an overdose.

For other interview respondents, separation from a partner was the primary trigger of homelessness, and their life had been relatively stable up until that point. This was the case for Derek whose homelessness had been triggered by divorce from his partner. Initially Derek was able to stay with his mum, but as he turned to alcohol as a way of coping with the separation, his mental health (depression and anxiety) rapidly deteriorated and his behaviour turned more erratic until his mother asked him to leave. At the time of interviewing Derek was in a hostel but had been offered local authority accommodation and was in the process of moving.

Fleeing domestic violence

Escaping abuse from a partner was the third most common reason for homelessness among all survey respondents. Again, respondents' stories from the qualitative interviews reveal more of the reality behind this statistic. In most cases, women had multiple experiences and long histories of domestic violence. Others had experiences of violence, abuse and neglect in the childhood home. Michelle was in

and out of social care as a child/teenager as a result of her mum's substance misuse and severe mental health issues (suicidal tendencies). At the age of 17, Michelle met a much older partner who became extremely violent and abusive towards her ('*I was with him for 19 years and 17 years he put me through hell*'). Denise, similarly, experienced a long history of domestic violence as well as an estranged relationship with her mother ('*my mum ostracising me, she don't understand cos when you've gone to jail it's cos she's been pissed up, caused murder with neighbours and then I've had to go out and fight her battles so I don't even feel like I've had support off me mum and I'm an only child*'). Many of the women we spoke to had been housed in inappropriate accommodation given their experiences of domestic violence. At the time of interview, Denise was in a large, mixed sex hostel where violence and drug use was prolific. Mandy described how she returned to her violent and abusive partner for six months after not being able to explain her situation properly (Mandy had been victim of bullying in the previous refuge and did not want to return there):

> *I went down to homeless and said I don't need a refuge, I'm not at risk now I'm out of there, so they took that as me saying that I don't need anywhere and didn't even give me the chance to explain […] I wasn't kicking off or anything and just from this one comment, it was really difficult cos the only place I could go back to was his. (Mandy, aged 41)*

Many of the women who had been victims of domestic violence for a long time spoke of the difficulty of escaping their situation completely - whether because of not wanting to risk losing their children, or a lack of support or suitable accommodation to escape to, or the struggle of 'starting again' (as Collette explains in the quote below). Collette had moved to Nottingham from another UK city to escape abuse from her partner. She was initially housed in a refuge but spoke about the difficulty of leaving without any finances (her ex-partner had taken control of her own) and being able to cope independently. In total, Collette had moved around 13 different refuges and the stress and insecurity of having to move on had significantly affected her mental health.

> *Then when I came to Nottingham I knew I couldn't do it any more, I didn't have the strength to start again and I knew, cos you go to a new area with nothing literally and it's like building a life up again and knowing no-one, with no money and I had food issues so I'd end up relapsing with my food as well and that was one of the reasons that used to bring me back cos I felt I couldn't cope without him (Collette, aged 50).*

Leaving, or being evicted from, a tenancy

A number of survey and interview respondents had become homeless after abandoning or being evicted from a tenancy, most commonly in the private rented sector. The reasons given for leaving a tenancy related to the standard of the property and the surrounding environment. Lisa, for instance, left her private rented tenancy even though she had nowhere to go afterwards. She said '*I left my property cos of the state it was in, the kitchen and bathroom was a state and I was being harassed by the neighbours constantly making noise […] I ended up being on the streets for four days, five days cos no-one would take me*'. When digging deeper, however, it was clear that respondents who had abandoned tenancies often had longstanding mental health issues and complex needs (which had mostly gone unrecognised or untreated) perhaps playing some part in the difficulty of sustaining a tenancy. Laura, for instance, was evicted from her flat for anti-social behaviour ('*it was the neighbours complaining about our music*') but also had a long-term substance misuse problem. Other respondents had been evicted for rent arrears. Judy, for instance, first became homeless eight years ago after falling into rent

arrears - the build-up to which involved a rapid deterioration of mental health and substance misuse following a violent rape.

Asylum seekers

A small number of survey and interview respondents became homeless as a result of difficulties with an asylum claim. Marwa came to study in Nottingham from her country of origin in 2015. When her student visa expired Marwa was asked to provide relevant paperwork for her claim but this was proving very stressful and long-winded ('*I didn't think I need all this time to bring the proofs before I get the support').*

4.2. Key features of respondents' homelessness trajectories

Once homeless, many respondents then experienced long periods without stable housing, or multiple subsequent episodes of homelessness. In this section we discuss some of the key features of respondents' homelessness trajectories.

Duration of homelessness

Survey respondents were asked how long they had been homeless, and when they last had somewhere 'settled' to live (see Figure 4.1). It is of some concern that over one quarter of those with mental ill health (28 per cent) had been homeless longer than three years. The 'comparator sample' is small but there is evidence that, **respondents with mental health issues were more likely to experience enduring homelessness.** For example, 34 per cent of those without mental health had been homeless for longer than one year (compared to 59 per cent for those with mental ill health).

Figure 4.1: When did you last have somewhere settled to live? (Mental ill-health only)
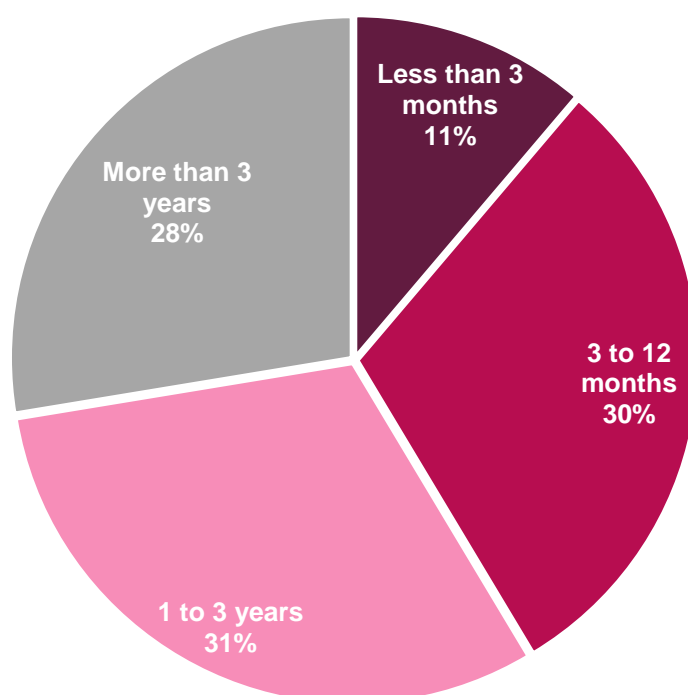
n=116

The majority of respondents first experienced homelessness as children or young adults. First experiences of homelessness can be seen in Figure 4.2. Over half of respondents (51 per cent) first experienced homelessness before they were 25 years old. The age of first homelessness was similar for both those with and without mental ill health.

Homelessness beginning in youth is similarly evident in our interview sample of homeless people with mental health needs. There are two potential conclusions that might be drawn from this. *Firstly,* that people with mental ill health find it particularly difficult to resolve their housing problems and/or are unable to access the support, help, or appropriate housing they require and so remain homeless for longer. *Alternatively*, these results might indicate that homelessness has a significant impact on mental health, making it likely that people who experience homelessness for longer will develop mental health issues. However, as we go on to explore in Chapter 5, there is often no clear direction of causation but, rather, a mutually reinforcing relationship between both homelessness and mental health. As well as the first experience of homelessness, interview respondents' mental health issues also started at a young age. In most cases, respondents had long histories of homelessness and mental ill health indicating that the two are intricately interlinked.

Figure 4.2: How old were you when you first experienced homelessness? (mental ill-health only)
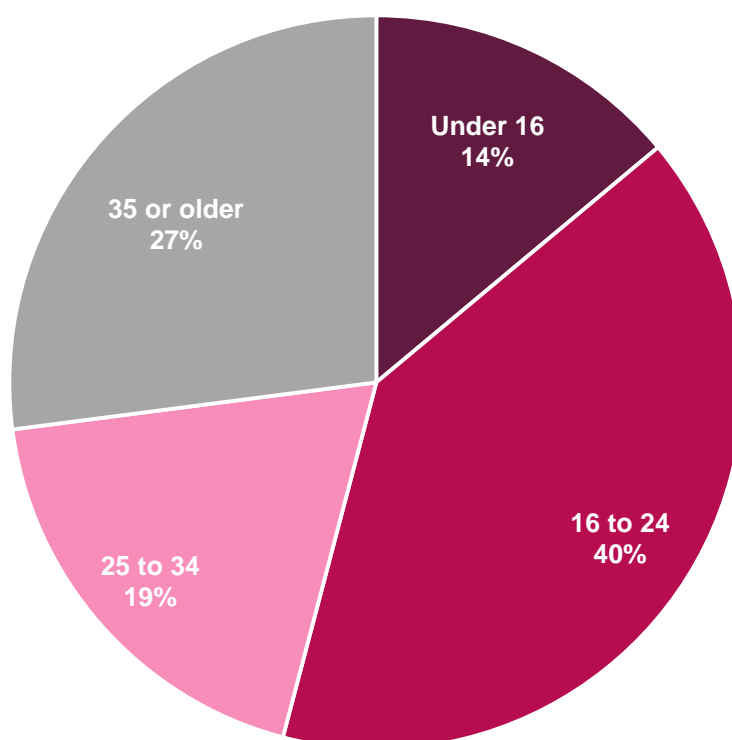
n=122

Frequency of homelessness episodes

Employing a 'homelessness pathway interviewing' technique allowed us to explore respondents' housing pathways alongside institutional engagement and life experiences and therefore to pick up on key points where a person's housing situation changed. Similar to their route into homelessness (see 'reasons for

homelessness'), participants' pathways through homelessness were also dynamic and varied. Evidence from the qualitative interviews shows how participants moved in and out of homelessness, and in many cases experienced several homeless episodes during the course of their housing pathway. With the exception of a small number of respondents, most had been homeless on more than one occasion.

Jess's housing pathway (see Jess's vignette in Box 6.1 in Chapter 6) is a case in point, having first become homeless at the age of 16, spending time in hostels, shelters and sleeping rough. Jess served nine short prison sentences in adolescence and developed a heroin addiction. Between the ages of 23 and 33, Jess had her own house, a partner and child, and a relative period of stability. She moved back into homelessness as her relationship with her partner broke down and her brother died. Jess moved back in with her mother, but started using drugs again and developed depression and personality disorder, until the relationship with her mother also broke down and the living situation became untenable. Jess subsequently moved into temporary accommodation. Several other participants moved between short periods of relative stability and homelessness. For most, however, the periods of homelessness occurred much more frequently - and for greater duration - than the periods of stability.

Moves between different forms of accommodation

It was common for respondents to have moved between different forms of accommodation and different 'types' of homelessness over the course of their housing pathways. This was often due to the short-termism of certain accommodation types. At other times it was related to the instability or unsuitability of living situations ('sofa surfing', for instance). In either case, it meant that respondents frequently had to move on to the next place (and when they were in accommodation, think about where this next place would be). An example of this chequered housing history and repeated 'moving on' between different forms of accommodation can be seen in Rosie's pathway below in Box 4.1.

As well as moving between different types of accommodation within the city, interview respondents had frequently moved between *cities*. Many participants had moved around different cities either with or to join family; to move away from violent and abusive partners or family; or through prison or stays in mental health facilities. Gavin (aged 66) was born in Glasgow, but had moved to South Shields (following his step-father), back to Glasgow (for work, and to join his mother after his step-father died), and then Nottingham (his mother moved to Plymouth and their relationship was estranged by that point).

Long stays in general needs temporary accommodation

In addition to a complexity of housing pathways, and frequent moves between different forms of accommodation and different geographical locations, we also found it was common for respondents to have spent prolonged periods of time in general needs temporary accommodation (including bed and breakfast accommodation). This was picked up in an interview with Lisa (among others). Lisa left the property she was privately renting because of *'the state [of disrepair] it was in'* and because the noise and anti-social behaviour of the neighbours made the environment difficult to live in. Lisa spent four or five days on the streets before being picked up by an Outreach worker who accompanied her to Housing Aid. Lisa was accommodated temporarily in two hotels in the city for a few weeks. Lisa described her experience of staying at these hotels: '*it was absolutely awful; the staff were really horrible, not a nice place to be in.'* Lisa was accommodated in bed and breakfast accommodation at a time when both her physical and mental health were in a critical condition. Shortly

Box 4.1: Frequent moving

Rosie

Rosie, aged 29, first became homeless at 21 as she was forced to leave the room in a shared property she rented from a friend following a breakdown in their relationship. From there, Rosie would alternate between sofas at friends' houses.

"I'd stop with one friend for one or two nights and then to give them space, I did that for quite a while and then I did it between three sets of friends"

When Rosie reached the point of feeling like she'd 'had enough' of this living situation, she approached Housing Aid for help. Rosie was offered a place at a large, mixed sex hostel first and eventually a place at a women's project. Rosie moved on to Sheffield afterwards, following friends and the 'party scene' (Rosie was using Ketamine, recreationally, at this point). Rosie stayed with a friend in Sheffield until she met her then partner. The relationship broke down and Rosie returned to Nottingham. The relationship ending had sunk Rosie into severe depression, and by this point, she had moved in with another Ketamine user, and had started injecting Ketamine and reported that she frequently felt suicidal. Rosie's physical health was extremely poor from the drug use at this point, but she managed to find support (both with her accommodation and for her addiction) before things got worse. Rosie moved into a cluster house run by a charity where she managed to come off Ketamine. Shortly afterwards, Rosie developed an addiction to amphetamines which she is still trying to control. After a short time on the street and sleeping on friends' sofas, Rosie moved into a private rented flat with her ex-fiancé. He was violent towards Rosie and wrecked the flat on two occasions. The second time led to Rosie being evicted and 'losing everything'. After eviction, Rosie alternated between sleeping rough and staying at her friend's supported accommodation. She was eventually picked up by the Outreach team. They helped Rosie fill in an application for a hostel space but as there were no vacancies at the time, Rosie went back to sleeping rough and staying on friends' (and friends of friends') sofas. On one of these occasions, Rosie was raped and sexually assaulted. At this point, Rosie reported that she was still being told she was 'not priority' by Housing Aid:

"I was rattling on heroin cos I was throwing up, sweating, and they were just like sorry you still don't have high enough priority to be housed. At first I was deemed intentionally homeless by the council which was really disheartening cos I lost the flat due to my ex's behaviour towards the property."

Instead, Rosie was initially 'taxied' to a bed & breakfast outside of Nottinghamshire, where she stayed for a week…

"…and then they sent a taxi to come and pick me and X up, so they shipped me out with this other girl and put us in local hotels here, I wasn't even there a night before they told me and there was a hostel space."

Rosie was then offered a hostel space at a large, mixed sex hostel and then moved to a complex needs hostel for women (where she was staying at the time of interview).

afterwards, Lisa attempted suicide and then was placed in a secure mental health unit. Lisa strongly emphasised how inappropriate the bed and breakfast accommodation was that she was placed in, an issue we return to in Chapter 5:

I think they put too many people in there and they're trying to get rid of everybody cos the hotels are meant to be for people just to come for a night or two but [they] are putting too many people in hotels for too long and they're not getting any help, some of them are just getting left and some end up getting kicked out cos of stupid reasons.

Lisa was certainly not the only participant to have been placed in bed and breakfast accommodation for a prolonged period of time: Jasmine stayed in a hotel for two months, Denise for six weeks, and Andy for about six weeks in total.

4.3.   Conclusion

What emerges most clearly from this chapter is the cyclical and entrenched nature of homelessness. Interview material highlights the chains of complex and traumatic life events leading up to an individual first becoming homeless and the setbacks that occurred thereafter. Homelessness repeated itself, as most participants lacked a secure family unit to offer a home and safety net when things went wrong; and as complex and severe needs were not met with appropriate support. Nearly all of the people we spoke to had been 'stuck' in the temporary accommodation system for years - moving in and out with only brief spells of relative stability. It is vital for future interventions to take into account the features of these homelessness pathways, and the reasons for participants' homelessness.

Mental ill health: cause or consequence of homelessness?

<div style="text-align:right">5</div>

We know there is a strong association between homelessness and mental ill health. The results presented in Chapters 2 and 3 concur with other studies of homelessness that find high levels of mental ill health reported by homeless respondents. Our results also confirm local intelligence - reported by stakeholders and revealed by their monitoring data - that a high proportion of homeless people in Nottingham present with mental health problems. Monitoring data from one of the largest homelessness services in the City, Framework, shows that more clients present to that service with mental health issues than with any other support need.[61] But the relationship between these experiences is complex. In some cases there may be a clear linear trajectory from mental ill health to homelessness, or vice versa. Often, however, there is no clear direction of causation but, rather, a mutually reinforcing relationship. In addition, the impact of homelessness on mental health, or the role mental health plays in precipitating or sustaining homelessness, is often mediated by other needs and experiences, in particular drug or alcohol abuse.

In an effort to explore the relationship between mental ill health and homelessness, survey respondents were asked whether they had been diagnosed with a mental health condition before or after they first became homeless. However, no clear pattern emerged, with a significant proportion of diagnoses being made both before and after the first episode of homelessness, with some variation by diagnosis (depression was more commonly diagnosed after a first episode of homelessness while psychosis diagnoses were more likely to predate homelessness).[62] In any case, this did not tell us when respondents' mental health issues first arose, only when they were diagnosed.

A much clearer picture emerged from the qualitative interviews. In these interviews we were able to explore in detail the interaction between respondents' mental health and their housing situations, and obtain a chronological 'life story'. **With few exceptions, respondents had some form of mental health issue prior to their first episode of homelessness.** As indicated by the survey results, not all had been diagnosed with a specific condition prior to homelessness, many were stable, managing their mental health well. Some were unable to articulate the nature of their early mental ill health beyond vague assertions such as 'not feeling right'. But, on a spectrum from severe diagnosed conditions, to low level depression or 'not feeling right', virtually all traced their mental health issues to a time that predated

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[61] Nottingham City Council (2016) *Agency Data Questionnaires.*
[62] See Chapter 4 of the interim report from this project for further details of this analysis. Available from: http://www4.shu.ac.uk/research/cresr/ourexpertise/understanding-mental-health-needs-homeless-people-nottingham

their homelessness. In some ways, then, our respondents might most accurately be described as a population of 'people with mental health issues who became homeless'.

5.1. The impact of mental ill health on homelessness

A sequential relationship is not the same as a causal relationship. Just because mental ill health tended to predate homelessness, it does not follow that mental health issues were the direct cause, or trigger, of homelessness.

In fact, there were only a small number of cases where mental health issues were clearly the primary and immediate trigger for homelessness and these were discussed in Chapter 4.1. Typically, respondents had either left accommodation, or were asked to leave as a direct result of deteriorating mental health. There was, however, also **evidence that a mental health crisis resulting in detention under the Mental Health Act presents a homelessness risk**. Two interview respondents had to give up, or were unable to return to their settled accommodation following a stay in hospital, and had no other settled accommodation to move in to. The interview respondents in this situation went to stay with family or friends but in both cases this temporary arrangement soon broke down.

Survey respondents were also asked about their housing situations before and after hospital detention. In total, 31 survey respondents reported having been detained under the Mental Health Act,[63] and information was available on the housing situation before and after their last period of hospitalisation in 29 of these cases. Of these:

- Just over half were living in settled accommodation[64] when they were detained, and one third moved into or returned to settled accommodation when they were discharged.

- Just over one quarter of respondents remained in (not necessarily the same) settled accommodation.

- Around one quarter appear to have become homeless. These respondents were in settled accommodation when they were detained but were discharged to a situation of homelessness.[65] It is important to note that independent living may no longer have been appropriate for some of these respondents. They may have been placed in temporary accommodation by the local authority pending an offer of suitable permanent supported housing.

- Nearly half were homeless when they were detained and remained so when they were discharged. The housing situations of these respondents did not, therefore, necessarily worsen (although some did - for example those who had been in hostel accommodation but slept rough when they were discharged) but their detention had not presented an opportunity to resolve their housing problems. This was also true for interview respondents, nine of whom had been detained at least once in hospital under the Mental Health Act.[66] **In at least five cases respondents were homeless when they were admitted and remained**

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[63] We do not know from the survey whether respondents had been detained in hospital for treatment/assessment or whether they had been detailed under Section 136 by the police for 24 hours. However, when interview respondents talked about being Sectioned they were always talking about being detained in hospital so it is likely that this is true of the majority of the interview respondents.
[64] This includes social and private rented tenancies, owner occupied accommodation, and living with parents or a partner on a permanent basis.
[65] Including all forms of temporary accommodation, rough sleeping, squatting, and sofa surfing.
[66] A further two respondents had been admitted to hospital following suicide attempts but it was unclear whether they were admitted under Section, or voluntarily, and a further two respondents had been detained by the police under Section 72 of the Mental Health Act.

homeless when they were discharged (in three cases respondents' circumstances were unclear), either to homeless hostels, or to stay temporarily with friends or relatives.

- In total, **20 respondents (out of the 29, 14 of whom were homeless at the time) were discharged to a situation of homelessness, six of whom slept rough on the night they were discharged**. Most commonly respondents (seven in total) moved into general needs hostels.

Discussion so far has concentrated on situations where respondents' deteriorating mental health can be seen clearly to have triggered an episode of homelessness. However, there were many more examples where respondents' mental ill health was a contributory, or underlying factor in their subsequent homelessness, but where **trajectories from mental illness to homelessness were mediated by other problems and circumstances, most notably drug or alcohol abuse.** It is to this that we will now turn.

The mediating effect of drugs and alcohol

Drug and/or alcohol misuse was common amongst the survey and interview samples. Around one third (34 per cent) of all survey respondents with a mental health diagnosis reported an alcohol dependency and 38 per cent reported a drug dependency. This compares with less than 10 per cent of those without mental health issues, suggesting a strong association between mental health and substance abuse. We also noted in Chapter 2 that one third of survey respondents with a mental health diagnosis had dual diagnosis (24 per cent of all survey respondents).

However, it is important to emphasise **the complexity of the interrelation between homelessness, mental health and drug or alcohol use** (and other mediating issues such as violence, domestic violence, self-harm and trauma - see Chapter 6 for further discussion about additional support needs). Amongst our respondents, a clear linear trajectory could sometimes be traced, for example from trauma, to mental ill health, to drug or alcohol abuse, to homelessness, but it was usually more complex than that.

For example, drugs and alcohol were used by some to 'self-medicate' for mental health issues, but also to numb traumatic experiences (themselves a trigger for mental ill health in many cases), including homelessness. Leona, for example, has been abusing cannabis since she was 11. In the absence of medication (she has struggled to convince health professionals that her extreme anger constitutes a mental health problem) she finds cannabis helps her to control her mental health issues. Jimmy, Nicole, and Rosie similarly, all talked about using drugs and alcohol to self-medicate:

> *It was to help with my depression and anxiety, coz when I drink and when I take the weed I've got no worries. (Jimmy, aged 53)*

> *I like to feel numb. It's escapism. I'm bored of drinking but I guess it's my mental state of mind. (Nicole, aged 28)*

> *It [Ketamine use] was recreational back then…it became heavy use and when I came back from Leeds that's when I started injecting it, coz I was extremely depressed, I was extremely upset for the best part of a year, I felt suicidal every day over the relationship breakdown and I just got worse and worse on the Ketamine [I: so was there a link between your increased use of Ketamine and your feeling of depression?] I think so, definitely, coz the K just numbed it. (Rosie, aged 29)*

We will see below that Derek's alcohol use (and mental health issues) eventually led to him becoming homeless, but he then used alcohol even more excessively to cope with the experience of living in a hostel:

> *I couldn't cope with it [hostel] at first. In fact I was in such a state when I first came in here I was on a bottle of vodka a day to cope. (Derek, aged 55)*

Derek was not alone in using drugs or alcohol as a mechanism for coping with (or anesthetising against) the experience of homelessness. Jimmy started drinking in childhood when he ran away from local authority care and found himself rough sleeping. He found that alcohol helped him cope with being on the streets (a long-term alcohol and then drug problem followed). Denise described conditions in the hostel in which she was staying and talked about how difficult she found the environment. When asked what strategies she used to deal with this she responded by saying, simply *'I drink'*. Others used drugs or alcohol to ameliorate the emotional distress causes by other difficulties. Judy for example, reported '*using drugs to numb the pain'* associated with a series of traumatic life events.

Table 5.1 presents results from the survey. These confirm that a significant proportion of homeless people with mental ill health 'self-medicate' with either drugs (most commonly) or alcohol or both. Table 5.2 suggests that drugs and alcohol are also used as a mechanism for numbing the experience of homelessness.

Table 5.1: Do you use drugs or alcohol to help you cope with your mental health (respondents with mental ill health only)?

	%
Yes drugs only	27
Yes alcohol only	15
Yes drugs and alcohol	20
No, neither	38
Total	100

n=122

Table 5.2: Do you use drugs or alcohol to help you cope with being homeless/sleeping rough? (all respondents)

	%
Yes	41
No	59
Total	100

n=162

Drug or alcohol use can also prompt the *onset* of certain mental health conditions or exacerbated respondents' mental ill health. Judy, for example, attributes her first mental health crisis to her drug use, explaining that *'that's where all the mental health problems came from'.* Jess, who has been diagnosed with Depression and Personality Disorder, also expressed the view that these conditions were *'the after effects of doing drugs.'* When her brother passed away and her relationship broke down she explained that '*it was just easier to use drugs, and that's where all the mental health problems came from'.* Donald, meanwhile, had his first psychotic episode when he accepted an offer of drugs from a resident in the hostel where he was living. Donald was an alcoholic but had never previously taken drugs.

Box 5.1: The complex relationship between homelessness, mental health, and drug and alcohol misuse

Derek developed depression and thoughts of self-harm and suicide following the break-down of his long-term relationship. He explained that *'I became so depressed I didn't want to do owt. Some days I wouldn't get out of bed all day, I couldn't face anything.'* He left the family home and went to stay with his mother. He started drinking heavily, which exacerbated his mental health issues, and his mother eventually asked him to leave. The local authority then found him a place in a hostel. Derek found the environment initially very difficult to deal with and drank even more excessively.

Mick is 47 and was diagnosed with Passive Schizophrenia about 15 years ago. He explained that the *'very first time, 15 years ago, when I had the mental breakdown. I finished a relationship and things didn't go well, I cracked up, I was drinking and taking medication on top and I couldn't cope no more, just went to pieces'.* He was detained under the Mental Health Act, diagnosed and started taking medication to manage his condition. Over the next decade Mick moved between hostels and staying with friends and with family. About five years ago he moved in with his sister but she found his behaviour difficult to cope with and asked him to leave. Mick explained that *'coz of my mental health problems they didn't want me there, coz her fella, I frightened him coz I might just flip, so eventually my sister said she didn't want me there so I just walked out.'* He slept rough for a year and, while on the streets, started taking drugs as a way of coping with rough sleeping and *'to get through the time'.* He suffered several mental health crises over this 15 year period, resulting in detention under the Mental Health Act. Describing these times he explained that:

> *Well, it was depression, isolation, when I used to get ill I won't eat, I won't dress myself properly, wash, I just felt depressed, like I'm not getting nowhere, everything got on top of me and it just came to a point where my head, I was hard on drink, drugs, taking overdoses of my medication, didn't matter what tablets they were, I just wanted to end it all*

Mick was eventually found by outreach workers who helped him access a hostel. He moved through several hostels before securing a place in a supported housing project for people with mental health issues.

Mandy, who has been diagnosed with Complex Post-Traumatic Stress Disorder, described a catalogue of personal problems including the sexual abuse of her daughter by a partner, a violent and abusive mother, experience of domestic violence, and temporary separations from her young daughter during periods of homelessness fleeing her violent partner. She has had ongoing poor mental health and wellbeing for most of her life but the abuse of her daughter triggered deterioration in her mental health, and escalation of drinking. Mandy clearly articulates the interconnection between her mental health and her alcohol use. '*I started drinking, it turned into a problem, but there are reasons for addicts, and detrimental mental health is all part and parcel, it's a spiritual sickness'.* She also acknowledges the cyclical nature of these problems when she says:

> *You can't screw up your brain chemistry [by drinking] which is already screwed [mental health] and there not be consequences and more weakness in thought functions [mental health].*

It was common for respondents' increased alcohol or drug consumption to go in tandem with deteriorating mental health, typically following a traumatic episode, such that the two were intrinsically linked and seeking 'cause and effect' is futile. In some cases, erratic, violent, or ant-social behaviour ensued and respondents became homeless because those with whom they lived, or their landlord, could no longer tolerate or cope with their behaviour. Derek was asked to leave by his mother, Mick was asked to leave by his sister and Leona was evicted for anti-social behaviour. In other cases, rent arrears accrued - as in Judy's case - as respondents ceased prioritising domestic responsibilities and became focused mainly on buying and using drugs or alcohol.

Thus, drug and alcohol use, homelessness, and mental ill health were each a cause and a consequence of the other, sometimes cyclically. We can illustrate these complexities and interrelationships with reference to some examples, presented in Box 5.1 We see in these case studies that deteriorating mental health and alcohol and/or drug use often went hand in hand, but also had a reinforcing or cyclical relationship. In each case, mental ill health alongside drug/alcohol abuse emerged together following difficult life experiences, with drugs/alcohol being used both to manage mental ill health and to numb emotional pain. In Derek's case drug use exacerbated his mental health issues. Homelessness was the result in all cases but without one clearly identifiable trigger. There are clear implications here for supporting and treating homeless people with dual diagnosis. Because drug and alcohol use and mental ill health are often so entangled, and sometimes rooted in the same traumatic experience, it is difficult for people with dual diagnosis to disentangle them in order to address them separately or sequentially.

5.2. The impact of homelessness on mental health

We presented evidence above suggesting most homeless people with mental health issues first experience poor mental health before they become homeless. However, this does not mean that the relationship between mental health and homelessness is one-directional. Survey and interview data suggest that:

- **Although mental ill health tended to precede homelessness, the experience of homelessness can bring people to the point of mental health crisis.** So, homelessness was rarely the primary 'cause', or trigger, of mental ill health *per se*, but it could be the trigger for a mental health crisis. It may not be accurate, on the basis of the results from this study, to say that homelessness *causes* mental ill health, but it might be accurate to say homelessness can cause *problematic* mental ill health.

- Whatever the causal relationship between mental health and homelessness, **it is absolutely clear that homelessness has a detrimental impact on mental health and wellbeing** and can exacerbate existing conditions.

We will now explore these two points in more detail, drawing on interview respondents' stories for illustration.

A minority of respondents described the experience of homelessness (and/or of the homelessness accommodation in which they were living) as *engendering* a mental health crisis, although all had pre-existing mental health conditions. For example:

> *…the day they told me I was coming in here [hostel] had a nervous breakdown, I was crying they went 'it's not as bad as it's cracked up to be'. It's worse. (Denise, aged 39)*

Being homeless and being through all these systems made me give up on life. I didn't give up on life until I came along this, and then I feel like what's the point? I asked for help, I lost my son, I lost my house and I feel like there's no point now…I've thought about [suicide] loads of times. (Leona, aged 26))

Jasmine has a history of self-harming and had recently attempted suicide during a period of homelessness (while staying with a friend). Following discharge from hospital she then spent a few months moving between a friend's house and hostels and, during this time, ceased self-harming, although her mental health remained fragile. While waiting for a place in an interim supported housing project she was housed in several hotels for two months, during which time she started self-harming again and took her second overdose. She explained:

I stopped [self-harming] for two months and then when I ended up in the hotels I stated again [I. Was it the housing that you were in that worsened how you were feeling?] Definitely, coz it's isolated being in a hotel. (Jasmine, aged 28)

Jasmine notes a clear correlation between the relative stability of her housing and her state of mental health, to the point of attributing her mental health issues to homelessness:

It [mental health] started cos of the homelessness. Obviously I've had it [depression] since I was like 16, well, 14, but it did get a lot worse when I was made homeless and it's got better since I've been in here [interim self-contained accommodation] so it was at its worse when I had nowhere…(Jasmine, aged 28)

Not all respondents talked in terms of homelessness precipitating a crisis in their mental health. However, **in virtually all cases mental health issues were *exacerbated* by the experience of being homeless** - the stress associated with losing the home and family as well as the stress of having to adjust to temporary accommodation and, often chaotic, insecure and/or unsafe living environments. The descriptions Freddie (who suffers with depression, anxiety and also has ADHD) and Mick (who is diagnosed with Schizophrenia) gave of the impact of homelessness on their mental health were fairly common:

I'd say they [mental health issues] were kind of there before, but it wasn't that bad and then I became homeless and they just got worse, went downhill. (Freddie, aged 24)

Somebody informed outreach and they came and woke us up at 7 in the morning and my brother didn't want owt to do with them, he'd rather not go into a hostel but sleep rough. I just couldn't. I just needed to get a place. I'd lost weight, I wasn't feeling right. I reckon if I'd stayed on the streets another six months they would have ended up locking me up [in hospital]. (Mick, aged 47)

This is reflected in the survey results which show that the vast majority of homeless people find that their experience of homelessness negatively impacts on their mental health or wellbeing, exacerbating existing conditions. Figure 5.1 shows that 85 per cent of all respondents reported that their mental health or wellbeing was affected to some extent by their homelessness.

Particular (overlapping) issues associated with homelessness that impacted on interview respondents' mental health were: isolation and loneliness; feelings of worthlessness; insecurity and frequent moving; and the homelessness environment (general needs temporary accommodation, the streets). We now explore each of these in a little more detail.

Figure 5.1: To what extent, if any, would you say your mental health or wellbeing has been negatively affected by being homeless? (All respondents)

Don't know 2%

Not at all 14%

Not much 7%

A bit 11%

Significantly 40%

Quite a lot 26%
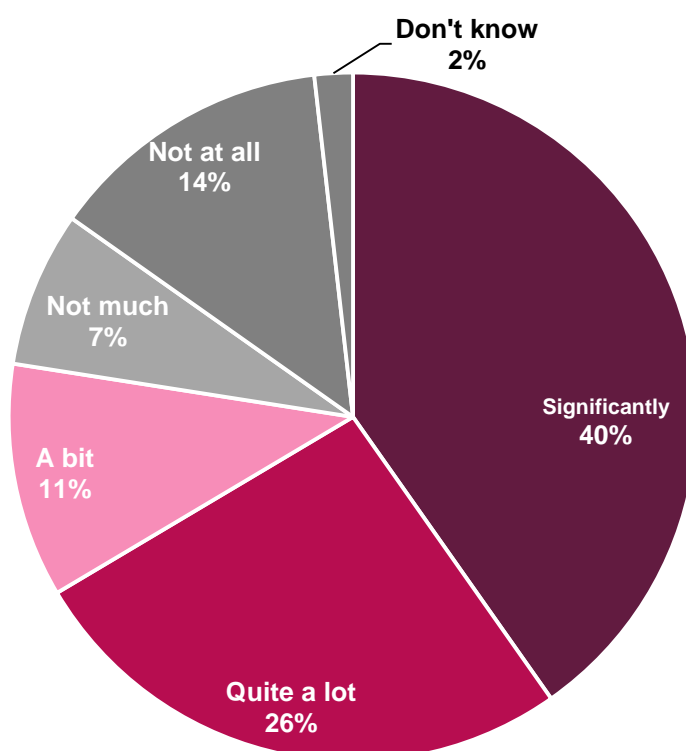
n=164

Isolation and loneliness

We saw above that it was partly the isolation of living in hostels that prompted Jasmine to resume her self-harming. Others too talked about feeling isolated from friends and family, being alone, lonely, and this impacting very negatively on their health and well-being. Respondents often knew no-one in their new environment, and had no support networks there, although these did sometimes develop over time. For example:

> *It like twisted in my head, I didn't like being on my own, you get lonely (Jack, aged 20, talking about rough sleeping)*

> *When I was in the refuge it was from October to December, my mental health was really bad, I wasn't coping, I'm completely isolated on my own, I don't know anyone, I knew I couldn't go back home coz I didn't have the strength to stay away from him [violent ex-partner]. (Collette, aged 50)*

Feelings of hopelessness, loss and failure

Respondents reported strong feelings of despair, hopelessness and loss in the context of their homelessness. They expressed emotional distress at their changed situation and described 'giving up' as a result. Regardless of the circumstances under which they became homeless a sense of self-blame was often implicit. Respondents often explicitly connected these feelings with deteriorating mental health. For example:

> *Just feel like I've lost everything, and I feel like I'm either going to end up in Highbury [psychiatric hospital] or end up in a police cell cos I'm going to do something which I don't want to do (Rosie, aged 29)*

[Homelessness] made me feel unwanted from my family, didn't want to speak to me, ended up slicing [self-harming]…a lot. (Freddie, aged 24)

Being homeless and being through all these systems made me give up on life. I didn't give up on life until I came along this and then I feel like what's the point? I asked for help, I lost my daughter, I lost my house, and I feel like there's no point now….I've thought about [suicide] loads of times. (Leona, aged 26)

Talking about her experience of living in a general needs hostel, Collette described feelings of detachment from mainstream society, while Leona, whose young son is temporarily staying with her mother, expressed similar feelings of not belonging:

You lose your confidence, your money goes on rubbish and I think you feel very detached from the rest of the world, and then it feels harder, that you'll never be a part of it again (Collette, aged 50)

Coz I'm a mum I feel like I need to be able to still do things like a mum, feel like I belong, at the moment I feel like I'm a wasted person…it's all I've done since I was 16. (Leona, aged 26)

For some, it was the contrast between their past life and their current homelessness situations that undermined their self-worth, confidence and motivation. Jess, for example, attributes her mental ill health primarily to her drug use. Never the less, in the following extract we see that the experience of becoming homeless - of having to 'give up' her beautiful stable home - had a detrimental impact on her health and well-being such that it was only at this point that she reached crisis. Rosie, meanwhile, feels like 'a waste of space' when she thinks about the life she could have had:

I've always had some form of mild depression, very mild, since early 20s, but it hit really hard when I came back to Nottingham…it hit worse when I had to come back here and give up, I had a beautiful three bedroomed housing in the country and I had to give everything up. (Jess, aged 35)

I don't know how I'm still here to be honest. I've been really down and I just feel like I'm a waste of space. I still do, coz I'm nearly 30 and I've got a degree and things, and I could have done so much more and I haven't. I feel like all I've become is a junkie. (Rosie, aged 29)

Marwa, a refugee, was diagnosed with PTSD and depression following the death of family members in her country of origin. A suicide attempt followed. Like Jess, she too has found it very difficult to cope with her changed situation, as her comments below demonstrate:

After I was homeless, when I was homeless all the problems, I got them in my mind and I completely be crazy coz it's no easy for a women, used to live nice and high class life before [in country of origin] and even I was own my own house, I did not live in hostel….so that I make my life completely crazy. (Marwa, aged 40)

I feel disgusting and I can't even eat, I can't sleep and I am scared… (Marwa, aged 40)

I used to have my own company, cars, my family live in high luxe villa, I don't know anything about this life and that's why it's making me depressed. (Marwa, aged 40)

Insecurity and frequent changes/moving

Insecurity is unsettling for anyone but it can be particularly challenging for people with mental health issues. This was particularly notable amongst respondents with anxiety, but most felt that stability was key to their mental health recovery. We reported above that Jasmine noted a clear correlation between her housing situation and her mental health, which was 'at its worst when I had nowhere'. She went on to explain more precisely what affected her about being homeless and insecurity was at the heart of her distress:

> *…not knowing where I was going to be from one day to the next, coz I stayed in three different hotels in eight weeks and it was not knowing where I was going to be. (Jasmine, aged 28)*

Others described similar feelings:

> *It was hard, it was very stressful, I lost so much weight, it was just wearing me down, I couldn't take no more, not knowing where I'm going to sleep tonight. You know when you're staying at people's house they run hot and cold with you, if you've got money and you've got something to give them they're alright but when you haven't got nothing to give them you can just feel that. (Benji, aged 54)*

> *I think if you've got your own place where you can go and lock your own door and you're secure, with me, if I had that, my mental health would drop down… (Jimmy, aged 53)*

Such was Ross's anxiety about frequent moving that he was reluctant to move into a more adequate situation when given the opportunity. Ross was living in a hostel (possibly provided by the Probation Service). Following release from prison about a year before he had stayed in a bail hostel, slept rough, and been recalled to prison for a further three months. He recounted the conversation with his probation worker when she told Ross he had been offered a flat in an interim supported housing project for ex-offenders.

> *[She said] 'you've got to move'…I thought 'I'm going to kill you', I said 'where to?' She said 'we've got a flat for you'. I thought 'I'm not going', coz I'm comfortable, you know my anxiety issues, I don't like change and it takes me months to get adjusted somewhere.*

Although now very happy in his accommodation, Ross went on to explain that *'the only thing I'm not settled with is this is temporary'*. He has high levels of anxiety about the temporary nature of his accommodation: *'it'll not be long before two years is up and it's back to square one when you're running around trying to find suitable accommodation and then inevitably homelessness, I'm not getting to that stage again'*. He is considering renting a caravan but this would, of course, remove Ross from the support he currently receives and assistance with appropriate move-on accommodation. There is also the risk that Ross would feel isolated once again.

The challenges of living in temporary accommodation

All respondents had, at some point, stayed in one of the City's general needs homelessness hostels.[67] We saw in Chapter 4 that many had spent a significant proportion of their homelessness trajectories in these hostels. With few exceptions, respondents reported that these environments were detrimental to their mental

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[67] This partly reflects the sampling strategy for the study and so cannot be generalised. We accessed some respondents through general needs hostels.

health, although respondents occasionally pointed to some benefits of temporary accommodation. The company of others, for example, was important to everyday survival, particularly for people who had lost contact with or become estranged from family (siblings; parents; children and grandchildren) and friends.

Most, however, found temporary accommodation frightening and isolating. Respondents described environments where noise, drug and alcohol use, and violence were commonplace and also found the chaos, insecurity (see above), and surveillance extremely challenging. We have already noted in this chapter that the move itself into a hostel, refuge or B&B sometimes triggered anxiety attacks. The privacy and tranquillity that many respondents craved were in very short supply. It is very likely that other residents found some of our respondents challenging to be around and that, at times, they will have contributed to the very problems they described. Never the less, respondents spoke powerfully about the impact of staying in hostels on their health and wellbeing: For example:

> *This place is challenging on all levels […] you sit in a room and you get depressed cos you can't face all the other energies in here […] I find I'm more anxious. I have no patience and drinking a lot more as well, every day. (Nicole, aged 28)*

> *It kind of sent my head into a whole new ball game. Many days I just sat on the bed crying.' (Michelle, aged 36)*

> *In here it's so difficult coz I see so many things happening and it shocks me and for a person like me, I've never seen these kind of things, I don't say nothing but it does bring me down…it brings you down really bad, people how they are and how they act… [I. How does it bring you down?] I go in my room and I cry and I cry the whole day…. I'm not motivated, I feel more down, I can't go out. (Rosanne, aged 30)*

Some respondents talked about the way in which hostel environments triggered distressing memories, or other conditions (eating disorders, self-harming). For example, one respondent who had fled domestic violence spoke of how the hostel surveillance evoked the way her ex-partner would seek to control her. Collette, meanwhile, has an eating disorder and, because of that, *'to have to share a kitchen [in the refuge], it was just hugely stressful.'* Many respondents had experienced violence in their lives - often a contributory factor in their homelessness and/or their mental ill health - and interviewees reported the extent to which the hostels were also sites of violence. Those interviewed spoke of witnessing acts of physical brutality. The nature of the hostel environment therefore could trigger traumatic memories or generated new memories of violence. For people with certain conditions - PTSD, for example - this was very damaging.

Respondents in recovery from drug or alcohol dependencies faced additional challenges in temporary accommodation. They talked about the ease with which they could get drugs and alcohol and how that was undermining the support they received. For example:

> *They [addiction service] try to help me but I relapse again coz living in in here is very difficult…I can't help thinking if I wasn't in this position it [the support] would work quite well, everything would be in place, but while I'm here… (Simon, aged 47).*

Because respondents' drug or alcohol use and their mental health issues were so interrelated (see 5.1 above) it was often imperative for their mental health recovery that they abstain from drugs and alcohol.

A common response to the challenge of living in temporary accommodation was for respondents to remain in their room or spend time elsewhere. Jasmine, for example, explained that *'I try to stay out as much as possible'.* However, this could increase their sense of isolation which, in turn, some found detrimental to their health and wellbeing (see above).

There was clear consensus amongst the stakeholders interviewed - including those working in, managing and commissioning general needs temporary accommodation - that general needs hostels were inappropriate environments for homeless people with mental health problems. Several expressed the view that the exacerbating effect on this population group of living in a hostel could also lead to the development of further support needs.

Hostel workers and managers fully acknowledged that they were not meeting these clients' needs, but there was recognition across stakeholder groups that hostel workers were not trained, qualified, or paid to work with people with significant mental health needs.

Why think the average hostel worker, by spending some time in training, is now going to be able to deal with complex mental health issues. There needs to be additional resource going in. It's not just making people more aware, that's not going to qualify them as a nurse. (Local authority housing/homelessness department)

People are getting supported by people who aren't necessarily qualified to support them or haven't got the capacity to support them[…]they feel like they're doing an injustice to the person…it feels like they're getting by based on that bit of luck and the basics of training and really if there was something disastrous happened and there had to be any serious case review I wonder whether it would be found that those people weren't appropriately qualified to be dealing with some of the people they're having to deal with. That to me seems really wrong. (Local authority, housing strategy)

A lot of the staff who work in those who are quite low paid, not to say low skilled, but were employed as hostel and housing workers, are being required to manage daily mental health crisis and behaviour when they're not technically employed or certainly paid at any levels to do that so they're firefighting. (Voluntary sector housing and support)

Homeless people also pointed to a lack of expertise around mental health in general needs hostels. Mick, for example explained that *'I didn't like it at all, there weren't no support, nobody understood people's mental health issues'.*

Stakeholders in the hostel sector explained that these general needs hostels were commissioned to house non-statutory homeless people,[68] but because of pressures on, and cuts to other services, they were increasingly housing statutory homeless people, including those with mental health problems.[69] Thus one outreach worker reported that *'any bed that comes up in a non-stat hostel will go to someone in TA [with priority need].* A hostel manager reported similarly that *'…most people we're housing now are being housed under a [statutory] Duty'.* The manager of one hostel emphasised the problems and potential consequences associated with housing people with such complex needs in accommodation that was not commissioned to meet their needs:

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[68] That is, single people without priority need.

[69] This was reported to be having an impact on availability of hostel spaces for non-statutory homeless people (the target client group), a point worth noting but not the focus of this study.

I think a big challenge for us is preventable deaths. We have, not so much recently, but we go through phases where we have lots of self-harmers, we've had people commit suicide on the premises, we've had people trying to commit suicide, specifically people who are under mental health teams. We have lots of people who aren't under mental health teams who try to commit suicide. It's a difficult one cos if somebody comes here, as I said we're not here for statutory homeless people, most people with a diagnosable mental illness should be statutory homeless, so by definition they shouldn't be here. (General needs hostel)

The idea is that people with complex needs shouldn't be coming here in the first place, or mental health problems, but cos the city council struggle to find anywhere else for them everybody comes here. We house people with mental health problems along with sex offenders, arsonists, ex-offenders, drug users, drinkers, we've got vulnerable women fleeing violence alongside people who are perpetrators of violence. (General needs hostel)

This is a vulnerable population, and it is worth noting that in addition to the expressed difficulties of living in general needs temporary accommodation, homelessness was also found to expose people to exploitation and other experiences likely to be detrimental to their health and wellbeing. Two women, for example, had been sexually assaulted while staying temporarily with friends:

I got mentally tired of people wanting to touch me. When you're homeless on the streets as a woman it's harder that it is for a man coz people really do want to violate you sexually, that's the hardest part….I was staying with a friend but every day was uncomfortable coz I was thinking, where, it got to the point where I'd just go and sit in the park coz I don't want to go back and stay in that house coz they constantly want to touch you when you're drunk, it's like you can never breathe. (Nicole)

I ended up going to a guy called X's house, who I'd previously stayed with, who was a nightmare when I stayed the first time, he just lost it...and I felt like I was treading on eggshells coz I could say the wrong thing and it would set him off…so it was quite scary at times, and stressful. Then I ended up getting flu whilst I was there and during the time I had flu he sexually assaulted me…and that led to me leaving there. (Rosie)

5.3. Conclusion

This chapter focused on exploring the complex relationship between mental ill health and homelessness. However, in the course of presenting illustrative examples in the form of biographies of some of the homeless people interviewed, it is clear that mental ill health and homelessness (and drug or alcohol abuse) are rarely the only challenges faced by this population. In the next chapter, we explore in more detail respondents' other support needs.

Additional support needs

<div style="text-align: right; font-size: large;">6</div>

It has become clear that mental ill health and homelessness were rarely the only two support needs or adverse life experiences affecting participants in this study. This has emerged during discussion of respondents' mental health trajectories (Chapter 3), their homelessness pathways (Chapter 4), the interaction between mental health and homelessness (Chapter 5), and presenting case studies and contextual biographical information.

Drawing on interview and survey data, in this chapter we suggest that **homeless people with mental ill health might be more accurately described as having 'multiple or complex needs' or as a population facing 'multiple exclusion homelessness'.**

6.1.   Multiple and complex needs: survey findings

The survey evidence shows that **mental ill health is often just one of a number of support needs homeless people present with.** Table 6.1 shows that a considerable proportion of survey respondents indicated physical health issues, dependencies, self-harming behaviour and experience of domestic violence. In addition, nearly one quarter (24 per cent) of respondents with mental health issues reported having a learning disability or learning difficulty.

Respondents were also asked about time they had spent in institutional settings. Table 6.2 shows that over half indicated some kind of institutional background. In particular, a very high proportion had been in prison. Respondents with mental health issues were much more likely to have spent time in an institution (with the exception of the armed forces) than those without mental health issues. Only 17 of 124 respondents (14 per cent) with mental health issues did not report one of the additional needs in table 6.1, OR report having been in an institution, OR report a learning disability or difficulty.

Table 6.1: Would you say any of the following apply to you? (Respondents with mental ill health only)

	%
I have physical health issues	46
I have a physical disability	24
I sometimes self-harm	37
I have experiences domestic violence	48
I have an alcohol dependency	32
I have a drug dependency	38

n=124

Table 6.2: Do you have any of the following backgrounds? (Respondents with mental ill health only)

	%
spent time in prison	60
spent time in a secure unit/Young Offender Institute	29
spent time in local authority care	24
spent time in the armed forces	5
none of these backgrounds	47

n=110

More detailed analysis of the survey was undertaken to understand the interaction between mental ill health, homelessness and a variety of other factors, using logistic regression.[70] A range of questions in the survey identified factors which might be associated with mental ill health. The independent variables used from the survey were:

- age when first homeless;
- physical health issues;
- physical disability;
- drug dependency;
- experience of domestic violence;
- spent time in prison;
- spent time in a secure unit or young offenders institution;
- spent time in local authority care;
- spent time in the armed forces;
- ethnic origin;
- gender;
- age.

A range of different models were tested to investigate the association between these 12 independent variables and whether a survey participant had a diagnosis of mental ill-health. Our analysis sought to identify those variables in the survey which were most strongly associated with mental ill-health diagnosis.[71] Four factors were identified which, when taken together in a model, provided the strongest predictor of a mental ill-health diagnosis amongst our sample of homeless people.[72] These were:

- having spent time in prison;
- having physical health issues;

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[70] A logistic regression was used to investigate the relationship between a dichotomous variable (in which there are only two possible outcomes) and a range of other variables (known as independent variables). The dependant variable from the survey was 'any mental health diagnosis'. n=163, No mental health diagnosis = 42, MH diagnosis =121

[71] Due to the relatively small sample size the model sought to identify a maximum of 4 co-variants (following Peduzzi, P., Concato, J., Kemper, E., Holford, T.R., Feinstein, A.R. (1996) A simulation study of the number of events per variable in logistic regression analysis. *Journal of Clinical Epidemiology,* 49, pp.1373-1379).

[72] Overall model statistics: Chi-square = 55.0 (6 df), Cox & Snell R Square = .325, Nagelkerke R Square = .474

- having experienced domestic violence;

- age band.

Within our model, homeless people were:

- 11 times more likely to have a mental health diagnosis if they had spent time in prison.[73]

- Six times more likely to have a mental health diagnosis if they had physical health issues.[74]

- Six times more likely to have a mental health diagnosis if they had experienced domestic violence.[75]

- Four times more likely to have a mental health diagnosis if they were aged under 25.[76]

These findings have a number of implications. They suggest that:

- Certain sub-groups of homeless people may be particularly at risk of mental ill health. This, in turn, presents opportunities for targeting intervention and preventative work.

- Mental health issues are closely associated with adverse life experiences.

- The picture is one of multiple overlapping needs.

There are several caveats which should be noted. This was exploratory analysis, and additional factors which were not included in the model may also be associated with a mental ill-health diagnosis amongst homeless people. These might include other factors included in the survey[77] and other factors which were not measured. A much larger sample would be required to develop this analysis further.

Nevertheless, the qualitative interviews provide a means of triangulating these findings, and they strongly mirror the results from the regression model. We have already seen in Chapters 4 and 5 that mental health issues and homelessness could often be traced to early life difficulties or to trauma and that respondents' needs overlapped and reinforced one another to a high degree. In the previous chapter we discussed the relationship between mental health and homelessness, pointing to the mediating effect of drugs and alcohol. Here, we see that many other domains of exclusion are also present in the lives of homeless people with mental health issues.

These findings also concur with the results of other studies of 'multiple exclusion homelessness' that find a high degree of overlap between experiences of homelessness and other domains of social exclusion (including mental ill health).[78] They conclude that multiple exclusion homelessness is often positively associated with childhood deprivation and trauma; and note cohorts within this population who have very complex needs, with mental ill health and homelessness combining with a

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[73] It should be noted that the confidence intervals for these values are broad due to the relatively small sample size. For prison the 95% confidence interval is 3.3 to 37.2. Exp(B) =11.1

[74] The 95% confidence interval for physical health is 1.6 to 23.4. Exp(B) = 6.0

[75] The 95% confidence interval for domestic violence is 1.8 to 18.1. Exp(B) = 5.7

[76] The 95% confidence interval for under 25 is 0.7 to 20.1. Exp(B) = 3.7 against reference age band of '50 years and over'.

[77] This is known as Type 2 error - or a false negative result. Type 2 errors can occur when there is a significant result but the sample is too small to identify it.

[78] Fitzpatrick, S., Johnsen, S. and White, M. (2011) Multiple Exclusion Homelessness in the UK: Key Patterns and Intersections. *Social Policy and Society,* 10 (4), pp. 501-512.

multitude of other experiences including institutional care, experience of violence, and high rates of suicide and self-harming.[79]

In the remainder of this chapter, we illustrate this point with reference to a series of case studies.

6.2. Multiple and complex needs: qualitative case studies

All interview respondents were homeless and had mental health issues. Every one of these respondents recounted other experiences associated with deep exclusion and significant support needs. Respondents, typically, had lives characterised by trauma, poverty, childhood neglect (in some cases), violence, and associated drug or alcohol abuse, institutional care, and offending. Self-harming and rates of suicide attempts were alarmingly common, echoing findings of a large scale study of multiple exclusion homelessness. That study found self-harming and suicide attempts to be common amongst their cohort of homeless people with mental ill health, and even more so amongst those who, like many of our respondents, had experienced victimisation.[80]

Those with stable early lives, whose homelessness and/or mental health issues were triggered by a specific traumatic event (relationship breakdown, bereavement, or assault), quickly developed a host of other problems including substance abuse and offending behaviour. Many of the women interviewed had suffered physical and/or sexual violence, sometimes in childhood, and this was also true for a minority of the men interviewed. Donald and Ray both suffered sustained childhood abuse. Ray then experienced further abuse in a *'special needs school to help me and that, to keep me secure and safe'* and again in prison. Donald, meanwhile, started offending very young having been emotionally, physically and sexually abused by family members. Around half of interviewees had drug or alcohol dependency issues, and over one quarter had served custodial sentences.

The severity of interviewees' experiences was shocking - multiple bereavements, violent attacks, and distressing childhood neglect - but it was the *multitude* of adverse experiences that really characterised respondents' lives. We see this in the case studies presented below, but it was true for many more. Denise, for example, had suffered domestic violence for many years. Her mother, with whom she stayed when trying to leave her violent partner, lived a chaotic life in an area rife with drugs. Denise had developed dependencies on drugs and alcohol. The last time she left her ex-partner she was sexually assaulted and robbed, and then her mother asked her to leave. Although Denise had nowhere to go she was keen to leave in any case explaining that *I'd fled from the domestic violence and beatings and stuff, and the drugs, to come and have to live with them again.* She has subsequently moved from friends, to hostels, to night shelters, to hotels, sometimes evicted from temporary accommodation for aggressive behaviour. She has been arrested because of her aggression and received a suspended sentence. Following a recent overdose when Denise attempted suicide, her medication for depression had been stopped. There are strong parallels between Denise and Judy's biographies (below), which include dependency, trauma, violence, and frequent moving. The longevity of respondents' mental health issues is clear in Jess' story (below) and highlights the need for long-term support. Jess had periods of relative stability but in times of adversity, struggled to cope without the right support in place.

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[79] Fitzpatrick, S., Bramley, G. and Johnson, S. (2013) Pathways into Multiple Exclusion Homelessness in Seven UK Cities. *Urban Studies*, 50 (1), pp. 148-168.
[80] Fitzpatrick, S., Bramley, G. and Johnson, S. (2013) Pathways into Multiple Exclusion Homelessness in Seven UK Cities. *Urban Studies*, 50 (1) pp. 148-168.

Box 6.1: Multiple and complex needs

Judy

Judy is 47 and first became homeless eight years ago when she was evicted for rent arrears from her family home. We have already touched on some of the circumstances leading up to this eviction in previous chapters but it is worth reiterating those here. By the time she was evicted, Judy was self-harming, drinking heavily, and suffering from severe depression. With these problems, Judy stopped prioritising rent payments. She explained that *'When I got evicted my mental health was bad…I was self-harming and everything'.*

There appear to be two main underlying events that triggered Judy's depression, alcohol abuse, and self-harming. Firstly, about 10 years ago Judy's children, all adults by this time, left home. In Judy's narrative it is this that first triggered her depression which, in turn, she medicated (along with the trauma of her children leaving) with alcohol and self-harm:

> *I never drank when I was bringing my kids up, but they started leaving home, my youngest, I got depression big time.*

However, Judy was also raped not long after, and was diagnosed with PTSD. She was badly injured and her assailant was convicted (but has recently been released, to Judy's great distress). Judy was, and is still, prescribed medication for her depression. She has discussed counselling with her GP but this has never materialised. However, Judy acknowledges that she is not always fully open with her GP about how she feels, partly because she is reticent about counselling in case there is an expectation for her to discuss her rape. She explained that *'I've had the same doctor for 8 10 years. I need to come out more of my shell and tell him, that's what I need to do, tell him more. I do need this and I'm going to do it'.*

Judy has remained homeless since she was evicted, moving between different temporary housing situations - typically general needs hostels and hotels, and, about a year ago, served a short prison sentence (she served three months of a six month sentence but was recalled for a further 28 days). She was bullied in one hostel and had to leave as a result. Judy implies that she may be prone to bouts of aggression, stemming from the anger she feels, but tries hard to control.

Judy's mental ill health and problems with alcohol and self-harming persist. She derives much comfort from her relationship with her adult children and grandchildren who she sees regularly.

Jess

Jess, who is now 35, first became homeless at the age of 16. When her parents divorced, she went to stay with her sister but they didn't get on and, when she started a relationship with a man who was homeless, she left her sister's to stay in hostels and sometimes sleep rough with him. She lived quite a chaotic life for about five years, developing a drug dependency and serving several short prison sentences for drug related offences. In her early 20s she addressed her dependency, formed a new relationship, had a child, and lived a stable life for a decade. However, when that relationship ended, coinciding with the death of her brother (who was also a drug user) she started using drugs again and her mental health quickly deteriorated. She described feeling at the time that *'I don't know what's wrong with me, I'm either up here or down here and there's never any in between. I don't know what it feels like to feel normal'*, *'staying in bed for weeks at a time crying'* and *'either in bed or…out there using drugs'*. She was eventually diagnosed with Depression and Personality Disorder. She explained the onset of her mental health problems as follows:

> *...not being able to cope with the fact that I wouldn't be in a relationship anymore, coz I was expecting to be married, have more children…and then all of a sudden I was on my own again and I was using drugs to numb the pain a bit…instead of dealing with it I didn't, and my brother passed away as well at the same time so it was just easier to use drugs, and that's where all the mental health problems came from.*

Unable to cope or care for her son, she moved back to her home town of Nottingham and stayed with her mum, but this arrangement soon broke down and she moved into a hostel, leaving her son with her mother.

6.3. Conclusion

The evidence from this and previous chapters suggests that homeless people with mental ill health in Nottingham also have a range of additional complex needs. It is rare for mental ill health and housing problems to be the only issues facing this population group. In addition, we have seen that the range of support needs homeless people with mental health issues present with, are often intrinsically linked. This has important implications for service commissioning and delivery.

Understanding multiple exclusion homelessness: the distinctiveness of the client group

7

Within the field of mental health - amongst practitioners and those with mental ill health - there is sometimes frustration that mental ill health is not understood or accorded the same gravity as physical ill health. Having time off work with a broken leg, or flu, for example, is thought to be more accepted than being off sick with depression or stress. Mental ill health can still be seen as a 'weakness' and something to 'snap out of'. But mental ill health can be very debilitating, as Lisa articulates well:

> *If your head's messed up and it's not functioning right you're not going to function right. So mental health is just as worse as physical health cos you need your brain for everything and if that's gone and it's not working correctly cos you suffer so much with your health it makes things difficult and impossible to be honest, and you're not getting the help what are you meant to do? (Lisa, aged 30)*

It can be as difficult getting out of bed in the morning with severe depression, as it can with flu. Homelessness too can be debilitating, but is rarely recognised as such, and associated behaviours - drug use, for example, or offending - are often interpreted as lifestyle choices, and therefore easily changed. But there are debilitating aspects of homelessness (multiple exclusion homelessness in particular) that make it very difficult for a homeless person with complex needs to comply with certain processes, to attend appointments, to engage with services, to 'calm down'. This is summarised to some extent by one stakeholder interviewed:

> *there is a predominance of mental health, substance misuse and alcohol problems way and above that of the normal population, there's also a lot of social problems from poverty, problems to access to getting care, or it may have changed over the years to becoming a problem with appropriate access, so people that are homeless generally speaking don't understand the system, don't use it to the best way, aren't savvy about how to get what they need and a lot of the time don't really know what they need or are not keen on making changes that's appropriate for their health. So all those things together make them a very health-deprived population (GP)*

It is worth reflecting, then, on what might be distinct about (multiply excluded) homeless people, such that it might be incumbent on service providers and commissioners to consider new or tailored services to ensure equality of access to support and treatment. It is important that homeless people with mental health issues are understood as a disadvantaged population group with specific needs,

rather than an anti-social population making lifestyle choices. This chapter reviews some of the distinctive features of multiply excluded homeless people within Nottingham City.

7.1. Features of homelessness

Previous chapters have already gone some way to establishing this group as severely disadvantaged and excluded. And whilst not condoning problematic drug use, offending, and such like - these activities have devastating consequences for families and communities - the biographies of those interviewed for this study show that the picture is not so simple. Based mainly on the qualitative data, here we highlight some of the **distinctive features of homelessness, or characteristics of homeless people with complex needs:**

- **Daily survival is a challenge for homeless people and represents a set of priorities that most housed people don't have.** Meeting basic daily needs - food, warmth, shelter, company, safety - can be difficult and time consuming. This is compounded by the efforts required to resolve or address issues in the longer term (homelessness, drug or alcohol use, damaged relationships, separation from children, physical health issues) and the associated multitude of appointments and applications which ensue. This can impact on the time available, and the motivation to engage with mental health and wellbeing services.

- As a result, **mental health is not always prioritised.** In the context of the many problems that homeless people have, their mental health was not always considered a serious enough problem to prioritise. Stakeholders suggested that this client group often prioritise daily survival needs over mental health until they hit a mental health crisis, and this was certainly true of some of the homeless people interviewed. There was evidence from stakeholders and homeless people that the 'threshold' at which homeless respondents judged themselves to be in need of support, or to be ill, was relatively high, reflecting a deeper resilience derived from the many challenges life had thrown at them:

    People will often seek help when they feel they have nowhere else to go and homeless people are so resilient they have to deal with so much on a day to day basis they might not think of coming to a mental health appointment when they're ok, it's not a priority to them coz they've got other stuff to be sorting out. But when it comes to the point where they can't deal with it anymore, they'll end up in A&E or with the police, that tends to be how it is. (NHS mental health service)

    They also have very low expectations of health, so they don't see small problems as being important and so wait for something to be really big and crisis before they take action. (GP)

    I don't think I've ever spoken to any of the staff here about my mental health issues. I speak to them about other stuff but not about that. Mainly because it's not that bad. But I know they're there if it did get bad and I needed someone to talk to. (Jasmine)

- There can be a very **small window to effect change** that is incompatible with the slow process of accessing many services (e.g. waiting lists). A number of stakeholders explained that there will be particular moments when homeless people are in the right 'place' (physically, psychologically and emotionally) to begin addressing their mental health needs. If these are missed, it may be a long time before the opportunity arises again.

So in Nottingham there's something called the single point of access, if you want somebody to access a longer term mental health service that's where you put the referral, their waiting lists are so long, the nature of homelessness is it's quite fluid, it can change rapidly, you have small windows really to get people to engage… When someone comes out of hospital they've done a detox, they're clean, they're reflective, they're in a good place, they've got the right medication and you think now is the time, by the time they're seen at their assessment and gateway for services nine times out of ten that's changed, the person's back into using and the problem is that narrative of they're too chaotic, it's due to drug use, and it goes on that person's record, well known to services, difficulties with drug use, doesn't attend appointments, and you think there was this incredible moment to make a difference. (Community Psychiatric Nurse - CPN)

We can put people into accommodation quite easily, it's just once they're there, that's great for a week or two then they start realising they've got no job, they've got no friends, even if they've got a job it's zero hour contract, low wages, so there's no future, there's no motivation to do anything different. (General needs hostel)

This was reflected in the pathways of several of the homeless people interviewed where the critical point at which they needed, and were willing to engage with help passed. This was true for Jess and Ray, for example:

If they'd done something in the first couple of months [when MH deteriorated] I think a lot of pain would have been…it would have helped a lot, and then maybe I would have gone to a counsellor. But I just got that sick of having to say the same stuff, I just wanted to wrap it all up in a box and get rid of it and not talk about it anymore. (Jess, aged 35)

When people split up that's a crucial time when you need someone to talk to. That failed me coz at time when I needed the help I had to wait months or weeks to see someone. (Ray, aged 53)

For the same reason it is imperative that further avoidable delays or problems do not occur. When Lisa was released from prison, having received regular psychiatric intervention that she found very beneficial, she was referred for continued support at a local facility. When she arrived for her appointment, they could find no record of her appointment or referral. She was contacted by telephone a week later, staff apologised for their mistake and gave her another appointment. By this point, she did not want to engage. By the time she decided she wanted support again, there was a long waiting list.

- **The family circumstances of homeless people with complex needs are often chaotic, conflictual, or insecure.** Staying temporarily with family and friends during a period of homelessness, or when independent living is not appropriate (for example following a period of hospital detention) often does not represent the safe, supportive, stable environment that it might for others. Amongst the homeless people interviewed, family and friends were often part of a 'homelessness circuit' where respondents could only stay very temporarily; with people on whom they had already over-relied; who had very few resources themselves; where they were not always welcome; in families where conflict and tensions exist; and where other household members themselves had support needs (usually mental health issues and/or substance abuse). At one point, Mick, for example, went to stay with a friend. From the perspective of professionals this may have seemed like a good, stable interim arrangement. His friend had a spare room, so although Mick was initially sleeping on an

inflatable mattress on the floor he had privacy and space of his own. However, his friend suffered from depression and was prone to violence:

> *It started getting a bit violent…grabbing me by the throat and pinning me against the wall, then he wanted me to hit him back, I just couldn't [did he do that for any reason?] I don't know, I don't know if he was trying to get me going or what. He was suffering with depression himself so I think that might have been it. (Mick, aged 47)*

Mick left his friend's house, rather than endure these conditions, despite having nowhere else to go. This issue is, perhaps, particularly relevant in the context of people being discharged from hospital who are unable to return to their previous accommodation, or who were already homeless on admission. Professionals may assume that, like those who are not in this client group, patients are going into supportive, healthy, suitable environments. For many homeless people, this will not be the case. Amongst those who had been hospitalised because of their mental health (including suicide attempts), whether voluntarily or under detention, it was relatively common for respondents to stay with a friend or family member on discharge and for that arrangement to break down quickly.

- Homeless people's previous experiences of support services (across all policy fields), and of the damage inflicted by those close to them (parents, partners) often results in a **lack of trust of others and/or a strong sense of self-reliance**. Such defence mechanisms can manifest as unwillingness to cooperate, sullenness and, sometimes, aggression. For example:

> *I can't trust no-one, you don't want to speak and keep opening yourself up, and that's another reason why I kick off, that's my comfort blanket, keep people at arms-length. (Denise, aged 39)*

> *…there's an increasing mistrust of services. I think people are feeling let down by the system. Three years ago we'd speak to someone, get them a cup of coffee, get a lot of information. Now sometimes we just get aggression. People are used to being let down by services and we're another service, we get a lot of people won't give us their details. (Homelessness outreach)*

> *I just soldier it out. I have my days when I'm happy and I have my days when I'm pissed off, but when I'm pissed off and really down I just go to my room and sleep, just try to soldier it out. I'm a strong person. I didn't realise I was so strong. You have to be. (Benji, aged 54)*

> *[can you put your finger on maybe why you didn't push more to get help?] ..a bit of pride, I thought I've been to prison by myself, and no letters, no nothing and just did it by myself and thought if I can do that, and to a certain extent it's made me a little bit harder, stubborn. (Richie, aged 41)*

- This is **a particularly transient population**. The temporary nature of their accommodation means they move frequently within the City but many respondents had also lived elsewhere in the country. For example, some were raised in Nottingham, left for work, or study, or to join a partner and returned when they became homeless, often because they still had family or friends in the City with whom they could stay. Others were raised, or had lived for many years in Nottingham but had to rely on a geographically wide network of friends and family when they became homeless, and so moved back and forth between Nottingham and other places. We noted this in Chapter 4 where we discussed respondents' housing and homelessness pathways. There are clear implications

here for engagement with services and continuity of care. Respondents rarely stayed in the same 'catchment' area for long, did not receive letters, and services struggled to locate them. For example:

From my experience it would be the very transient nature of how the services get hold of them if they haven't got a set address to send appointments to, some services would just get the referral name and it would be sent to a care of address or a hostel address and that might not actually reach the person. (NHS mental health service)

When asked whether she was receiving any support for her mental health, Collette explained that:

I am now coz I've managed to stay in one place, and that's having become homeless and gone through it so many times. When you move from place to place you have to register with a new GP, they don't know you, you have to register with a new GP, it takes a while for your notes to be transferred. (Collette, aged 50)

In this context, the policy of NEMS Platform one surgery to operate with no catchment area is a positive one, and several respondents were using this surgery.

- **Progress and recovery can be slow.** The multitude and complexity of this client group's needs, combined with other factors such as undermined trust in services, and transience (see above), means it can take a relatively long time for significant positive change. Apparently small steps can represent giant leaps for this client group. Yet, the effectiveness of services is often measured in terms of short term outcomes. One stakeholder interviewed, who works in the field of dual diagnosis reported that it can be a minimum of three years to see positive outcomes, but commissioning tends to be based on throughput.

- **Low self-esteem or feelings of hopelessness are common** amongst this client group. We have reported elsewhere that survey respondents' wellbeing scores were relatively low (see Chapter 2), that rates of attempted suicide were high (Chapter 6), and that homelessness impacted significantly on wellbeing (Chapter 5). Such feelings can impact on motivation and capacity to engage with services. Stakeholders also reported that homeless people often lack hope and optimism with regard to their future selves and, quite simply, see little point in trying to improve their wellbeing.

So in many respects what we're working with isn't homelessness it's poverty, that psychological effect of having no future […] it's difficult to be excited about life if life's crap. (general needs hostel)

7.2. Conclusion

The discussion in this chapter provides important context for Chapters 8 and 9, where we explore homeless people's use of, and access to, mental health and other support services. These distinct features of homelessness - multiple exclusion homelessness in particular - influence access to support services and people's capacity to engage.

Patterns of service use and engagement

8

We saw in Chapter 3 that the majority of respondents self-reporting mental health issues had been told by a medical professional that they had a particular mental health condition. This suggests that homeless people in Nottingham are accessing health services. In this chapter we explore in more detail the services homeless people are accessing, and the treatment and support they are receiving. We begin by presenting the survey results, before moving on to the findings from the qualitative interviews.

8.1. Levels of service engagement

Over half (59 per cent) of all survey respondents with mental ill health were currently accessing support or treatment for their mental health issues, with a further 19 per cent reporting that they did not need any support or treatment. This leaves one in five respondents receiving no support or treatment, but requiring it (two per cent did not know). It is important to note that this is a snapshot. We learnt from the homeless people interviewed in depth that mental health service engagement fluctuates (sometimes, but not always, in line with mental health needs). It is likely, therefore, that some of those not currently receiving support will have accessed services in the past. Conversely, just because someone is currently receiving treatment or support does not mean they will always have done so when it was needed. Never the less, this provides a useful picture of general levels of service engagement and suggests that - notwithstanding the important 20 per cent - **the majority of homeless people with mental ill health who feel they need support or treatment, are accessing services.**

8.2. Types of mental health support and treatment accessed

Figure 8.1 details the types of support respondents were receiving and shows that prescribed medication was the most common treatment, followed by help from general health providers and many were receiving support from specialist services such as talking therapists, mental health workers and CPNs.

Medication and other forms of intervention often went in tandem, with most of those receiving medication also receiving support from a specialist mental health service. Of the 50 respondents prescribed medication, around two thirds were also receiving support from a CPN, community mental health team (or similar) or were accessing talking therapy.

Figure 8.1: Are you receiving any support/treatment to help you with mental health issues? (Frequency of responses)

Prescribed medication 50

Other (GP, general health provider), 34

Talking therapy 27

A specialist mental health worker, 25

Dual dagnosis service 20

CPN 14

Peer support, 12
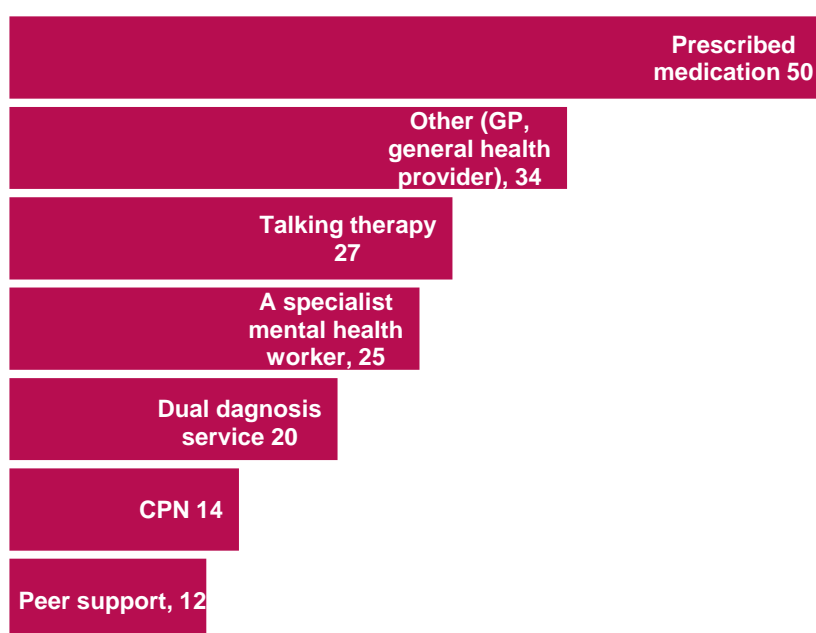
n=79

Respondents were asked whether the support/treatment they received was from a statutory or voluntary sector agency or both. Table 8.1 shows that the vast majority (92 per cent) were receiving their support from statutory sector agencies although sometimes alongside voluntary sector support. This may reflect service provision, with mental health primarily the responsibility of statutory health services, albeit with the voluntary sector providing (or hosting) some projects and services, sometimes supported by statutory sector funding. In-depth interview respondents were sometimes unclear about the organisation providing support (particularly in the case of support rather than clinical treatment) and so these figures should be treated with caution.

Table 8.1: What type of organisation is providing that support? (Respondents receiving support for mental health issues only)

	No.	%
Voluntary sector / charity	3	5
Statutory organisation	47	70
from voluntary *and* statutory services	15	22
I don't know	2	3
Total	67	100

8.3. Use of primary healthcare services

The survey also gathered evidence on the use of primary healthcare services by respondents with mental health issues. Figure 8.2 shows that more than three-quarters of survey respondents (77 per cent) had seen a GP about their mental health needs (55 per cent had done so more than three times). Almost half (48 per cent) had been to A&E for a mental health issue, with 17 per cent visiting more than three times. Two-fifths of respondents had used an ambulance (40 per cent) or been

admitted to hospital (43 per cent) for a mental health issue. More than one in ten respondents had done so more than three times at 12 per cent and 14 per cent respectively for ambulances and hospital admissions. In contrast, less than one in five respondents (19 per cent) had used homeless healthcare services although this is, perhaps, to be expected as these are less prevalent. These findings are broadly consistent with levels of service use found in research by the Department of Health.[81]

Figure 8.2: Have you used the following services or facilities because of a mental health need? (Mental ill health only)
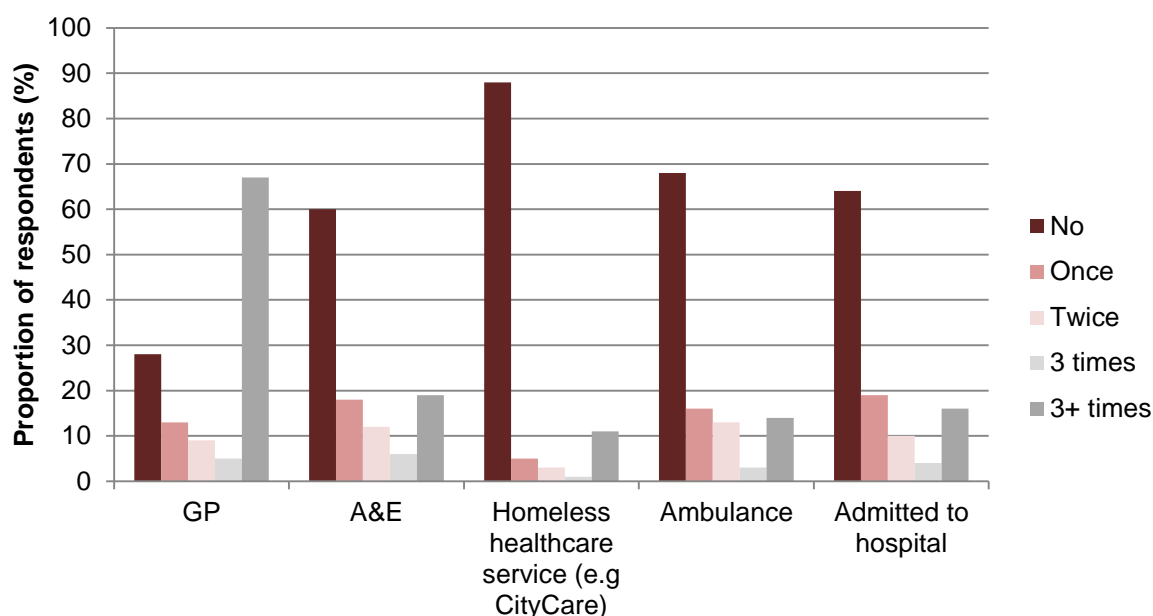
n=108-122

It is concerning that a relatively high proportion have presented at A&E or required an ambulance because of mental health needs, in some cases on multiple occasions. Use of emergency services can (although does not, necessarily) indicate that appropriate mental health services have not been available or accessible to some respondents until they reached crisis point. For example, research conducted in Nottingham and Nottinghamshire in 2016 identified a number of respondents who specifically commented that failed attempts at seeking support from NHS services had resulted in use of emergency services when, they felt, this could have been prevented had adequate support been available and accessible.[82] This was also true of some people interviewed for our study. We revisit this issue in Chapter 9 where we consider the extent to which homeless people's mental health needs are being met.

On the other hand, it is encouraging that a high proportion of respondents had seen a GP about their mental health needs. A GP is often a first port of call and so, perhaps, this is not surprising. However, as noted in Chapter 3, it is well documented that homeless people encounter significant barriers registering with, and using GPs. This was an issue raised by some stakeholders in Nottingham and problems were encountered by the homeless people interviewed (discussed further in Chapter 9), but this did not emerge as a significant issue in the City. Nearly all of the 37

[81] Department of Health (2010) *Healthcare for Single Homeless People*. Available from: https://www.housinglin.org.uk/_assets/Resources/Housing/Support_materials/Other_reports_and_guidance/Healthcare_for_single_homeless_people.pdf
[82] Healthwatch Nottingham and Healthwatch Nottinghamshire (2016) *Insight: Experiences and views on seeking support during a mental health crisis. Engagement activity report.*

homeless people with mental health issues who were interviewed for this study were registered with a GP, and many talked about making and attending appointments.

8.4. Use of non-healthcare services

Use of non-healthcare services by respondents with mental health issues during the previous twelve months is presented in Figure 8.3. Four types of services were used by more than half of respondents. These were hostels/night shelters (80 per cent), Housing Aid (79 per cent), Benefits advice (63 per cent) and employment support (51 per cent). We would not expect all respondents to use each of these services. Further questioning suggests that the majority of respondents were accessing the services they needed. Between 85 per cent and 100 per cent of respondents who needed these services reported accessing benefits advice (85 per cent); Housing Aid (91 per cent); day centres (92 per cent); drug and alcohol support (92 per cent); employment support such as Jobcentre Plus (96 per cent); hostels (96 per cent), social services (99 per cent although this only represents 23 people) and probation services (100 per cent, representing 35 people).

Figure 8.3: In the last 12 months have you used any of the following services? (Mental ill health only)
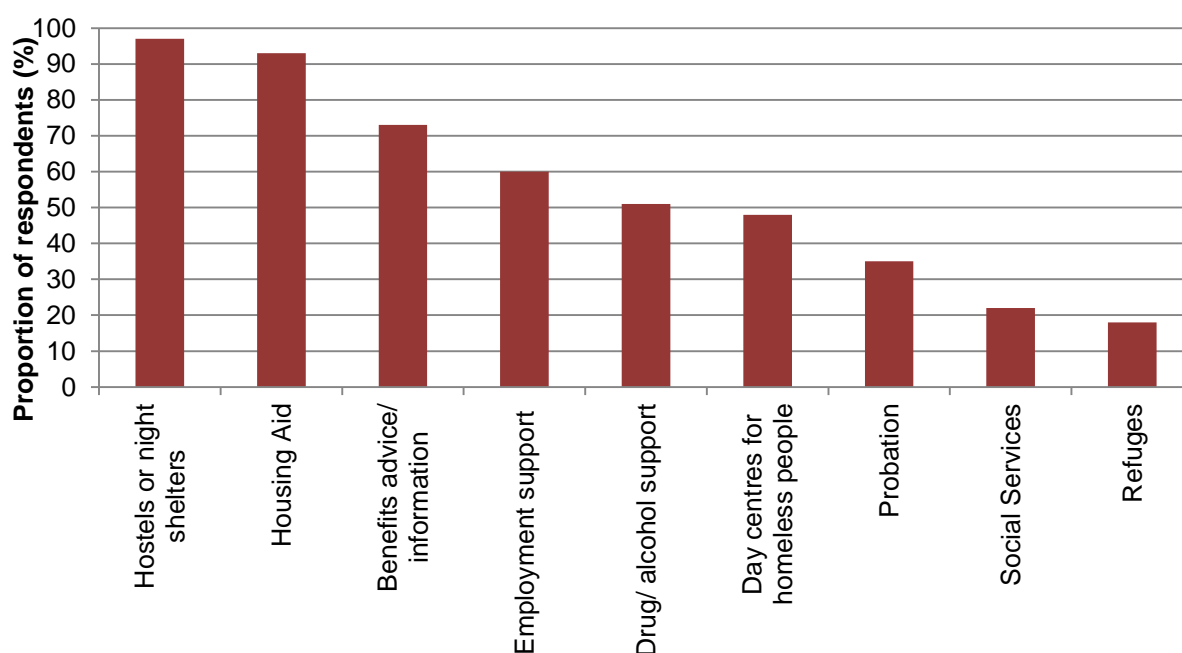
n=111-121

8.5. Patterns of service use: qualitative findings

Efforts were made to build a picture of interview respondents' engagement with mental health and other support services. This was not always easy. Respondents sometimes talked generically about the services and professionals supporting them. They referred to 'mental health teams' or 'mental health workers' but could not always specify the organisation for which they worked. Or respondents reported having been referred to, or having used, a particular facility ('Highbury' 'Platform One' 'Opportunity Nottingham') but could not offer further detail about the role of the professional they saw there. And sometimes, respondents simply knew their support/health worker by name. It is also likely that we did not obtain a fully comprehensive picture of every agency respondents had come into contact with and the details (e.g. geography, time) of this engagement. Never the less, as detailed

and accurate a picture as possible was pieced together in an effort to explore patterns of service use in Nottingham (see Chapter 9 for discussion about respondents' *experiences* of using these services).

The diversity of experiences is immediately clear from examining the support and treatment received by respondents. This is, perhaps, not surprising when so many variables are at play - eligibility criteria, thresholds, service preferences, differential capacity to engage, referral routes, service pathways, variable needs and so on. What is appropriate for, and accessible to, one individual will not be for another. People detained under the Mental Health Act, for example may then be routed into services or treatments that others would not access. Support and treatment for people with serious mental health conditions, or specific mental health conditions (Personality Disorder, say) will not be accessed by people without these conditions. And our sample included people at every point of a spectrum of mental health needs.

Never the less, it is of interest that no clear patterns emerged, for example indicating that certain types of services are heavily used, or readily accessible, while others are not; or suggesting that the needs of this client group are most often addressed by a certain service sector, or specialism (voluntary sector, for example, or support services rather than clinical services). Notwithstanding this diversity of engagement, analysis revealed the following:

- Concurring with the results of the survey, **most respondents were receiving, or had received support or treatment for their mental health needs**, although not all were currently doing so.

- **A wide range of mental health services were being accessed by homeless people in Nottingham.** This includes: psychiatrists and psychologists in various agencies and facilities for ongoing treatment as well as one-off assessments, for example following suicide attempts or Detention; talking therapies (Let's Talk Wellbeing was the only specific provider mentioned); CPNs; the Crisis Resolution Home Treatment team also known as the Crisis Team (24 hour telephone helpline and face to face support);[83] specialist mental health worker / nurse sessions in homelessness services (hostels, day centres) and drugs services (e.g. Recovery Nottingham); support groups for those with specific conditions (personality disorder, schizophrenia), and for specific groups (e.g. AWAAZ for Black, Asian, and minority ethnic people with mental ill health), Wellness in Mind, and oral and injected medication.

- **The majority of respondents were also in contact with non-mental health services.** Housing Aid was widely used,[84] and around half of those with drug or alcohol problems were in current contact (albeit sometimes sporadic) with substance abuse support services (typically Recovery Nottingham). Reflecting their histories, some had (currently or in the past) probation officers and social workers and a minority were attending other support groups. All of those in hostels or interim supported housing projects had key workers although levels of engagement on both sides varied.

- **The majority of respondents had been prescribed or offered a prescription for medication** (although not all took it), usually for depression, schizophrenia, ADHD, or psychosis.

- **No significant issues emerged with regard to accessing GPs** (several used the NEMs Platform One practice but many were registered with other GP

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[83] Stakeholders and the homeless people referred just to 'the Crisis Team'. This is the Crisis Resolution Home Treatment team.
[84] This partly reflects the sample. Many respondents were recruited through hostels and other interim accommodation and accessed that accommodation through Housing Aid.

practices). As the gateway to other services this is a crucial finding. Respondents were not always subsequently able to access the secondary mental health services they required (see Chapter 9), but we can conclude from this that homeless people in Nottingham - in contrast to some other cities - appear able and willing to register and see a GP.

- **A small but important minority of respondents first received mental health support (any, or the first beneficial support) while in prison**. This was true of at least four of the ten or so interviewees who had served prison sentences after they had developed mental health issues. Lisa, for example, explained:

  > I'm glad I went to prison coz it saved my life and they got me proper diagnosed, they seen me for a few months, psychiatrist GP and she was brilliant, she seen me every week, twice a week, for a few months and she said I've got it quite bad. (Lisa, aged 30)

  Richie expressed frustration that the various GPs he has been registered with over the years have only prescribed him medication when '*I just want someone to sit and listen to me.*' It was in prison that he accessed treatment other than medication, seeing a psychiatrist every two weeks. Neither Lisa nor Richie received ongoing support or treatment on release from prison. Ross, who had been seeing a psychiatrist in prison every day, was provided with interim support to help his transition into the community but since then has received no further support. Of the four, Johnston was the only interviewee for whom a smooth transition and longer-term support appears to have been arranged.

- **The support and treatment interviewees received after a mental health crisis - i.e. suicide attempt, hospital admission, hospital or police detention under the Mental Health Act - was very variable**. Some interviewees appeared to have received no follow-on support whatsoever, while others were referred for regular psychiatric input, prescribed much needed medication, Crisis Team, or CPN support. This will partly reflect differential needs at the point of assessment / discharge, the severity of the crisis, and the varying obligations and responsibilities of statutory services depending on the situation. There were no instances of interviewees rejecting support when assessed during or following such crises.

- **Although most interviewees had received support or treatment from mental health services in Nottingham, this was sporadic, uneven, and did not always align with respondents' needs**. Patterns of service use could not always be explained with reference to key variables that should dictate service access - e.g. severity of condition, eligibility for the service, willingness to engage. Few had regular, consistent, current support or treatment for their mental health needs, other than medication in some cases. Around half of all interview respondents were not *currently* receiving support or treatment other than medication for their mental health needs, although some had had recent contact with services or had been offered referrals (typically to talking therapies) and had rejected the option presented to them. Michelle is a case in point. Michelle has multiple and complex needs. Her interaction with mental health services is, however, limited. She sees her GP and has been prescribed medication and is in contact with a service supporting sex workers, but appears to have no contact with specialist mental health services. There was some indication that she may have been offered opportunities for talking therapies but has chosen not to engage. The support on offer is not what Michelle feels she needs. So, although the broad brush picture appears promising, the details are crucial. This is discussed further in Chapters 9 and 10.

- **There was some evidence of inappropriate use of services** by interviewees. This was typically driven by difficulties accessing appropriate services (see Chapter 9) and included:

    - **Interviewees asking professionals to detain them under the Mental Health Act**, or making concerted efforts to be detained (through a suicide attempt in one case and by going *'mental'* in another), believing this would be a route to treatment and support. This applied to at least five of the homeless people interviewed, including Jimmy and Rosie:

        I've even said to the police, when the police come, 'I want sectioning to get help' and he said 'we can't do that, it's up to the psychiatrist people to do that. (Jimmy, aged 53)

        …went mental, went absolutely bonkers, I was hitting the wall and making loads of noise in a small community area and just thought someone's going to call the police, and they dropped me off at the hospital….(Rosie, aged 29)

    - **Relying on support workers in other fields** (e.g. homelessness, substance abuse) to provide mental health support. To some degree this will be appropriate. Support workers in other fields will be equipped to provide a degree of mental health support and this will fall within their remit. However, there were instances where support workers were the only professionals providing mental health (or therapeutic) input, and where respondents with significant mental health needs appeared to be overly reliant on these workers during periods of intense mental health stress. Drugs workers, in particular, appeared to be providing much needed mental health support. A couple of respondents were relying heavily on housing key workers and other support staff. Arnold, for example, suffered a terrible tragedy when his long-term partner and very young baby both died within a few weeks of one another. With PTSD, depression and anxiety, Arnold walked out of his home and has been homeless ever since. He has never spoken about these events but recently decided to open up to his hostel key worker. He explained that *'I spoke to one of the staff about what happened and I felt alright about it, but I feel weird now where I see them.'* Stakeholders we interviewed working in hostels confirmed that they were ill-equipped to support people with significant or complex mental health issues, but were increasingly having to do so.

    - **Use of primary health care services** including GPs, A&E, and out-of-hours walk-in centres. Ray, for example, reported that the only person he would approach, or talk to, about his mental health was his GP. He explained that:

        Sometimes when I've got a lot of things on my chest, that's the only person I can talk to now. When I went for assessment to do with ESA, disability assessment, they put me down as I'm seeing my GP too often and yet, to me, if you've been messed about in the past then you need someone you can trust on a regular basis and you get to see the same face. (Ray, aged 53)

        Ray was receiving no other support for his mental health when he was interviewed. He had suffered a very traumatic childhood, has a long history of depression and anxiety, was detained once under the Mental Health Act as a teenager and was assessed for detention recently following a suicide attempt. He is sleeping rough. His GP has offered a referral for counselling

but Ray is not keen, having tried counselling in the past and not found it effective.

Stakeholders also noted inappropriate use of emergency services, pointing out that this results in homeless people not coming into contact with the right specialist front-line professionals with the requisite skills and expertise:

They over-access A&E but in an inappropriate way, they wait for some huge crisis to occur and then present when really it's not an A&E problem, it might be a mental health problem, a drug problem, a withdrawal from alcohol problem, that's not what they need, they need some kind of specialist help with that. (GP)

- As indicated by the discussion above, it was relatively common for the homeless people interviewed to **seek help for their mental health problems in times of crisis.**

8.6. Conclusion

Taken together, the evidence suggests that most homeless people with mental ill health are accessing some services. It is difficult, however, to draw firm conclusions from this evidence without further understanding the circumstances under which respondents used these services and their experience of doing so. Frequent use of services, for example, can indicate that relevant support is accessible and that the full range of a person's needs is being met. Or it might indicate the opposite - that a person is moving around services precisely because none are fully meeting their needs. Just because a person accesses a service, it does not necessarily follow that their needs are adequately met there. And the fact that a person is in contact with a service now, does not mean that engagement will be sustained. These are some of the issues we explore in subsequent chapters, where we consider the extent to which respondents' needs were met, whether service provision matches their service preferences, and explore their experiences of mental health support and treatment.

Homeless people's experiences of mental health services

9

In the previous chapter we saw that the majority of homeless people with mental health issues in Nottingham appear to be engaged with support or treatment, although evidence from the qualitative data raised some questions about the consistency and adequacy of this support. In this chapter we explore whether mental health support and treatment is meeting needs. We begin by presenting results from survey questions that suggest that the mental health needs of many homeless people in the City are not being met adequately. This is not a surprise. After all, it is for this reason that Nottingham City CCG commissioned this study. In the rest of the chapter we draw on evidence from interviews with homeless people and stakeholders to explore why this might be the case.

The study is primarily interested in understanding the *mental health* needs and experiences of homeless people and so data collection and analysis focused on these services. However, the study also gathered information about respondents' use of other services. We present, and draw on this information where relevant, not least because it provides insight into homeless people's service preferences, and the general barriers they encounter accessing any service, both of which offer learning that is transferable to a mental health service context.

Implicit in the evidence and accounts presented in this chapter, are *barriers* to accessing services and meeting needs, although we draw out these implications in Chapter 11 which focuses specifically on consolidating the evidence into a series of key barriers.

9.1. Meeting needs?

We reported in Chapter 8 that 59 per cent of respondents were receiving support or treatment for their mental health issues. Looking at responses in more detail, however, reveals that **only 27 per cent reported receiving support or treatment *that met their needs*** (see Figure 9.1). A further 32 per cent were receiving support but indicated that this was not sufficient, or not the right kind of help, and 20 per cent were accessing no help despite feeling it would be of benefit. Assuming the 19 per cent of respondents reporting no support/treatment requirements have accurately assessed needs, this still leaves over half (52 per cent) of respondents with mental health issues without, in their view, the support or treatment they require.

In the remainder of this chapter we explore survey and interview respondents' experiences of mental health support and treatment in an effort to understand why current service provision does not appear to be meeting the needs of this client group. We begin by exploring respondents' experiences of trying to *access* services, before moving on to their experience of *using* services.

Before proceeding, it is important to note a number of recent service developments in Nottingham that may not yet have translated into positive outcomes for this client group, and so may not be reflected in our survey results or in the qualitative experiences of the homeless people interviewed. The Primary Care Mental Health Team had only recently been commissioned when the fieldwork for this study was underway and the addition of a psychiatric nurse to the Homelessness Health Team, which runs outreach sessions in homelessness services, was also a relatively new development. There was emerging evidence that these two services were impacting positively on homeless people's access to mental health support and treatment (see 9.3 below) but, as recent developments, did not yet feature significantly in the experiences and trajectories of the homeless people we interviewed.

Figure 9.1: Are you receiving any support/treatment to help you with mental health issues? (Respondents with mental ill health only)
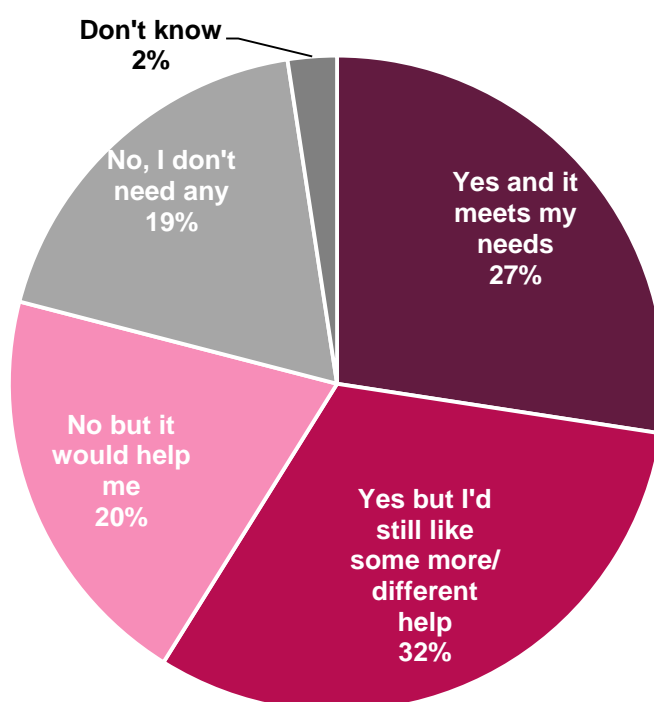
n=124

9.2. Experiences of trying to access support and treatment

Just over half of survey respondents with mental health issues reported that on at least one occasion in the past 12 months they had needed, but not received an assessment, treatment, or support for a mental health issue (see Figure 9.2). Three quarters of these respondents reported being homeless at the time.

This very much echoes the experiences of interview respondents, several of whom reported asking, or in some cases, 'begging' for help.

I was on my bended knee asking for help but I didn't get nowhere (Jimmy, aged 53)

You ask for help and then eventually you break down for help, that's my way of thinking (Vin, aged 50)

I was begging for help for two years, every week I was in the doctors crying, saying to them 'I don't know what's wrong with me', I'm either up here or down there and there's never any in between. I don't know what it feels like to feel normal (Jess, aged 35)

Not knowing the full clinical position with regard to respondents' mental health makes it difficult to judge whether they should have been able to access the services they felt they required. Just because someone wants, for example, to be detained under the Mental Health Act, or to see a psychiatrist, or to be prescribed medication, does not mean that would be an appropriate course of action or that they meet the criteria. What we do know, however, is that respondents in this situation felt they needed help with their mental health, and could not access support they felt would be beneficial. We also know from respondents' description of their health and their wider circumstances at the time, that they were usually in some distress, and typically also had a history of mental health issues, including previous suicide attempts and periods of detention in some cases.

Figure 9.2: Was there any time during the past 12 months when, in your opinion, you personally needed an assessment, treatment, or support for a mental health problem but you did not receive it? (Respondents with mental health issues only)
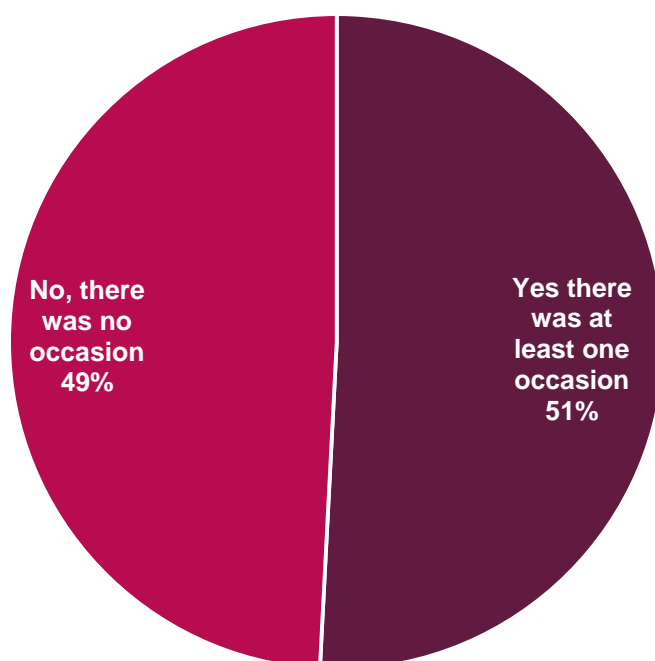
n=122

Stakeholders confirmed that they were finding it increasingly difficult to help their clients to access mental health services. As one GP explained:

Accessing mental health care is a growing challenge. It seems to be increasingly difficult over recent years to get people in quickly and routinely. The thresholds seem to just be going up and up to get people seen. You kind of get to the point of, what can I say to get people in? You have people that are telling

you they're suicidal, that have been bounced back to the emergency department and they've been on the train tracks that day and you just think how worse can it get? So it seems to be increasingly difficult to access […] I don't think services have a choice; they're just swamped and they have to try and select people that they feel need it the most but there's just not enough of the services to go around (GP)

In an effort to understand why people might need, but not access help with their mental health, survey respondents who had indicated struggling to access support (Figure 9.2) were presented with a list of potential explanations and asked if any applied. The most common reported reasons for not receiving support needed in the past 12 months were:

• Couldn't get an appointment;

• Did not know where to go for help;

• Due to drug or alcohol use;

• Waiting lists.

We can see here that the main reasons respondents had been unable to access services were a combination of: high demand / the way in which services are accessed (as indicated by issues with waiting lists and appointments); lack of information about the services that exist and how to access them; and barriers associated with individuals' characteristics and needs (as indicated by exclusion because of dependency).

Combining survey evidence with the experiences reported by interview respondents reveals the following key reasons why homeless people were unable to access the support they required. These are:

• Not having mental health needs acknowledged;

• Falling between service thresholds;

• Dual diagnosis;

• Waiting lists;

• Inappropriate referrals.

We will now explore each of these in more detail, drawing on illustrative examples.

Not having mental health needs acknowledged: being 'left in the shadows'

To access appropriate mental health services, people must first be recognised as having mental health issues. Several respondents described times when they had fallen at this first hurdle. There was evidence that homeless people can encounter difficulties having their mental health issues - or the severity of their mental ill health - acknowledged. For example:

I was begging for help for two years…I'd kicked off that much and nobody was willing to help me. (Jess, aged 35)

I feel let down by the whole system. I'm a person who's already tried to commit suicide, I did self-harm, can't go out the flat coz he's agoraphobic, that is isolated, alone, but asking for help. So where do you draw the line to say 'get him some help'? It feels like I've been left in the shadows. (Ross, aged 37)

I've asked the doctor, the doctor just says there's nothing wrong with me, I'm alright. I say I don't feel alright, I weigh 7 stone….and he says that's not a concern, but it's a concern to me cos it's making me unwell and unhappy. (Leona, aged 26)

These respondents had approached their GPs for help (sometimes amongst other health professionals), but the problem of recognition was also encountered by people admitted to hospital following suicide attempts, or hoping to be detained, or kept in hospital (voluntarily or under detention) for longer but who were discharged. Assessments were always made, and respondents were judged to be well enough to be discharged. From the respondent's perspective they felt unwell, in need of support or treatment and, therefore, should stay in hospital. It may be that these respondents were not unwell enough to be detained, detained further, or kept in hospital voluntarily. But, the absence of immediate (or in some cases, any) intensive follow-on support left respondents feeling extremely vulnerable. Jimmy is a case in point:

I had depression for a long time, took my first overdose, got took to hospital, seen psychiatrist people up there and he goes 'there's nothing we can do.[…] no further intervention from anyone, no-one come and seen me or nothing. So then I had to leave there [shared accommodation] coz I had problems there, then I come here [general needs hostel]. (Jimmy, aged 53)

Similarly, following her second suicide attempt in a relatively short period, Jasmine explained that *I was there [hospital] for two or three nights, I was seen by a CPN and she basically said there was nothing wrong with me.* Jasmine did not agree with this assessment. She has since been referred to professionals at Highbury Hospital but, as she is intending to move away from Nottingham, she does not plan to keep her appointment. Rosie, meanwhile, reported feeling 'distraught' when an assessment led to no further intervention. With complex needs, but no diagnosis of a serious mental health condition, she had been struggling to access any support and actively sought detention under the Mental Health Act in the hope this would provide a route into services. She explained what happened next:

They sent a social worker and a psychologist out to see me and then they just said I was depressed and to go home, they did an assessment and that was it….[I was] distraught to be honest cos I felt like I needed more help than that. (Rosie)

In these cases, it seems that the severity of respondents' mental health needs was not recognised, or their mental health needs were not severe enough to meet service thresholds. In other cases, respondents encountered health professionals who did not recognise their distress, or their behaviour, as a mental health issue at all. We can illustrate this with reference to Leona, whose circumstances are outlined in Box 9.1, and presented visually in Figure 9.3. Leona reported that her 'anger' issues were frequently interpreted as a behavioural choice or the consequence of drug use and, by implication, something she could readily change. Stakeholders made similar points, citing examples of clients whose behaviour was not recognised as related to mental health needs. For example:

I've even heard it from my staff, someone's got a personality disorder and it becomes 'they're attention seeking again'. We need more training at ground level, saying that's not attention seeking, that's crisis, they're desperate…so when they're acting in a weird way, is it their mental health, are they having a breakdown, or have they taken something? We don't know. (Supported accommodation for people with mental ill health)

Box 9.1: Problems having mental health issues recognised by professionals

Leona has always had extreme difficulty managing her anger, and is firmly of the view that this represents a mental health problem. She has had issues since she was 13 - and at that time received some anger management support but it was not effective. At school Leona had been bullied for being Black and had tried bleaching and filing her skin. She also self-harmed in other ways during this time. She reports that this has left her feeling not liked by anyone *'even if they talk to me I still think they don't like me'*. She describes being unable to control her anger, feeling angry at the slightest thing, and is aware that her anger is abnormal, misplaced, and problematic for others. She avoids people and places when she is feeling bad, because she does not trust her behaviour. In her own words:

> *…just get stressed about my reaction, cos I don't know what's it's going to be. If someone says something, I don't know what I'm going to do. I don't go places coz of that. It's like I don't go to a restaurant in case they bring food I don't like coz I know I'm going to kick off about it. Can't even go to the pictures, or go for a meal, just little things that I can't do that really stresses me. I should be able to go for a meal with my partner without kicking off.*

> *Some days I don't eat cos I'm too mad to eat.*

> *Someone says summat little and I just go mad.*

She is barred from a number of services (hostels, medical centres) as a result. Her anger issues have been compounded by depression at times. Leona has been asking for counselling or some other form of help for some years but as yet, has not been referred. The first time she asked for help she was 17 (about nine years ago) and had just had her first child. Feeling depressed, she visited her GP and asked for counselling. Instead, her depression was attributed to recent motherhood and she was referred to social services. She rang two counsellors herself and was told she needed to be referred by a GP. This pattern has continued - we reported above that most recently, Leona has been trying ('begging') for two years for her anger issues, and her 'not normal' feelings to be treated as mental health issues. She slept rough for a year during this period.

> *…they were saying I'm alright and I'm saying I might look alright but I'm mentally not alright…everyone says I'm alright so when I kick off they say I'm alright, so I must just be kicking off, it must just be normal, but I don't feel normal. I feel like I am either going to do something seriously bad and kill myself or summat seriously bad and someone else is gonna kill me. If I say summat to the wrong person I'm just gonna get knocked out aren't I?*

> *It just feels I'm not getting anywhere. I tell someone I need to see someone about my cannabis or my anger and they say 'just grow up'. I am growing up. It's hard.*

> *They just said 'you've got anger problem' that's all they say, 'calm down', it's not that easy. Everyone says 'it's cannabis' but if I stop smoking cannabis I smash things, so the only reason I do smoke cannabis is so I don't smash things. I will scream and shout but I don't smash things or punch people's head in.*

As these quotes indicate, Leona feels that her problems are seen as behavioural, a result of her chaotic life, her drug use, her rough sleeping, rather than as a mental health issue.

Figure 9.3: Leona

Life Events	Housing Situation	Service Contact and Outcome

Has a child age 15. History of anger issues and self harm

ASB order against others in her street so landlord 'advises' her to leave so she is distanced from it.

2013
Living with Mum at home with her 5 year old child

Homeless → Approaches council

Develops mental health issues/ anger issues persist. Cannabis use

Given accommodation at Mother and baby hostel

Loses place at hostel as smoked cannabis. Son goes to live with father.

Approaches council – Unable to be housed as Council considers her *'a failed tenancy'* (probably found intentionally homeless). Advised to apply as a single person.

General needs hostel → Hostel refers her to mother and baby hostel

Mother and baby hostel with son

Son stays with father part of the week and Leona stays with friends on these nights.

Mother and baby hostel

Feels she needs support but Mother and baby hostel feels she is capable of independent living. Receives no support for mental health/ anger management and cannabis use.

Loses place at hostel for sleeping away too many times.

Approaches council but not owed a Duty

2016
Father applies to court for custody of son. Son permanently with Father.

Homeless - Rough sleeping July 2016

Contacted counselling service- needs to be referred by GP or hostel

Working various jobs while rough sleeping. But loses jobs due to anger management issues.

Young Person's general needs hostel

Approaches GP. Medication to help her deal with rough sleeping. Asks for mental health support.

Implicit here, as in Leona's case amongst others, is the possibility that homeless people's wider circumstances and support needs might affect professionals' judgements about their mental health. Although not prominent in the in-depth interview data, survey respondents indicated that poor treatment by staff had deterred them from accessing support, with some reporting the view that they were treated differently *because* they were homeless. The fourth (out of 11) most common reason given by survey respondents for not accessing help was that *'the way I was treated initially put me off'*. Nearly half (46 per cent, or 29 out of 63) of respondents who had experienced difficulties accessing support said they thought they were treated differently by mental health services because they were homeless. When asked to explain this in more detail, responses revealed a deep sense of exclusion and resentment. Of the 23 respondents providing further detail, the majority highlighted a sense of stigma, or negative perceptions because they were homeless. Respondents reflected how their treatment made them feel *'judged and let down'*, how they felt *'belittled…looked down on'* or how they were not a *'full human being'*. Respondents had at times felt *'judged'* by their *'appearance first before assessment.'*

Although this did not emerge as a significant issue for interview respondents, a small number of respondents had negative perceptions of accessing care at doctor's surgeries - of how they had been spoken to and treated by frontline staff; of the discomfort of being in the waiting room; and of others' perceptions. These participants had experienced a sense of intolerance of mental health conditions, homelessness or behaviour that is different from the 'norm':

> *I'm going there cos I'm mad so I should be able to go in […] and I want to go crazy and that lady will go and sit there and I don't care if I want to walk round in circles, she's alright with it, she don't feel threatened. (Leona, aged 26)*

> *Yeah, just by being rough sleeping, you are, you feel different than the rest, and even some of the staff, I'm not saying just in here, but some of them look down to you, don't respect you, look down at you. I see some of the staff talk to you like you're some kind of idiot, if they're not going to treat you like an adult, unfortunately that happens in a lot of places. (Ray, aged 53)*

Falling between service thresholds: 'not mental enough' and 'too complex' for services

Across all stakeholders, thresholds for services were raised as an issue in relation to homeless people accessing support and treatment. This manifests with thresholds being too high, and being too low, and is complicated further by respondents' other support needs. In addition, stakeholders reported that non-standard behaviour that does not fit a clear diagnosis (see Leona, above) means some people slip through the net.

> *In terms of the threshold, there are people who want services but when they get assessed, usually by a crisis team, there's a feeling that they don't meet that threshold. There's lots of people that display bizarre behaviour that would want services but they don't meet the criteria. (General needs hostel)*

> *We have got a number of families who we are working with where we think they should be with a mental health service but they kind of don't fit anyone's criteria, so there's no assessments being done and so we're sticking with them cos we're the only service they're with. (Supported housing)*

> *I think as well there's quite a few people who have post-traumatic stress which is not necessarily diagnosed but needs some sort of mental health response, and whether or not someone reaches the threshold to get access to services. It*

seems to me there's another cohort of people which are just underneath the threshold, and it might be quite marginal between people who are receiving services and people who are not. (Local authority housing / homelessness department)

These reports very much chime with the experiences of the homeless people interviewed. Echoing the discussion above about difficulties getting recognition for mental health issues, many respondents found they did not meet thresholds for mental health services despite having significant mental health needs. Vin, for example, reported being supported very well by the Crisis Team following each of his suicide attempts but has struggled to access ongoing support. Vin has been formally diagnosed with depression, but articulates his mental health issues in various other terms too, including 'flipping' easily, and having a 'split personality', exacerbated by decades of alcohol and drug abuse. He explained that following a crisis, and regular effective support from the Crisis Team, he was disappointed that there was nothing further available to him (until his next crisis) because:

They just couldn't find evidence of serious mental health issues. The only problem was I was suicidal, very emotional, anxiety attacks, depression obviously. (Vin, aged 50)

Jasmine found that, moving from child to adult mental health services, the professional assessment of her mental health changed, despite no change in her mental health. As a child, she met the threshold for psychiatric services but as an adult she did not. She explained:

I had her [psychiatrist] for two years and she was nice but then when I hit 18 and I went to see the adult ones they basically said I wasn't ill enough to have a psychiatrist. (Jasmine, aged 28)

We have reported elsewhere that Jasmine has since suffered with mental health issues, self-harm and suicide attempts.

In other cases, respondents reported that their needs were assessed as *too high* for certain services, typically talking therapies. Ironically, respondents' needs were often *simultaneously* too high for some services yet not high enough for others. There seemed to be no intermediate support for these homeless people. We can illustrate this point with reference to Jimmy and Rosie, whose experiences of trying to access support are outlined in Box 9.2.

Dual Diagnosis

In both Rosie and Jimmy's cases (see Box 9.2), amongst others, drug and/or alcohol abuse was a key factor rendering them ineligible, or 'too complex' for mental health services. Yet dual diagnosis was very common amongst survey and interview respondents. At times this left respondents caught between health services and drugs services as each deemed the other to be the primary need requiring treatment.

Mental health is the big thing but the other thing is complex and multiple needs, pretty much everybody they're seeing in services has mental health issues but a large proportion of those have got additional issues. Then accessing the appropriate support for them seems to be a problem and we do hear with dual diagnosis issues, bouncing in between drug services and mental health services (Local authority homelessness strategy)

Jess describes just such a situation:

They was sending me to [X drug service, that was] saying 'we can't help you', the doctors got to help you, and both doctors between two different places were sending me backwards and forwards and between each appointment there was another month go past… (Jess)

Reflecting Jess' experience (see above) respondents reported the view that their presenting mental health issues were sometimes interpreted as the result of drug use and, therefore, not properly the concern of mental health services.

[I would like] people to be a bit more understanding about your mental health, and try and work with you and help you, cos I don't think there's much help out there for people that's got mental health issues. People put it on the drugs and stuff, but there's a reason why people smoke the drugs, cos they're not getting the right help in the first place. Some people have suffered before they smoked the drugs and they haven't had the help […] people think cos you're on drugs it's [mental health issues] come from there but I suffered before I smoked anything for a long while…but drugs have just made it worse (Lisa)

Box 9.2: Needs too low and too complex for services

When **Jimmy** was discharged from hospital following an overdose he reported that *'I said I need to go into a place what can help me' [they said] 'oh no, you've got to be really mental'.* Jimmy reported that each assessment found '*there is nothing we can do', I'm not severe enough, I goes 'what do I have to do, cut my throat, or stab myself?''* Meanwhile, Jimmy is also struggling to access services for lower level mental health needs, because his support needs are quite acute. He explained that '*there's not much out there for me. There's nothing out there, you go and ask, and 'oh no, you've gone too far, there's nowt we can do''. (Jimmy)*

Rosie has a long history of drug dependency and intermittent homelessness and has suffered periodic severe depression. She feels her mental health issues extend beyond depression and she would like an assessment and diagnosis. We saw above that, in desperation, Rosie once 'faked' a crisis episode in the hope of being detained under the Mental Health Act.

It's really all the way through [that I have wanted help], cos I feel like I have got some mental health going on, and I feel like I've always wanted a bit of a diagnosis as to what's going on with me, but when I've asked, I've not been mental enough to access services, so it's difficult. (Rosie)

Her GP suggested that she self-refer to talking therapies. She explained what happened when she was turned down after her initial telephone assessment:

I just got fed back that my needs were too complex and I think that disheartened me on the whole idea of counselling. (Rosie)

With needs *'too complex'* for some services but *'not mental enough'* for others, her drugs worker was filling the space where she wanted mental health services to be.

There was a dual diagnosis team operating in Nottingham during the fieldwork period but they were only mentioned by one respondent. When Rosie (see above) had her self-referral to talking therapies rejected she reported contacting the dual diagnosis team and being turned down but she could not recall the reasons why. Dual diagnosis as a barrier to accessing services was an issue raised by several

stakeholders, who confirmed that it could be very difficult to access mental health services whilst abusing drugs or alcohol, but also difficult to access dual diagnosis support. For example:

> *I'm talking 20 years ago we were frustrated over people saying 'we can't do a diagnosis cos he's under the influence' and we're still hearing that now despite the existence of dual diagnosis teams. (General needs hostel)*

> *That whole thing of I am here and I don't want to tackle my drink but what I do want help with is the housing, well you can't have housing until you tackle your drink or you can't do this until you've done that. (CCG Commissioner)*

> *There's a dual diagnosis service which is a secondary mental health service for people who've got an established mental health diagnosis and a drug and alcohol problem, but they're really difficult to access, sorry they're tertiary mental health services, so you have to already be working with a secondary mental health service in order to access them. (CPN)*

> *There's been a dual diagnosis team [… but] they deemed themselves as a tertiary referral which was no good to us, to help us with the drug, alcohol, mental health problems with individuals. (GP)*

Given the difficulties homeless people with mental health issues experience in accessing secondary mental health services, tertiary services may be one step too far. Yet, services that can work with people with dual diagnosis, and not require them to address these problems sequentially, are essential for this client group. If we refer back to discussion in Chapter 5, it is often virtually impossible to disentangle mental health issues from drug or alcohol use in the context of multiple exclusion homelessness.

Waiting lists

Homeless people and stakeholders alike reported long delays between referrals and the start of support or treatment, particularly in relation to secondary mental health services. It is, therefore, likely that some of those survey respondents who reported needing, but not receiving support or treatment (see 9.1 above), may well have been referred for appropriate support, but were still waiting for it to materialise.

Collette for example, was on a waiting list for nine months for group therapy for people with complex personality disorder - a service she is now deriving great benefit from. She was also referred to a CPN, who started seeing her more regularly, but Collette had been without support for many years by this time. When we interviewed him, Ross had been waiting a year for Cognitive Behaviour Therapy (a referral made at his request). Ray, meanwhile, registered quickly and easily with a GP when he moved to Nottingham and was promptly referred for counselling. Ray talked positively about this experience saying *'done it through the GP, soon as I got down here I registered and they was quite helpful'*. However, he then experienced a delay. During this waiting period Ray attempted suicide (he had been sectioned once previously). He explained the importance of timely treatment:

> *It gets worse as it goes along. If it's to do with a mental health issue and you get help at the right time, before it gets…. you've got to control it...I think it's hard to get help. You've got to wait months to see a counsellor so how long you have to wait to see a specialist I don't know (Ray, aged 53)*

As indicated by Ray's experience, during a period of time on a waiting list, mental health could rapidly exacerbate with respondents reaching crisis point. Ray was not

the only respondent to attempt suicide while waiting for an appointment with secondary mental health services. And it need not be a particularly lengthy wait for people's mental health to deteriorate to the point of crisis. Freddie, aged 24, who was one of the few respondents with very regular, consistent support and treatment from the same professionals described what happened when he could not get an urgent appointment with his CPN:

> *Freddie: I tried to speak to someone in mental health and they're a bit busy and end up overdosing…[…..]*
>
> *Interviewer: at the time you took the overdose were you able to see somebody straight away or was that why you ended up taking the overdose?*
>
> *Freddie: That's why I ended up taking an overdose…I wanted to see my mental health worker about my meds. My meds wasn't working.*

Freddie's contact with services is depicted in Figure 9.4.

Although access to primary healthcare and assessments was reported by stakeholders to be 'good', and most homeless respondents reported ready access to GPs, some did report relatively lengthy waiting times for appointments at some surgeries. When interviewed, Leona, for example, had just been issued with an appointment one month ahead and Ray reported that the waiting list at his GP surgery for a pre-booked appointment is currently six weeks (although you can also phone early for a same day appointment).

Figure 9.4: Freddie
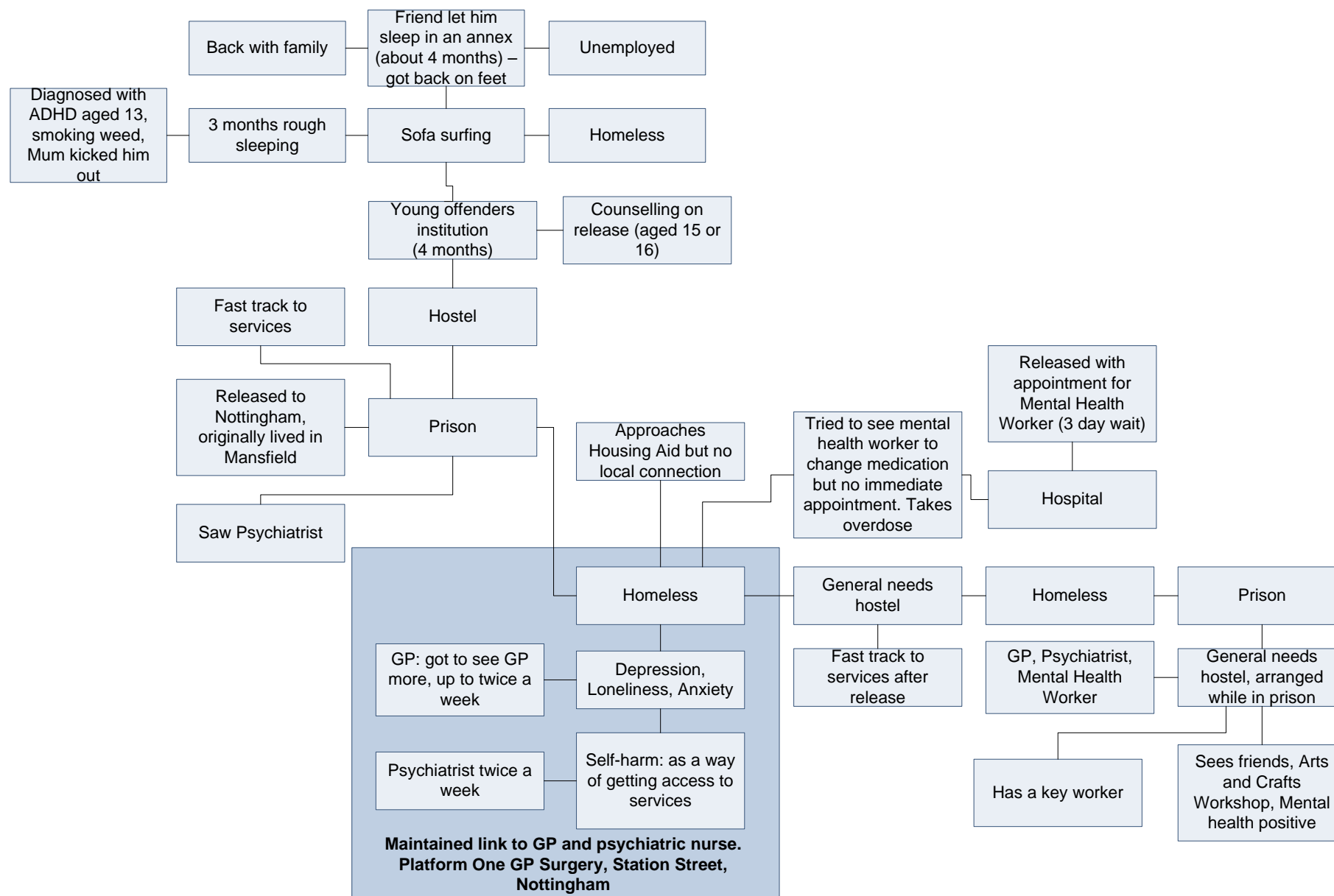
Inappropriate or 'dead-end' referrals

There were examples where respondents had been referred to services (or health professionals informed them about, or offered to refer them to a service) but this did not translate into effective support or treatment. We have already discussed evidence above that the needs of homeless people with mental ill health are sometimes considered 'too complex' for the services they are referred to (particularly talking therapies). The referring professional (often a GP) may not be in a position to assess their patients' needs such that they could anticipate this outcome. Never the less, homeless people with mental health issues are being referred to services that will not support them. Some were referred to the same service more than once. When we interviewed him, Ross, for example, had just been referred for talking therapy by adult mental health services, to an organisation that had recently rejected him following a GP referral:

> They came out, did an assessment, they said 'we'll talk about what's best move on for you and where to go from here' and then said 'Let's Talk', I said…'I've spoke to these before, I'm too high risk, they won't deal with me', but I got a letter from these 'we've received a referral, we're currently reviewing the information to decide if we're the most appropriate service for you' so that'll be a no, I know what to expect. (Ross, aged 37)

For the homeless people we interviewed, rejection from a service usually left them back at square one (although not necessarily in Ross's case, now he is in contact with professionals in adult mental health services). There appeared to be little tracking of referrals, or follow-up, or signposting on to another more relevant service. One stakeholder reported that GPs receive little information from secondary health services about the outcome of referrals, which may help explain this result. The onus is therefore on the patient to re-present to their GP, or actively seek out alternative services, which can be particularly difficult for homeless people.

We reported in Chapter 8 that some of those respondents with very limited contact with mental health services had sometimes been offered, but had rejected support, usually in the form of talking therapies. We discuss homeless people's service preferences in Chapter 10 and will see that, although there were mixed experiences of talking therapies, a large cohort of respondents were resistant to this form of intervention, often for specific and understandable reasons. Many respondents had been offered a referral to counselling or some form of talking therapy, had refused this, and no other suggestions had been forthcoming for alternative support or treatment. From the homeless person's perspective, they had been offered inappropriate or ineffective intervention. One stakeholder articulated well the multiple barriers facing homeless people in accessing forms of talking therapies. She pointed to restricted access to these services because of complex needs, but questioned how appropriate they were, in any case, for people in unstable situations:

> …our client group struggled to access them cos of the chaotic lives they lead, often a lot of services, there's almost restrictions around things like drug use and so on, particularly if you're somebody with a personality disorder, the established therapeutic line is through our personality disorder network which is group therapy, but one of the caveats of that is you have to be fairly psychologically stable before you access it, cos you'll be talking about very difficult things, it doesn't help you do that if you're in a period of chaos, and obviously if you're homeless by its very nature you're not particularly stable and it wouldn't do you any good to go and talk about it and try and unpick things and then go back to sleeping on the streets that night, that would massively increase the risk. (CPN)

The *means* of referral was also sometimes an issue, and not always appropriate for the respondent. It is important for this client group that some services are available through self-referral or direct access. Referral requirements (i.e. from other professionals) have long acted as a barrier preventing homeless people from accessing all sorts of housing, health and support services. However, some homeless people's lives are also chaotic - particularly in the context of multiple exclusion homelessness - and they will have many other issues to resolve, such that a self-referral for their mental health may never become high priority. In the majority of cases where primary healthcare professionals signposted rather than referred respondents to secondary healthcare services, this was not followed up. When asked what might have helped Jasmine from reaching crisis point, for example, she replied:

> *I don't know, cos I was going to the doctor's and they told me to self-refer to talking therapy which I never did cos it was a phone call and I don't do phone calls, but that probably would have helped, having someone to talk to, but then that's my fault cos I didn't phone them. [Your GP wouldn't have referred you?] No, she told me to phone them. [Would you have done it if the GP had referred you] Yeah. (Jasmine, aged 28)*

We cannot know whether Jasmine would have attended an appointment had her GP made the referral, or indeed whether the service would have accepted her, or been able to provide her with an appointment rapidly enough in the context of her deteriorating mental health at that time. Nor can we know whether this support and treatment would have been effective in Jasmine's case. Never the less, it is clear that the means of referral prevented Jasmine from potentially accessing much needed help.

Having explored respondents' experiences of trying to access support and treatment, we will now turn to their experience of the support received.

9.3. Homeless people's experiences of mental health services

As with their patterns of service use (see Chapter 8), respondents' experience of the support and treatment they received was diverse. Wholly positive or negative experiences of specific services or types of service were not unanimously reported by respondents. For example, many respondents were resistant to group or individual talking therapies while others found such intervention beneficial. Nicole, for example, described the counselling she received while in a refuge '*amazing'* while others had found it to be of no use whatsoever:

> *[It was] therapeutic, we got along and I found it interesting cos I could see myself just sitting there talking to someone, I found it interesting cos this person doesn't know anything about me, I don't know how to explain it, it's magical, it makes me feel better. (Nicole, aged 28)*

> *The first time I had to go and speak about my problems, second time I was in there with a group of people sharing experiences and that, and it just wasn't for me. (Freddie, aged 24)*

Similarly, medication was welcomed by some and rejected by others (this partly, but not wholly, reflected the specifics of their mental health conditions). However, when respondents were critical of services, reported negative experiences, or minimal outcomes, the source of their discontent was usually related to the *intensity* (or lack of), rather than the *nature* of the support received (with the exception of a small number of respondents who had experienced talking therapies and reported it ineffective). It was the fact that they had to wait a long time for their first appointment,

or could only see their psychiatrist once every few months, or that the support was short-term only, or they were not referred on to other services, or that the support/treatment was not, on its own, enough to fully address their mental health needs that they bemoaned. Mick's comment about the psychiatric support he received illustrates this well:

> *The psychiatrist, he was very good. They were all good at their job but they never used to stay too long with us. They had to move somewhere else, so I had a different psychiatrist basically every three months. (Mick, aged 47)*

There are some positives to be taken from this finding. *Firstly*, that **the support and treatment itself was generally welcomed and respondents derived some benefit from it**. Those respondents who had received psychiatric treatment, for example - whether as an inpatient or outpatient - all reported this to have been beneficial. CPN support was also welcomed and the few respondents who had engaged on an ongoing basis with group therapy and support groups (including groups for people with specific conditions, and those seeking to improve general wellbeing) were very positive about their experience and outcomes. Notwithstanding issues associated with onward referrals to secondary mental health services (see 9.2 above) few respondents had any criticism of their GPs.

Secondly, **there was a general willingness amongst respondents to engage with statutory and voluntary sector mental health services.** There were some issues with trust, particularly amongst those who felt they had been let down by services in the past, and willingness does not always translate into action - homeless people with complex needs will not always prioritise their mental health - but respondents generally wanted input to help them recover good health and wellbeing.

These are positive foundations on which to build. There were also a **number of services that stakeholders singled out as working particularly well**, and making a noticeable difference in the City to this client group. These were:

- The Primary Care Mental Health Service: stakeholders reported that this service had 'filled a gap' between primary and secondary health services, and provided those often excluded from other services with much needed access to mental health treatment and support. For example:

  > *Primary Care Mental Health Service also filled a gap. They provide clinical support so can adjust meds and do MH assessments. If we see somebody who [we] are concerned about and know IAPT services will turn them away because needs are too complex then we refer to PCMHS and they can work with them for up to 12 weeks. It's a more immediate source of support but they've been inundated and don't see people as soon as they'd like. (Mental health support service)*

  > *We've got a fantastic service that has been set up called the primary care mental health service which has come about cos of these difficulties with people who are chaotic, cos what we had in the past was that they were too risky for IAPT services and the talking therapies that anybody can access but they weren't risky enough for secondary mental health services, so we had a massive group of people who weren't being seen. The primary care service has been commissioned specifically really to see those people who would otherwise be refused a service through other primary care providers and they're really good (CPN).*

- Several specific GP surgeries, and GPs, were mentioned by stakeholders as having a good understanding of homeless people and contributing to

accessibility of healthcare in the City for this client group. One stakeholder contrasted this with another city in which she had worked.

- The addition of a CPN to the Homeless Health Team was universally welcomed by stakeholders. Those working closely with homeless people pointed to the difference this has made to their work, and to their clients:

  Since we've had the psychiatric nurse coming to do drop-ins it's been really useful… it certainly makes a big difference for us and I think it makes a big difference for the service users as well. One of the indicators is people come back so she's obviously offering something they want… Having a professional pair of eyes to have a bit of a chat and make a bit of an assessment, all informal, but at least it feels like something's moving, somebody's being supported, cos we can't do anything unless we've got that….prior to that there was nothing we could do, we would watch people deteriorating and eventually get GPs involved and people would get sectioned, if they get really bad they might get arrested and then sectioned. (General needs hostel)

  A few years back someone would turn up and we'd spend all our time ringing round trying to find out risk, background, medication but instantly now with consent we can access medical records and find out if they've been sectioned in the past and what the diagnosis is and it also helps with homeless applications. (Homelessness outreach)

- Opportunity Nottingham is one of 12 projects in England funded through the Big Lottery's National Fulfilling Lives programme. It is not a mental health service but does work with people with mental health issues, and was described by stakeholders as filling an important gap by ensuring continuity of support. For example:

  [It's] a big help for a service like ours who, before, were just faced with supporting these individuals when they were rough sleeping on their own then they go somewhere, prison, hospital, hostel, and then having no contact and then supporting them again for a month, at least now with Opportunity Nottingham that person follows them through so that's good. (Homelessness outreach)

It will be no coincidence that the services singled out as offering effective and accessible support to homeless people with mental health issues are services that target homeless people and/or people with multiple needs.

Stakeholders also suggested that there were some good examples of partnership working in the City, and good strategic engagement within the local authority:

From a partnership perspective agencies work together well in Nottingham, charity and faith and third sector. X attends a multi-agency meeting with frontline workers every two weeks which is attended by pretty much every agency, that's to discuss issues and share risks and concerns. (Homelessness outreach)

So I think we do have a good system of being able to identify this, alert people and channel them into let's ask for something to be done about this. I think that's a really positive thing, potentially in other places people could not know where to take their concerns. I think that does work well… people do seem to want to try to change things, to try something different and help make the system better. (Local authority homelessness strategy)

Notwithstanding the relatively positive experiences of mental health support and treatment, and some apparent good practice in the City, **very few respondents had received comprehensive, effective, and consistent support** throughout their mental health journey. It was this lack of continuity and intensity of support that respondents bemoaned (not just in relation to mental health services) and that often left them feeling abandoned or let down:

> *I've had mental health issues most of my life. I was taking anti-depressants before I moved to Scotland, though the system's let me down all my life. (Ray, aged 53)*

It was not only in relation to mental health services that respondents felt 'let down'. Most had both positive and negative experiences of many support services - housing, social services, probation, primary healthcare - but some recounted episodes where they had tried and failed to access help for a range of practical and support needs. Jack, for example, expressed the view that *'they failed me, social services, all my life it's been a straight fail, failed my duty of care so I told them where to stick it'* while others described the assistance they received from Housing Aid as '*pretty useless' (Scott)* and being left feeling *'like the system is letting me down…and you've got a barrier there now cos you don't trust someone'* (Ray). Respondents were generally more critical of statutory services than voluntary sector services but this partly reflects the higher expectations of statutory services, particularly around provision of accommodation (an expectation placed on the LA housing department, social services, and the Probation Service). Others recounted experiences of these services to the contrary, and drug support services - drug workers in particular - were praised by a number of respondents.[85] But, where problems were encountered, these experiences were stored alongside experiences of mental health services leaving respondents feeling that 'the system' was failing them. As Jack and Ray's quotes above indicate, this can erode trust and affect people's willingness to engage.

Respondents were also sometimes left confused when faced with, what they interpreted as, **variable assessments** of their needs by different health professionals. This echoes the experiences reported above where respondents were simultaneously assessed as not meeting thresholds for some services but as having needs too complex for others. In some cases, very similar scenarios resulted in different outcomes. This was true for Jasmine when she was discharged from hospital following suicide attempts:

> *Well, the first time I went in [to hospital] they were good and they told me to go, the first time I saw a CPN and she said to go and see the team at [X NHS psychiatric service] but then the second time when I got seen by the CPN, even though I was worse cos I was hearing voices at that point, she just basically said I don't need a referral to anywhere. (Jasmine, aged 28)*

Tracing respondents' 'pathways' through mental health services, the overarching picture, then, was one of patchy, sometimes inconsistent support and treatment with respondents spending long periods of time with no input from mental health services, or with partial support that just about helped them maintain stability. Mick, for example, had had Schizophrenia for 15 years and has been detained under the Mental Health Act several times. Over this period he described excellent support and treatment from psychiatrists and from various professionals in hospital, and was prescribed medication. But his treatment has been sporadic. At one point Mick was

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[85] It is important to be clear that this study was not an evaluation of local services. The information presented here is based on reported experiences of homeless people, triangulated in some cases with data from local stakeholders.

rough sleeping. He was on medication for depression but was not receiving any other support. He said, at that time:

I would have thought, with us having a mental health issue, being diagnosed schizophrenic or whatever, the mental health team would have got involved and helped you find somewhere as quick as possible, but nobody really got involved, nobody came out. (Mick, aged 47)

It is not clear how services would have known about Mick's situation, or known how or where to engage with him. But, having previously been in contact with psychiatric services it is clear that at some point Mick's course of treatment came to an end and there was no system for him to easily re-engage with if required.

Respondents frequently reported that their **treatment and support (across all mental health services) was terminated sooner than they had wanted, and those who had accessed psychiatry usually wanted more frequent appointments than they received.** Freddie, for example, lamented the reduction in the contact he now had with professionals compared with the intensity of support he had been receiving and Mick, who was seeing a psychiatrist every 4-6 weeks during one period of treatment and every three months during another, said *'really I could have done with it on a more regular basis'.*

As highlighted by Mick's case, **continuity of care was a particular issue.** Respondents were frequently 'discharged' from one service without, in their view, adequate follow-on support. Deteriorating mental health, or a crisis would frequently follow relatively soon after, suggesting that respondents' self-assessment was often accurate. They may not have still required support from the service from which they were discharged, but they required some input, and many were left with a gap in their support.

Richie, for example, finally accessed psychiatric support in prison that he valued greatly. On release he was referred to his GP who continued his medication but there was no follow-up psychiatric or therapeutic support, or referrals/signposting to other support services. Johnston, meanwhile, endured a break in his medication and CPN input when he moved to Nottingham from another city. Following some suicide attempts, Vin had what he described as good, regular support from the Crisis Team. When he was no longer deemed in need of that specific service he felt *'a bit disappointed'* and still in need of support with his mental health. He was also supported by AWAAZ, a charity supporting minority ethnic people with mental health issues, but that too was only temporary. Stakeholders also raised the short-term nature of support as a problem for this client group:

I think another barrier is some services are a lot shorter term now, so you will be fixed in this amount of time, and with the client group, for some or a majority, they've had a terrible life and it's all got to be sorted in six weeks and it's going to be lovely, well things might be improved but it's not going to be sorted. (Homelessness day centre)

Homeless people are likely to be at greater risk of disruptions in their care pathways because of frequent moving, within and between cities.

Some stakeholders suggested that, because of the demands placed on mental health services, where a homeless person is being provided with support, even if this support is perceived as unsuitable, statutory services sometimes withdraw support, or reduce their contact time on the grounds that the homeless person is receiving some care. As one commented:

I think the biggest challenge is, once they're placed in supported housing they're not seen as a priority for the mental health. When you get somebody that's really poorly and you're ringing up the care teams and they're saying 'well what do you want us to do about it?' We're not medically trained…we're trained to understand the people, to be empathetic and sympathetic, we're trained to follow policies and procedures and know when to contact the professionals and when we need to butt out cos they need professional help and there's a massive shortage of psychiatric nurses, they've got caseloads with people in the community and their attitude is 'I've got people coming out of my ears, I don't know who to go to next, they are in supported housing, at least they've got you, I need to get to the people in the street', which I totally understand, however when we've got somebody going into crisis they might only need to change their medication and now they're going to end up in hospital because the change in medication hasn't come cos the CPN can't get to them and they end up in hospital… we can sit for hours with someone talking about it and talk through the problems but we cannot give medication that will stop the voices[…] what they do is bring them into supported housing and then they discharge them, simply cos they've got us, that's not enough. (Supported housing for people with mental ill health)

Continuity of care *within* services was also highlighted as an issue, with staff changes reportedly undermining progress and, in some cases trust and engagement. This was an issue encountered in relation to all forms of support, but with clear learning for mental health services. For example:

Each one [psychiatrist], when they've left, someone else took over and I had to explain everything over and over again and it used to piss me right off, cos I were forgetting things, I couldn't remember dates, couldn't remember what the past psychiatrist said about the diagnosis…you get that trust for three months but after that it's somebody new then you've got to get used to another one and that takes a month or two and then they move on and you have to start all over again. (Mick, aged 47)

Yeah, but they're changing, it's new [housing support] staff, relief staff, and they're only here for two weeks, so it's 'give you so and so's number' but he's not here till next month, he's on holiday', so again I have to do things by myself. (Richie, aged 41)

I'm sick of being introduced to services and 'this is your key worker' and then they go on annual leave for six months. (Denise, aged 39)

Freddie, who has had continuity in his support and treatment, articulated well how important consistency can be to people with mental health issues:

The second time I came out [of the young offenders institution] it was a bit iffy cos I struggled to get back to my same mental health worker as what I had before I went to prison. After loads of arsing about, I managed to get him back. [Do you think that's important then, to see the same person, for that connection?] Yeah, it is, cos I kind of built up a bond with him where I can go and speak to him about my problems and that, and he understands cos he were in the same sort of position a few years before he got that job. (Freddie, aged 24)

And:

Cos I've been with them that long, they know me, they kind of understand what I'm going through… cos some people with anxiety, they like to stick to the same person and not different people. (Freddie, aged 24)

Collette made similar comments about her key worker, also demonstrating that it can take time for homeless people with mental health issues to build trust such that they feel able to open up to those supporting them:

One of them [key worker] was for quite a long time which was good cos I felt I could build a relationship with her. If you have a support worker for a short period of time it can be really, it can affect how supported you feel and would throw me. But cos I've had a period to get to know the staff and I was with one key worker for quite a period of time I felt comfortable, initially sometimes it has been hard cos I felt like my barriers were up, when I first started working with the key worker here I didn't want to work with her at all. I felt like she doesn't understand me, I felt like she was invading my space but as time went on she was a lovely caring person, it was my own issues. (Collette, aged 50)

Stakeholders made similar comments. For example:

I definitely think that when a patient has developed a relationship with someone then it's beneficial if it can continue to be with the same person. Again, patients have come across as feeling quite hurt personally if they've been provided support from someone and then that person changes their job role or gone on maternity leave. It hasn't been anything personal but they've said 'I've spent all this time and then they left' so they don't want to try again because it might happen again and it's obviously taken that person quite a lot to open up and trust that person and then that's lost. (GP)

One consequence of inconsistent packages or pathways of care is that **homeless people are required to 'tell their story' over and again.** For example:

They keep getting new staff and I don't want to keep explaining everything to new members of staff…I'm disengaging now, I've told you what I've got to tell you, if you want to know anything about me, read the paperwork and then come and talk to me. (Denise, aged 39)

I'd gone through it [my story] that many times with different people; I was just tired of it… (Jess, aged 35)

This was compounded by other aspects of respondents' experiences, notably being passed between services, and being referred to, but rejected by services. This was an issue raised by homeless people and stakeholders:

They would listen to me and then say 'I've listened to you, I believe what you're saying but I can't help you, I'm sorry'. (Jess, aged 35)

A lot of people in our client group find they'll be referred somewhere…they go through a massive assessment with them who say 'you're too high risk for us, you need to go somewhere else', they refer them somewhere else and that service will decide they're not appropriate for them and refer them on somewhere else and by that point, that person's probably been waiting months, had multiple assessments, talked about really traumatic stuff over and over again and they're pissed off. (CPN)

It is worth remembering that homeless people are often required to provide extensive information to housing professionals too, for example if they approach Housing Aid for assistance, when they enter a hostel, or when they apply for accommodation with a social housing provider. And other professionals - drug services, social services, probation - may have made similar demands. By the time a homeless person is

assessed by mental health services they may already have provided comprehensive information a number of times.

As indicated by the quotes above, this can result in reluctance to engage or to share information. One GP interviewed, for example, recounted her experience of patients refusing the see the mental health nurse:

> *Often I see people at [the homeless day centre] and they have quite significant mental health needs and I will say 'I really think you'd benefit from seeing a mental health nurse' and they'll say 'I just want to talk to you […] it's that having to start all over again with another new face. They've often had so many people they've had to talk through things with. (GP)*

It is important to recognise that service users do not distinguish different service sectors. They expect agencies in different sectors to be able to transfer information, and if they have repeatedly been asked to retell their story, or provide information, from, for example, housing services, they will be frustrated when asked to do so again by a health practitioner.

9.4. Conclusion

In Chapter 8 we reported that the majority of homeless people with mental ill health had engaged with mental health services. The findings presented in this chapter, however, raise questions about the extent to which their needs are being met. Exploring respondents' experiences of accessing (or trying to access) services, of using services, and the experiences of stakeholders working with them, suggests some significant barriers and gaps in provision. This, in turn, has consequences for future engagement and levels of trust.

To help us understand homeless people's requirements further, in the next chapter we report on their stated service preferences.

Homeless people's service preferences

10

The homeless population - in Nottingham City and more widely - face a range of significant, complex, and specific barriers to accessing appropriate support for their mental health needs (as seen in Chapters 8 and 9, and distilled in Chapter 11). In the previous chapter we explored homeless respondents' access to mental health support and treatment, as well as their experience of the support received and whether services are adequately meeting their needs. The chapter reported issues in relation to not having mental health needs acknowledged; falling between service thresholds; dual diagnosis; waiting lists; and inappropriate referrals.

Stemming from their experiences, respondents had their own ideas and suggestions about what might improve mental health services in the City - in terms of their accessibility and suitability for homeless people with mental health needs. This chapter draws on these stated preferences, expressed in the qualitative interviews and briefly in responses to an open-ended question in the survey.[86] It synthesises respondents' suggestions about what might help them to overcome certain barriers and enable them to access and maintain support for mental health.

The following key preferences emerged from the qualitative interviews and surveys:

- Homeless people would find it easier to access and negotiate services with the help of an **'advocate' or 'navigator'.**

- Homeless people would prefer to access mental health support at **known and trusted services.**

- Respondents suggested ways to improve **communication and advertising** methods.

- Respondents wanted more **'holistic' mental health support** which would be part of a wider package and would also include help with securing housing.

- Respondents wanted to feel like they were being **'listened to'** and **'cared about'.**

- Respondents wanted to see **more immediate-response, crisis services.**

- Respondents could relate more to support from someone who had been through the same experience (**'formalised peer support'**).

- Some respondents felt that more **training** was needed to improve health professionals' knowledge of homelessness.

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[86] The survey asked: "Thinking about your experience of accessing, or trying to access help for your mental health and related issues, what, if anything, could have been done differently to improve your experience?" The qualitative interviews involved a discussion around participants' service preferences regarding how services should be delivered to better accommodate their needs and what type of support and treatment they would like to see offered.

- Respondents wanted to see more **continuity in services and staff** (to avoid having to re-tell their story).

- Respondents felt they would benefit from **longer-term, ongoing and more intensive support** for mental health.

These points broadly coalesce around four key themes: service location and means of access; the structure and delivery of services; types of support; and staffing: In the remainder of this chapter we discuss each of these in turn.

10.1. Service location and means of access

Preference for an 'advocate' or 'navigator'

There was a notable difficulty of self-referring to health services and/or keeping appointments once respondents had accessed a service. Mental health itself was a barrier for accessing support, with participants remarking that their *'head [would] not [be] in the right place'* and that they would not even contemplate attempting to access mental health support unless a trusted individual sought help on their behalf. Adam emphasised that his depression severely affected his motivation to access support and that *'constant contact with [his] support worker and home visits would solve that'* by helping him to take 'simple steps' and 'attend appointments'. Ray, in the quote below, describes how his mental health issues made him feel *'in a world of [his] own'*, and without the help of a key worker, this made it difficult for him to find the right support.

> *That's what's not happening here, I've not witnessed it, that's what's lacking down here, the support, when you ask them for the help you need support with it, if you go from depression and anxiety and taking your tablets, some days you're in a world of your own. (Ray, aged 53)*

Several respondents felt they lacked the confidence and knowledge to approach services on their own, as illustrated by the following quote from Rosanne, and said they would welcome having someone to help them make these referrals:

> *I can't do it on my own. My dad used to do everything for us, speaking for us, he used to fill the form, [and] he used to do everything. I never used to do things by myself and maybe that's why I don't do anything or speak about it. (Rosanne, aged 30)*

Respondents were keen to have assistance with navigating what they experienced as an overly complex landscape of mental health (and other related support) services. Some participants were fortunate enough to have an 'advocate' or 'navigator' - often a trusted key worker or support worker - who helped with access to and engagement with services, such as referring to appropriate services, making the first contact, or helping participants to make and attend appointments.

This advocacy was important because although there was some evidence of GPs signposting respondents to mental health services, in the majority of cases, these referrals were not followed up. They spoke of the confidence, motivation and energy required to self-refer to a service - something they lacked at a time when their mental health and wellbeing was so poor. The following quotes illustrate how key advocates helped these respondents to access appropriate services, attend appointments and assist with practical support (such as form-filling).

> *She was only a temporary key worker […] she understood my problems and helped me get into X […] which suited me better. (Vin, aged 50)*

I had a support worker there who understood domestic abuse as well; they would come to you with appointments if you wanted and helped you fill out forms to do with benefits […] it was them that kept me going cos I wasn't getting the support from the refuge and being able to mix with some of the people that you felt you're a part of, you didn't feel so alone. (Collette, aged 50)

Mental health support at known and trusted services

There was a stated preference amongst interview respondents for qualified health professionals to be located in places familiar to the homeless person, such as day centres or hostels. At the same time, respondents also reported only feeling comfortable using that service if it was delivered by a qualified health professional.

In these places like [X day centre] I think there should always be some officer who can deal with special needs like mental health, I think it is urgent that they should take that into account[87] (Ray, aged 53)

[If] they ain't got a badge, a proper NHS badge or owt like that, if you don't look professional, I don't want to know. (Ray, aged 53)

Interviewees also preferred health professional to drop-in to their temporary accommodation for convenience and ease of access, especially as respondents had transient housing pathways which made accessing GP practices and other health services particularly difficult, as Vin explains in the quote below. It was also difficult for participants to travel to services, not only due to cost and practicality, but also for feeling unable to enter certain parts of the city – in Johnston's case this was to avoid people he had been involved with in the past and whom he feared would lead him astray (or back into previous substance misuse issues).

I've been changing GPs quite regularly due to where I'm living and moving so I find it more useful to talk to this GP on-site […] Here I can just put my name down for the GP […] and I can see a GP straight away. (Vin, aged 50)

I like them to come to me really cos I don't like walking through town, I see too many people, I don't want to get back into that scene anymore. (Johnston, aged 29)

Johnston's situation does raise an interesting dilemma, however. In his case, it was the city centre that he wanted to avoid, yet this is where many of the homelessness services are located, and where support services might be encouraged to establish themselves in order to be accessible to the homeless population.

Improved communication and more appropriate advertising

This was a theme that emerged more prominently in survey responses than the in-depth interviews, but relates to the appropriateness of services' communication methods. Coding the open statements from the survey revealed some key themes around suggestions for basic changes in communication. For instance, providing Freephone telephone numbers for services and advertising services on *'big posters in town [or] random pop up stalls'* were suggested by homeless survey respondents as ways to make mental health services more accessible for homeless people with mental health needs.

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[87] A CPN has now joined the Homeless Health Team that visits this day centre.

10.2. Structure and delivery of services

Joined up provision across different service sectors / interagency working

Respondents reported wanting practical support with securing their own permanent accommodation and finding a route out of homelessness. Having a safe and secure roof over their heads, they believed, would significantly improve their mental health conditions, and get them 'on the right track' towards being able to live a 'normal' life (being able to have grandchildren round, for instance). This finding supports the Housing First model of prioritising the securing of permanent accommodation as quickly as possible as the first step to addressing other needs. Rosie felt that 'getting housed' would help her to feel 'acknowledged'; and that if she was housed appropriately her mental health would start improving.

> I: If I asked you to describe to me what your ideal support package would look like, in terms of support for your emotional wellbeing?
>
> R: […] support with a property so I can have my grandkids round (Judy, aged 47)

> I think really getting housed and getting acknowledged as not being intentionally homeless, so just to have been acknowledged. I felt like I wasn't existing. (Rosie, aged 29)

Respondents expressed a preference for more holistic services that covered a range of issues and needs, or at least a more connected way of working together and of making referrals. Ray gives the example below of how mental health services might be able to work more closely with Housing Aid to explain that person's needs and help to find them appropriate support.

> It would be nice if they had the whole package, where you see somebody, we'll get somebody else onto this and help this. (Ray, aged 53)

> They [mental health services] could tell the council what is your needs rather than the council […] if it come from a professional they could break that barrier. (Ray, aged 53)

This was largely based on their experience of siloed, single-issue working, mainly across mental health and housing services, and the frustration of having to access each one separately. There was a sense among respondents that each service had little idea of respondents' needs outside of their own sphere of work and sometimes worked against each other.

Being 'listened to' and 'cared about'

Respondents expressed clear wishes to be 'listened to' by professionals who demonstrated empathy and care. Some had positive experiences of services where they felt they had been listened to and taken seriously - often for the first time - and expressed a preference for counselling if it was with the 'right person' who listened and understood (see 'the appeal of formalised peer support'). After coming out of prison, Richie at first tried to cope with his anxiety and depression on his own as he had been doing for most of his life. When he found someone who finally had the time to listen, Richie described how he was *'nearly in tears'*. This was in contrast to many of the health services Richie had previously engaged with who *'just don't give you time'*.

I basically just want someone to sit and talk to me. For six months when I came out I was going to a place called X who help you with jobs and CVs and stuff and a woman asked me 'you've just come out of jail, are you alright?' and no-one's asked me that in years, 'how am I?' […] it's been years since someone just said 'how are you?' I was nearly in tears. (Richie, aged 41)

I just want someone to sit and listen to me. (Richie, aged 41)

I: So when you were homeless what would you have liked?

R: […] actually being listened to in hospital when I was in there. (Jasmine, aged 28)

It was nice to be listened to and somebody believe what I was saying. (Jess, aged 35)

The value, for service users, of being listened to was re-emphasised by stakeholders:

The positive effect on them is astonishing, they're still complex people with multiple needs but the things that people can go on and achieve just by the simple act of actually being listened to, in many cases for the first time ever, and feeling like their opinion counts and is valued can be an incredible catalyst for achieving positive things. (Voluntary sector housing and support)

Interestingly, although respondents emphasised how they wanted someone to talk to, or to be listened to, there was also evidence of significant resistance to formal talking therapies. Many respondents indicated, or were explicit, that they did not want counselling or other forms of talking therapy. Some felt that talking about their mental health and related issues did 'more harm than good', especially if it meant having to recall and relive traumatic past experiences.

I think it's I've been there before and when you break down I think you're dragging certain things back up and it's doing more harm than good. (Ray, aged 53)

I tried it before but I just don't see that it helps so just don't do it. (Scott, aged 20)

This resistance to talking therapies was amplified where participants had to tell the same story over and over again due to a lack of continuity of health professionals in and across services (see Chapter 9).

Some participants also felt the stigma attached to talking about their mental health and were reluctant to share deeply personal and sensitive stories, and this was especially daunting in a group setting:

I just think it's my issue and I don't really need to share it; it's embarrassing. (Derek, aged 55)

I tried counselling; I just found it hard to open up about problems and that […] second time I was in there with a group of people sharing experiences and that and it just wasn't for me […] I don't like opening up about my problems when there's a load of them in the room. (Freddie, aged 24)

It was, like I said you're in a group, each one is talking a bit about each other's, but when you've got the whole class breaking down, that was it, it's terrible. (Ray, aged 53)

When asked whether she had ever received or been referred to talking therapies Michelle similarly, replied that '*I don't see the point in dwelling on it coz that was my past*' and '*I don't see the point sitting there talking about everything.*' Yet, Michelle regularly talks to and confides in a worker at the voluntary sector project for sex workers that she uses. It is, perhaps, the *formality* of talking therapies that deters respondents.

Participants who disliked talking therapies often preferred taking medication instead. Some were happy with medication alone, while others felt they were not getting enough support and wanted something additional (though different from talking therapies). Of course, medication was not always suitable for everyone either (even if it was their preferred option) and had in some cases been stopped, if that person had taken an overdose for instance. Some respondents did not like the idea of using prescribed medication and being too reliant on it:

> *I'd rather just learn to control it without drugs cos I don't want to rely on them and be panicking when I wake up and I haven't got none left, it's them kind of things I don't want. (Leona, aged 26)*

> *R: As far as I was concerned they wanted me switched off and it remains the case today and that's why I'm going through this for 20 years.*
>
> *I: Do you feel that they wanted you switched off by using medication?*
>
> *R: Yes (Ali, aged 47)*

More immediate-response 'crisis' services

Participants commonly expressed a need, and preference, for more immediate response 'crisis' services. This derived from their experiences of long waiting times to access specialist mental health services and limited accessible crisis provision. Leona suggested a 'walk-up' specialist mental health service and Freddie would like to see a more accessible mental health helpline that opens 24 hours instead of having to travel to a walk-in centre when in need of immediate support.[88]

> *Not through someone else and someone else, it should be somewhere you can just walk in and say 'I need to make an appointment, this is my issue', just go and have people there listening to your problems. (Leona, aged 26)*

> *R: […] if you've got a problem you can ring up on a direct number and actually speak to someone instead of having to travel. (Freddie, aged 24)*

> *You've got to wait months to see a counsellor so how long you have to wait to see a specialist I don't know. (Ray, aged 53)*

10.3. Staffing

The appeal of formalised peer support

One survey respondent reflected on their desire to find a professional '*that care[s] and understand[s]*'. Likewise, there was a clear preference amongst interview respondents for support from peers or trained professionals who had been through similar experiences to them, who they could relate to and feel comfortable sharing personal issues with, and who might have a deeper understanding of how they would

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[88] The Crisis Home Treatment Team in Nottingham does offer a 24 hour face-to-face and telephone support, although a couple of stakeholders did report that this team are often very stretched.

feel. This was either in the form of one-to-one counselling sessions, peer mentoring, or a peer support centre that people could drop into.

> *I kind of built up a bond with him where I can go and speak to him about my problems and that and he understood cos he were in the same sort of position a few years before he got that job. (Freddie, aged 24)*

> *It would be better if they had people who had recovered from mental health. (Denise, aged 39)*

> *I think they should get people together in similar circumstances. (Arnold, aged 36)*

> *I: So for you it would be nice to have a centre where you…*
> *R: Yeah, where people like me can talk to people like me and say 'what do you do to calm down?'" (Leona, aged 26)*

Sometimes this desire simply involved respondents feeling like they were being listened to, taken seriously and believed, and feeling like they were not being 'pushed aside' as they felt they had been by professionals in the past. For some, this entailed feeling that the health professional was going above and beyond 'just doing their job'; that they were in it because they cared:

> *If I don't feel like they really want to give me that support I'm not going to take it from them […] I want that care factor, that's what I'm looking for. (Jess, aged 35)*

> *Yeah it's all about listening really cos there's lots of people that don't listen, they just push you aside. (Leona, aged 26)*

> *I'd like someone to do something about it rather than keep talking and letting you go […] they don't think about you and they don't care about you […] I need some help and I'm not getting it. (Lisa, aged 30)*

> *It's a business to a lot of them, just a wage packet. (Ray, aged 53)*

Explaining why her experience of an alcohol support service had been favourable, Mandy says '*they give a damn, they care, and their counsellors are very good and have been through it'*.

This desire for formalised peer support was tied up with issues of trust. Respondents often expressed how they felt 'let down' by 'the system' and included health professionals in this categorisation (see Chapter 7). Ray, for instance, was reluctant to trust mental health services because of his past experiences with other authorities such as social services and the prison service. This distrust led to a sense of stoicism or self-reliance on the part of homeless participants, i.e. they tried to help themselves because they did not believe anyone else would (or could) help them. Trust often simply required spending time, over a repeated number of sessions, with the same worker:

> *From when I was a kid, social services, trust went when I came out of there; getting sent down for summat I didn't do, that's the biggest trust gone from the system […] I think that sort of thing has driven me from trusting anybody. (Ray, aged 53)*

> *My head's that messed up, I'm quite happy with what I'm doing at the moment. As bad as it is, I've just pushed everything away to one side […] I just go out in me tent away from everybody. (Ray, aged 53)*

I: But why do you feel that you should have to look after your own emotional wellbeing?

R: Nobody else is going to do it (Judy, aged 47)

Improving health professionals' knowledge of homelessness

Respondents reported wanting professionals to have a good understanding of the kinds of problems that, as homeless people, they faced and of their mental health issues. The general consensus among the majority of respondents was that health professionals were 'pushed for time', under-resourced and not always as understanding around mental health as they were with physical health. Collette described how it depended on 'luck' in terms of seeing the 'right' GP:

The GP in [X neighbourhood], she got it, she understood things very quickly and put me in the right direction. I was lucky cos you don't know who you're going to see. I think more mental health training as well with GPs - and resources cos they're pushed for time. (Collette, aged 50)

Continuity of support

A common theme to emerge from the interviews with homeless service users was the desire for continuity in their support, ideally from the same individual. Key worker models were an expressed preference: someone with whom respondents could build trust, who would get to know and understand them, who could advocate for them where necessary. This, it was felt, would help overcome many of the problems they encountered. We have already reported how frustrated respondents were at having to repeatedly 'tell their story' (to different people and different services) and the feeling that there was not only a lack of progress but a sense that their situation was regressing as a result:

I'd gone through it that many times with different people I was just tired of it […] I'd just feel exasperated constantly, I've said my story again and you still won't do anything and now you want to push me over to someone else and I've got to go through the same stuff with them again. (Jess, aged 35)

I feel like this is a circle that never ends. (Ray, aged 53)

I want someone who's going to get somewhere, not just keep going to meetings and I'll be in the same situation five years down the line. (Leona, aged 26)

Longer-term, ongoing and more intensive support

Several respondents expressed a desire - perhaps born of desperation - for a secure residential environment (or Detention under the Mental Health Act) believing this would provide the space, and contact with professionals, that would allow them to take time out to recover good health and wellbeing. Some respondents told us of the lengths they had gone to in order to attempt to access appropriate support for their mental health needs. We might interpret this as a desire for intensive support, away from the trials of everyday life, to address entrenched mental health and other problems. This was true for both Jimmy and Rosie:

I: You talked about the lack of mental health support, what do you think would have made a difference to you? What kind of help would you have really wanted?

R: To get help with me overdosing, help to go in a secure unit, the staff there who can control your tablets, give them you and you just take them, that's what I really wanted help with but they didn't want to know (Jimmy, aged 53)

I wanted Sectioning cos I thought that would be the break that I needed away from the drugs but also the break my head needed as well. (Rosie, aged 29)

Suggestions relating to the intensity of support also accounted for nearly a quarter of all responses to the open survey question, focusing on extending support rather than stopping it prematurely, or increasing time with mental health professionals rather than focusing on medicinal remedies. This latter issue was powerfully summarised by one respondent who noted *'more help is needed in therapy, as in…someone to talk to or turn to, to stop the feeling of hopelessness'.*

10.4. Conclusion

In this chapter we have reported on homeless people's expressed preferences in relation to support and treatment for mental health (and wider) needs. We can see that many of these mirror the more negative experiences that they have had trying to access mental health support and treatment reported in Chapters 8 and 9.

Barriers to meeting the mental health needs of Nottingham's homeless population

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Some of the barriers to meeting the mental health needs of homeless people in Nottingham have been implicit in the discussion in Chapters 7-9. In this chapter, we draw together information presented in the preceding chapters of this report, with additional data from stakeholder interviews, to draw conclusions about, and to make explicit, the key barriers facing homeless people, and the services working with them, in meeting mental health and associated needs.

The chapter begins with a discussion of the context in which the specific problems homeless people and local services encounter in meeting mental health (and other) needs. Publically funded services are stretched and departments have faced, and continue to face, budget cuts. It is also worth referring back to Chapter 7, where we discussed some of the distinctive characteristics of the client group. This too provides important context for understanding why certain aspects of mental health service delivery act as barriers to engagement for this client group.

11.1. Local political and service landscape

There was broad consensus across stakeholders that over the last two decades mental health, homelessness and other support services have been cut in Nottingham. The national programme of austerity has affected service provision in the City, generating the most recent examples of services being decommissioned, closed or reduced. Some respondents were able to name particular services and types of provision that no longer exist (floating support, mother and baby units) or particular homeless cohorts who they felt were now less well catered for (young people and women were mentioned). Among the changes mentioned was a reduction in the number of hospital beds for mental health patients and fewer specialist hostels.

> …in terms of quick access accommodation we're pretty much the only one for this client group, there used to be three and after 2010 when they started cutting back…(hostel)

> I've been here 16 years and I've watched so many other places close, there used to be quite a few places for women and mother and baby and now I think we're the only all female provision for young people in Nottingham and the other two I think are mixed. There are some short stay that accommodate young people as well but the number of places for young people is just getting less and less. (Supported accommodation)

The county's seen quite significant cuts to homeless prevention, so floating support, it's had 100% cut so there's no prevention work anywhere in the county, that was cut last year and they were almost going to cut the supported accommodation as well. (Homelessness outreach)

…cos of the austerity programme and various budget challenges and the general way in which mental health has been, not necessarily received the priority it deserves within health budgets, that the network of services that used to exist both in the voluntary and statutory sector that supported people to continue to remain in their accommodation has diminished and as a result of that people have fallen and their accommodation has been the last thing they've lost with that lack of support…there has been a disinvestment in the services that help people with mental health needs maintain their accommodation options… When people finally become homeless there has also been a significant disinvestment for all the same reasons in homeless programmes and the range of accommodation that used to exist doesn't exist anymore. It's been replaced with some very good services, so we have a mental health pathway in Nottingham which I'm sure you'll have learnt all about. (Local authority housing / homelessness department)

Homeless people too pointed to services they had previously accessed that no longer exist or had been scaled back. Andy, now aged 59, was diagnosed with Schizophrenia at the age of 17 and, although stable for much of the time, continues to have episodes of ill health. Most recently:

I knew the signs but I couldn't get help quick enough. Unfortunately, the mental health places I went to before to help me have all closed down…they've all closed. There was a place where you could do cookery and things like that, that was on Mansfield Road, that's closed. I enjoyed it, there was other people with the same type of illness…I got a lot more then than I have now. (Andy, aged 59)

Andy also reported that it was more difficult to secure regular appointments with a psychiatrist now, than in his earlier life (he was seeing a psychiatrist every month and now it is every three months), and Stephen, who also has schizophrenia, mentioned a support service that had helped him in the past but was no longer there. In some cases the specific services that stakeholders and service users referred to as having closed may have been re-provided or remodelled,[89] but the general picture was one of pressures on, and reductions in services due to budget cuts.

Stakeholders also highlighted the compounding effect of recent welfare changes, which has increased demand for services and brought about a concomitant rise in the homeless (including rough sleeping) population.

We're stretched and we're not able to spend as much quality time with people on the streets as we used to… last year 404 were found sleeping out, we're already well over that this year, only six months in we're up to 390.(Homeless outreach)

Stakeholders suggested that the supply of housing for homeless people generally is inadequate, and this has a number of consequences for homeless people with mental ill health. *Firstly*, stakeholders reported that those who are found to be statutory homeless and in priority need due to mental health problems are increasingly being housed by the council in hostel accommodation primarily intended for non-statutory homeless people. In turn, those not in priority need struggle to access temporary accommodation:

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[89] Full service mapping was not conducted as part of the study.

…cos of austerity the numbers of homeless people are rising, if you look at Nottingham hostels what were meant to be for some of the more complex people but who are non-statutory, they're just full of priority need people, so the people who would be there who are not priority can't get beds, can't move through so they're just stuck on the streets. (Voluntary sector housing and support agency)

Secondly, homeless people with mental health issues are being housed in unsuitable accommodation such as general needs hostels (see Chapter 5 for further discussion). *Thirdly*, people are reportedly moved-on from accommodation before they are ready. This echoes Collette's experience:

It wasn't that the staff weren't caring, they probably didn't have the understanding sometimes with mental health…coz they were telling me I was ready to move and I knew I wasn't. I've been here over a year since then. (Collette, aged 50)

And *thirdly*, stakeholders reported that people who are ready for independent living can become 'trapped' in supported housing because of a lack of move-on accommodation.

While there was broad consensus on the problems associated with the supply of housing for homeless people, there was less agreement among respondents on the availability of mental health services for homeless people and, in turn, where unmet need is the most pressing. A number of people pointed to the closure of wards in hospitals and a reduction in the number of hospital beds available as well as a range of primary care services run by the voluntary and statutory sector that are no longer available:

But mental health services have been slashed in Nottingham, there aren't beds in the hospitals any more. (Homeless outreach)

In more general terms there is the issue of we used to have a lot more homeless beds, we've got less than 300 now and we used to have 500 a few years and before we had even more, we had a huge range of provision but also a lot more beds. (Local authority housing/homelessness department)

I think a lot of the softer stuff around mental health has just been decimated. You go back years and there used to be groups for people to get involved in, links with what was Wellbeing Plus which was run by the Azra group and it was called Empowerment Plus. (Homelessness day centre)

Although there was broad recognition that services had been cut and an acknowledgment of the national political and economic drivers for this, there was also recognition of a political commitment amongst local statutory agencies to retaining services as far as possible, and innovating and developing services where they are needed. Respondents expressed a general sense of a collective political will within Nottingham City to support homeless people. It was suggested therefore that, when compared to similar cities, provision is relatively good and services are less scarce than they might be:

In terms of Nottingham city we are lucky, I think we have a local council who has, where not many others have, really tried to retain and support the services for homeless people and rough sleepers, they've funded it, there are rough sleepers outreach teams, they do put schemes in place every winter, winter shelters they're funding where they can against the backdrop of having their budgets slashed continually. So I would stick up for what the council have tried

to do, I think they're a rare breed and there are neighbouring authorities who have historically done nothing. (Voluntary sector housing and support agency)

Interestingly, many of the homeless people interviewed were so acutely aware of the pressures on services that they made efforts not to 'burden' them. For example:

Services are so starved at the moment I'd rather that appointment go to someone who genuinely might need it. (Rosie, aged 29)

'Sadie' has 23 residents on her own so I try not to ask for anything. (Ross, aged 37)

11.2. Specific barriers to meeting the mental health needs of Nottingham's homeless population

In this section we distil some of the problems encountered by homeless people and services into a series of key (overlapping) barriers. Barriers to meeting needs operate at the individual, organisational, and structural levels, although these are not mutually exclusive. It is worth noting that factors constraining *access* to services emerged as a more significant concern than effectiveness of support *per se*.

Insecure and inappropriate housing

In Chapter 5 we presented evidence about the detrimental impact of homelessness on mental health. We showed how the homelessness environment (sleeping rough, general needs hostels) was inadequate for people recovering from mental health issues and that staff in hostels often felt ill-equipped to support people with mental health issues. Stakeholders talked about how difficult it was to deliver mental health services to people who were living in environments likely to undermine, or undo any progress made.

Even if they are accessing services it might all be being undone cos of the environment they're being forced to live in. Sometimes that type of housing and support has to go hand in hand and be delivered together rather than they are being supported but then they're going back to [general needs hostel] and listening to people fighting and screaming all night and they might as well not have gone to that support session that afternoon cos by the time they wake up it's all been undone. It's no fault of those services cos they are doing the best they can. (Local authority homelessness strategy)

…if you're somebody with a personality disorder, the established therapeutic line is through our personality disorder network which is group therapy, but one of the caveats of that is you have to be fairly psychologically stable before you access it, cos you'll be talking about very difficult things, it doesn't help you do that if you're in a period of chaos and obviously if you're homeless by its very nature you're not particularly stable and it wouldn't do you any good to go and talk about it and try and unpick things and then go back to sleeping on the streets that night, that would massively increase the risk. (CPN)

Often people don't feel safe in temporary accommodation… they need a safe space to be in and if they don't have anywhere like that where they don't feel safe that's not gonna be good for their mental health. (GP)

The Mental Health Accommodation Pathway (MHAP) in Nottingham provides settled and appropriate accommodation for people with mental health issues who cannot live independently. Stakeholders were generally of the view that the MHAP worked well for those who accessed accommodation through it. However, as demonstrated

by this study, many homeless people with mental health issues do not access this accommodation, often because they do not meet the criteria/threshold or, perhaps, because they are not in contact with the secondary mental health services through which referrals are made. One stakeholder involved in the MHAP expressed the view that '*It is working well, but who falls outside?'* He explained that the accommodation provided through the MHAP was not always appropriate (for people with complex needs, or for the other residents in the accommodation, whose stability and mental health could be compromised). In relation to this client group he explained that *'we are struggling to cope with them. There is a lack of collective ability to make constructive progress with this group'.* Thus, too 'complex' or 'chaotic' for the City's supported mental health housing provision, but inappropriately housed in general needs accommodation, mental health recovery is clearly undermined. This prompted one stakeholder to suggest that:

> There seems to be a need for something in the middle, where it's not necessarily that they have needs that are severe as needing social care involvement or they might not have been sectioned… there's a lot of people that don't necessarily hit all the thresholds they need to for that support from a CPN or social worker but they're higher than your standard supported accommodation. (Local authority homelessness strategy)

Stable housing as a pre-requisite for recovery from other problems is enshrined in the principles of the Housing First approach. Popular in many (particularly northern) European countries and now being trialled in the UK, Housing First approaches do not require people to be 'stable' in other areas of their life before being offered settled housing. The recent introduction of a Housing First project in Nottingham may offer real opportunities for better meeting the needs of this client group, removing the barrier to recovery of unstable or inappropriate housing.

Thresholds

Across all stakeholders, thresholds for services were raised as a barrier to access, and this was reflected in the experiences of the homeless people interviewed (see Chapter 9). This manifested in three ways: *Firstly*, symptoms often fell just beneath the service threshold. *Secondly*, thresholds were reported to be very high (rather than patients' needs too low) and it was suggested that this reflected rationing of overstretched services. *Thirdly*, respondents' mental health needs had not been diagnosed or fully diagnosed (e.g. they may have been diagnosed with depression but felt their needs were more severe) and so they were not recognised as meeting thresholds. These points are partially reflected in the following comments:

> In terms of the threshold there are people who want services but when they get assessed, usually by a crisis team, there's a feeling that they don't meet that threshold. There's lots of people that display bizarre behaviour that would want services but they don't meet the criteria (General needs hostel)

> We have got a number of families who we are working with where we think they should be with a mental health service but they kind of don't fit anyone's criteria, so there's no assessments being done and so we're sticking with them cos we're the only service they're with. (Supported housing)

> I think as well there's quite a few people who have post-traumatic stress which is not necessarily diagnosed but needs some sort of mental health response, and whether or not someone reaches the threshold to get access to services. It seems to me there's another cohort of people which are just underneath the threshold, and it might be quite marginal between people who are receiving

services and people who are not and probably the frontline workers' experience, it can be quite marginal. (Local authority housing/homelessness department)

One question I've got in my mind is would you have to be more unwell if you were mentally unwell to trigger that sort of support than you would if you were physically unwell, if you have a physical disability you don't have to have been, it's not a very high bar to trigger some type of support. And learning disabilities, there's not always a huge amount of support but everybody with a learning disability is entitled to some social care assessment whereas in mental health it's almost like the threshold is decided based on what NHS treatment they've had in the past and once they've had that the social care services can kick in cos they've been treated by secondary mental health services, so if the threshold for those services changes and it's harder for people to get into secondary mental health services it then makes it harder. (Local authority public health)

As we have seen, services with lower thresholds (talking therapies, support groups) that respondents might have been able to access, they either did not want, or they were considered unsuitable for because of their additional support needs. There was acknowledgment that although services are available (e.g. Wellness in Mind and IAPT) they are not always suitable for, or accessible to this client group[90]:

I think sometimes it's the people who've got big problems with drug, alcohol and psychosis, personality disorder that don't get the kind of service they want…the support that they're offered is for people who have time to sit around and philosophise about their difficulties which is not an appropriate service for homeless people. They need some people who are practically going to help them to get housed, have some self-esteem, case working type stuff. (GP)

That homeless people's needs are often assessed as not meeting mental health service thresholds is partly a reflection of the way services (across all sectors) are structured, with each targeted at, and designed to support very specific needs (see point 3 below). The results from this study suggest that homeless people with mental health issues in Nottingham tend to have multiple mental health needs, and multiple other needs, such that the totality of their support needs may be extremely high, yet each taken alone is not always sufficient to render them eligible for secondary mental health services. A stakeholder made this point well:

Often people have a concomitant number of problems that just bubble under the criteria of various services so they don't get much of any service as each has its specialist area. There is a need to look at the individual holistically rather than looking at issues in isolation which in and of themselves don't meet criteria; all issues together add up to a significant problem. These are the people that services struggle with and who present as high volume service users. They end up presenting at A&E on an out of hours basis – often have personality disorder issues too so might be challenging to work with – it is the only service that they feel they can access. (NHS dual diagnosis)

'Silo' commissioning and delivery: (not) taking responsibility

Support services are usually commissioned and designed to address a specific issue, or meet the needs of a specific client group. This determines eligibility, thresholds and, sometimes, referral routes into the service. The evidence from this study suggests that most (mental health and other) support services operate tight boundaries around the support they are able to provide and the client groups they

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[90] Though Trent PTS offers talking therapies for those with complex needs and/or substance misuse

work with, such that strict service divisions are apparent. A 'core business' attitude prevails. This is understandable in the context of organisational objectives, statutory responsibilities, and (dwindling) resources. And, of course, services have responsibilities to commissioners and funders to use budgets for their explicit purpose. However, this is resulting in homeless people with mental ill health falling through the net. The complexity and multiplicity of their needs makes it difficult for agencies to determine exactly which 'need' must be addressed first and who has responsibility. A less generous interpretation would be that - in the context of stretched resources - it is easy to argue that homeless people with mental ill health are the responsibility of another service.

> *…a lot of these services are commissioned and set up to work in individual silos and so no-one is thinking complexity and when we're looking at how you engage them…what I think people need to do is realise that the chaos and cost that a lot of these people we work with cause and generate affects every frontline service so the solution is about pooling resources and budgets and combining services to meet all the needs cos it's everybody's problem. So you don't just go through one door to get your criminal justice need met and one for your substance misuse and another one for your mental health issue. (Voluntary sector housing and support agency)*

> *Only dealing with the issues a service is commissioned to do, bringing it down to the lowest common denominator in terms of what it is contractually obliged to do, is problematic. Service specifications need to address how needs can be more effectively met – difficult from a commissioning perspective to get that right. (NHS dual diagnosis)*

> *If they're using substances you often get 'we'll deal with your substances and then come back and speak to us about your mental health' and it's chicken and egg, you can't deal with one without dealing with the other. (NHS mental health service)*

Many people have multiple needs, but they are not always interconnected. They can be treated one by one by distinct specialist services. Someone with, for example, a physical health condition, who is unemployed, and has recently experienced a personal trauma such as bereavement or relationship breakdown could effectively address each of these needs in isolation with the relevant service. This is not the case for most of the homeless people with mental ill health who participated in this study, whose needs were *complex*, in the sense of being interconnected (see Chapters 5, 6 and 7).

Perhaps also partly reflecting limited understanding of the client group (see below), homeless people's needs were often interpreted as the domain - and responsibility - of another service or sector. Professionals were often seeking to identify a 'primary' need and to determine whether that properly falls within their remit. One stakeholder described the scenario that ensues:

> *When people are homeless and their mental health is assessed, a certain proportion of their difficulties are attributed to their social circumstances, which is probably a fair point, if you're homeless your mental health probably would be impacted…if mental health services are saying it's all social then they won't pick somebody up, if they don't pick somebody up then housing don't see them as high needs so they don't house them, so then we end up in this awful Catch 22 where they're just bouncing around. (CPN)*

All of the stakeholders interviewed for this study were empathetic to homeless people with mental ill health (itself, a very positive finding from the study). They also

recognised the inherent problem with the way support services are structured, when trying to meet the needs of people with multiple and complex issues. Never the less, stakeholders in housing services still tended to demand input and funding from mental health services, and vice versa, to holistically work with this client group. In other words, this client group's housing problems were (albeit accurately, within current funding structures) not generally considered to be the primary concern of mental health services, and vice versa. For example, one stakeholder, playing devil's advocate to some extent, pointed out that there is an organisation whose primary responsibility it is to meet the housing needs of vulnerable people (the LA housing department). Therefore, there should be no need for professionals discharging people from psychiatric wards to consider patients' housing needs, as long as they are signposted to Housing Aid. A strategic housing stakeholder, meanwhile, made it clear that funding should be made available from other service sectors to help meet the needs of this client group. Talking about the need for accommodation for homeless people with complex needs:

> …don't expect it to be funded from traditional homelessness funding sources. It might need a multi-agency approach, homelessness and housing budgets shouldn't have to be the ones providing the money cos there'll be lots of other people who haven't got complex needs but have a threat of homelessness. So if there isn't going to be an interim accommodation solution there should be some funding pumped into the homelessness system from health, criminal justice, all those other places where our service are expected to support. (Local authority hosing/homelessness strategy)

As we saw in Chapters 5 and 6, it can be virtually impossible to delineate homeless people's support needs. And, because they have multiple needs, their mental health issues may be masked by other needs and behaviours such as homelessness or substance abuse. As we reported in Chapter 7, homeless people do not always prioritise their mental health. When they ask for help, they may ask for assistance in meeting their daily needs, but this does not mean they have no need of mental health support.

The key question is this: if adequate housing (or reduced drug or alcohol use, or some other issue) would significantly improve someone's mental health, is that a housing problem (or an addiction, or some other problem) or is it a mental health problem? The answer, in relation to this client group, is that it is both a housing and a mental health issue but at present, homeless people with mental health are being bounced between the two (and other services).

Recognising this, stakeholders pointed to the need for more holistic services and commissioning:

> We need to move to setting up services that are geared up to meet complexity and that's done by having one front door with a skilled multi-disciplinary team who can meet all the need without passing on and that's got to be supported by political will and pooling budgets. It's difficult cos it's at a time when everyone's grabbing on to their shrinking budgets. (Voluntary sector housing and support agency)

> So the homeless health team is great but it's much wider than that, it should be all services, wherever these people turn up. That comes back to better integration and person-centred care to look at a person's needs as a whole and move away from silo commissioning. (CCG commissioning)

Inflexible service models: fitting square pegs in round holes

Evidence from this study suggests that many services do not operate in ways that are empathetic to the challenges facing homeless people, and their ability to use services in standard ways. Nor are they flexible enough to adapt their provision to accommodate the specific barriers homeless people face (as set out, for example, in Chapter 7). This was reflected in comments made by stakeholders, and in the experiences of the homeless people interviewed. Unrealistic expectations for homeless people to attend appointments, and then discharging them swiftly when they do not attend, was a very strong theme. Providing information and appointment dates by letter was another. Requiring homeless people to travel to their appointments was another. Other stakeholders pointed to requirements for sobriety that they felt were unrealistic. These points are reflected in the stakeholder quotes presented in Box 11.1.

Another aspect of inflexibility related to the **(un)responsiveness of services**: the operation of waiting lists, referral processes and such that delay someone's access to treatment. We saw in Chapter 7 how important it can be to respond in a timely way to homeless people with mental health issues: there may be a small window in which to intervene; they may not seek help until they are already in crisis; and they may move. For example:

> *I would say that we have a number of services that can deal with lower level things, anxiety, depression, they're not responsive enough for homeless people. (GP)*

> *When I call the Crisis Team no matter how severe the situation they're obviously swamped. I tend to get 'we can see them in two days at 1 o'clock' and that's often too late. (GP)*

The lack of flexibility within services is partly a product of how they are commissioned and designed, but may also relate to the knowledge and understanding staff have of the challenges of homelessness. This is an issue we turn to in point 5, below.

Box 11.1: Inflexible service models

If someone needs a mental health appointment and they've got all four of those (complex) needs and they've been sleeping rough for four years, as some of the people on our programme have, don't put them on a list and send them out an automated letter in 12 weeks' time and expect them to turn up for their appointment and when they don't, don't generate another letter that says sorry your referral's been closed. These people need a response like we go where you're prepared to go out…go out to where they are, flexibly at the drop of a hat. (Voluntary sector housing and support agency)

I think there is a lack of understanding of how bloody hard homelessness is by some services and we all have to comply with stuff, but the compliance of you have to attend appointments, if you haven't been to three then we don't see you again, not a lot of flexibility, I know there have to be rules but sometimes it's looking at circumstances and if someone's taking whatever and when people genuinely can't do something for a reason. (Homelessness day centre worker)

They might have been referred to secondary care but not turned up or bounced around or been excluded due to being homeless and not being able to access letters or go to appointments and they'd get discharged quite quickly if they didn't turn up. (NHS mental health service)

…people who don't attend just get discharged from services without any kind of assertive outreach so it's back to us, to the assertive outreach team, and waste time referring back into the system…you have one 'do not attend' and they write you a letter, which usually disappears into the ether cos they don't have an address, says we've tried to contact them, we've discharged them from our service. (GP)

I think it's about when services are designed I think the flexibility, the location, cos one of the barriers is people don't have any money to get a bus somewhere, so two quid, that may not seem much to people who design services but it can be a lot if they've got to go to an appointment at the hospital and there and back, the flexibility of how services are delivered, the personnel is so important. (Homelessness day centre)

Definitely flexibility and responding to their needs in a flexible way rather than offering set appointments and then expecting them to turn up and then discharging them if they don't, it's how can we offer them an appointment that's going to be attended rather than setting them up to fail and not having them attend…make sure they know what's going to be expected and that we aren't going to have to get them to repeat loads of what they've already told lots of people, that's a massive frustration for these people. I think certainly not to exclude them on the basis of drugs and alcohol use, that's a massive one. As long as they turn up and are able to have a reasonable conversation, we will see people who are under the influence, but they have to be able to have a meaningful conversation. (NHS mental health service)

Often appointments are missed and there's not much flexibility with re-booking appointments - it doesn't feel like there's much flexibility - so you might end up having to re-refer someone again. Part of the reason they're missed is their social situation but also their mental health in that they were anxious that day or they struggle with public transport so getting to appointments is very stressful - there's a fear of what's going to happen at appointments as well. (GP)

Professional knowledge and training

Perceptions around training needs among frontline staff varied. Respondents explained that some (non-homeless specialist services) needed training to help them understand homelessness better in order to provide more patience, compassion and empathy. Some felt that staff required more training (around mental health, in particular) as they are being asked to provide support to a group of people with high level and complex needs.

> *I do think some of it is maybe an educational role as well with services, that they do have an understanding of what homelessness is and what it means and why someone might have ended up in that situation, but that all takes time and resources to do that. (Homelessness day centre worker)*

Some felt that there are specific areas where frontline staff could be educated such as recognising high-risk warning signs and the need for mental health services to intervene and differentiating these from less serious displays of distress. By contrast, others felt that this training was required so that mental health crises are not missed:

> *What you'll find is somebody might make a very off the cuff remark about killing themselves and things like that and that can generate a bit of panic in people who'll then refer to secondary mental health services and mental health services will assess that person as not being acutely suicidal, that often gets people's backs up cos they don't understand the rationale for how services have arrived at that decision and I guess a bit of understanding about assessing people's distress and people's risk… I think sometimes people's expectations about how mental health can be treated can be a bit unrealistic. (CPN)*

Limited services able to work with people with complex needs

There are few services with a remit (wholly or partially) to support people with mental health issues that are explicitly set up to work with people with complex needs.

> *I think Nottingham's quite well kitted out really compared to other cities of a similar size, I think Nottingham is swamped with services, I'm not sure why that is, I'm not sure if there are specific social problems here that don't exist in other towns, I can't see that personally. But I think services are good, but especially around complex needs and mental health there seems to be a real lack of capacity. (General needs hostel)*

If generic services were accessible and could comprehensively meet needs then this would not represent a barrier to meeting the needs of homeless people with mental health issues. But the evidence points to the contrary. In particular there appears to be a gap in relation to dual diagnosis:

> *In terms of multiple complex needs, people go to an individual service, whether that's mental health or substance misuse but that service is only geared to meet that one specific need, they can't meet all the other things that come through the door with them, so very often they get turned away. And dual diagnosis is the obvious one that people mention. (Voluntary sector housing and support agency)*

Opportunity Nottingham - a Big Lottery funded service that forms part of the national 'Fulfilling Lives' programme - is a voluntary sector project that works with local partners to deliver support specifically to people with complex needs and was mentioned as good practice by other stakeholders. Beyond this, few services supporting people with mental health were reported to target this client group.

Inadequate linkages and pathways through support and treatment

We saw in Chapter 8 that, despite relatively positive accounts of the support respondents received and the professionals they encountered, their treatment and support was rarely consistent or comprehensive. This suggests that links, pathways and referral routes between services are currently inadequate for this client group. One stakeholder made the point that the neat way in which services and treatment pathways are depicted in organisational diagrams is inconsistent with homeless people's lives:

> When commissioners tend to create [service maps] they always draw perfectly rectangular boxes with neat arrows and when you're dealing with our client group they don't operate in a neat box in our world, they go all over the place. (Voluntary sector housing and support agency)

Respondents often seem to have simply got 'lost' in the system - for example because they moved, or they failed to attend an appointment, or were rejected from one service but not referred to another. The challenges they face managing daily life can make them less proactive than other people may be, in following up, chasing, asking for help, or providing new (e.g. contact) information. Information sharing - in terms of protocols but also the basics of technological capability - was raised by some as a problem in this regard because it prevents 'tracking' of patients, referrals, engagement and such like. As one stakeholder explained:

> GPs make referrals into secondary services then IT systems don't talk to each other so GPs can't see what is happening to a referral and feedback to them from secondary care is not good. So people are not sure what's happening e.g. with a mental health assessment. Something as simple as systems talking to each other would make it easier to keep people informed. That's the main frustration is people not knowing what's happening next, information not being made clear to people. (Mental health support service)

> One of the difficulties I've got is I don't have access to mental health records which are separate to GP records, it's a real problem, it means I can't see a wealth of information about clients... I'm being asked to make assessments about somebody and you need context for an assessment and the only context I've got is what that person tells me there and then. (CPN)

The short-term nature of much support is also relevant in this context:

> I think another barrier is some services are a lot shorter term now, so you will be fixed in this amount of time, and with the client group, for some or a majority, they've had a terrible life and it's all got to be sorted in six weeks and it's going to be lovely, well things might be improved but it's not going to be sorted. (Homelessness day centre)

> The majority of patients have had their mental health problems from a very young age and it's not going to be solved in a few weeks. (GP)

The needs of homeless people with mental health issues are unlikely to be met in a short time. But without key worker support, or support coordinators, they are also more likely to fall between the cracks of service provision when they are discharged from a service.

11.3. Conclusion

In this chapter, we have drawn together the research findings presented in the preceding chapters, supplementing these with additional data, mainly from the stakeholder interviews, to draw conclusions about the key barriers to meeting the mental health needs of homeless people in Nottingham. In the next chapter we present some national good practice examples that may provide ideas about ways in which some of these key barriers could be addressed.

Learning from good practice 12

This chapter presents relevant approaches and initiatives identified through a review of good practice in meeting the mental health needs of homeless people, that could help address some of the challenges highlighted in Chapter 11 and throughout this report. It is hoped that lessons, practice and innovation elsewhere can help Nottingham City CCG and partners improve and develop services to better meet the mental health needs of homeless people in the City.

Throughout the report we have seen the many difficulties and challenges encountered by homeless people and professionals in meeting the mental health and associated needs of homeless people with mental ill health. The previous chapter drew conclusions about the *key* barriers to meeting needs. We can, perhaps, distil these further into issues of:

- *Accessibility*: many of the key barriers identified in this study related to *accessing* services, rather than problematic experiences with service provision or professionals.

- *Continuity of care*, including intensity and length of support.

- *Limited services working with people with complex needs*: this is a 'complex needs' population group, and service developments designed to better meet their needs will have to be informed by this fact.

The examples presented in this chapter, identified through the good practice review, focus on addressing these key problems. The chapter begins with an overview of the broad approaches, principles and types of interventions that emerged as important and effective in meeting the needs of homeless people with mental health issues. This provides important learning for Nottingham City CCG and partner agencies. Section 12.2 then provides further details about some of the specific good practice examples referenced in Section 12.1.

12.1. What works? An overview

The Big Lottery funded 'Fulfilling Lives' programme, and the individual projects funded within that programme (of which Opportunity Nottingham is one) provide excellent examples of good practice in working with people with complex needs. Many of the other 'good practice' initiatives, principles and approaches that emerged through the good practice review as potentially addressing the barriers identified in Nottingham City, are enshrined in this programme.

Projects/models found to work effectively with people with complex needs tend to focus on the following:

- Improving access, including:
  - interagency working
  - innovative referrals, e.g. without the need for GP referral, anonymous referrals
  - 'out of hours' or extended provision
  - direct access
  - co-location
  - empathetic and non-judgemental approach
  - outreach and inreach

- Interagency working (assessment, referral, ongoing support), including:
  - common assessments
  - co-location
  - information sharing
  - partnership networks and agreements

- Key working principles, including:
  - service navigators, or case co-coordinators
  - long-term support
  - follow-on or aftercare support, or onward referral
  - intensive support.

There are a number of types of initiatives that were common amongst those identified as potentially representing good practice, in the context of the specific issues that emerged in this study.

- **Common single assessments:** for example using the principle of COUNT (collect once, use numerous times). This is an agreed common assessment of need. Data is collected from the beneficiary once and shared with other service providers removing the need for multiple assessments and ensuring that service users do not have to tell their story to different agencies numerous times. In some cases, this may provide a **'passport'** to a range of services without further assessments (see *Golden Key Project, Bristol Fulfilling Lives; The Intelligent Common Assessment Tool (iCAT) used by Birmingham Changing Futures Together*).

- **Direct access services:** for example, the first point of access to *Leeds No Fixed Abode Health Centre* is through a daily drop-in mental health clinic that any person, once registered at the practice, can access whenever they wish to. The team also **works closely with outreach agencies**, to facilitate a way into appropriate interventions for those people experiencing difficulty in accessing the service.

- **Peer support:** attention is drawn to peers' ability to draw upon personal experiences and, as such, develop a shared understanding, decrease stigmatization, develop trust and empathy, provide role modelling, provide key support for navigating through complex and fragmented systems, and increase engagement with healthcare services. Such services are found to reduce use of A&E departments and days spent as inpatient, and reduce substance use among persons with co-occurring substance use disorders (see for example, *Groundswell Homeless Health Peer Advocacy; Blackpool Fulfilling Lives; Adults facing Chronic Exclusion Programme*).

- **Having dedicated mental health workers within homelessness services:** working within the homelessness sector, dedicated mental health workers have a good understanding of the client group and so are able to deliver an

empathetic, non-judgemental service, understanding the barriers homeless people can face. Clear goals and a well-defined role within the organisation or team are reportedly important. One example is the *Mental Health Coordinators at Crisis Skylight*.

- **Intensive support and key working:** The sustained involvement with service users that come with these approaches are found to be effective in a number of service areas including family intervention projects and homelessness. They are flexible, often delivered to the client in their own environment as well as within a service, and aim to provide help over as long a period as is necessary. The key is engagement. The *Leicester Homeless Mental Health Service* has adopted some of these principles. They say that, *"our goal, when working with people with a history of complex trauma, is as simple and as complex as just staying in touch with them. Many are trapped in a cycle of abusive, transient relationships, aggression or substance misuse which may lead them to be excluded from hostels and back onto the streets. We try to make our service as accessible as possible by meeting people wherever it suits them".*

- **Promoting partnership working:** meeting the mental health needs of homeless people requires services to work together which may not have established close links. *The Homeless Patient Advisor at the Cornwall Homeless Hospital Discharge Project,* for example, is in a unique position to bridge the gap between services that want to work together but find it challenging to do so. Key members of operational staff and decision-makers, in hospitals, mental health facilities and partner agencies, are encouraged and supported to adopt the protocol so that agreed care pathways for discharged patients are consistently followed. *The Fulfilling Lives programme* offers many examples of good practice in partnership working.

- **Co-creation, design and delivery of services:** involving and engaging the service user from the point of creation and design of a service through to its delivery is held up as good practice in a number of the initiatives outlined below. The *Newcastle and Gateshead Fulfilling Lives programme*, for instance, gives service users the opportunity to co-design the way the programme is delivered and allows them to train as Peer Navigators in order to continue their involvement in the programme (see also *Bristol Golden Key project; Blackpool Fulfilling Lives; Islington and Camden Fulfilling Lives; Mayday Trust's Personal Transitions Service; Voices*).

- **Strengths-based models:** The *Mayday Trust* uses a strengths (or assets)-based model for people experiencing homelessness and going through difficult life transitions. The approach is an attempt to restructure the way services are traditionally delivered to people and a shift towards placing more power and control into the hands of those who receive it. The focus is on facilitating people to see their own strengths so that their journey out of homelessness starts with evidence of current strengths and successes rather than past failures (see also *Newcastle and Gateshead Fulfilling Lives; Shelter's Inspiring Change*).

12.2. Specific good practice examples

THE JAIL INREACH PROJECT (International - USA)[91]

The Jail Inreach Project **bridges gaps between services provided in the jail with services provided in the community.** The most effective strategies seem to be those that introduce personal connections and reduce the distinction between inpatient and outpatient services. Linkage is better served when the step to what has traditionally been called aftercare is treated more as a transition than as a change. Practices that include contact with the ongoing care agency before discharge have proven to be beneficial. However, the program is restricted by the limited capacity of community resources to provide services after a detainee is released.

Issues addressed: continuity of care, access to community based support/treatment.

THE START TEAM (UK, London)[92]

The START team, within the South London and Maudsley NHS Trust, provide **assertive outreach** to homeless adults who have a severe and enduring mental illness and are unwilling or unable to engage with mainstream services. They accept referrals directly from homeless charities, as well as from individuals. In so doing, they bypass the need for clients to be engaged with healthcare professionals in order to secure a referral. START works in close partnership with local charities to identify homeless people who have severe mental health problems. The team includes two psychiatrists, three psychologists, six care coordinators and a psychotherapist from the St Mungo's LifeWorks project (see below). They work in the streets, hostels and day centres to assess the mental health needs of homeless people before making a decision whether to refer to the inpatient or to outpatient care, or to provide care directly through the team.

Issues addressed: continuity of care, access to treatment.

ST MUNGO'S LIFEWORKS PROJECT (London)[93]

The St Mungo's LifeWorks Project, established in 2008, offers homeless people access to fully-qualified psychotherapists **regardless of diagnosis or active substance use**. It provides individual psychodynamic psychotherapy to chronically excluded adults who are homeless or at risk of homelessness, including rough sleepers. Treatment takes place in a range of locations, including St Mungo's sites and GP surgeries. In evaluating the service, St Mungo's found 75 per cent of clients showed an improvement in their mental wellbeing according to the SLaM Mental Wellbeing Impact Assessment Measure and that the costs of the LifeWorks service appeared to be offset by clients' reduced use of other healthcare services, such as emergency and crisis services, within one year.

Issues addressed: continuity of care, integrated services, access to treatment.

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[91] Buck, D.S., Brown, C.A., and Hickey, S. (2011) The Jail Inreach Project: Linking Homeless Inmates Who Have Mental Illness With Community Health Services. *Psychiatric Services*, 62 (2), pp. 120-122.
[92] http://www.slam.nhs.uk/our-services/service-finder-details?CODE=SU0552
[93] Homelessness, mental health and wellbeing guide - Homeless Link www.homeless.org.uk/sites/default/files/site-attachments/Mental_Health_Guide.pdf

CITY AMBITION NETWORK (UK, Glasgow)[94]

The City Ambition Network (CAN), formed in 2015, is a partnership of the Simon Community, Glasgow City Mission, The Marie Trust, Turning Point Scotland and Glasgow Health and Social Care Partnership (Glasgow City Council and NHS Greater Glasgow and Clyde) and is focused on some of the city's most vulnerable and excluded homeless people. These are people who have, for many years, circulated between prison, hospital, rough sleeping and emergency or temporary accommodation. Staff and services were spending significant time and resources in crisis management of this group. The network initially worked with 12 of the most chaotic and vulnerable people (of 70 potentially suitable clients) but hope to expand with further funding. CAN explain their approach as follows:

*'The approach was simple: we'd stick with people no matter what, we'd work as a team – from different organisations – to support each other and find solutions, we'd build and use networks to connect people with the resources they needed and we'd provide enough staff to have the right intensity of response that each individual person needed. The **inter-agency** operational team are given support and authority from our organisations to find solutions, push the boundaries and do things that work for people.'*

Issues addressed: continuity of care, and integrated services.

BRISTOL GOLDEN KEY PROJECT: BIG LOTTERY FUND FULFILLING LIVES PROGRAMME (Bristol)[95]

Golden Key provides access to services for individuals with multiple needs by 'unlocking lasting change' through the communication of agencies working together and the **input of individuals with lived experience into the design and delivery of services.** As part of this approach the following elements are central to the project's delivery, and are potentially relevant to addressing the key barriers to meeting need identified in Nottingham:

- A lead co-ordinator team.
- Peer mentors.
- Golden Key Agencies (any agency working with the target client group who sign up to the project's approach).
- 'Anonymous' referrals (i.e. referrals with no history attached so people are not excluded from services based on past behaviours).
- 'Telling Story Once' website – a website utilising a variety of media options to record client stories. These stories will be controlled by the clients who can share them with their support providers with a view to reducing the need for numerous assessments.
- Psychologically Informed Environments.
- Multi-disciplinary team.
- A common single assessment using the principle of COUNT: collect once, use numerous times.

Issues addressed: access to treatment, peer support, integrated service, co-creation/delivery, strengths-based model.

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[94] https://www.glasgowcitymission.com/about-us/what-we-do/city-ambition-network.php
[95] Moreton, R. et al. (2016) *Fulfilling Lives: Supporting people with multiple needs. Annual Report of the National Evaluation 2016.* Leicester: Big Lottery Fund.

BIRMINGHAM CHANGING FUTURES TOGETHER: BIG LOTTERY FUNDED FULFILLING LIVES PROGRAMME (Birmingham)[96]

The 'Changing Futures Together' model comprises a team of lead workers who work intensively with a case load of between six to eight clients, as well as linking into the other programme work streams. The Changing Futures Together Project comprises the following initiatives of potential relevance to meeting the needs of homeless people with mental health issues in Nottingham:

- The 'No Wrong Door Network' is a group of networked agencies committed to information-sharing and common approaches and standards in supporting people with complex needs. Psychologically Informed Environment (PIE) Training is offered to the No Wrong Door Network members to add to the quality of their work.

- Intelligent Common Assessment Tool (iCAT), a shared tool that supports more effective **inter-agency collaboration** and enables a 'whole person' response.

- Lead Workers and Peer Mentors: a group of skilled, empathetic frontline staff who take responsibility for formulating each client's care plan and co-ordinating, reviewing and overseeing a multi-agency care and support package. Lead workers are supported by paid Peer Mentors.

Issues addressed: peer support, integrated services, access to treatment.

GROUNDSWELL'S HOMELESS HEALTH PEER ADVOCACY (HHPA) PROGRAMME (London) [97]

Groundswell's Homeless Health Peer Advocacy (HHPA) programme, established in 2010, seeks to empower people experiencing homelessness to overcome the barriers to accessing care through the provision of intensively trained **Peer Advocates**, all of whom have previous or continuing experience of homelessness themselves. The aims of the HHPA programme are threefold, to:

- Provide one-to-one support, through volunteer Peer Advocates, for homeless people to make and attend health appointments.

- Support people experiencing homelessness to overcome the practical, personal and systemic barriers which prevent them from accessing healthcare.

- Increase the confidence and skills of people experiencing homelessness to independently access healthcare services.

Issues addressed: peer support, access to treatment.

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96 http://mcnevaluation.co.uk/about/the-project/birmingham/
97 Finlayson, S., Boelman, V., Young, R. and Kwan, A. (no date) *Saving lives, saving money: how homeless health peer advocacy reduces health inequalities.* London: The Young Foundation.

LEICESTER HOMELESS MENTAL HEALTH SERVICE'S 'ONE STOP SHOP' (Leicester)[98]

The Leicester Homeless Mental Health Service (HMHS) provides assessment, treatment and support to homeless adults over the age of 16 with mental health difficulties across the city of Leicester. The 'One Stop Shop' project has seen the team develop from a 'single post service', where the logistics of providing a dispersed service were very challenging, to their current **'one stop shop' concept.** The development of the 'one-stop shop' concept has facilitated **communication with other agencies** which has knock-on effects for the homeless clients. By being **accessible and approachable in places where homeless people present**, they have been able to build trust and mutual respect. The challenges of supporting homeless people have altered in accordance with the developments in changing legislation and the logistics of accessing dispersed services. In-fitting with homeless people's lifestyles, which they recognised as being chaotic, Leicester Homeless Mental Health Service adapted their clinical practices to help improve homeless people's access to mental health services.

Issues addressed: access to treatment, integrated services.

DAILY DROP-IN MENTAL HEALTH CLINIC AT LEEDS NO FIXED ABODE HEALTH CENTRE (Leeds)[99]

This initiative provides multidisciplinary primary healthcare to people of no fixed abode in Leeds, offering 'mental health first-aid', group work, psychological counselling, case management and care coordination, and support in accessing 'mainstream' services. The intention is to provide interventions that are timely, accessible, recovery-focused and relevant to the person's current experience and immediate circumstances. Points of good practice relate to the service's first point of access which is through a daily drop-in mental health clinic that any person, once registered at the practice, can **access whenever they need to**. The team also works closely with outreach agencies to facilitate a way into appropriate interventions for those people experiencing difficulty in accessing the service.

Issues addressed: access to treatment, integrated services.

FOCUS HOMELESS OUTREACH AND STREET POPULATION (Camden and Islington, London)[100]

Focus Homeless Outreach and Street Population offer an 'assertive' outreach service to street homeless people and homeless people in hostels. The service works specifically with homeless people with mental health problems aged 18 years and over. The team advocate on the client's behalf and offer support around social and practical issues (a holistic care service). The team also assist with clients' progression to resettlement and more permanent accommodation, linking people to services appropriate to need. They also work with hostel staff to offer advice and support on working with mentally ill people and help them to formulate treatment and crisis plans.

Issues addressed: continuity of care, access to treatment.

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[98] DCLG and National Mental Health Development Unit (2010) *Meeting the psychological and emotional needs of homeless people.* London: DCLG.
[99] *ibid.*
[100] http://www.candi.nhs.uk/services/focus-homeless-outreach-team

CORNWALL HOMELESS HOSPITAL DISCHARGE PROJECT (Cornwall)[101]

Established in 2013, the Cornwall Homeless Hospital Discharge Project is run in partnership by Inclusion Cornwall, St Petrocs, Shelter, Cornwall Council, Cornwall Housing, NHS, Health for Homeless, and Coastline Housing. It is available to patients over the age of 16 who have settled accommodation prior to admission but are unable to return to it for medical reasons, as well as patients who were homeless or living in temporary accommodation prior to admission. The project has two aims which might be of relevance to Nottingham City CCG:

- To develop and implement a county-wide **multi-agency protocol**, to ensure that no patient is discharged from hospital onto the streets or back to accommodation without their underlying housing and health problems being addressed.

- To provide appropriate facilities for those requiring ongoing medical support after hospital discharge to allow time for recovery. All too often, the homeless end up in a hostel that is not an appropriate environment for their recovery or treatment plans.

Partnership working is a critical element of this project. Key members of operational staff and decision-makers, in hospitals, mental health facilities and partner agencies, are encouraged and supported to adopt the protocol so that the agreed care pathways for discharged patients are consistently followed. The designated 'Homeless Patient Advisor' role helps to bridge a gap between services that want to work together but find it a challenge to do so. They bring an understanding of the restrictions of each provider and knowledge of the appropriate level of involvement from stakeholders to improve multi agency working.

Issues addressed: integrated services, multiagency working, continuity of care

TOWER HAMLETS AND THE CITY – HHELP (London)[102]

Working with homeless people who have a severe or enduring mental illness, HHELP are a multidisciplinary outreach team comprised of CPNs, social workers, psychologists, and psychiatrists. The process is about involving users in a care plan that is owned by the user and the service provider and is regularly reviewed. HHELP are encouraging its use in hostels as an effective way of involving users and sustaining a stay in a hostel and a planned resettlement.

HHELP are increasing their links with primary care through Health E1. The consultant psychiatrist gives consultant time to the GPs and nurses to discuss particular cases to enable them to better address the clients' mental health needs. They are also looking at operating a triage system where the nurses and GPs will pass people on to HHELP if they show signs of an enduring and severe mental illness.

The team has a Somali worker with a specific role to work with the Somali population. Hidden homelessness is a big issue in the Somali population and they found they needed to have somebody familiar with the culture and acceptable in the local mosque to access this population. There are many people ostracised from the community who are sleeping in cars or sleeping out and who may be using Khat houses, who the worker has made contact with.

Issues addressed: integrated services, peer support, multiagency working

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[101] Shelter (2016). Cornwall Homeless Patient Hospital Discharge Service. Evaluation Report. Shelter: London.
[102] Gorton, S. (2003). Guide to models of delivering health services to homeless people. London, Crisis.

ADULTS FACING CHRONIC EXCLUSION PROGRAMME (across England and Wales)[103]

This programme engages with adults who lived chaotic or isolated lives and were hard to reach (either they were reluctant or unable to engage with local services, or local services were unable or unwilling to engage with them). The programme contains 12 pilots that differed in terms of the characteristics of their clients, the intervention, the cost of the service and their outcomes. Despite these differences, the pilots were all tasked to help clients access local services and benefits (system navigation), support clients with transition points in their lives, and change the way in which local agencies responded to the needs of the clients (system change). In most cases, service provision centred on the offer of support from a consistent, trusted adult, who built a trusted relationship with a client. The pilot workers often worked as consistent, trusted adults. They worked effectively with the most chaotic and isolated adults to help them navigate the local services and move between transition points in their lives.

The pilots were effective in bringing about better outcomes for the individuals, particularly in terms of health. The evaluation found that the pilots were successful in getting clients to use health services more appropriately, with less use of the emergency services and increasing access to outpatient appointments.

Issues addressed: peer support, access to treatment, continuity of care.

CRISIS SKYLIGHT'S MENTAL HEALTH COORDINATOR SERVICE MODEL (Birmingham, London, Newcastle and Oxford)[104]

Crisis wished to provide specific support for those homeless people who wanted to use Skylight services but who might have specific support needs due to poor mental health. Mental health coordinators, funded by the Department of Health, were placed in four Crisis Skylight services to **enhance service provision**. The mental health coordinators have enhanced access to health and social services, improved access to counselling and **assisted the social integration of single homeless people with mental health problems**. Service users reported that the coordinators and the wider Skylight services created tolerant, understanding services in which they did not feel stigmatised by their mental health problems or their experiences of homelessness. There was evidence that the coordinators could directly enhance the well-being of homeless people with mental health problems and also **improve their access to counselling and NHS services**. The coordinators also facilitated and supported access to the wide range of meaningful activity, education, training and work related programmes offered by the wider Skylight teams of which they were a part.

Issues addressed: peer support, access to treatment, continuity of care.

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[103] Cattell, J., Mackie, A., Gibson, K., Hitchins, T., Parry, W., Porsch, L. and Savage, J. (2011) *Simple but effective: Local solutions for adults facing multiple deprivation.* London: CLG.
[104] Pleace, N. and Bretherton, J. (2013) *A review of Crisis Skylight's Mental Health Services.* London: Crisis.

BLACKPOOL FULFILLING LIVES: BIG LOTTERY FUNDED FULFILLING LIVES PROGRAMME (Blackpool)[105]

Blackpool Fulfilling Lives (BFL) is a seven-year programme funded by the Big Lottery, targeted at people living very chaotic lifestyles who do not currently engage with services.

People with lived experience are closely involved in delivering the programme through a number of roles, including: paid navigators, service user volunteers, and peer mentors. Their team of 'Navigators' provide intensive support to people to access and navigate through the services they need in Blackpool. They work with service users on a long-term basis to help them live more 'fulfilling lives'.

The service is provided from 10am-11pm, 7 days a week, 365 days a year, based on the indication that individuals with mental health needs are most vulnerable during unsocial hours and when other local services are out of operation.

Issues addressed: peer support, continuity of care, access to treatment, co-creation/delivery.

SHELTER'S INSPIRING CHANGE: BIG LOTTERY FUNDED FULFILLING LIVES PROGRAMME (Manchester)[106]

The Inspiring Change project is designed to meet the diverse requirements of people in Manchester living with a variety of complex needs (including a history of problem drug and alcohol use, mental health or emotional well-being issues, accommodation problems and offending). The project is commissioned and delivered by Shelter, with specialist support from Community Led Initiatives, Back on Track and Self Help Services.

The project aims to trial **new ways of coordinating services**, through the following:

- **An Engagement Team:** A partnership between a substance misuse specialist, probation and a homelessness street outreach provider including volunteer peer mentors. The Engagement Team is the entry point into the programme; it **focusses on people's assets and potential**. It helps them navigate their way to support and focuses on long term and sustainable positive change.

- **A Mental Health Pathway:** Providing support around emotional wellbeing, and promoting resilience and self-esteem via talking therapies and psychological support. Supports service users, staff and volunteers by creating and maintaining a Psychologically Informed Environment (PIE).

- **A Community HUB:** A place where people involved in the programme can meet and work together incorporating a PIE. It has been **produced in partnership with people who have experienced support services**.

- **Programme Team:** Hosts the Inspiring Change Core Group, the body made up of **people with lived experience of multiple needs that helped design the programme**, commission its service providers, recruit staff, steer delivery and evaluate its success. The programme team also promotes systems change in the city based on learning from the Fulfilling Lives programme.

Issues addressed: peer support, access to treatment, co-creation/delivery, strengths-based model.

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[105] https://www.addaction.org.uk/services/blackpool-fulfilling-lives
[106] https://inspiringchangemanchester.shelter.org.uk/

NEWCASTLE AND GATESHEAD FULFILLING LIVES: BIG LOTTERY FUNDED FULFILLING LIVES PROGRAMME (Newcastle and Gateshead)[107]

The project focuses on people who often 'spiral around the system', are excluded from the support they need, and experience a combination of homelessness, reoffending, problematic substance use, and mental ill health. The aim of the project is **to improve and better coordinate services** to support people across Newcastle and Gateshead living with multiple and complex needs, and **'to see people for the potential they have, rather than for their problems'**. Their Experts By Experience (EBE) Network gives service users an opportunity to **co-design** the way the programme is delivered and allows service users to train as peer navigators. Peer navigators help to tackle the individual needs of beneficiaries by providing them with constant companionship to support them in finding their way through the services available and to gain confidence in doing so.

Issues addressed: peer support, access to treatment, co-creation/delivery, strengths-based model

VOICES (Stoke-on-Trent)[108]

Voices work with people whose lives have been affected by events and conditions over a prolonged period. They may present frequently at emergency health care facilities, drug and alcohol services, homelessness or mental health services. Alternatively, they might have been excluded from specific services in the past.

The primary approach of Voices is 'Golden Ticket'. This provides an individual with complex needs **guaranteed access to a range of services**, a personal budget, **a peer mentor** and a **service coordinator**. The funding and flexibility associated with the ticket allows an individual to be in control of their recovery journey with assistance from their service coordinator. Partner agencies sign up to the 'Golden Ticket' and adopt its standards. These include but are not limited to:

- Accepting that the ticket provides access to their service without further checking or filtering.

- Not barring, evicting or excluding a Golden Ticket holder (unless there is an immediate danger and then always with a right of appeal and peer advocacy) from accessing and using their service.

- Recognising the value of Expert Citizens as valid and valuable advocates.

- Actively recruiting and monitoring staff with relevant lived experience.

In order to deliver this scheme, the project is staffed by a team that is directly recruited rather than via secondments. The **design and leadership of the project is co-produced with expert citizens** who have 'lived experience' of multiple needs.

Issues addressed: peer support, access to treatment, co-creation/delivery

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[107] http://www.changing-lives.org.uk/about-us/fulfilling-lives-newcastle-gateshead/
[108] http://www.voicesofstoke.org.uk/

WAVES OF HOPE: BIG LOTTERY FUNDED FULFILLING LIVES PROGRAMME (Liverpool)[109]

Liverpool Waves of Hope primarily aims to influence systems change to ensure there are appropriate services in place to support adults with complex needs. There are four main aspects to the programme delivered through a partnership of local experienced providers; intensive support; an accommodation based support service, peer mentoring and 'Waves New Beginning', which provides 'meaningful activities' for service users. Waves of Hope place client engagement at the heart of their service model, with the understanding that **co-creation is fundamental to improving outcomes**.

Issues addressed: peer support, co-creation/delivery.

MAYDAY TRUST'S PERSONAL TRANSITIONS SERVICE (Oxford)[110]

Mayday Trust has been using the Personal Transitions Service since 2012. It is the first **strengths-based model** for people experiencing homelessness and going through difficult life transitions. The approach is an attempt to restructure the way services are traditionally delivered to people and a shift towards placing more power and control into the hands of those who receive it. The Mayday Trust describes it as being 'about building strengths, aspirations, relationships and purpose rather than focussing on needs and problems'. Each Asset Coach (delivery worker) is able to work with up to 35-40 people at any one time due to the facilitative and community-based nature of the approach making this a much more cost effective way of working. The model has four core concepts:

- Personalisation: Giving control to people, and delivering on what they want to change. Standardised and time-limited interventions are not used.

- Asset-based: Using the concept of 'Developmental Assets' to facilitate people to see their own strengths so that their journey out of homelessness starts with evidence of current strengths and successes rather than past failures.

- Advantaged thinking: Having positive conversations about 'thriving and not just surviving' and offering hope and inspiration, rather than 'fixing' weaknesses.

- Relationships and purpose: Focusing on building positive networks in the community and spending time with people who offer support through difficult times; and having a sense of purpose to help people continue trying to achieve things that matter to them.

Issues addressed: co-creation/delivery, strengths-based model.

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[109] https://liverpoolwavesofhope.org.uk/
[110] https://www.maydaytrust.org.uk/the-personal-transitions-service

ISLINGTON AND CAMDEN FULFILLING LIVES: BIG LOTTERY FUNDED FULFILLING LIVES PROGRAMME (London)[111]

This programme supports people with multiple and complex needs with issues around drug and alcohol use, homelessness, offending and mental ill health. The project aims to achieve three main outcomes:

- People with multiple and complex needs are able to manage their lives better through access to more **person-centred and co-ordinated services**.

- Services are better tailored and connected to empower users to fully take part in effective service design and delivery.

- Shared learning and improved measurement of outcomes will demonstrate the impact of service models to key stakeholders.

The project focuses on making maximum use of the existing resources in the area, believing that the issue faced by people presenting complex needs is one of access rather than a large scale lack of resources. The team of specialist link workers, alongside a team of **peer mentors** who have lived experience of related issues, provide flexible, creative, intensive support to enable each client to lead on and better navigate the pathway to their recovery.

Issues addressed: co-creation/delivery, peer support, access to treatment

12.3. Conclusion

This chapter presented the results of a review of good practice in meeting the needs of homeless people with mental ill health, or with potential relevance to this client group. We have seen that a number of key principles tend to underpin good practice initiatives. This includes improving accessibility, offering sustained involvement with service users, helping people navigate services, simplifying systems - for example using single assessment or 'golden key' principles - partnership working, and peer support. We take these principles and the full findings from the study into the final chapter of this report, which concludes with a series of recommendations.

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[111] https://fulfillinglives.shp.org.uk/

Conclusions and recommendations

The results from this study confirm the need to consider homeless people as a specific group in the development of mental health commissioning strategy and in service delivery across sectors. The research findings show clearly that in Nottingham City - as elsewhere in the country - homeless people are very likely to have mental health issues, including a disproportionate prevalence of serious mental health conditions such as psychosis and high rates of detention under the Mental Health Act. Homeless people are, therefore, very much the concern of the CCG and NHS services.

But homeless people with mental ill health are also the concern of other agencies. A key conclusion from this study is that 'homeless people with mental ill health' are a population that could accurately be described as having multiple and complex (very complex, perhaps) needs: *multiple* in the sense that they tend to present with many support needs and domains of exclusion (poverty, disrupted childhoods, experience of violence, learning difficulties, history of care and custody, dual diagnosis); *complex* in the sense that these needs are intrinsically linked, such that they cannot be resolved in isolation.

There are some encouraging results from the study. There does not, for example, appear to be a significant cohort of homeless people with mental health issues in the City who are completely unknown to health services, and most of those self-reporting mental ill health have had mental health issues identified by a medical professional. This offers important opportunities for engagement, at least. There have also been some positive developments locally, such as the relatively newly commissioned Primary Care Mental Health Team, the addition of the CPN to the Homeless Health Team, and Opportunity Nottingham's successful bid to the Big Lottery's Fulfilling Lives programme for a seven year project for people with complex needs that started in 2015 (a partnership, with Framework the lead delivery partner). As the study was drawing to a close, local partners were scoping out the potential for a Housing First approach in the City, as part of a homelessness prevention agenda that has received renewed vigour following the new Homelessness Reduction Act 2017.
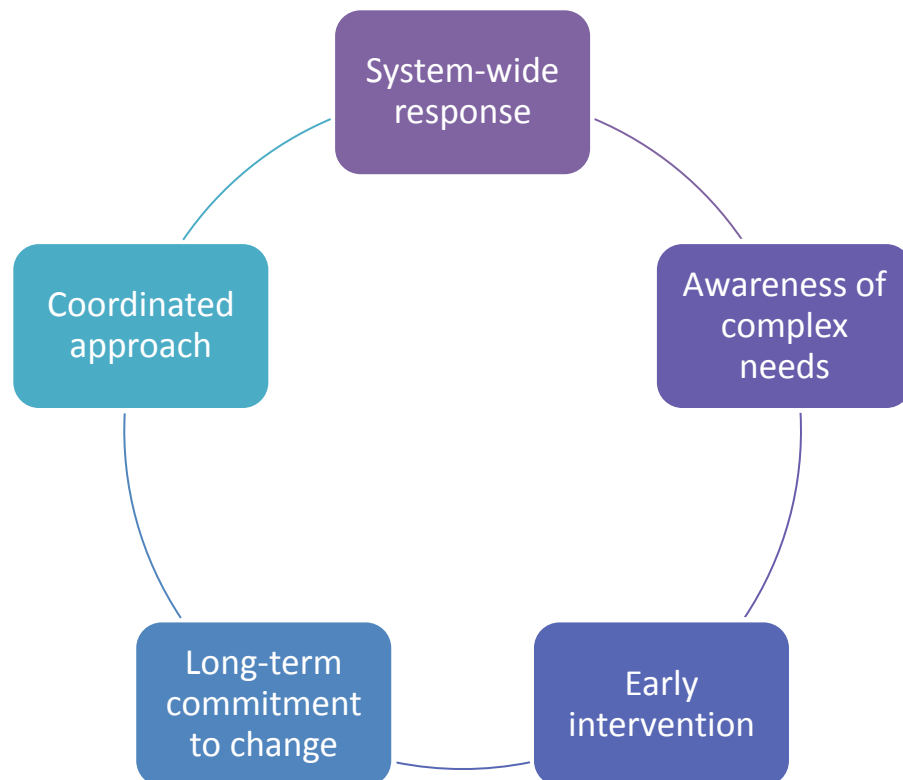
There also appears to be political will to meet the needs of homeless people with mental health issues, and significant empathy towards them amongst stakeholders. It was interesting, for example, that in the course of interviewing a wide range of stakeholders for this study, all focused on the difficulties faced by the client group, rather than on the difficulties facing services/themselves in working with them. There are also a number of strategic partnerships, and partnership groups operating in Nottingham that bring together housing and health (and sometimes other) services.

The challenge is translating this will, empathy, and strategic partnership working into appropriate commissioned services and front-line delivery. For, despite these more positive findings, the results from the study were very clear that the needs of homeless people with mental ill health are not currently being met in the City. Very few of the homeless people participating in the study were receiving appropriate, consistent support or treatment that met their needs. Issues relating to the *accessibility* of services were particularly prominent and very few current services are targeted at (or able to work with) people with complex needs. Issues related to the supply and appropriateness of supported accommodation for homeless people with mental health issues (and complex needs) are leaving many living in very inadequate temporary accommodation that undermines recovery and, in some cases, exacerbates or engenders mental health crises. The detrimental consequences for providers of general needs homelessness accommodation and their target client group (non-statutory homeless people) are also highlighted by the study.

The results from the study are very concerning but they are not particularly surprising. After all, the CCG commissioned this research precisely because of local concerns that the mental health needs of homeless people in the City were not being met adequately. In itself, that is a positive step forward towards a situation where homeless people's mental health needs will be better understood and relevant agencies will be better equipped to respond appropriately. But this journey is unlikely to be straightforward, and there may be no easy, quick-fix solutions. This is a multiply excluded group, with significant mental health and other support needs that are likely to require a deep understanding of their wider circumstances, services tailored to these circumstances, and a partnership approach requiring involvement from a range of agencies and services. These challenges are not unique to Nottingham and there is good practice elsewhere that local agencies can learn from, to help them design and commission provision that will better meet needs.

Drawing on the findings presented in this report and the good practice review, we made a series of recommendations to Nottingham CCG and other local stakeholders within Nottingham. We believe that, if actioned, these recommendations have the potential to significantly improve homeless people's access to, and the effectiveness of, mental health and related support and treatment. These recommendations were based on five key principles which are outlined in Figure 13.1

13.1. Recommendations

13.2. Key Principles

1. **System wide response.** The mental health needs of homeless people within Nottingham cannot be met by any one service. The interconnections between issues relating to housing, mental health and wider support needs mean that a range of services will need to co-ordinate their response. This may result in the integration of services and budgets. It is vital that there are clear pathways of support, particularly at points of transition (e.g. hospital discharge, leaving prison, care leavers).

2. **Services founded on awareness of complex needs, and histories of citizens.** All commissioners and providers of support will need to ensure that they are aware of the particular difficulties faced by homeless people with mental health and other complex needs. This will include the need to ensure that staff receive training to deliver services based on Trauma Informed Principles. It will also include the need to recognise the diversity of experiences within this group (e.g. domestic violence, BME, no recourse to public funds). It also requires shifts in culture and processes to better accommodate people who are homeless through flexible, less conditional and more inclusive delivery models (i.e. rather than, or in addition to commissioning new services).

3. **Early intervention.** The aim must be that all citizens receive the support they need in order to prevent homelessness amongst people with mental health issues (and all citizens more generally). In order to do this, there is a need to ensure that interventions take place at the earliest possible opportunity (i.e. in childhood or early adulthood). Homelessness exacerbates mental health issues so we need to do everything possible to prevent people with mental health issues reaching this point. This is needed to prevent the human cost of those who experience mental ill health and homelessness but also to prevent the financial cost to public services.

4. **Long-term commitment to change.** An awareness of the client group and their complex support needs requires a long-term commitment to change across all sectors (Housing, Health and others). There is a need to (re)design services around long-term, intensive and non-time limited support so that staff can better meet needs and spend time building clients' trust. Long-term commitment to change also involves learning from and incorporating good practice from projects/models found to work effectively with people with complex needs. These could include peer support, common single assessments, intensive support and key working, partnership working, co-creation and delivery of services and strengths-based models.

5. **Coordinated approach for people with complex needs (proactive broker / advisor / navigator).** The sustained involvement with service users that comes with intensive support and key working are crucial for effective treatment. There is a need to provide support to individuals in navigating often complex and fragmented systems, and in turn, helping to increase this group's engagement with healthcare services. This approach would also include a central assessment and information point where client data can be shared with other service providers (removing the need for multiple assessments and ensuring that service users do not have to tell their story to different agencies several times). It is important to place the person at the centre of this system, i.e. the person gives permission for their information to be shared across agencies.