Down and Out?

The final report of St Mungo's Call 4 Evidence: mental health and street homelessness

December 2009 | Executive Summary

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Introduction

Charles Fraser CBE, Chief Executive, St Mungo's

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

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

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

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The problem starts at the very top. Homelessness is seen by Government as a housing problem, and responsibility for it sits within Communities and Local Government. Meanwhile the Department of Health, despite growing work around health inequalities, has yet to carry out any significant analysis of the barriers to treatment for groups such as rough sleepers who face chronic social exclusion.

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

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

There was a resounding (and at times depressing) similarity in the problems identified - despite the wide range of expert contributors. Homeless individuals face exclusion from health services and support, because the complexity of their need does not match clinical criteria, or because mainstream services simply cannot provide specialist interventions. Projects to support positive occupation, which is so fundamental to people's mental health recovery, are difficult to sustainably fund. Meanwhile people are crying out for more housing with a specific mental health remit – especially high support/ complex needs projects. The evidence showed that there are many examples of good practice, and certainly many committed professionals – but overall there is a systematic failure to adequately meet the mental health needs of homeless people, which undermines the universal principles of the NHS.

The submission from the Department of Health unfortunately highlighted how far we have to go. It gives the responsibility to treat homeless people's mental health problems to Primary Care Trusts. This Call for Evidence shows this is not working, with far too many people ending up on the streets, in hostels and in prison. Abdicating responsibility to the local level is proving inadequate to the extremity of need faced by rough sleepers – who by definition are not settled in geographic communities, and whose numbers are too small to be picked up by current needs assessments. And people with complex problems, such as dual diagnosis, are not getting an adequate service – making them even more likely to become tomorrow's rough sleepers. Homeless people, and the people most vulnerable to homelessness, are falling through the gaps in service responses.

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

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

The Problem

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

There are examples of good practice in the voluntary and the statutory sector, but these are patchy. Generally, statutory services are failing these individuals, allowing them to fall through gaps and excluding them because of their complex needs and substance use. St Mungo's, on reviewing the findings of this Call for Evidence, has come to believe the Department of Health must now take the lead on health and homelessness and, following a cross department audit, ensure these gaps in services, particularly regarding dual diagnosis services, are plugged. The Joint Strategic Needs Assessments are insufficient in ensuring homeless people's needs are provided for because of their small numbers. More must be done to ensure the voices of the vulnerable are heard and acted upon.

Conclusion

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

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

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

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

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

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

St Mungo's Key Recommendations

The Government:

1. Government needs to act decisively to ensure nobody with a mental illness sleeps rough:

- The Government should issue national standards for addressing mental health amongst homeless people – recognising the full breadth of mental health problems faced by homeless people.
- There should be direct ministerial responsibility for health and homelessness within the Department of Health.
- The Public Sector Agreement 16 framework should be reviewed, and extended to include people with complex needs such as homeless people.

Department of Health:

2. The Department of Health needs to show leadership and recognition of the extent to which its service problems lead to, and fail to help people away from, rough sleeping:

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

Local commissioners – local authorities, PCTs, etc:

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

- Integrated commissioning is vital - mental health treatment must never exclude people who take drugs or alcohol – dual diagnosis is common, and in homelessness is the norm.
- Commissioners and service providers would benefit from an indicator of multiplicity of need – so that multiply vulnerable people do not fall below individual service thresholds.
- Gaps in services must be addressed - homeless people need access to talking therapies and appropriate supported housing (in particular better access to high support housing addressing complex needs) and adequate hospital provision. Service provision should be based on need not speed.
- People with mental health problems should receive well supported sign-posting - towards housing and mental health services - from their GP/mental health or housing contacts. Mental health, health and housing workers all need training that supports this awareness and knowledge set.

4. Specialist commissioning is required:

- For back to work and activity schemes that meet the specific needs of former rough sleepers and single homeless people in recovery from mental health problems.
- We need direct recognition in local and national strategies and commissioning of the high incidence of personality disorder amongst rough sleepers and single homeless people.

CLG:

- The CLG should consider tasking local authorities with getting independent assessment of needs for higher/longer term housing to support those that require long term support towards recovery.

Homeless services providers:

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

We are London's largest charity for homeless people and people whose complex needs mean they are at real risk of street homelessness. We provide over 100 accommodation and support services day in and day out.

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

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

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

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