

# Arrangements for adult service users who are homeless in English mental health trusts

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## Abstract

**Purpose** – The purpose of this paper is to report an analysis of arrangements in English mental health trusts to meet the needs of adult service users who are homeless. Homelessness is associated with various forms of mental ill-health, yet homeless people are not always well-served by statutory mental health services. In recent years, practice guidance seeking to improve health outcomes for the homeless has emphasised the need for NHS services to improve care pathways and professional provision for this service user group, in part by collaborating more closely with homelessness organisations.

**Design/methodology/approach** – Responses to freedom of information requests sent to trusts were analysed. The requests asked trusts for information concerning partnerships with external agencies, particular projects/staff, training available to trust professionals, referral pathways, and intervention models/approaches informing work with homeless service users.

**Findings** – In total, 49 trusts provided information that could be used in the analysis. Just under half of these had dedicated arrangements or resources, including outreach teams and clinical staff co-located in accommodation and support services for the homeless. The remaining trusts indicated that they either had some limited specific arrangements, such as links between local agencies working with the homeless and existing services, or no dedicated arrangements in place. Training to help trust professionals address issues associated with homelessness tended to be minimal if provided at all.

**Originality/value** – This analysis adds further evidence to concerns that homeless people's mental health needs are not being adequately considered by services at a local level and that there is a lack of appropriate pathways through which they can access care and treatment.

**Keywords** Outreach, Freedom of information, Homelessness, Partnership working, Staffing/resources

**Paper type** Research paper

## Introduction

This paper reports an analysis of arrangements in English mental health trusts to meet the needs of adult service users who are homeless.

The link between homelessness and poor mental health is well-recognised. The prevalence of mental health problems is disproportionately high in the homeless population, with increased rates of depression, anxiety, schizophrenia, personality disorders, self-harm and attempted suicide (Fazel et al., 2008; Folsom and Jeste, 2002; McGilloway and Donnelly, 2001; Sims and Victor, 1999; Sundin and Baguley, 2015). However, homeless people are not always well-served by mental health services.

Various factors contribute to this state of affairs (see Bhui et al., 2006; Bines, 1994; Crane and Warnes, 2001; Rae and Rees, 2015; Williams and Stickley, 2011, for overviews). The extent to which homeless people's social and medical needs are intertwined makes it difficult to assign responsibility for care to one professional group over another. Because of more pressing practical concerns, homeless people can fail to prioritise their healthcare needs and not seek help until urgent or emergency care is required. Difficulties in registering with a general practitioner and accessing primary care services can impede navigating initial treatment and

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onward referral to secondary care and specialist services. Homeless people can also fall between alcohol/substance misuse and mental health services, with unmet needs that reside under the domain of one precluding access to the other.

Work with the homeless is, furthermore, commonly a challenging emotional labour. On account of histories of trauma and experiences of discrimination, homeless people often present with combinations of vulnerability and volatility and can be ambivalent about receiving help. This, in turn, stimulates over- and under-identification from professionals and creates challenges in building working relationships, managing personal distress and avoiding 'burn out' (see Adlam and Scanlon, 2005; Scanlon and Adlam, 2006).

Over the past seven years or so, government strategy seeking to improve health outcomes for the homeless and practice guidance on working with the homeless in healthcare settings has highlighted the importance of collaboration between health services and homelessness organisations (Faculty for Homeless and Inclusion Health, 2013; HM Government, 2011). This guidance underscores the need for careful consideration of care pathways between homelessness and healthcare provision at a local level and the utility of moving clinical services closer to the homeless population, for example in the form of open-access clinics and health professionals being co-located in hostel accommodation or other services used by the homeless. Evidencing what works in intervention with homeless people suffering mental ill-health is a work in progress, but, overall, systematic analyses of controlled studies indicate that coordinated community provision is superior to usual care, and that good mental health and housing outcomes are linked to "assertive outreach" models of psychiatric care and close collaboration with housing providers (Coldwell and Bender, 2007; Hwang *et al.*, 2005; Rees, 2009; Wright and Tompkins, 2006). Of course, this does not necessarily mean that these are the approaches implemented. In the context of austerity and cuts to resources, limited supporting research evidence or an equivocal evidence base can offer further justification for funding reductions in services, even when these serve hard-to-reach groups or a valuable community purpose (Hannigan, 2013).

Several secondary care services in England are documented as dedicated to working with the adult homeless population specifically. A notable example of which is the specialist teams established in London through the Homeless Mentally Ill Initiative in the 1990s (see Perry and Craig, 2015; Craig *et al.*, 1995). However, many of these services have been subject to significant budget cuts or disbanded completely (St Mungo's, 2016). Moreover, recent studies addressing homeless people's access to mental health services indicate that arrangements can be variable (Crane and Warnes, 2011; Homeless Link, 2014; St Mungo's, 2016). Crane and Warnes (2011), for example, examined access to healthcare services in South Yorkshire for single homeless people, i.e. persons without a home, but who do not meet priority need criteria for the local authority to house them under homelessness legislation. In their study, only 26 per cent of the homelessness staff they surveyed believed current arrangements for accessing mental health services worked well, 48 per cent had mixed views and 26 per cent believed they did not work well – with long waiting times and delays in accessing treatment and advice reported by respondents. Furthermore, in interviews with 61 homeless people, most (79 per cent) volunteered that they had some form of mental health "issue" and 57 per cent that they had received a formal diagnosis. However, of this group, only 37 per cent said they were currently receiving treatment.

The aim of this study was to add to this research and provide a representative account of arrangements in place for adult homeless service users in NHS mental health trusts. Specifically, we wanted to ascertain the extent to which partnerships between trusts and other statutory or voluntary agencies are in operation, the training trust professionals have access to regarding best practice with this service user group, and the nature of any projects or initiatives dedicated to the homeless and the treatment approaches guiding them.

## Method

Freedom of information legislation was used in this study because of the potential it offered to maximise the relevant data that might otherwise be obtained via conventional survey methods. Passed into law in 2000 and fully in force from January, 2005, the UK *Freedom of Information Act* institutes a public "right of access" to information held by public authorities. It obliges public

authorities to publish information about their activities and enables members of the public to request information directly and free of charge[1]. The *Freedom of Information Act* has, overall, tended to be undervalued by researchers, particularly in the health and social care disciplines, though this is changing with various research studies now reporting its use as a means of accessing a wide range of institutional data (Brooker *et al.*, 2016, Fowler *et al.*, 2013, Lee, 2005, Murray, 2013, Savage and Hyde, 2014).

The approach for this study was informed by guidelines developed by Bourke *et al.* (2012). A clear and succinct request was drafted and piloted to minimise misinterpretation by trust representatives. It was then sent to the information and governance departments of individual trusts. The following information was requested:

1. a description of how the adult homeless population and their mental health needs are worked with in the trust and whether there is any provision dedicated to this population;
2. if there are any specialist projects or professional roles, to describe them in as much detail as possible, including numbers of staff and professional disciplines, particular psychiatric conditions and/or sub populations worked with, and intervention models/approaches informing practice; and
3. to provide an indication of the training trust professionals have access to or undergo to improve staff awareness around, and knowledge in, working with service users who are homeless.

As soon after receipt as was practicable, responses were anonymised and entered into an NVivo database for qualitative content analysis based on Hickey and Kipping's (1996) multi-stage approach. When initially sent out, the requests referred specifically to services for the adult single homeless. However, most often, responses from trusts did not distinguish between adult homelessness and single homelessness and instead referred to arrangements for the adult homeless population using broader terms such as "homelessness", "statutory" and "non-statutory" homelessness, "rough sleepers" and "street sleepers". Thus, the focus of our reporting in this paper is a more general one, of arrangements for the adult homeless population.

The extent to which research studies based solely on the use of freedom of information legislation require the same level of ethical scrutiny as other types of research has been questioned (Savage and Hyde, 2014). In using freedom of information legislation for research purposes, researchers are exercising a citizenship right and do not carry the same level of responsibility for assessing the risks in generating data as they would with primary research methods. Nevertheless, for this study, following the recommendations of Savage and Hyde (2014), we applied for and obtained approval for the study from the research governance and ethics board of the university department in which most of the research team were based when the study began. We also developed a protocol to respond to trusts in the case of respondents unwittingly disclosing information of a personal or sensitive nature.

## Findings

Of the 51 trusts with whom contact was made, 49 (96.1 per cent) responded with information that could be used in the analysis. All these trusts responded within a reasonable timeframe, most within a month of receiving a request. Responses to questions varied from a single short sentence to documents of several hundred words as well as policy briefings and web links.

Reviewing the responses around descriptions of services, modes of delivery, and the kind of focus the adult homeless received, we discerned three groups of trusts:

1. no special arrangements or services for adult homeless people as a distinct group;
2. specific arrangements within existing services, including referral pathways or links with local agencies, which catered for the adult homeless; and
3. dedicated professionals or teams delivering a service for adult homeless people.

Each of these groups will be attended to in turn before addressing the matter of training separately.

### ***No special arrangements***

In total, 15 trusts (30.6 per cent) provided very brief responses, reporting their services were universal and oriented towards meeting the needs of all individuals within their catchment area. Often these responses included an implicit or explicit rejection of a standpoint favouring dedicated or specialist service provision for the homeless. Blanket statements were, for example, made along the lines of, "Our trust seeks to ensure that services are tailored to the diverse needs of the population we serve, and that no one group is placed at a disadvantage over others". The implication being, in contrast to practice guidance emphasising the need to proactively engage this service user group (Faculty for Homeless and Inclusion Health, 2013; Keats *et al.*, 2012), that special or dedicated provision is not only unnecessary but in a sense, discriminatory. Another common statement in these responses was that there was no recording of information relating to homelessness by the trust. Although people who were homeless could be using services they provided, the trust would be unable to specifically identify individuals who were, by way of the information systems they had in place.

### ***Specific arrangements***

In all, 12 trusts (24.5 per cent) indicated that they had developed specific arrangements within existing services, recognising the particular needs identified as characteristic of the homeless population. These arrangements encompassed proactive multi-agency liaison with other providers, including local authority housing or third sector organisations providing supportive accommodation and drop-in services. They did not, however, involve workers or teams with a specified or exclusive remit for addressing homeless mental health.

### ***Dedicated arrangements***

Responses from 22 trusts (44.9 per cent) indicated special arrangements in the form of dedicated provision. These trusts described close links between the trust and accommodation projects, hostels, local authority housing departments, housing forums, third sector homeless resources (including drop-in centres and drug and alcohol services) and mental health charity organisations. Some responses also indicated that there were protocols in place for liaison over hospital discharge procedures and accommodation support.

Twelve of the trusts with dedicated arrangements described teams working with the homeless specifically, including the capacity to provide both short-term and long-term case management services. The teams varied in size, from three to nine full-time equivalent professionals, albeit responses indicated that team sizes were commonly closer to the lower end of this range and tended to be made up of part-time posts. Teams were multi-disciplinary with a range of professional groups represented, including psychiatrists, psychologists, social workers, occupational therapists, support workers and mental health nurses. All responses in this group stated that work was undertaken directly with adult single homeless persons and referrals were accepted from accommodation providers and other homelessness services. Reflecting the more developed evidence base of this approach and establishment in some areas through earlier initiatives (Coldwell and Bender, 2007; Craig *et al.*, 1995), the majority were engaged in outreach work, including assertive community treatment. This involved work on the streets, in hostel accommodation and shelters, and initial assessment and long-term support with the objective of accommodating or rehousing and re-engaging service users with mental health services in the locality. Some teams also provided psychotherapy, counselling and group therapy interventions.

The ten trusts without specialist teams but in the dedicated arrangements grouping had professionals in posts devoted to homeless mental health. The activities of these practitioners included consultation with mental health professionals on cases involving homelessness issues and visits to accommodation projects or drop-in centres. There were also secondment, "crossover" posts (for example a mental health nurse working in a local authority's housing options team) and direct or liaison work with local authorities and third sector organisations.

Five of the trusts in this group, spanning those with dedicated teams for meeting the mental health needs of the homeless and those without, also described involvement with primary healthcare services specifically commissioned for the homeless. In a few cases, this involved trust

mental health professionals being seconded to these primary healthcare services, and a part focus on refugees. A few trusts also reported in-house accommodation professionals who liaised with hostels and other accommodation providers.

In some responses in this grouping, dedicated provision was reported as only available in certain parts of a trust's catchment area. It could also be subject to the changing priorities of local clinical commissioning groups and the funding capacity of local authorities and other organisations with whom the trust was engaged in partnership arrangements.

### *Training*

Across the three groups of trusts, there was little evidence of organised training to improve staff awareness of, and knowledge in, working with the homeless. Of the 15 trusts with no dedicated arrangements or services in place, four stated some training had been made available. This training could involve covering the topics of homelessness and work with homeless service users but this was generally as one element of broader training programmes professionals had access to inside and outside of the trust, addressing related subjects such as accommodation, equality and diversity, and risk management.

There was a similar picture in trusts with specific arrangements. Only one trust in this group provided training addressing homelessness specifically. Many did not mention any training being carried out and some indicated that homelessness was an issue covered in broader training programmes.

There was a slight improvement in trusts with dedicated arrangements. In four of these trusts, professionals and teams who had a remit to work with the homeless specifically trained trust colleagues. These trusts also indicated that dedicated practitioners provided placements for other professionals, consultancy to third sector organisations, information on how to refer to their teams, and "awareness raising" training on mental health to professionals from agencies working with the homeless. Four trusts in this group also noted that specialist training was provided to trust professionals on homelessness and housing issues by a local authority or external agency, and three responses indicated that trust professionals and teams working with the homeless specifically had access to further training, conferences and online resources to support their work.

### **Discussion and conclusion**

This study was a preliminary and exploratory consideration of the arrangements in place for adult homeless service users in English mental health trusts. It can be considered limited in terms of the level of information that could be obtained across trusts and from trust information professionals specifically, and the fact it was not linked with other data addressing local population needs and levels of homelessness. For instance, we can note that in general, dedicated arrangements tended to be based in trusts serving larger metropolitan areas. Also, trusts in the North West and south coast areas were more likely to have dedicated arrangements than other parts of the country. However, the study resources and data set we worked with, prevented going beyond this and providing a more extensive analysis.

These limitations notwithstanding, this study is, as far as we are aware, the most comprehensive and up-to-date analysis of its kind and a useful illustration of the value of freedom of information legislation for research into organisational awareness of issues of access and social exclusion and the uptake of policy or practice guidance across services (see also Fowler *et al.*, 2013; Murray, 2013).

Overall, the findings add further evidence to concerns that homeless people's needs are not being adequately considered by mental health services in England and that a lack of suitable care pathways exist through which they can access care and treatment (Crane and Warnes, 2011; Homeless Link, 2014; St Mungo's, 2016). The analysis establishes that many trusts are providing outreach and targeted work, and that homeless peoples' mental health needs are at least considered in most mental health trusts. However, arrangements can vary considerably between

trusts and it is a concern that some trusts appear to not just lack specific arrangements and training to raise awareness of barriers homeless people face in accessing treatment, but also fail to monitor whether homeless people are accessing the services they provide.

Work being carried out in primary care and other services may help to explain, to some degree, this variability in arrangements. In particular, homelessness organisations themselves have been developing more sophisticated approaches to mental health needs in recent years, particularly psychological trauma, notably for instance in the “psychologically informed environments” initiative, which have been seized upon by housing services and commissioners (see e.g. Haigh *et al.*, 2012; Keats *et al.*, 2012). This said, mental health trusts still have an important role to play in ensuring the mental health needs of this population group are attended to. Primary care services are well positioned to address physical health, mental health and substance and alcohol misuse together (Hewett and Halligan, 2010), and accommodation providers are well positioned to provide support that has practical and therapeutic features. However, a gap remains for the more focused, specialist input of secondary mental health services, whether by way of consultation with other services or direct work. In this vein, it is important that questions are asked about the extent to which, and how, trust staff are being equipped to work with service users who are homeless and whether satisfactory adjustments are being made in services to meet their needs, including close consideration of how secondary mental health services can effectively collaborate with primary care and homelessness provision.

Lastly, with regard to future research, it bears acknowledging that this analysis was undertaken at a time the NHS in England is being radically overhauled with the *Health and Social Care Act 2012* abolishing primary care trusts and devolving responsibility for decisions about local healthcare resources to clinical commissioning groups. Building on the research reported here, we have begun an analysis of information gathered from clinical commissioning groups across England regarding their activity around homeless mental health, including working links between NHS providers, local authority housing teams and homelessness organisations. By way of this analysis, we will be further exploring the range and scope of provision available through primary and secondary care pathways, and independent and voluntary providers. We will also determine the prioritisation of homeless mental health by clinical commissioning groups who are expected to commission in a way that is mindful of inequalities in access to care and outcomes of care. There nevertheless remains a need for research that can supplement this which addresses awareness raising of homeless mental health, the impact of austerity measures on the availability of mental health input to the homeless population and the respective use of, and relationships between, different (NHS and non-NHS) services at a local level.

## Note

1. Outside of requests that are “vexatious” or if it would cost the authority more than £450 in administrative costs to locate and extract the information requested.

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