Homelessness guidance for Mental Health Professionals

Making the most of your support

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Contents

Introduction

Who is this resource for?

This document has been written for mental health professionals who work within NHS mental health services in England. It aims to provide an overview of how homelessness services operate, and some of the ways in which mental health professionals' input can support better outcomes for people. We hope to introduce practitioners to the key issues facing people who do not have stable housing and how these challenges interact with mental health and wellbeing.

The focus of this guidance is on people without dependent children in their household, who are less likely to receive a statutory housing duty. For more information on family homelessness please see Shelter's resources: http://england.shelter.org.uk/

Supporting better outcomes for people who are homeless

Mental health services are frequently under pressure. Particularly in terms of assessment, there is a tendency for acute risk and the appropriateness and practicality of a relatively narrow range of treatment options to be the main things that are actively considered.

Someone with a complex social situation, which is linked to more chronic risks, and who might not be ready or in a position to safely start certain forms of treatment can lose out. In fact, they may greatly benefit from considered input from a mental health professional – this may be because a specific treatment or intervention can be identified, or it may simply be that the way in which the assessment is carried out and communicated is informed by a greater understanding of the system, the nature of homelessness, and its interactions with mental health.

This could mean that an assessment by mental health services is able to support better decisions from housing services regarding needs and entitlements. In other situations, an assessment, or a formulation, from mental health services has the potential to increase the understanding of the person involved and those they are already in touch with, such as housing workers, in ways that can be helpful in the short and longer terms. Please see the case studies below.

Overview of Homelessness and Housing Services

The definition of homelessness is in some ways straightforward – it is the state of being without somewhere secure to live. That said, some knowledge of the legal definition that Local Authorities have to apply when considering their duties, alongside other key legal concepts, can be valuable to a mental health worker whose assessment of someone's mental health, and its impact on them, might enable housing services to make better and more appropriate decisions. It is also helpful to understand the criteria and definitions that might be used by other sources of accommodation and support in your area.

This section provides an overview of legislation and what might be available to guide your practice. It should not be used for decision-making in individual cases.

Quick reference

Is there an immediate and urgent concern for their health or safety? Call 999

Are they sleeping rough? Refer to local outreach via StreetLink: www.streetlink.org.uk – note that this is not an emergency response, see below for details

Are they under 18? Urgent referral to Social Services

Are they homeless and vulnerable? Homelessness assessment by the Local Authority.

Are they threatened with homelessness within 56 days? Advice and support from the Local Authority.

Do they need practical or social advice and support? Connect to a local advice service or day centre: www.homeless.org.uk/search-homelessness-services

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Approaching the Local Authority for support

Homelessness Reduction Act 2017
Anyone can apply to the council for help if they are homeless or if they are going to be within the next 56 days. Having some understanding of the tests and considerations that the council will need to make to establish their duties will also allow you, in discussion with the person themselves, to present your impressions and understandings in a way that is relevant.
For detailed guidance see Shelter:
https://england.shelter.org.uk/housing_advice/homelessness/guide/get_help_from_your_council_when_homeless/overview

The Homelessness Reduction Act, which came into force in April 2018, introduced significant changes to the previous legislative framework, in particular by introducing new duties on local housing authorities and public bodies to prevent and relieve homelessness. The Act signals a change in culture away from a focus on process and meeting statutory requirements, and towards a system centred on prevention or relief of homelessness for everyone. Mental health professionals can play an important role in this culture change, for example by advising on the type of tailored support that can help an individual to find, or remain in, housing.

Professionals with prior knowledge of statutory Housing legislation should ensure their knowledge has been refreshed in light of the Act, to take into account changes such as:

- o **Improved advice and information about homelessness and prevention of homelessness**
  The Act places greater duty on authorities to make advice and information available, providing up to date local information on preventing homelessness, securing accommodation, rights, available support and how to access this support.

o **Extension of the period "threatened with homelessness"**
Under the new legislation, people can now be assessed as threatened with homelessness if they are likely to become homeless within 56 days (increased from 28 days). This means the period of time that housing authorities have to undertake prevention work is increased.

o **New prevention and relief duties**
A key component to the Homeless Reduction Act is that all eligible people who are found to be homeless or threatened with homelessness will be entitled to more tailored support from the housing authority, regardless of priority need and intentionality. This support will be set out in a Personalised Housing Plan.

o **Assessments and personalised housing plans**
Under provisions introduced by the Act, housing authorities will conduct as assessment with people who are either homeless or threatened with homelessness. This includes an assessment of what accommodation would be suitable, and whether the applicant needs support to obtain and keep accommodation. These assessments can be contracted out to other organisations.

The assessment is used to develop a Personalised Housing Plan, which sets out the steps the individual and the local housing authority will take to remain in or source accommodation options. Housing authorities can involve other services in agreeing these steps. Mental health professionals will have a role to play in helping the local authority to understand what support is required and what would be 'reasonable' for the individual.

o **Duty to refer and encouraging public bodies to work together**
Homelessness prevention work is best delivered through effective partnerships working, and the Act requires public bodies to work together to address the range of complex needs that individuals may be facing. From October 2018, the Act introduces the "duty to refer", a framework in which councils and referring agencies work in partnership to develop effective referral pathways and joint planning of support. Health services, such as "hospitals in their function of providing inpatient care" are included in the duty to refer, and guidance on their role will be published before October 2018. While not explicitly named in legislation, mental health services should play a key role in developing local homelessness strategies.

In addition to duties under the Homelessness Reduction Act, local authorities remain bound by duties laid out in the Housing Act 1996 to provide housing for those that are not intentionally homeless and satisfy their priority need status. The tests that a council needs to apply to establish what duties they might have towards someone who is applying to them as homeless are:

1. **Is the person legally homeless**? A council could decide someone is not homeless if they have a home somewhere else (even if it's in a different country). The council would need to consider if it's reasonable to expect someone to return to a home they have left – your views, as a mental health professional, may be relevant to this decision.

2. **Are they in priority need for help**? A council has a duty to house someone found in "priority need". A household with children; someone who is pregnant within it; and in a situation in which someone's homelessness has been due to a disaster such as a fire would be considered automatically to be in priority need. People are also seen as being in priority need if they are classified as "vulnerable". Mental health issues may be grounds for someone to be seen as in priority need.

   a. The test that the Local Authority would be applying in making a decision about whether someone meets the vulnerability criteria is how their health (including mental health) and activities of daily living might be impacted by homelessness – and whether their particular

issues such as mental health – makes them more vulnerable than another person (without health issues) who also found themselves homeless. Clearly your views and knowledge as a mental health professional may be very relevant.

3. **Do they meet the immigration conditions, i.e. are they "eligible for assistance"?**[1] In your role, you may not be in a position to provide significant input in relation to this test.

4. **Are they "Intentionally" homeless**? To determine what duty a council owes an individual they may look to determine if someone is homeless through actions they have taken. An eviction related to previous anti-social behaviour or a decision to leave their previous accommodation might be reasons why someone is found to be "intentionally" homeless. Your perspective on the circumstances in which someone left previous accommodation, or on how things have changed since, may be highly relevant here. For example, if past behaviours which led to eviction or abandonment were connected to mental health symptoms which are no longer present, or if their decision-making was impaired because of poor mental health, then these could be reasons to question the idea that their homelessness was intentional.

5. **Do they have a "local connection"**? In some circumstance your skills as a mental health professional may mean that you are able to elicit information and record a history that will help the process of someone communicating the nature and extent of someone's links to an area more effectively than if this process is undertaken in a housing department.

Emergency housing from the council

In a situation where someone makes a homelessness application, and it would appear at all likely that they might meet the first three tests above i.e. they are legally homeless, they are in priority need and they meet the immigration conditions – then a Local Authority should help with emergency housing, and should not refuse this because they suspect someone might be "intentionally homeless" or because they might not have "local connection". Emergency accommodation may be a bed and breakfast, a hostel or a self-contained flat or house. Generally, it should be within the local area, but can be outside of this if there isn't anything suitable available locally. Consideration should be given to factors such as where people's support networks are when a decision is made around the location. Your perspective may be relevant to these decisions.

If a council does not accept that they have a duty to house someone or to provide them with emergency accommodation, they still have a duty to provide advice, an assessment and a personalised housing plan to relieve homelessness. The person who has had their homelessness application declined also has the right to appeal. The council should provide them with advice around seeking support with this process.

Apart from their specific duties towards individuals who meet the criteria described above, Local Authorities also have wider responsibilities around reducing homelessness and in the prevention and relief of homelessness. These responsibilities are sometimes fulfilled through the commissioning, or joint funding, of some of the services such as hostels and outreach teams described below.

Support to access Private Rented Accommodation

In some areas, councils have schemes to help people to access their own tenancies in the private sector. These are sometimes used as a means to prevent or relieve homelessness, even for people who the council do not have a duty to house. The level of support varies between simply having information available about

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[1] https://england.shelter.org.uk/housing_advice/homelessness/rules/immigration_and_residence_restrictions_on_homelessness_help

landlords who will consider taking people on benefits, to rent deposit or guarantee schemes, and sometimes social lettings agency and other more extensive support.

Commissioned homelessness services

Alongside the statutory homelessness and housing services, typically accessed through the council's Housing department, many Local Authorities also commission services for 'single' homeless people (i.e. people without dependent children in their household) who are not owed a housing duty. These services aim to prevent or respond to homelessness, and rough sleeping in particular. Broadly speaking, areas with higher levels of people sleeping rough tend to have more single homelessness provision available. The exact type and scope of provision varies from place to place, and might include, for example: outreach teams, night shelters, 'No Second Night Out' assessment hubs, hostels, and supported housing.

Routes into these services vary. Some will only accept referrals for people who have a 'local connection' according to local criteria (e.g. they have lived or worked in the area for a certain number of years). Bed spaces may be prioritised for people found sleeping rough by the outreach team. There is usually a requirement to be eligible for Housing Benefit or Universal Credit to cover the cost of rent and service charge. For some projects, abstinence will be a condition of access, while others will house people with a range of support needs e.g. using drugs. Each project will have its own referral route and criteria. You can find these by contacting the local authority or by searching the Homeless England database for services in your area: www.homeless.org.uk/search-homelessness-services Note that most projects do not accept self-referral and access is via the local authority, outreach team or other designated service. There will often be a waiting list.

Street outreach teams

Outreach teams are typically commissioned by the local authority and run by homelessness charities – there are some non-commissioned outreach groups, but they don't usually have referral rights into accommodation. Outreach teams make contact with people who are sleeping on the streets and offer them support to access shelter or accommodation, and to take steps to end their homelessness, e.g. by claiming benefits or accessing healthcare. Outreach workers usually have good knowledge of local services and how to access them, along with a skilled approach to engaging people who may have a range of presenting needs and behaviours.

In most areas of England and Wales, the only way that a referral can be made to street outreach is via the national referral service, StreetLink: www.streetlink.org.uk/. Anyone can call StreetLink to refer someone who is sleeping rough, or to make a self-referral. The details of where that person is sleeping are passed on to the outreach service who will then seek to make contact with them at their sleep site during the next available shift. If the person sleeping out is in an area without an outreach service, then the Local Authority Housing Department will usually be tasked with following up.

Most inner London boroughs have a locally commissioned street outreach team, and there is also a London Street Rescue mobile street outreach service, commissioned by the Greater London Authority[2].

Outreach services vary in scale and scope from area to area e.g. a city borough vs. a large rural area. They will always entail some element of late night or early morning shifts, but frequency varies. Because of this, StreetLink referrals work well if someone is 'bedded down' in the same place regularly, but are less effective if someone is more mobile, simply because of the challenges for the team in locating the person involved.

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[2] https://thamesreach.org.uk/what-we-do/response/outreach-services/london-street-rescue/

It's important to note that there is no emergency response to rough sleeping, and it could be a number of nights before the outreach team is able to visit a sleep site. Where possible, efforts should be made to connect the person sleeping rough with other services, such as the local authority or a day centre, as well as making the referral to StreetLink. Search for local services on Homeless England: www.homeless.org.uk/search-homelessness-services

If someone remains street homeless for some time, outreach workers may get to know them well. In some circumstances it may be that the outreach team becomes increasingly concerned that someone's mental health is affecting their decision making. For example, someone may be declining the assistance that is available. It is important in these situations that an outreach team is in a position to consult with local mental health services to consider whether grounds are met to progress a mental health referral. The mental health professionals involved should be ready to listen to the particular reasons why the outreach worker is concerned about this individual.

Workers in commissioned outreach teams are likely to have good knowledge about entitlement to benefits and different housing options. When offering advice about practical issues, mental health workers should consult with them before suggesting things that may in fact have already been explored.

Sleeping rough and homelessness, in themselves, do not limit people's entitlement to most DWP benefits. There may be practical challenges such as needing an address, but frequently people can give the address of a day centre or similar. Nevertheless, a significant proportion of people who are homeless do have limited benefit entitlements based on their immigration status or other factors.

The approach to support: single service offers and No Second Night Out

Outreach teams in many areas will use an assertive approach to outreach based on 'no second night out' principles and using a 'single service offer' approach. Single service offers arose from a concern that, in areas with multiple homelessness services, some people were refusing support in the hope that another agency would make a different or better offer, such as access to social housing. This could mean that people were on the streets rough for longer, with associated risks such as deterioration of health and isolation from social networks.

Assertive outreach is closely associated with the 'No Second Night Out' principles that were set out in the 2011 Government strategy and Homeless Link guidance of the same name[3]. The core of the No Second Night Out approach is that each area should have a system in place whereby people new to rough sleeping are identified. They should be offered a place of safety where their needs can be assessed, from where they can be reconnected to the area where they are entitled to help. Any reconnection is to include an offer of accommodation, not simply a ticket home.

Single service offers should:
- be credible and realistic, based on assessment
- include an offer of accommodation, whether locally or as a reconnection
- include the support required to ensure that the individual will not sleep rough in your area or elsewhere
- be acceptable to all services.

This reduces the risk of an individual continuing to sleep rough with the expectation of getting a better offer. Once someone has a single service offer, commissioned homelessness services will not offer an alternative.

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[3] www.homeless.org.uk/our-work/resources/adopting-no-second-night-out-standard

The views of a mental health professional may be very relevant in establishing what is a reasonable single service offer, including what sort of support is needed. If someone declines a single service offer, there may be a need to consider whether that decision is mentally capacitous, or whether mental health symptoms are impacting someone's decision making. It may be that a person's circumstances have changed and a mental health professional can help to make the case that the single service offer needs review.

In London, No Second Night Out (NSNO) also refers to a GLA-funded, pan-London service. Anyone new to the streets found by an outreach team should be offered a place in one of three NSNO hubs across the capital. The shelter offered is very basic. The hubs should be considered as an assessment hub or waiting room, not accommodation; the aim is that people should move on as soon as possible.

If someone is seen by mental health services while at No Second Night Out, decisions about whether to start any sort of treatment need to take into account the fact that they might not be there for very long.

Severe Weather Emergency Protocol (SWEP)

While there is no legislation to protect people sleeping rough, there is an accepted protocol that when the weather is particularly cold or severe, Local Authorities should ensure that extra provision is available for people who are sleeping rough.[4] Provisions varies, for example B&B places, the floor of a hostel's communal area, or a dormitory-style night shelter in a church hall.

SWEP is a humanitarian response and should be available to anyone who needs it, without any barriers such as eligibility criteria around local connection or recourse to public funds. Each local authority decided when to open SWEP and how it is delivered, although in some areas like London there are now city-wide protocols to open when there is a forecast of freezing for one night or more. Referral routes need to be checked locally, and may be through the housing team or outreach (i.e. StreetLink). SWEP services will usually only remain open while the temperature remains below freezing, so this is a very temporary form of homelessness response.

Day Centres and other voluntary or faith-based provision

There are a range of other services available to people sleeping rough but, again, provision varies from place to place. Some of these are part-funded by the local authority, but many are independent and funded by charitable trusts or public donations.

Day centres are the most common service, typically providing advice (e.g. housing, benefits) and basic support (e.g. food, showers, clothing). Some will offer additional support such as on-site health services, employment and training, and activities like art or drama and work with people from the local community, not only those sleeping rough. These services are often highly effective in preventing homelessness for people who are in vulnerable housing situations[5].

Day centres often have a close working relationship with outreach teams, and occasionally have referral routes into accommodation via outreach or other charity provision.

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[4] www.homeless.org.uk/our-work/resources/guidance-on-severe-weather-emergency-protocol-swep-and-extended-weather-provision
[5] For more about day centres: www.homeless.org.uk/our-work/national-projects/day-centres-project/resources-for-day-centres

There may also be church or community drop-in centres, advice centres, night shelters, soup runs or street activist groups in your area. These services are more likely to work with people who aren't eligible for commissioned services, for example people with no local connection or no recourse to public funds. The ethos of many of these projects is to offer of hospitality and acceptance rather than a service per se. This can be incredibly important for the people who use these services, but mental health professionals should bear in mind the limits of these services, who may lack robust policies and procedures e.g. for information sharing, and whose volunteers may have little training.

One of the most significant elements of what the faith sector offers is church winter shelter schemes. These often involve several churches in an area coordinating shelter seven nights a week in a particular area. This is generally a church hall or similar, where people share a sleeping space. To access church shelters for any period of time, people need both mobility and personal organisation, so they are not suitable for everyone, but for some individuals they are a real lifeline.

Some areas have hosting or overnight schemes, where volunteers invite people to stay in a spare room, usually for a short time. For example, members of the NACCOM network run hosting schemes for destitute migrants https://naccom.org.uk/, and De Paul's Nightstop supports young people https://uk.depaulcharity.org/NightstopUK. These schemes have limited spaces and designed for people with very low support needs.

Find local services on Homeless England: www.homeless.org.uk/search-homelessness-services

Case Study 1: Homelessness application

Paul, 50, is referred to NHS mental health services by his GP. After he has been seen twice by a CPN from the Mental Health Assessment Service they write this letter to support his homelessness application and request for emergency accommodation:

To Whom it may concern

Re: Mr Paul Castudi, d.o.b. 15/02/1968, currently of No Fixed Abode

We are currently working with the above named man in our capacities as a Community Psychiatric Nurse and a Speciality Trainee in psychiatry with the Assessment Service. I understand that Mr Castudi made a homelessness application and has also requested that he be considered for emergency accommodation.

We understand that he was evicted from his previous address on the 15th March this year – he is currently staying on the sofa at his sister's address.

We have had contact with him on 26th March and today 5th April. Our colleague in the Single Point of Access also spoke with him on the 24th March. His GP since 2008, Dr Brown of the High Street Practice, referred him to our services and has provided some background information.

Our impression is that Mr Castudi is currently presenting with symptoms of moderate to severe depression. This is manifest in low mood, disturbed sleep, poor concentration and limited appetite – he currently finds it difficult to identify positives for the future. Although our contact with Mr Castudi is recent, the background information provided by the GP indicates that he has experienced at least some of these symptoms for at least three years. It is also apparent that Mr Castudi was previously someone who was well able to manage his life and sustain relationships – this is not the case currently.

Our strong impression is that Mr Castudi's homelessness would have been avoided had his poor mental health not impaired his ability to address his situation earlier. We also feel that if he were to become street homeless currently, his mental health symptoms would render him significantly more vulnerable than another person in that situation. For example we feel that he would be less able to manage the processes involved of finding shelter and negotiating with others that are inherent in staying safe on the street because of his low mood.

In addition to this Mr Castudi has recently started treatment with Mirtazapine (15mg). This is an antidepressant that can also have a sedative effect – it would not be safe or appropriate for him to sleep out and to continue taking this medication.

Mr Castudi is currently staying with his sister – we understand that she and her partner live in a two-bedroom flat with their young children. It is not reasonable for this situation to continue, apart from anything else it is putting strain on Mr Castudi's one current supportive relationship. We feel that it could be helpful and appropriate if you were to consider offering him emergency accommodation whilst you consider his homelessness application further. If this was to be within our catchment area this would make his ongoing contact with our services, and his sister, viable and this would be preferable and safer.

Please contact us with any further questions – however given the limits to our team's remit it may that his care is transferred to our colleagues in the home treatment team or the recovery service. You may also wish to discuss Mr Castudi's case with support staff at St Christopher's Day Centre – they attended with Mr Castudi today. Mr Castudi is aware that we are writing this letter and we have given him a copy.

Yours sincerely
Chidi Onwukwe, CPN
Dr Oliver Jones, ST2

On the basis of this letter the Housing Department agreed to provide Paul with emergency accommodation. Paul's depressive symptoms did respond to treatment over the coming weeks. He was discharged back to the care of his GP with advice around accessing support, including potential talking therapies, via Mind. He remained engaged with the homeless day centre – the Local Authority did not find him to be in priority need, but were able to support him in accessing private rented accommodation via a rent deposit scheme.

Homelessness and Mental Health

Nature and extent of mental health challenges in the homeless population

There is long-term evidence of a strong link between homelessness and mental health difficulties, both in terms of people experiencing mental health problems becoming homeless, and people experiencing homelessness developing mental health problems.

Research on mental health and homelessness has found that there are higher rates of mental health problems found in homeless populations than in the general population[6]. Homeless Link found that 80% of homeless respondents reported experiencing a mental health issue[7]. Of these, 45% reported having been given a diagnosis, compared to 25% of people in the general population. Another study found that the prevalence of mental health problems within the homeless population was as follows (people experiencing homelessness are listed first and studies of the general population in brackets)[8]:

- Schizophrenia 16-30% (1-4%)
- Personality Disorder 50-70% (5-13%)
- Anxiety Disorders and Depression 50-80% (11%)
- Attempted Suicide 42% (1.3%)

Studies are often limited in their ability to capture complexity, and it is likely that people may have experiences that fit multiple diagnostic categories, alongside other difficulties such as substance misuse, which may make identifying their specific needs (and the best course of intervention or support) more challenging.

Brain Injury, Learning Disability and Autism

Sleeping rough or living in temporary accommodation also brings a greater likelihood of brain injury, undiagnosed learning disability or autism.

Brain Injury

Being homeless has been linked to high rates of traumatic head injury, and research suggests that roughly half of all homeless people may have had a traumatic brain injury at some stage.[9] These injuries are often related to combat, alcohol misuse, or physical assaults. The impact of undiagnosed brain injuries (and dementia) is that behaviour may be misunderstood and people may be excluded or evicted from services.[10]

Autism

The link between autism and rough sleeping is a relatively unexplored topic. There have been a few small studies; research by the Welsh Government found that 12% of people sleeping rough were on the autistic spectrum, while a small study in Devon identified 9 of 14 people sleeping rough long term could be classified as such.[11] We know that around 1% of the general population falls somewhere on the spectrum, and the figure is likely to be significantly higher in the homeless population. People experiencing autism may have difficulties in how they relate to support staff, other residents and mental health services.

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[6] Maguire et al, 2009
[7] www.homeless.org.uk/facts/our-research/homelessness-and-health-research
[8] Cockersell, 2011
[9] McMillan, 2015
[10] www.homeless.org.uk/brain-injury-and-homelessness
[11] www.homeless.org.uk/connect/blogs/2015/oct/06/autism-and-homelessness-–-missing-piece-of-puzzle

Homelessness, trauma and mental health

There is strong and consistent evidence supporting an association between trauma and homelessness.[12] Homelessness is a traumatic experience in itself. People experiencing homelessness are under constant stress, unsure of whether they will be able to sleep in a safe environment or obtain a decent meal. Even if a person has temporary housing they often also struggle with the financial resources, life skills and social networks needed to change their circumstances. An overwhelming percentage of people without stable housing have been exposed to additional forms of trauma, including neglect, psychological abuse, physical abuse, and sexual abuse during childhood and throughout their lives.[13] Lankelly Chase Foundation (2015) found that 85% of those in touch with criminal justice, substance misuse and homelessness services have experienced trauma as children.

A significant number of homeless people have experienced additional trauma in the form of exposure to war or natural disasters in other countries.[14] Sleeping rough and sofa-surfing are common experiences amongst asylum seekers and refugees, both before[15] and after[16] they have been granted leave to remain. It is paramount to reflect on different cultural traditions and ways of understanding and processing trauma, as there is a long-held understanding that culture has a significant impact on the presentation of distress. Having an awareness of some of the more prevalent cultural understandings and expressions of distress allows for a more sensitive approach to the management of these. For example, there are huge variations in the prevalence of self-harming behaviours between countries, and our own understanding of the meaning of self-harm may give rise to judgements being made about the severity of distress depending on whether or not people self-harm, rather than us having an understanding that the likelihood of such behaviour may well have its background in an individual's culture.

The psychological impact of trauma, and particularly compound trauma (meaning multiple traumas) often makes it difficult for people to cope with the innumerable obstacles they face in the process of exiting homelessness.

Homelessness is associated with multiple and complex needs. Many homeless people and rough sleepers experience poor education, diagnosed and/or undiagnosed mental health problems, substance misuse problems and physical health conditions.[17] Recent research by Aldridge et al (2018) found that socially excluded populations have a mortality rate that is nearly eight times higher than the average for men, and nearly 12 times higher for women.

Outside of the specific context of homelessness (though homeless-specific research is likely to follow), increasing attention is being paid to the evidence that most mental health difficulties can be better understood through a trauma informed framework.[18]

There is evidence of a clear relationship between the severity, frequency and range of adverse experiences, and the subsequent impact on the development and maintenance of mental health problems.[19] Despite this, the significant impact of social trauma (including poverty, racism and homelessness) is often not recognised in

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[12] Maguire et al, 2009
[13] Hopper, et al 2009
[14] Refugee Council, 2017
[15] www.homeless.org.uk/our-work/resources/supporting-people-with-no-recourse-to-public-funds
[16] www.homeless.org.uk/our-work/resources/practical-guidance-on-working-with-refugees
[17] Cockersell, 2018
[18] Sweeney et al, 2016
[19] Dillon et al. (2012)

our formulations of our clients' mental health difficulties. The higher percentage of mental health issues within the homeless population needs to be understood in relation to the likelihood of these individuals suffering, or having suffered, compound trauma. A full appreciation of the context of trauma can facilitate the development of care and support plans which meet the complex needs of people experiencing severe and multiple disadvantage.

Re-traumatisation, social exclusion and poverty

'The unhoused and the dis-membered are feared and pushed away because they threaten our idea of what it is to feel that we are in a 'housed' state of mind.'[20]

Alongside social exclusion and poverty, understanding the impact of compound trauma upon how people experiencing homelessness engage with mental health services is paramount.

Re-traumatisation
The reality of homelessness brings a risk of re-traumatisation. The basic experience of not being able to meet one's basic needs, day to day, is re-traumatising in itself. An experience in the present (such as being evicted from accommodation, difficulties in contact with support services, and unstable social relationships) that is reminiscent of a past traumatic event can trigger the same emotional and physiological responses associated with the original event. For example, people who have experienced parental rejection and/or neglect in childhood, are more likely to suffer similar feelings of rejection or neglect by services if they feel their needs are not being met or understood. Without understanding this key issue of re-traumatisation, people's reactions may simply be viewed as being disproportionate to the situation, rather than understandable in the context of their histories.

Given the well-known links between developmental trauma, emotional dysregulation and interpersonal difficulties[21], it is important that we are alert to how the past impacts on the present in terms of behaviour when carrying out assessments, and working with people who have experienced trauma. For example, where someone is rejecting of services, we may need to consider whether their behaviour is indicative of a learnt survival response, that the only way they have got through situations of threat is to escape, as opposed to simply not wanting service involvement.

Poverty and social exclusion
Homelessness is often the result of extreme poverty and social exclusion. The experience of socioeconomic disadvantage, including unemployment, low income, poverty, debt and poor housing, is consistently associated with poorer mental health[22]. Meeting one's basic needs (safety, warmth, food) can become the sole focus of existence, and people may remain in a permanent state of survival, continuously experiencing threats to their physical and mental safety and therefore constantly drawing on their survival resources, and existing coping strategies (such as substance misuse and rejection, which are likely to result in further exclusion).

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[20] Foster and Roberts, 1998 in Scanlon and Adlam, 2008
[21] Dillon et al. (2012; Read, 2014)
[22] Macintyre, 2018

In a briefing paper that formulates the psychological impact of austerity, the Psychologists for Social Change[23] movement outline five key psychological processes that may result from socioeconomic deprivation:

1. Humiliation and shame
2. Fear and distrust
3. Instability and insecurity
4. Isolation and loneliness
5. Being trapped and powerless

These psychological processes are applicable to the people experiencing homelessness, and can have a significant impact on an individual's ability to engage with mainstream mental health services, as well as other health and social support structures.

Given the current political and economic situation, mainstream services are under significant pressure. Many services are now run as pathways focusing on single diagnosis (which people often don't neatly fit into) and eligibility criteria are often tight and unyielding to 'non-standard' situations. Unfortunately, the outcome of this context is often cumulative exclusion from services and re-traumatisation.

Despite the challenges of compound trauma and risks of re-traumatisation, research also shows that organisations that adopt a trauma informed approach can help to both mitigate against the possibility of re-traumatisation and support growth and flourishing.[24]

Trauma informed care

'Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.' [25]

What is trauma informed care in practice?
In a trauma-informed service, it is assumed that people have experienced trauma and may consequently find it difficult to develop trusting relationships with support staff, and feel safe within services. Accordingly, services are structured in ways that prioritise physical and psychological safety.

Hopper (2009) describes the key principles of TIC as:

- An awareness of the nature and later expression of past trauma;
- An emphasis on safety within their systems and structures;
- Creating, within or through the service, opportunities to rebuild control;
- Adopting a 'strengths-based' approach. This approach works with the abilities and positive characteristics people may have, (or be helped to find) rather than focusing primarily on their difficulties.

A complementary framework that many services also drawn upon is the PIE (Psychologically Informed Environments) approach. The PIE framework aims to support frontline homelessness services to effectively

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[23] http://www.psychchange.org/
[24] Hopper, 2009
[25] Consensus-Based Definition Hopper, 2009

meet the social and emotional needs of their service users. The PIE concept offers direction to staff in their engagement with service users and each other through 'key elements'. The PIE 2:0 model outlines these elements as:

- Psychological awareness
- Staff training and support
- Learning and Enquiry
- Spaces of opportunity
- 'The Three Rs'
- Reflective Practice and Relationships are seen as underlining all of the above

These elements are seen to support the development of 'psychologically aware' and 'emotionally intelligent' staff teams and systems. For more information see: http://pielink.net/pies-2-0/.

TIC can be understood as both an approach that rightfully stands alone and also a 'model' for developing psychological awareness within a PIE approach.

Trauma Informed Care and Substance Use
A significant number of people who experience homelessness also use substances as a way of coping with distressing experiences. This may be understood as and called dual diagnosis.

From a trauma-informed perspective, substance misuse is way of managing the emotional impact of past and current trauma. It is one tool people use to survive in the context of compound trauma.

Mental Health assessment and formulation may guide decision-making around what intervention/service in most useful in the first instance, however joint working between Mental Health and Substance misuse services will often be key for people experiencing homelessness.

There is practice-based evidence that people can make good use of psychologically and trauma informed interventions (individual and systemic) while they are using substance and that this can help prepare them for other types of intervention.

The role of mental health professionals
Mainstream mental health teams are well placed to support frontline non-health professionals within homelessness services. Many frontline homelessness workers are extremely knowledgeable and skilled and can often offer reflective and practical ideas to manage the challenges that their residents may encounter. Specialist mental health knowledge and training can add to this existing skill base, where it can be provided through the local mental health service.

Mainstream mental health professionals may have different opportunities to engage with someone experiencing homelessness. Below are some key principles to hold in mind, although service constraints that you work within may make some of these key principles challenging to implement. These principles draw from a trauma informed and systemic framework. Practice-based evidence from mental health teams specialising in homelessness suggest that these are the most useful approaches for engaging with residents and staff teams.

Key Principles

Initial assessment and screening

Given the impact of compound trauma on people's everyday and relational lives, attending an assessment appointment is a significant achievement. Initial assessments can be a positive experience where the person experiencing homelessness and mental health challenges feels heard and understood. There is also the opportunity for your assessment to influence the wider system, through providing feedback, advice, and recommendations

1. Safety

   Consider what you can do to facilitate the person to feel safe during the assessment. Speak to their key worker/outreach worker or the person that referred them. Where possible consider what location, time, and setting may engender a sense of choice and control.

2. Boundaries
   - Interpersonal trauma often involves boundary violations and abuse of power.
   - Aim to be clear about your role and the intentions behind questions or decisions.
   - Explain your expectations and agree behaviour, where specific challenges are known to exist.

3. Respect/Control/Choice
   - Check what language people prefer to use to describe their challenges and make sense out of their experiences. They may not choose clinical terminology.
   - Involve the person in considering what kind of support, and from whom, may be appropriate.

4. Information gathering
   - Ask what has happened to the person, rather than what is wrong with them, though be mindful that sharing painful experiences in detail may be overwhelming during an initial appointment.
   - Ask about experiences of past and current trauma and negative influences of power (racism, sexism, homophobia, ageism, poverty).
   - Ask about what people have to do to survive.
   - Remain sensitive to different cultural ways of making sense out of trauma.
   - Who is in their support network? Ask about who they turn to at times of struggle.
   - Ask appropriate questions to identify any potential experiences of brain injury, learning disability and autism. This is important information in your formulation of behaviour that is challenging.

5. Elastic tolerance
   - Elastic tolerance is a term often used in homelessness services as a positive way to manage relationships. The term relates to how services understand behaviour within a trauma informed context. Behaviour is seen as a response to threat and a meaningful expression of distress.
   - The impact of trauma of the reality of homelessness may make it very difficult for people to attend specific appointment times, lengthy meetings or regular sessions. If you can, offer flexible appointment times and some tolerance around missed sessions.
   - Elastic tolerance does not need to mean being accepting of unacceptable or threatening behaviour, but may require some prior consideration of how such behaviour can be effectively managed without completely alienating the client.

6. Involve the staff team
   - If the person gives consent, invite the project/outreach/support worker into the appointment and involve them in the conversation.
   - Ask the staff member about how they prioritise physical and psychological safety in their policies and procedures.
   - Who do they have the best relationship with? Has anything change within their relationships recently?

7. Resilience Factors
   - Find out about when they are not struggling.
   - What are their strengths?
   - What is there relationship and engagement in their community?
   - What do they like doing?
   - How have they managed to keep going?

8. Safety plan (this is different to a risk plan)
   - Work with the person seeking help and the staff team supporting them to consider what factors are important in helping them to feel safe, and what might need to change as part of their safety plan.
   - Consider the physical/environmental and relational context and how the person is emotionally supported.
   - Aim to identify what the triggers may be (based on past experience) for re-traumatisation. For example, is being in a small room particularly difficult?

Case Study 2: Trauma-informed response in a hostel setting

Rosa is 44 and has lived at Fairview hostel, a medium support hostel for people who have complex needs, for the last year. Rosa has a history of developmental trauma (her father was murdered and she was abused by her step-father), domestic violence from multiple partners, offending, substance misuse and homelessness. She is currently mainly using alcohol and possibly opiates. Rosa has had previous contact with adult mental health services but had difficulty engaging due to significant anxiety about trusting unknown people.

Since a new male resident moved next door, Rosa has become increasingly distressed and pre-occupied with the idea that her father has been kidnapped and the same people attempted to kidnap and rape her. She has been found in her room shouting, screaming and hyperventilating. There was also a situation where a water leak was noticed downstairs and Rosa was found standing in her shower upstairs in "a daze". Rosa complains of feeling very depressed, she says "it must be the schizophrenia".

Rosa's longstanding keyworker, with whom she had a very good relationship, moved to a different job three weeks ago, around the time the new male resident moved next door. Rosa has been given the choice by management of a new keyworker, but has not yet decided who she will select. Before her last keyworker left Rosa, told her that she did not feel safe in the hostel and she was concerned that one of the perpetrators of the kidnapping lived there.

Within this period of high distress, staff have noticed that Rosa was calmer and positive when she was engaged in a cooking activity with a staff member and resident with whom she trusts.

After a serious altercation with the new male resident, about playing loud music, Rosa's distress levels increased to the point where staff were concerned about her safety and risks of violence to the male resident. Staff referred Rosa to the local Crisis team. In the referral staff noted their concern about whether Rosa was re-experiencing past traumas.

Before attending the appointment, the allocated social worker from the Crisis Team contacted the hostel manager to request that whoever had the best relationship with Rosa was present for the meeting. The social worker also enquired about where would be the best place to meet Rosa, in order to create as much of a sense of safety as possible. The hostel staff advised that her room would likely to be the best place. A social worker and psychiatrist from the Crisis Team attended and completed a mental health assessment the following day.

As part of the assessment the Crisis Team asked Rosa about her experience of feeling safe within the hostel. Building on Rosa's response, the hostel staff member shared some ideas about what staff members could do to facilitate Rosa to feel safe. When the social worker asked about triggers to distress, the hostel staff member was able to note their observation about the change in Rosa's mental health after the new male resident moved next door and her keyworker left. Rosa herself noted the she felt worse at night. The psychiatrist asked about the ways Rosa, and the staff, managed when the distressing feelings and unusual beliefs were strong. Rosa shared that sitting in the shared garden with a staff member can help. The hostel staff member also mentioned that when Rosa had been found shouting in her room and "in a daze" a staff member had repeated "you are safe in your room, you are at Fairview, I am here with you."

As part of the action planning from the assessment, the Crisis team, together with Rosa and the hostel staff team, agreed a number of steps that could be taken to increase Rosa's feeling of safety. It was agreed that a) the male resident would move to the other side of the building and b) a decision about Rosa's new keyworker needed to be finalised. Plans were also made to build on Rosa's existing interests (cooking), the areas of her life where the distress was not as present, and the things that she and the staff did that already helped her to manage when distress was strong. The Crisis team also made a referral to the recovery team, requesting both a medication review and input from the team psychologist. The referral suggested the benefits of specific psychological trauma work and the potential of further collaborative consultation from mental health professionals, with the hostel staff team, around creating a trauma informed environment.

Supporting and increasing the capacity of housing staff

Often the most effective way of supporting people who are homeless and experiencing mental health challenges is to work with the system of support around them. Good mental health interventions can support people and systems to maintain appropriate housing.

- Get to know the staff team and particularly the key worker of your client. They are a valuable source of information and key to implementing and enabling any recommendations that you may suggest.
- Remain mindful about fostering a respectful relationship with support staff that values their skills and experience.
- Where appropriate, offer to support staff an understanding of challenging behaviour as expressions of distress and as meaningful responses to threat, and suggest alternative methods of managing conflict.

- Work with staff teams to develop safe environments and emotionally safe relationships.
- Project/outreach workers job roles can be very challenging and staff turnover and burnout can be high. Mental health professionals have the potential to offer a containing presence to staff. Changes in staff teams can be re-traumatising to people and therefore maintaining staff wellbeing is a key systemic intervention.

Communication
- People experiencing homelessness often have a complex system of health and non-health professionals working with them.
- Where consent is given, aim to ensure that relevant information is communicated with all the people and services working with a person.
- Consider holding a network meeting before situations reach crisis point.

Choice and control
Control is often taken away in traumatic situations, and homelessness itself is disempowering. Consider how you can enable the person to re-build a sense of efficacy and personal control over their lives. This includes involving people in the planning of support, and ensuring that people are aware of all the different choices and options they have, including where they really don't have options, as is often the case in service delivery such as housing.

Triggers
- What is happening in the current environment and relationships that may be re-traumatising for this person? (e.g. gender of support worker, smell, presence of another resident, contact with family member, loss of relationship, time of year).
- Consider what environment/relational changes could be made to remove or lessen this trigger

The bigger picture
There are well-documented reviews about the limitations of prioritising psychiatric frameworks for understanding human distress above other alternative frameworks (BPS, 2018). This stance is particularly relevant in the context of homelessness, where people routinely have multiple and complex health and social care needs. Difficulties in providing effective care for people with complex needs is often seen as being an issue with the person, rather than with the inadequacy of the system around them to intervene and provide services which can work harmoniously to address their many needs. Where possible, statutory services should consider how to maximise the role of input from the voluntary sector as well as informal support, and provide input to set up 'wrap-around' care for the person.

Mental health professionals working in mainstream services may experience a conflict in between their professional training, personal values and the wider systems boundaries. Changing systems and policies to meet the needs of the most excluded people in our society, to make our services less complex, is a political and economic issue. More fundamentally, to really address the relationship between homelessness and mental health we need to address the systemic inequality that exists across our society. In the meantime, we need to consider how we can work with people in a way which seeks to minimise the impact of inequality, and hopefully some of the ideas in this guidance will support front-line workers to consider what changes they can make in their working practices to achieve this.

Mental Health Law and Homelessness

Mental Capacity Act and Mental Health Act

Professionals working within NHS mental health services will already be familiar with the key pieces of primary legislation and statutory guidance around mental health. They may have had less reason to consider them in detail in relation to the particular circumstances and risks that can apply if some is homeless.

Following the death of a man who was sleeping rough in Lambeth in 2010 there was a serious case review. Different agencies had been in contact with this man and were very concerned for his welfare, the weather was extremely cold and he consistently refused offers of shelter. After his death it was established that he had been previously been known to local mental health services. In the past he had been in hospital and been treated for major mental disorder, but had subsequently disengaged and was discharged from services. One of the recommendations of the review was the development of guidance and screening tools, relating to the Mental Health Act and the Mental Capacity Act – these are particularly orientated towards housing and outreach workers to help them frame and communicate their concerns so that better decisions can be reached in communication with mental health services.

These can be found at: www.homeless.org.uk/our-work/resources/guidance-on-mental-capacity-act
Where someone is referred to mental health services, and there is a scenario in which:

- Outreach workers (or similar) are very concerned for someone's welfare because of risks connected to their homelessness; and
- There is concern that their continued homelessness might be linked to mental health symptoms.

Directing the homelessness services to these materials, and following this up with a detailed discussion of what they then record, would be appropriate. It may be that this process enables the outreach worker to better accept the limits of what can be done to reduce risks if, in fact, there are not reasons to believe that someone's decision to decline assistance is incapacitous – in other situations it may emerge that there are grounds to consider other interventions including use of the Mental Health Act.

It is important in situations such as these that the mental health professionals give appropriate weight to different perspectives and understandings of the situation. For example, how well do the outreach team know the person involved and what are the detailed reasons that they are concerned about the risks that this person faces? Situations can emerge where experienced workers, who have spent considerable time with someone, have very legitimate concerns for someone's welfare and real grounds to believe that their decision-making is impaired, but these concerns are disregarded in favour of the perspectives of others who know the person far less well but who stick to the conviction that someone is making a 'lifestyle' choice in spite of evidence that this choice is impaired. Equally, and especially in light of the evidence highlighted above relating to complex trauma, the risks of intervening in a way which takes control away from people should never be disregarded.

Hospital Admissions

Where someone who has been, or remains, homeless is admitted to hospital there may still be a role for homelessness services. This might be in further communicating to the ward-based team the way in which someone's mental health issues impacted them in the community, and it might be that their knowledge of services and entitlements can enable an earlier or more appropriate discharge plan to be made.

The pressure on services means that NHS inpatient psychiatric services are increasingly focused on people who present with acute and immediate risks and who are often quite floridly unwell. This is a more difficult environment for people to spend time. It is also a more challenging setting for further assessment and treatment of someone for whom the risks are more chronic and whose symptoms may be less immediately evident, as might be the case for many people who are homeless.

Case Studies 3 & 4: Rough sleeping

Oleg is sleeping rough in an area. His sleep site is hidden away and he appears to lead a very solitary life, never accessing any homelessness services, and he has not been seen interacting with anyone else. His self-care is poor and it is not clear whether he is in receipt of benefits or how he is getting by in terms of food.

He tolerates contact from the local outreach team but gives only brief responses when they ask him questions, he refuses all offers of assistance with accommodation, he avoids eye contact and has on occasion appeared distracted.

The outreach team are concerned for his welfare and believe that poor mental health may be behind his homelessness and his refusal of assistance. They contact local mental health services but initially it is not clear to the person taking the referral what the reasons for contacting mental health services are.

The outreach team continue to visit Oleg and, especially as colder conditions begin, their concerns become more acute. They make contact more regularly and persist in asking him to explain about his reasons for remaining where he is. One evening he becomes more animated and expresses some anger towards them stating that he knows that "they are part of the conspiracy".

The outreach team again contact mental health services, this time they articulate their concerns more clearly – referencing the details of why they are particularly concerned about him because of his isolation and poor self-care, not simply that he is sleeping rough. They also describe more around his limited eye contact, distraction and the ideas about the outreach workers being part of a conspiracy.

The referral is accepted, and attempts are made by the assessment service to meet him at his sleep site. When contact is made, the mental health social worker who attends with an outreach worker elicits from Oleg some further ideas that appear to relate to a delusional belief system – this includes a fear that there is a plot to target him with poisonous gas and steal his blood.

When further attempts to engage him with mental health services or accept accommodation fail, he is referred for assessment under the Mental Health Act. He ends up being admitted under section, initially for assessment and then for treatment.

The inpatient team assess him as suffering from a schizophrenic illness and he is treated with anti-psychotic medication, he also accesses psychology and occupational therapy. His symptoms significantly respond to treatment. With Oleg's consent, outreach are able to remain involved, and attend occasional ward rounds. On discharge the outreach team are able to support his application to supported semi-independent accommodation outside of the area where he is an inpatient, which he qualifies for as a 'verified rough sleeper'.

George is a long term rough sleeper, referred to mental health services by an outreach worker who is concerned that he consistently refuses offers of help or shelter, even in extremely cold weather. George readily engages in conversation with the outreach workers and others in the neighbourhood where he is well known.

The outreach worker is questioned by the mental health team as to what evidence there is to indicate that mental health problems might be impacting George's decision to decline help. The answer refers to how

extreme and risky a situation George is placing himself in, but there is little that indicates that his decision-making is impaired. The outreach worker is directed towards the MCA screening tool in the guidance and offered advice about what might be relevant to consider.

With this support, the outreach team continue to meet with George and openly explore with him their concerns about the dangers he is placing himself in. George engages with these discussions, acknowledges the risks, and suggests that he would agree to accept help if his physical health were to deteriorate or if the weather was particularly bad, but he still declines assistance for now.

The outreach team are still worried for his welfare but feel more confident that they have done everything they can and accept George's choices. They continue to visit him regularly and make it clear that they can still assist if he changes his views.

The following winter George accepts a place at the severe weather emergency (SWEP) shelter when there is a particularly cold patch of weather. Following this he appears more willing to consider alternatives to sleeping out and is supported by the outreach team to apply to the council for more permanent housing. No further role for mental health services emerges.

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What we do

Homeless Link is the national membership charity for organisations working directly with people who become homeless or live with multiple and complex support needs. We work to improve services and campaign for policy change that will help end homelessness.

Let's end homelessness together

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