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

Interim Report

August 2017
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Executive Summary

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

This report details the results from Phase 1 of the study: a survey of 167 homeless people in Nottingham City. The survey was conducted between February and May 2017 in generic homelessness services. This included homelessness hostels, night shelters, day centres, refuges, Housing Aid, temporary supported housing schemes, and through street outreach workers. Some tentative insights are also offered from the small number of in-depth interviews with homeless people that had been conducted at the time of writing.

Key findings

- The results from this survey suggest that homeless people in Nottingham have significant mental health needs. This includes a disproportionate prevalence of serious mental health conditions such as psychosis and high rates of detention under the Mental Health Act.
  - three quarters of all survey respondents had experienced mental ill health and a similar proportion indicated having had a mental health diagnosis.
  - 63 per cent of survey respondents with mental health issues (or 46 per cent of all respondents), indicated a diagnosis of at least one serious mental health condition
  - nearly one in five respondents (19 per cent) had been detained under the Mental Health Act at some point in their lives

- Using established measures of wellbeing the results suggest that homeless people experience relatively poor wellbeing. In addition, a strong association was found between mental ill health and poor wellbeing with the wellbeing scores lower for respondents with mental health issues than for those without. It is also worth acknowledging those respondents who reported no mental health issues but did have below average wellbeing scores (15 per cent of all respondents). Although a minority, these respondents may form an important cohort - people who, perhaps, would benefit from intervention, or may be at risk of deteriorating mental health, or who have mental health issues that are not recognised.

- Only a small number of respondents (4 per cent) self-reporting mental health issues did not have a diagnosis. This suggests that homeless people in Nottingham have, at some point, accessed health professionals and had their mental health issues acknowledged, assessed and diagnosed. The qualitative interviews conducted thus far, however, suggest that a more nuanced analysis of diagnoses may be required. Some interview respondents felt that their mental health issues were more severe than their diagnosis, or that only certain conditions had been diagnosed while others went unrecognised. Never the less, there is no evidence of a sizeable cohort of homeless people with mental health issues who are unknown to health services. This provides opportunities for engagement, at least, and development of appropriate intervention.
There is evidence that **homeless people with mental health issues have multiple and complex needs.** Many respondents had multiple mental health issues as well as complex personal circumstances such as a history of institutional care/prison and use of alcohol and drugs. For example:

- the majority (73 per cent) of respondents with a mental health diagnosis had received more than one diagnosis.
- nearly one quarter (24 per cent) of all respondents reported dual diagnosis
- over half of all respondents had spent time in institutional settings (e.g. prison, local authority care)

The majority (66 per cent) of the homeless people with mental ill health surveyed had been homeless for longer than one year. Half had been homeless longer than two years and over one quarter (27 per cent) had been homeless longer than five years. Notwithstanding a caveat about the limited reliability of our small 'comparator sample', **respondents with mental ill health were much more likely to experience enduring homelessness than those without.** This might indicate that people with mental health issues find it much more difficult to resolve their housing problems. Alternatively, it might reflect that homelessness has a significant impact on mental health, making it likely that people who experience homelessness for longer will develop mental health issues.

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

The relationship between mental health and homelessness is complex. In some cases a clear linear trajectory can be traced from mental health to homelessness, or vice versa. Often, however, there is no clear direction of causation but, rather, a mutually reinforcing relationship sometimes mediated by other issues such as drug or alcohol use. The survey provides evidence that **homelessness impacts on mental health** with the majority of respondents (84 per cent) reporting that their mental health or wellbeing had been negatively affected by their homelessness. There were also **various ways in which respondents’ mental health precipitated, or reinforced homelessness.** This included respondents losing settled accommodation while being detained under the Mental Health Act and a minority who reported not being able to access housing because of their mental health issues.
Introduction

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

1.1. Background to the study

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

Reflecting nationwide trends, rough sleeping has risen sharply in Nottingham in the past couple of years. Meanwhile local services have been reporting an increase in clients with mental ill health, dual diagnosis and complex needs and there are concerns locally that the mental health needs of the homeless population are not being met adequately. As a result, the issue was raised with the Mental Health sub group of the Health and Wellbeing Board, prompting Public Health to suggest this to the CCG as a theme for research. Recognising, acknowledging and wanting to respond to these issues, the CCG commissioned this study to inform how they can work with local partners to better meet the needs of homeless people with mental ill health in the City, and to support the development of effective commissioning strategies for this group.

1.2. Homelessness in Nottingham

The research was conducted at a time when homelessness in Nottingham was increasing. This reflects the growth in homelessness across England in recent years. Some of the key features of the changing context within Nottingham are:

- an increase in rough sleeping;
  - in 2016, the street outreach team found 510 people sleeping rough in Nottingham. The team had already found 226 people sleeping rough in the first three months of 2017 - almost as many as they found in the whole of 2014
  - a second winter shelter was opened during the winter of 2016/17 to meet demand.

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• increased use of temporary accommodation;
  - in 2015/16, an average of 119 households per month were staying in temporary accommodation within Nottingham City. The average length of stay was 29 weeks for families and 16 weeks for single people. This is eight weeks longer for families and three weeks longer for single people than two years ago.
  - there were 804 placements in bed and breakfast hotels (B&Bs) for temporary accommodation in 2016/17. Nottingham City had zero use of B&Bs for temporary accommodation prior to 2014/15 for over a decade.

• the changing role of the private rented sector as both a cause of, and solution to homelessness;
  - most private rented tenancy agreements are ‘Assured Shorthold Tenancies' (ASTs) and can be terminated by the landlord with two months' notice and by the tenant with one months' notice. No reason needs to be provided for ending the tenancy. There has been a dramatic increase in the number of people presenting to local authorities as homeless who cite the reason for their homelessness as the ending of their AST (43 per cent of homeless presentations in 2016/17 compared to 25 per cent in 2015/16, and 18 per cent in 2011). At a national level, the ending of ASTs has been largely responsible for the growth in homeless acceptances in the past five years.3 The rise in the ending of ASTs as a reason for homelessness coincided with changes (reductions) in the amount of Housing Benefit people in the private rented sector could receive and commentators suggest this has prompted some landlords to give notice to benefit claimants renting from them.4 Other research shows that private landlords are increasingly reluctant to rent to benefit claimants because of welfare reform changes.5
  - the private rented sector is increasingly being used to accommodate households deemed to be homeless. Since the introduction of the Localism Act in 2011 local authorities in England have been allowed to meet their obligations under the homelessness legislation by accessing housing in the private rented sector for people to whom they owe the main housing duty. Wider homelessness preventative work, and efforts to help people resolve homelessness by local authorities and the voluntary sector increasingly focus on accessing private rented housing. In general, this sector is insecure (see bullet point directly above).

• new legislation and government policies are predicted to increase demand on services. For example:
  - the Homelessness Reduction Act 2017 increases the duties on local authorities to assess, prevent and relieve homelessness. Local authorities are concerned that the resource associated with the new legislation will not be sufficient to meet demands.
  - most of the financial impact of welfare reforms (83 per cent) announced in 2015 will be felt during or after 2017/18.6 Nottingham City will be one of the 10 per cent of local authorities most affected by these welfare reforms.

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1.3. The Research

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

The study is being conducted in four overlapping phases:

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

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

**Phase 3: Understanding the stakeholder perspective.** Through a series of around 20 interviews with local stakeholders (across the fields of health and housing, in the statutory and voluntary sector, and including managers, commissioners and front-line staff), this phase explores people’s experiences of working with, and commissioning services for homeless people with mental ill health and the challenges of meeting the mental health needs of this population group.

**Phase 4: Learning from good practice.** This phase involves a review of good practice to identify lessons that might be transferable to the Nottingham context and can help shape the recommendations that eventually flow from the study.

1.4. The Survey of homeless people

In total, 167 people with a recent experience of homelessness (currently or in the past 6 months) were surveyed by the study team between February and May 2017.\(^7\) Survey questions covered different aspects of mental health, wellbeing, housing and homelessness situations, access to and experience of using different services. To our knowledge, this represents the most detailed survey of mental health and homelessness conducted in England.

Surveys were conducted in generic homelessness services so as not to skew the sample towards people with mental health issues. This included homelessness hostels, night shelters, day centres, refuges, Housing Aid, temporary supported housing schemes, and through street outreach workers.

Most surveys were conducted face-to-face although some respondents chose to self-complete with guidance and checking from a member of the study team. A small number of surveys were conducted in the respondent’s first language by, or with the assistance of a staff member with the relevant language skills. Eleven surveys were self-completed without

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\(^7\) There are ‘missing’ responses against some questions and so the total number of responses to each question was sometimes fewer than 167. This occurs when respondents prefer not to answer a question, when they terminate the survey before it is complete, or where a survey/partial survey is withdrawn because of concerns about data quality. In addition, some questions were only asked of certain ‘sub groups’ (e.g. those indicating mental ill health, or those who had used services). For these reasons the results presented in this report are sometimes based on a sample of less than 167. The total number is always stated.
the presence of a researcher where it was not appropriate for the team to visit in person during the course of the survey.

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

1.5. Definitions and sampling criteria

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

Homelessness

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

We do know, however, that homeless people often move in and out of homelessness. Indeed this can be a feature of homeless people’s housing pathways – particularly those whose needs are not met. We therefore include in the study people who have experienced homelessness any time in the past six months according to the definition set out above.

No homeless sub-group is being excluded from the study providing they meet the definition set out above and currently reside (including sleeping rough) within the City of Nottingham boundary. Thus people with no recourse to public funds can participate, although are not being actively recruited.

Survey participants were recruited through services working primarily with single homeless people and interview respondents are being recruited from the survey, or through these same services. Some are statutorily homeless (i.e. owed the main housing duty), for example on the grounds of vulnerability, including mental ill health, although many are not.

We have not made a distinction for sampling purposes between those who are and who are not owed the main housing duty. This recruitment strategy means the sample is dominated by single homeless people, which reflects Nottingham City CCG’s original focus for the study. However, the definition of homelessness we are employing, and our approach to sampling, does not preclude the participation of families in the study.

Mental health

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

It is important, however, that the results do distinguish different forms and levels of mental health and wellbeing. Much homelessness research makes no distinction between mental

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8 As set out in the Housing (Homeless Persons) act 1977
9 In the context of homelessness ‘single’ refers to people without dependent children rather than people who are not in a relationship.
health and wellbeing, or between diagnosed (or diagnosable) and undiagnosed conditions. Studies frequently find very high levels of (self-reported) 'mental ill health' but it is rarely clear what this means. The survey was therefore designed to ensure we can distinguish different types and severity of mental ill health and the interview sample will include:

- people with a range of different mental health issues, from severe mental illness (enduring, psychotic conditions), to more common conditions such as depression and anxiety, to more general poor wellbeing;
- people with diagnosed and undiagnosed conditions;
- people who are and are not in contact with mental health services.

Given the interaction between mental ill health and substance misuse we will also include some people with substance misuse issues in the interview sample.

1.6. The Report

This report - the first output from the study - presents analysis of the survey of homeless people in Nottingham (Phase 1) conducted between February and May 2017. Where relevant, the survey findings are supplemented by secondary data and evidence where this sheds useful additional insight or allows us to benchmark the results. We will revisit the survey towards the end of the study, conducting further analysis as necessary.

In-depth interviews with homeless people with mental health issues and with local stakeholders (Phase 2 and 3) are ongoing at the time of writing. Although it is not appropriate at this early stage to draw conclusions from these qualitative interviews, some emerging insights are presented alongside the survey data where appropriate.

The review of good practice (phase 4) is ongoing for the duration of the study and we are gradually compiling a compendium of good practice. Until we are clear about the particular issues locally that may need addressing (i.e. following analysis of the survey and qualitative interviews) it is difficult to discern what would constitute ‘good practice’ in the Nottingham context, and may be worth transferring locally. The results from this phase are therefore best presented in the final report, when we are able to draw conclusions about the barriers locally to meeting mental health needs and can use best practice appropriately to inform our recommendations. Never the less, in this report we reflect briefly on the services, interventions and approaches identified thus far, highlighting common themes and presenting a small number of illustrative examples (see Chapter 7).
Prevalence of mental ill health amongst homeless people in Nottingham

A number of studies have identified high levels of mental ill health amongst homeless people. Homeless Link, for example, conducted a survey of over two thousand homeless people in 2014 and the results suggest that a number of severe mental health conditions are at least twice as common amongst homeless people when compared to the general population. However, most homelessness surveys/studies include only a very limited number of questions about mental health and these are often non-specific - for example simply asking respondents whether they have mental health issues with no further scrutiny. In contrast, studies, evidence and data about mental health rarely gather sufficient information about people's housing status to extrapolate data specifically for those who are homeless. In addition, national surveys such as the Homeless Link study are not able to reflect the specific profile and needs of homeless people with mental ill health in Nottingham, yet there are notable geographic differences in the scale and nature of homelessness. Some local research has been conducted that identifies high levels of mental ill health amongst homelessness service users but such evidence is scant.

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

2.1. Prevalence of mental ill health

Mental ill health was prevalent amongst survey respondents, with three quarters indicating that they had experienced mental health issues. This included respondents who 'self-reported' (i.e. agreed with the statement 'I have mental health issues'), and/or indicated that

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14 It is difficult to accurately benchmark this figure. Although there are studies assessing the prevalence of mental health amongst homeless people each uses a slightly different sample (e.g. rough sleepers, or people in temporary accommodation) or different measures of mental ill health and so results are too affected by these factors to provide meaningful comparators.
they had been diagnosed with a specific condition, and/or reported having been detained under the Mental Health Act. Taking each of these overlapping indicators of mental ill health separately:

- 62 per cent of respondents agreed with the statement ‘I have mental health issues’
- 74 per cent of respondents had been told by a doctor or health professional that they have at least one specific mental health condition (indicating a diagnosis) either in the past 12 months, or more than 12 months ago. This concurs with monitoring data from a local homelessness service (Framework) showing that in 2014 75 per cent of 159 residents had a mental health diagnosis.
- 19 per cent of respondents had been detained under the Mental Health Act either in the past 12 months or more than 12 months ago.

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

### Table 2.1 Self-reported mental health issues and diagnosis

<table>
<thead>
<tr>
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</tr>
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<tbody>
<tr>
<td>Self-reported mental health issues AND diagnosis</td>
<td>59</td>
</tr>
<tr>
<td>Self-reported mental health issues and NO diagnosis</td>
<td>4</td>
</tr>
<tr>
<td>No self-reported mental health issues but diagnosis of MH condition</td>
<td>15</td>
</tr>
<tr>
<td>No self-reported mental health issues and no diagnosis of MH condition</td>
<td>21</td>
</tr>
</tbody>
</table>

n=163

If we consider further the interaction between self-reported mental health, and diagnosis by medical professionals we find that only a small number of respondents (4 per cent) self-reporting mental health issues did not have a diagnosis (Table 2.1). This is encouraging. It suggests that the majority of homeless people with mental ill health in Nottingham have, at some point, accessed health professionals and had their mental health issues acknowledged, assessed and diagnosed. The qualitative interviews conducted thus far issue a note of caution, however, and suggest that a more nuanced analysis of diagnoses may be required. Some interview respondents felt that their mental health issues were more severe than their diagnosis, or that only certain conditions had been diagnosed while others were recognised. Typically in these cases, respondents had been diagnosed with depression by their GP and provided with medication (anti-depressants) but they felt this did not adequately identify or meet their mental health needs.

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

16 In some cases respondents may have an active diagnosis but not accept that diagnosis, or may have a diagnosis of a common mental disorder and not consider that this constitutes having mental ill health.
Nevertheless, there is no evidence of a sizeable cohort of homeless people with mental health issues who are unknown to health services. This provides opportunities for engagement, at least, and development of appropriate intervention. The qualitative interviews will explore this issue in more detail, assessing the match (or mismatch) between mental health needs and diagnosis.

2.2. Detention under the Mental Health Act

Respondents were asked if they had ever been detained under the Mental Health Act (sometimes referred to as ‘being sectioned’). The results are presented in Figure 2.1 and show that nearly one in five respondents (19 per cent) had been detained under the Mental Health Act. Four per cent of all respondents (or one in five of all those who reported having been detained) reported being detained under this legislation in the previous year. This is much higher than is found among the general population. In 2015/16, around 0.1 per cent of the population of England were detained under the Mental Health Act. The survey suggests that respondents were 34 times more likely to have been detained under the Mental Health Act in the previous year than the general population. It is worth noting however, that the survey did not distinguish between being detained in hospital for treatment/assessment and being detained by the police under Section 136 for up to 24 hours. We are exploring detention in more detail in the in-depth interviews so it should become clearer whether some of these respondents were, in fact, detained under Section 136.

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

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

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

- **Yes - in the last 12 months**: 4%
- **Yes - more than 12 months ago**: 15%
- **Don't know**: 1%
- **No**: 80%

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17 63,600 people were detained in England according to NHS figures compared to population of 54.8 million (ONS mid-year estimate for 2015).
2.3. Wellbeing

This study employs an inclusive definition of mental health (see Chapter 1.5) that encompasses wellbeing and health. It is important not to conflate poor mental wellbeing with mental health conditions. People with diagnosed mental health conditions can and do experience mental wellbeing. But health and wellbeing can have a mutually reinforcing relationship. As noted in the Nottingham Adult Mental Health and Well-being Strategy, ‘Poor mental wellbeing does not necessarily lead to mental health problems, but when they are unbalanced our mental health is at risk’ (p7)\(^{18}\).

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

The Short Warwick Edinburgh scale (SWEMWBS)\(^{19}\) is a useful and widely used measure of mental wellbeing. This scale gives a score between seven (lowest mental wellbeing) and 35 (highest mental wellbeing) and was incorporated into the survey of homeless people in Nottingham. The results are presented in Figure 2.2 and show that wellbeing scores were in the full range from seven (five respondents) to 35 (three respondents).

Figure 2.2: Mental Wellbeing scores (Short Warwick Edinburgh metric)
Overall, wellbeing scores were relatively low. The mean score for the full sample was 19.4, compared with 23.6 for England and 24.8 for Nottingham. The 75th percentile score for the sample was 22.3. This means that more than three-quarters of the sample had a mental wellbeing score which was below average. A significant minority of respondents had very low SWEMWBS scores with one third of the sample scoring below 17. It should also be noted however, that 20 per cent of survey respondents recorded scores higher than the national mean average score.

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

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

Figure 2.3: Life satisfaction scores

![Life satisfaction scores](image_url)

Exploring the relationship between mental health and wellbeing suggests there is a strong association between them. Amongst our survey sample, mental health issues are

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associated with lower wellbeing as measured by both the SWEMBWS and the ONS. For example:

- the mean SWEMBWS score for those with mental health issues was 18.2 compared to 22.8 for respondents without mental health issues\(^{23}\)
- 82 per cent of all respondents with lower than average SWEMBWS scores had mental health issues and those with the lowest scores (below 15.8) all reported mental health issues
- the average ONS score for overall life satisfaction was 3.9 for those with mental health issues compared to 6.0 for all other respondents, while the average score for anxiety was 5.8 for those with mental health issues compared to 4.2 for all other respondents.

A relationship between poor mental wellbeing and mental ill health is clearly established here.

It is also worth acknowledging those respondents to our survey who reported no mental health issues but did have below average SWEMBWS scores. This applied to 18 per cent of all survey respondents with lower than average scores, and 15 per cent of the full survey sample. Although a minority, these respondents may form an important cohort - people who, perhaps, would benefit from intervention, or may be at risk of deteriorating mental health, or who have mental health issues that are not recognised.

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\(^{22}\) Respondents defined as 'with mental health issues' are those who agreed with the statement 'I have mental health issues' AND/OR reported that a doctor or health professional had told them they had at least one of the specific conditions listed AND/OR had been detained under the Mental Health Act.

\(^{23}\) \(n=123\) and \(n=40\) respectively.
Specific mental health needs

In the previous chapter we concluded that homeless people - in Nottingham as elsewhere - have significant mental health needs and are far more likely to experience mental ill health than the general population. We reported that almost three-quarters had received a mental health diagnosis at some point. In this chapter we explore these needs in more detail, looking at the specific conditions and diagnoses reported by survey respondents.

3.1. Mental health conditions and diagnoses

Survey respondents were asked the question ‘Has a doctor or health professional ever told you that you have any of the following conditions?’ and were presented with a list of mental health issues. The results are presented in Figure 3.1 and show that the most common diagnoses were depression (61 per cent of the full sample, or 80 per cent of all those with diagnosed mental health issues) and anxiety disorder or phobia (43 per cent, or 55 per cent of those with diagnosed mental health issues) but that a significant minority of respondents had received diagnoses of personality disorder (17 per cent; or 21 per cent of those with diagnosed mental ill health), psychotic conditions, including schizophrenia and bipolar disorder (15 per cent, or 19 per cent of those with diagnosed mental ill health) and post-traumatic stress disorder (15 per cent, or 18 per cent of those with diagnosed mental ill health). Nearly one quarter (24 per cent) of respondents reported dual diagnosis (or one third of those with a mental health diagnosis). We see in Section 3.3 that although depression and anxiety were the most common mental disorders, they were frequently diagnosed alongside other, more severe, conditions (see Figure 3.4). Most respondents had received their diagnosis over than 12 months ago (see Figure 3.2) although a sizeable proportion had been diagnosed more recently.

In addition, respondents were asked if a doctor or health professional had ever told them they have a learning disability or difficulty, or if they have Autism/Asperger’s syndrome. In total, 18 per cent reported having a learning difficulty or disability and two per cent indicated a diagnosis of Autism or Asperger’s syndrome. There was significant overlap between those reporting a learning disability/difficulty and/or Autism/Asperger’s, and those reporting a diagnosed mental health condition. Only three of the 28 respondents who reported having a learning disability/difficulty and/or Autism/Asperger’s did not also report a diagnosed mental health condition.

24 It should be noted that this is much higher than the general population and is likely to include a range of issues which were perceived by respondents as a ‘learning difficulty or disability’. These could include ADHD, dyslexia, and other difficulties. These are distinct from a formal intellectual disability diagnosis.
Comparing the results from our survey with what is known about the prevalence of different mental health conditions in the general population suggests that **homeless people in Nottingham are significantly more likely to have been diagnosed with all mental health conditions than the general population.** The Adult Psychiatric Morbidity Survey 2014 represents the largest survey of mental health and wellbeing. It did not include homeless people and so provides a useful national comparator. It found that:

"One adult in six (17.0%) had a Common Mental Disorder... Other disorders were rarer, for example psychotic disorder and autism each affected about one adult in a
Bipolar disorder…traits [were found] in about one adult in fifty. Signs of drug dependence were evident in one adult in thirty, with a similar level found for probable alcohol dependence.\textsuperscript{25}

Common Mental Disorders are an umbrella term combining 'different types of depression and anxiety. They cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition.'\textsuperscript{26} Our survey of homeless people in Nottingham found that 65 per cent had been diagnosed with either depression or anxiety disorders at some point. No directly comparable national statistics are available but 16 per cent of adults currently had symptoms of CMD in 2014.\textsuperscript{27}

Statistics on local rates of mental disorders are not particularly robust\textsuperscript{28} making it very difficult to benchmark our survey results against the local population with any accuracy. In addition, local recording of mental health conditions is reported to vary widely. Rates of depression, for example, are reported to vary from 0.7 to 21.5 per cent of the population while recorded rates of serious mental illness range from 0.12 to 4.3. In 2015/16, the prevalence of depression was 7.6 per cent of adults within Nottingham City CCG area.\textsuperscript{29} The prevalence of Psychosis was found to be 0.97 per cent. Despite these variations, the upper estimates here remain significantly lower than rates of mental disorders found amongst our survey sample.

The high rates of mental illness indicated by our survey are not a surprise. Precise and reliable statistics on the nature and extent of mental ill health amongst homeless people may be limited but all available evidence concurs that rates of mental ill health are significantly higher amongst homeless people than is found in the wider population. Department of Health analysis in 2011, for example, concluded that 'people who are homeless have 40–50 times higher rates of mental health problems than the general population.'\textsuperscript{30} Homeless Link, meanwhile, concluded in 2014 that 'serious' diagnosed mental health problems are at least twice as common amongst homeless people as the general population.\textsuperscript{31}

Our survey results alone do not, therefore, suggest unusually high prevalence of mental ill health amongst Nottingham's homeless population compared to homeless people elsewhere. However, comparing our survey results to the results of a survey of homeless people conducted by the charity Homeless Link in 2014\textsuperscript{32} suggests that the range of mental health conditions may be more prevalent amongst the homeless population of Nottingham when compared to other studies of homeless people.\textsuperscript{33} The Homeless Link survey found the following prevalence of diagnosed mental health conditions:\textsuperscript{34}

\begin{itemize}
  \item p38, ibid
  \item The study team is still working to identify any local statistics that could prove a useful benchmark. Statistics regarding local rates of different mental disorders tend to have been derived by applying local population data to national statistics with a caveat that this is likely to underestimate.
  \item HM Government (2011) No health without mental health: A cross-government mental health outcomes strategy for people of all ages, p43.
  \item Homeless Link (2014) The Unhealthy State of Homelessness: Health audit results
  \item The Homeless Link survey had 2,590 respondents between 2012 and 2014 from across England.
  \item Where possible, the Nottingham survey used the same question as the Homeless Link survey so we could benchmark the results
\end{itemize}
• depression - 36 per cent. This is much lower than the proportion of respondents in Nottingham reporting diagnosed depression (at 61 per cent). Homeless Link did find that 67 per cent of respondents 'felt depressed' and 73 per cent 'often felt stressed'. Similarly, in a longitudinal study of multiple exclusion homelessness, 79 per cent of respondents 'had a period in life when very anxious or depressed'. These various self-assessments of common mental health conditions are similar to rates of indicated diagnosis in our survey. Our higher figures could potentially, therefore, reflect better access to GPs/diagnosis rather than higher rates of common mental disorders.

• PTSD - 7 per cent. Respondents to the Nottingham survey were more than twice as likely to report diagnosed PTSD (15 per cent).

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

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

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

It is worth noting, however, that the results from our survey are more in line with Department of Health (2011) analysis than with the Homeless Link findings.

3.2. Multiple mental health needs

Exploring respondents' mental health diagnoses in more detail reveals a picture of multiple needs. The majority of respondents with a mental health diagnosis reported having more than one diagnosed condition. This may provide a partial explanation for the prevalence of mental health diagnoses found in the last section. Almost three-quarters (73 per cent) of respondents with a diagnosed mental health issue reported having received more than one diagnosis. Just less than half (45 per cent) reported three or more different mental health diagnoses (See Figure 3.2).

As reported above, depression and anxiety were the most common diagnoses but because it was rare for respondents to have only one diagnosis many had more severe mental health issues. Figure 3.4 provides details on the combinations of mental health diagnoses. This shows that 63 per cent of respondents with mental health issues (46 per cent of all respondents) had a diagnosis of something other than depression and/or anxiety:

• 37 per cent of those with a mental health diagnosis (or 26 per cent of all survey respondents) had a diagnosis of depression or anxiety or both only (i.e. without any other diagnosis),

• 8 per cent of those with a mental health diagnosis (or 6 per cent of all respondents) had one diagnosis of a more serious mental health condition such as psychosis, personality disorder or PTSD

• 55 per cent of those with a mental health diagnosis (or 40 per cent of all respondents) had received a combination of two or more diagnoses, at least one of which was not depression or anxiety.

This cautions against treating homeless people in this survey as uniform in their mental health needs. It also points to opportunities to target intervention, for example at those with multiple needs.

35 McDonagh, T. (2011) Tackling homelessness and exclusion: Understanding complex lives, York: JRF
Figure 3.3. Number of Mental Health Diagnoses (respondents with a mental health diagnosis only)

- Four or more: 19%
- One: 27%
- Three: 26%
- Two: 28%

n=109

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

- Depression only: 16%
- Anxiety only: 3%
- Depression and anxiety only: 18%
- Other combination of two or more diagnoses: 55%

- One diagnosis - not depression or anxiety: 8%

n=109
The relationship between mental ill health and homelessness

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

Qualitative methods are required to explore these relationships in greater depth and so we will report on this more fully following phases 2 and 3 of the study (qualitative interviews with homeless people and with stakeholders). Some insights can be gleaned from the survey, however, and we report these here.

4.1. Mental ill health - cause or consequence of homelessness?

In an effort to explore the relationship between mental ill health and homelessness, survey respondents were asked whether they had been diagnosed with a mental health condition before or after they first became homeless. This does not, of course, establish that one impacted on the other - and there may have been no causal relationship at all in some cases - but it provides an indication of the role of mental ill health in homelessness pathways.

In fact no clear pattern emerged, with a significant proportion of diagnoses being made both before and after the first episode of homelessness (see Figure 4.1). The results did vary a little by diagnosis, however. Diagnoses of depression and anxiety were as likely to have been made before a first episode of homelessness as after. This also applied, but to a slightly lesser extent, to diagnoses of Personality Disorder and dual diagnoses. Diagnoses of Psychosis, on the other hand, were much more likely to predate homelessness and, to a lesser extent, this was also true of PTSD. In contrast, the majority of eating disorder diagnoses were made after respondents first experienced homelessness.38

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37 Nottingham City Council (2016) *Agency Data Questionnaires.*
38 The number of people with diagnoses of Psychosis, personality disorder, PTSD and eating disorders are small, particularly when divided between those receiving a diagnosis before and after they became homeless, and so must be treated with caution. For this reason we have reported the overall picture, rather than percentages and in the table we report numbers rather than percentages.
The fact that a mental ill health condition developed before a respondent became homeless does not necessarily mean it impacted on their housing situation, just as a diagnosis after an episode of homelessness does not mean the mental health condition developed as a result of that homeless experience. This is something we need to explore further through the qualitative interviews being conducted in phases 2 and 3 of the study. We do know from the survey, however, that the majority of homeless people in Nottingham feel that their experience of homelessness has negatively impacted on their mental health or wellbeing. Figure 4.2 shows that 84 per cent of respondents reported that their mental health or wellbeing was affected to some extent by their homelessness.

We also know that mental health issues (or, more specifically, a mental health crisis) prompted some respondents to lose their homes when they were detained under the Mental Health Act. The survey results show that, of all respondents (31 in total) who had been detained:

- just over half were living in settled accommodation when they were detained, but only one third moved into or returned to settled accommodation when they were discharged
- just over one quarter of respondents remained in (not necessarily the same) settled accommodation but just under one quarter appear to have become homeless as a result of being detained. These respondents were in settled accommodation when they were detained but were discharged to a situation of homelessness. It is important to note that independent living may no longer have been appropriate for some of these respondents. They may have been placed in temporary accommodation by the local authority pending an offer of suitable permanent supported housing.

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39 We do not know from the survey whether respondents had been detained in hospital for treatment/assessment or whether they had been detailed under Section 136 by the police for 24 hours.
40 This includes social and private rented tenancies, owner occupied accommodation, and living with parents or a partner on a permanent basis.
41 Including all forms of temporary accommodation, rough sleeping, squatting, and sofa surfing.
nearly half were homeless when they were detained and remained so when they were discharged. The housing situations of these respondents did not, therefore, necessarily worsen (although some did - for example those who had been in hostel accommodation but slept rough when they were discharged) but their detention had not presented an opportunity to resolve their housing problems. In total, 20 respondents (out 31 who had been detained) were discharged to a situation of homelessness.

**Figure 4.2. To what extent, if any, would you say your mental health or wellbeing has been negatively affected by being homeless?**

There is also evidence that mental ill health can affect the extent to which homeless people are able to resolve their housing problems, either temporarily or in the longer term. A small but important minority of respondents (14 per cent) stated that, whilst homeless, they had not been able to access accommodation because of their mental health issues.

### 4.2. Mediating factors - drug and alcohol use

The relationship between mental ill health and homelessness, and the impact of one on the other, is often mediated by other needs and experiences. We will see in the next chapter that this is a population group with multiple and complex needs, and we have already reported the overlap between respondents reporting learning disabilities and difficulties or autism and those reporting mental health issues (see Chapter 2). The qualitative interviews will shed more light on respondents' life experiences and additional support needs and the way these interact with their mental health issues and their housing situations. Survey data highlights the relationship between drug and alcohol use, mental ill health, and homelessness.

Nearly one third of all respondents (31 per cent) reported a drug dependency and 27 per cent reported an alcohol dependency. We noted in Chapter 2 that 24 per cent of all survey respondents (and one third of those with a mental health diagnosis) had dual diagnosis. It is not surprising to find relatively high rates of drug and alcohol use in samples of homeless people or people with mental health issues. Drugs and alcohol can be used by people to 'self-medicate' for mental health issues as well as to numb traumatic experiences, including homelessness. The experience of one respondent illustrates this point well. Following a traumatic experience while working abroad (he was eventually diagnosed with PTSD) he
started drinking very heavily until his mental health deteriorated to such an extent that he was detained under the Mental Health Act, during which time he lost his accommodation.

Drug and alcohol use can also, however, prompt the onset of certain mental health conditions (psychosis, for example) and can indirectly result in homelessness as relationships break down, rent goes unpaid, or landlords evict for anti-social behaviour. Table 4.1 shows that a significant proportion of the respondents with mental ill health ‘self-medicate’ with either drugs (most commonly) or alcohol or both, and Table 4.2 suggests that drugs and alcohol are also used as a mechanism for numbing the experience of homelessness.

**Table 4.1** Do you use drugs or alcohol to help you cope with your mental health (respondents with mental health only)?

<table>
<thead>
<tr>
<th></th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes drugs only</td>
<td>27</td>
</tr>
<tr>
<td>Yes alcohol only</td>
<td>15</td>
</tr>
<tr>
<td>Yes drugs and alcohol</td>
<td>20</td>
</tr>
<tr>
<td>No, neither</td>
<td>38</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

n=122

**Table 4.2** Do you use drugs or alcohol to help you cope with being homeless/sleeping rough? (all respondents)

<table>
<thead>
<tr>
<th></th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>41.4</td>
</tr>
<tr>
<td>No</td>
<td>58.6</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

n=162
Profile of homeless people with mental ill health in Nottingham

In this chapter we profile the survey respondents with mental health issues. The numbers of people without mental ill health in our sample are too small to provide a robust comparator but we nevertheless report these figures for information or highlight where the sample of people with mental ill health differs from those without mental health issues.

Caution is required in interpreting some of these results, particularly with regard to general demographic characteristics. The gender profile of the sample, for example, will have been influenced by the services in which surveying took place and the response rate in each. Some services were mixed but others were gender specific. To ensure that the views and experiences of women were represented, the study team actively targeted some women's services towards the end of the fieldwork (resulting in an additional 11 surveys being completed by women). In addition, there may be some groups who find existing services unwelcoming, or threatening, or not adequately able to meet their needs and so may be under-represented in any survey of homeless people. We know, for example, that women can be deterred from using homelessness day centres and night shelters and this may also apply to other groups, for example transgender people, some black and minority ethnic groups and disabled people.

Nevertheless, the survey results provide us with an indication of the profile of the population and useful insight into respondents' housing and personal situations. The study team has recently secured some local data that might provide additional information on the profile of homeless people with mental health issues in Nottingham. If this proves useful we will be able to provide a more comprehensive profile of the population for the final report.

5.1. Demographic characteristics

Broadly reflecting the wider sample, the majority (68 per cent) of respondents with mental health issues were male, while 30 per cent were female.

The age profile of respondents with and without mental health issues is presented in Table 5.1. People in all age groups are represented in the sample, and this reflects the sampling strategy employed by the study team. The age profile of survey respondents was monitored throughout to ensure the views and experiences of all age groups were represented. It is of interest, however, that the age profile of those with mental health issues is slightly older. Over half (56 per cent) of survey respondents with mental ill health were over the age of 35.

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43 A very small proportion were transgender (2 per cent, representing two respondents) or ‘other’ (1 per cent), in contrast to the sample of people without mental ill health, all of whom identified as male or female.
44 Although no targeted or remedial efforts were required to achieve this.
Table 5.1 age profile

<table>
<thead>
<tr>
<th></th>
<th>With mental health issues</th>
<th>No mental health issues</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>no.</td>
<td>%</td>
</tr>
<tr>
<td>Under 25</td>
<td>22</td>
<td>18</td>
</tr>
<tr>
<td>25 to 34</td>
<td>31</td>
<td>26</td>
</tr>
<tr>
<td>35 to 49</td>
<td>45</td>
<td>38</td>
</tr>
<tr>
<td>50+</td>
<td>21</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>119</td>
<td>100</td>
</tr>
</tbody>
</table>

The majority (72 per cent) of respondents with mental health issues were White British, although 28 per cent were from a minority ethnic group, mostly ‘Other White’ or ‘Mixed or Other’. Although the number of respondents without mental health issues is small and so the results must be treated with caution, the difference in the ethnic profile of respondents with and without mental health issues is quite stark. Black and minority ethnic respondents (BAME) were much less likely to report mental health issues than their White British counterparts. This translates into similar results when looking at the immigration status of respondents with mental health issues. British nationals reported higher rates of mental ill health issues with nine out of ten people (89 per cent) with mental health issues being British Citizens compared to half of those without mental health issues.

This is a curious result and may simply reflect that the ‘comparator’ here is not reliable. Certainly there is no evidence to suggest that BAME groups have low levels of mental ill health, and some evidence that certain BAME populations are over-represented in some psychiatric services and/or have higher levels of mental ill health. The Department of Health, for example, reported in 2010 that black men are six time more likely to be detained under the Mental Health Act than the national population while local research in Nottingham has highlighted increased risk of mental health issues amongst asylum seekers and refugees. Another possible explanation is that BAME groups have different pathways into homelessness but on the basis of this information alone, this can only be speculation. The in-depth interviews may offer further insight.

Table 5.2 Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>With mental health issues</th>
<th>No Mental Health Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>no.</td>
<td>%</td>
</tr>
<tr>
<td>White British</td>
<td>89</td>
<td>72</td>
</tr>
<tr>
<td>White Irish</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Other white group</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Black British</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Black African</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Asian British</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Indian</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Pakistani</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Chinese</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mixed or other ethnic group</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>124</td>
<td>100</td>
</tr>
</tbody>
</table>

45 Research cited in JSNA report (2016) on Adult Mental Health
5.2. Housing and homelessness situations

Current housing situation

Survey fieldwork was conducted in a range of homelessness services - hostels, night shelters, temporary supported housing schemes, refuges, day centres and through outreach workers - but no specialist mental health services were included so as not to skew the results towards people with mental health issues. Respondents were asked where they slept the previous night but as many of these 'sampling points' were accommodation providers, and none were specialist provision, responses are not particularly informative. In other words, respondents' 'current housing situation' reflects, to some extent, the study team's approach to recruiting survey participants as well as the accommodation services available in the City.

Two thirds of respondents with mental health issues were living in generic hostels, night shelters or bed and breakfast accommodation (similar to the housing situations of those without mental health issues). We cannot generalise from this - people living in temporary accommodation for people with mental health would not have been surveyed unless they used one of the day centres where surveying took place - but it does mean that people with mental health issues are living in generic temporary accommodation. Put another way, three quarters of the people we surveyed living in generic hostels, night shelters or B&Bs reported having mental health issues. This concurs with the reports of stakeholders working in generic homeless accommodation services that many of their residents have mental health problems. This is reported to raise issues for service providers (as well as residents) who do not feel adequately equipped or trained to meet the needs of people with mental ill health.

A further 13 per cent of respondents (16 people) with mental health issues were living in temporary accommodation arranged by the local authority. All respondents living in this situation had mental health issues and so it is possible some were statutory homeless people accommodated because of their mental health issues. People with mental ill health were more likely to be sleeping rough currently than those without mental health issues (6 per cent and 2 per cent respectively) although the numbers are too small to draw confident conclusions. Put another way, of the nine survey respondents sleeping rough, eight reported mental health issues.

Duration of homelessness

Respondents were also asked how long they had been homeless, at what age they first experienced homelessness, and why they became homeless for the first time. It is of some concern that the majority (66 per cent) of the homeless people with mental ill health surveyed had been homeless for longer than one year. Half had been homeless longer than two years and over one quarter (27 per cent) had been homeless longer than five years. Notwithstanding the caveat about the limited reliability of our small 'comparator sample', respondents without mental ill health were much less likely to experience enduring homelessness (38 per cent had been homeless longer than one year and eight per cent had been homeless longer than five years).

There are two potential conclusions that might be drawn from this. Firstly, that people with mental ill health find it particularly difficult to resolve their housing problems and/or are unable to access the support, help, or appropriate housing they require and so remain homeless for longer. Alternatively, these results might indicate that homelessness has a significant impact on mental health, making it likely that people who experience homelessness for longer will develop mental health issues.

It is also worth noting that respondents with mental health issues were more likely to have become homeless at a relatively young age. In total, 41 per cent of respondents with mental
health issues had first become homeless in their teenage years (compared to 21 per cent of the 42 people without mental health issues, although this only represents nine respondents). It is not clear, however, whether these respondents had mental health issues at the time they became homeless.

**Reason for homelessness**

The most common reason for respondents with mental ill health to have first become homeless was a relationship breakdown with their parents (see Table 5.3). In the vast majority of these cases (27/34 or 79 per cent), respondents indicated that their parents had asked them to leave. This concurs with local evidence about causes of homelessness amongst the wider homeless population. Table 5.3 also shows that separation from a partner and escaping abuse from a partner were two other common ways in which respondents first became homeless. In total, 14 per cent of respondents became homeless escaping abuse.

**Table 5.3. Thinking about the first time you became homeless, why did you leave the accommodation you were in?**

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

### 5.3. Multiple and complex needs

The survey evidence suggests that **mental ill health is often just one of a number of support needs homeless people present with**. Table 5.4 shows that a significant proportion indicated physical health issues, dependencies, self-harming behaviour and experience of domestic violence. Only 18 of 124 respondents (15 per cent) with mental health issues did not agree that at least one of these statements applied to them. In addition, nearly one quarter (24 per cent) of respondents with mental health issues reported having a learning disability or learning difficulty.

Respondents were also asked about time they had spent in institutional settings. Table 5.5 shows that over half indicated some kind of institutional background. In particular, a very high proportion had been in prison. Respondents with mental health issues were much more

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46 It is important to note that we do not know whether these respondents had mental health issues at the point they first became homeless.

47 See for example Nottinghamshire Homeless Watch Findings, 2015

48 Once the data for respondents without mental health is broken down by ’reason for homelessness’ the numbers are too small to draw any meaningful conclusions.
likely to have spent time in an institution (with the exception of the armed forces) than those without mental health issues.

Table 5.4. Would you say any of the following apply to you? (Respondents with mental ill health only)\textsuperscript{49}

<table>
<thead>
<tr>
<th>Statement</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have physical health issues</td>
<td>46</td>
</tr>
<tr>
<td>I have a physical disability</td>
<td>24</td>
</tr>
<tr>
<td>I sometimes self-harm</td>
<td>37</td>
</tr>
<tr>
<td>I have experiences domestic violence</td>
<td>48</td>
</tr>
<tr>
<td>I have an alcohol dependency</td>
<td>32</td>
</tr>
<tr>
<td>I have a drug dependency</td>
<td>38</td>
</tr>
</tbody>
</table>

n=124

Table 5.5. Do you have any of the following backgrounds? (Respondents with mental ill health only)

<table>
<thead>
<tr>
<th>Background</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>spent time in prison</td>
<td>60</td>
</tr>
<tr>
<td>spent time in a secure unit/YOI</td>
<td>29</td>
</tr>
<tr>
<td>spent time in local authority care</td>
<td>24</td>
</tr>
<tr>
<td>spent time in the armed forces</td>
<td>5</td>
</tr>
<tr>
<td>none of these backgrounds</td>
<td>47</td>
</tr>
</tbody>
</table>

n=110

\textsuperscript{49} 'I have mental health issues' was also included in this list of statements and asked of the full sample.
Patterns of service use; access to services and treatment

We saw in Chapter 3 that the majority of respondents self-reporting mental health issues had been told by a medical professional that they had a particular mental health condition. This suggests that homeless people in Nottingham are accessing health services. In this chapter we explore in more detail the services homeless people are accessing, the treatment and support they are receiving and how adequate and appropriate they consider this help to be.

6.1. Patterns of service use

Over half (59 per cent) of all respondents with mental ill health were accessing support or treatment for their mental health issues, with a further 19 per cent reporting that they did not need any support or treatment. Table 6.1 details the types of support respondents were receiving and shows that prescribed medication was the most common treatment, followed by help from general health providers but that many were receiving support from specialist services such as talking therapists, mental health workers and CPNs. Most of those receiving medication were also receiving support from a specialist mental health service. Of the 50 respondents prescribed medication, around two thirds were also receiving support from a CPN, community mental health team (or similar) or were accessing talking therapy.

Figure 6.1. Are you receiving any support/treatment to help you with mental health issues? (frequency of responses)

<table>
<thead>
<tr>
<th>Support/Treatment</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribed medication</td>
<td>50</td>
</tr>
<tr>
<td>Other (GP, general health provider)</td>
<td>34</td>
</tr>
<tr>
<td>Talking therapy</td>
<td>27</td>
</tr>
<tr>
<td>A specialist mental health worker</td>
<td>25</td>
</tr>
<tr>
<td>Dual diagnosis service</td>
<td>20</td>
</tr>
<tr>
<td>CPN</td>
<td>14</td>
</tr>
<tr>
<td>Peer support</td>
<td>12</td>
</tr>
</tbody>
</table>

n=79
Respondents were asked whether the support they received was from a statutory or voluntary sector agency or both. Table 6.2 shows that the vast majority (95 per cent) were receiving this support from statutory sector agencies although sometimes alongside voluntary sector support. This may reflect service provision, with mental health primarily the responsibility of statutory health services, albeit with the voluntary sector providing (or hosting) some projects and services, sometimes supported by statutory sector funding.

Table 6.2. What type of organisation is providing that support? (Respondents receiving support for mental health issues only)

<table>
<thead>
<tr>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary sector org/ charity</td>
<td>3</td>
</tr>
<tr>
<td>Statutory organisation</td>
<td>47</td>
</tr>
<tr>
<td>from voluntary and statutory services</td>
<td>15</td>
</tr>
<tr>
<td>I don't know</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>67</td>
</tr>
</tbody>
</table>

The survey also gathered evidence on the use of primary healthcare services. Table 6.3 shows that two-thirds of respondents had seen a GP about their mental health needs (44 per cent had done so more than three times). Two in five (39 per cent) had been to A&E for a mental health issue with 13 per cent visiting more than three times. Around one-third of respondents had used an ambulance (32 per cent) or been admitted to hospital (36 per cent) for a mental health issue (one in ten respondents had done so more than three times at 10 per cent and 11 per cent respectively for ambulances and hospital admissions). In contrast, less than one in five respondents (17 per cent) had used homeless healthcare services although this is, perhaps, to be expected as these are less prevalent. These findings are broadly consistent with the high levels of service use found in research by the Department for Health.50

Figure 6.3. Have you used the following services or facilities because of a mental health need?

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Respondents’ use of other, non-healthcare, services in the previous twelve months is presented in Figure 6.4. Four types of services were used by more than half of respondents. These were hostels/night shelters (80 per cent), Housing Aid (79 per cent), Benefits advice (64 per cent) and employment support (55 per cent). Some respondents indicated that they did not need these services and so the proportion of those needing these services who use them will be higher.

Figure 6.4. In the last 12 months have you used any of the following services?

Taken together, the evidence suggests that most homeless people with mental ill health are accessing some services. It is difficult, however, to draw firm conclusions from this evidence without further understanding the circumstances under which respondents used these services and their experience of doing so. Frequent use of services, for example, can indicate that relevant support is accessible and that the full range of a person’s needs is being met. Or it might indicate the opposite - that a person is moving around services precisely because none are fully meeting their needs. And just because a person accesses a service, it does not necessarily follow that their needs are adequately met there. One interview respondent, for example, lamented the reduction in the contact he now had with professionals compared with the intensity of support he had been receiving. Homeless people’s use and experience of services is a key theme being explored in the qualitative interviews.

That a relatively high proportion have presented at A&E or required an ambulance, in some cases on multiple occasions, does, perhaps indicate that appropriate mental health services have not been available or accessible to some respondents. This was certainly true for a couple of the people interviewed thus far for this study. ‘Rosie’,51 for example, described having tried, unsuccessfully, to access talking therapy and a dual diagnosis service. Desperate for some kind of help she made attempts (also unsuccessful) to be detained under the Mental Health Act. She explained that “I just thought ‘no-one’s going to do this but me’...[so I] went mental, went absolutely bonkers, I was hitting the wall and making loads of noise in a small community area and just thought someone’s going to call the police.” This resulted in involvement from emergency health and other (police) services. Similarly, research conducted in Nottingham and Nottinghamshire in 2016 identified a number of

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51 All names used in this report are pseudonyms to protect confidentiality.
respondents who specifically commented that failed attempts at seeking support from NHS services had resulted in use of emergency services when, they felt, this could have been prevented had adequate support been available and accessible. Notwithstanding these reported experiences, without further evidence we should be careful interpreting these survey results. In some cases use of emergency health services could also indicate a readily accessible health service able to rapidly respond to people's needs at a time of crisis.

The survey did gather some information about respondents' experience of services which provides some indication of the extent to which they feel their needs are being met. It is to this that we now turn.

6.2. Experiences of mental health support - meeting needs?

We reported in Section 6.1 that 59 per cent of respondents were receiving support or treatment for their mental health issues. Looking at responses in more detail, however, reveals that only 27 per cent reported receiving support or treatment that met their needs (see figure 6.5). A further 32 per cent were receiving support but indicated that this was not sufficient, or not the right kind of help, and 20 per cent were accessing no help despite feeling it would be of benefit. Assuming the 19 per cent of respondents reporting no support/treatment requirements have accurately assessed their needs, this still leaves over half (52 per cent) of respondents with mental health issues without, in their view, the support or treatment they require.

**Figure 6.5. Are you receiving any support/treatment to help you with mental health issues? (Respondents with mental ill health only)**

A similar proportion of respondents reported that at some point in the past 12 months they had needed but not received an assessment, treatment, or support for a mental health issue. Figure 6.6 shows that this had occurred on at least one occasion for 51 per cent of respondents with mental health issues. Three quarters of these respondents reported being homeless at the time.

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52 Healthwatch Nottingham and Healthwatch Nottinghamshire (2016) *Insight: Experiences and views on seeking support during a mental health crisis. Engagement activity report*
Respondents indicating that they had struggled to access the support they needed were presented with a list of potential explanations and asked if any applied. The most common reported reasons for not receiving support needed in the past 12 months were:

- couldn’t get an appointment
- I did not know where to go for help
- due to my drug or alcohol use
- waiting list

We can see here that the main barriers to accessing services are a combination of: high demand / the way in which services are accessed (as indicated by issues with waiting lists and appointments); lack of information about the services that exist and how to access them; and barriers associated with individuals’ characteristics and needs (as indicated by exclusion because of dependency). In relation to the first of these, in open ended questions asking respondents for more detail about their experiences, operational issues were raised in relation to the speed of response, with respondents reporting frustration that service providers could not or did not act ‘instantly’.

In order to obtain a broader understand of difficulties faced accessing help for mental health issues, all survey respondents (not just those reporting problems accessing services in the past 12 months) were presented with the same list of potential explanations and asked if they had ever needed but not received help for these reasons. A similar picture emerged although waiting list/appointment systems and lack of knowledge were more common barriers than thresholds for or exclusion from services (for example because of drug dependency). The most common reasons all respondents gave for not receiving the support they needed (where applicable) were:

- waiting list
• couldn't get an appointment  
• I did not know where to go for help

The results also raise issues about the way in which homeless people are treated by services. The fourth (out of 11) most common reason given for not accessing help was that 'the way I was treated initially put me off'. We do not know whether reported poor treatment had anything to do with respondents' homelessness but we do know that nearly half (46 per cent, or 29 out of 63) of respondents who had experienced difficulties accessing support said they thought they were treated differently by mental health service because they were homeless. When asked to explain this in more detail, responses revealed a deep sense of exclusion and resentment. Of the 23 respondents providing further detail, the majority highlighted a sense of stigma, or negative perceptions because they were homeless. Respondents reflected how their treatment made them feel 'judged and let down', how they felt 'belittled…looked down on' or how they were not a 'full human being'. Respondents had at times felt 'judged' by their 'appearance first before assessment'. Other respondents highlighted a sense of differential treatment because of their nationality or language/accent, and a sense of prejudice linked to their ethnicity.

With regard to services meeting other needs (housing, education, employment, drug and alcohol use) the majority of respondents with mental ill health, as well as those with no mental health needs, appeared to be accessing these services if required. We do not, of course, know the quality of respondents’ experiences, nor whether their needs were adequately met, and there are early indications from the qualitative interviews that homeless people with mental health issues often feel 'let down' by a range of services. There is also a significant minority who are not accessing these important services. Nevertheless it is worth noting that between 81 per cent and 100 per cent of respondents who needed these services reported accessing benefits advice (81 per cent); day centres (84 per cent); drug and alcohol support (85 per cent); Housing Aid (90 per cent); employment support such as Jobcentre Plus (92 per cent); hostels (95 per cent), social services (96 per cent although this only represents 22 people) and probation services (100 per cent, representing 35 people).
Meeting the needs of homeless people with mental health issues in Nottingham

Phase 4 of this study comprises a review of good practice in working with homeless people with mental health issues. It is hoped that lessons, practice and innovation elsewhere can help Nottingham City CCG and partners improve and develop services to better meet the mental health needs of homeless people in the City.

The survey results presented in this interim report have started to build a picture of these needs. However, survey data can only take us so far. It is through qualitative research with homeless people and stakeholders that we can truly understand and reveal the issues locally that need considering or addressing. And until we are clear about this it is difficult to discern what would constitute ‘good practice’ in the Nottingham context. Thus, although the study team continue to search for and compile examples of relevant services, practice and innovation, a thorough review of this material is best conducted towards the end of the study when good practice can be used most appropriately to inform recommendations.

Nevertheless, in this chapter we present some insights from an initial scan across the good practice identified, drawing also on comments made by survey respondents, who were given the opportunity to reflect on what actions could be taken to improve services in the City for homeless people with mental health issues.

7.1. Barriers to meeting the needs of homeless people with mental health issues

When reviewing the initiatives identified through the review of good practice, attention was paid to the particular issues or problems these services were set up to overcome. This provides insight into some of the barriers to meeting the mental health needs of homeless people. Broadly, these can be categorised into practical, personal and systemic barriers.

**Practical barriers** include:

- *competing priorities*, with homeless people often having a multitude of issues (housing, benefits, relationships, dependencies) to resolve. We reported in Chapter 5 that many survey respondents had multiple support needs in addition to their mental health and, of course, all had severe housing problems to address;

- *having no fixed address*, for example to securely receive post (including notification of appointments or results) or to register with services;

- *understanding and navigating health services*. This can prove difficult for anyone but for vulnerable people the complexities of the system can be prohibitive. This is an issue that
has also been identified locally in the Mental Health Joint Commissioning Groups report into adult mental health;\textsuperscript{53}

- travel costs, for example to attend appointments;
- frequent mobility, that might demand reregistering, transferring between services and may result in missed communication about treatment and appointments.

**Personal barriers** include:

- negative prior experiences of mental health services, that can deter people from engaging further. We reported in Chapter 6 that prior experience of 'poor treatment' by services was commonly cited as a reason why respondents' mental health needs had not been met;
- low confidence, that can deter people from seeking help and approaching services;
- poor literacy/limited knowledge of services. We reported in Chapter 6 that 'not knowing where to go for help' was commonly cited as a reason why respondents' mental health needs had not been met.

**Systemic barriers** include:

- strict access criteria for mental health services that can leave some homeless people with mental ill health failing to meet high thresholds, or excluded because of other needs (for example drug or alcohol dependency). In turn, this results in limited support for people with lower mental health needs.
- stigma. We reported in Chapter 6 that some respondents felt they were treated differently by mental health services because of their homelessness and associated stigma. For others the stigma association with homelessness can deter them from approaching services for help
- inappropriate communication methods for people with no fixed abode. This echoes some of the 'practical' barriers above, including continued reliance by some services on written communication
- referrals from GP required, representing an additional 'hurdle' to pass before accessing the service required.

These barriers are not necessarily specific to homeless people - they may apply to other vulnerable groups also - nor to mental health services. Indeed homeless people experience many of these problems accessing other services. These are, however, some of the issues that have been identified elsewhere in relation to homeless people's access to appropriate mental health support and have prompted service developments for this client group.

### 7.2. What works? 'Good practice' in meeting the mental health needs of homeless people.

Survey respondents were asked what action might be taken to improve services for those experiencing mental health issues. Their responses are informative, indicating as they do the types of initiative and broad approaches that homeless people feel would most effectively meet their mental health needs. These views had formed from personal experience of existing services and attempts to access appropriate support.

\textsuperscript{53} http://jsna.nottinghamcity.gov.uk/insight/Strategic-Framework/Nottingham-JSNA/Adults/Adult-Mental-Health-(1).aspx
Responses were varied, but coding these open statements revealed some key themes. Basic changes in communication were suggested, for instance, providing freephone telephone numbers, advertising services on ‘big posters in town [or] random pop up stalls’, or signposting for people leaving hospital or prison. These suggestions chime with one of the key barriers identified by some services included in the good practice review above - i.e. methods of communication that are inappropriate for homeless people.

Beyond these improvements in communication other prominent suggestions related to the intensiveness of the support on offer, or the nature of the treatment/support. These suggestions accounted for nearly a quarter of all responses, focusing on extending support rather than stopping it prematurely, or increasing time with mental health professionals rather than focusing on medicinal remedies. This latter issue was powerfully summarised by one respondent who noted ‘more help is needed in therapy, as in…someone to talk to or turn to, to stop the feeling of hopelessness’. Several qualitative interview respondents also expressed a desire for some form of talking therapies or commented that their therapy has recently been reduced.

One discrete area for improvement was in enhancing individuals' sense that professionals care, that they can be trusted, and that they will listen. One survey respondent reflected on their desire to find a professional 'that cares and understands the support you need'. This chimes with the views expressed by some of the homeless people interviewed in-depth. Jack is a case in point. This young man had few positive words to say about the health, housing and social care services he had encountered in his lifetime but spoke very positively about one particular service. When asked to explain why this service was different he said simply that "They actually seemed to care."

Additional improvements were suggested in relation to speeding up access to services, improving health professionals' knowledge of homelessness, and providing services in a more peripatetic way.

From an initial scan of good practice examples, there are a number of approaches that are relatively common, and appear to be working well. We provide brief details of these and include an illustrative example.

- **Peer support**: attention is drawn to peers’ ability to draw upon personal experiences and, as such, develop a shared understanding, decrease stigmatization, develop trust and empathy, provide role modelling, provide key support for navigating through complex and fragmented systems, and increase engagement with healthcare services. Such services are found to reduce use of A&E and days spent as inpatient, and reduce substance use among persons with co-occurring substance use disorders (see for example, *Groundswell Homeless Health Peer Advocacy*).

- **Having dedicated mental health workers within homelessness services**: working within the homelessness sector, dedicated mental health workers have a good understanding of the client group and so are able to deliver an empathetic, non-judgemental service, understanding the barriers homeless people can face. Clear goals and a well-defined role within the organisation or team are reportedly important. One example is the *Mental Health Coordinators at Crisis Skylight*. While there were some challenges in delivering this service, the coordinators view themselves as delivering an innovative and effective service response.

- **Promoting partnership working**: meeting the mental health needs of homeless people requires services to work together which may not have established close links. *The Homeless Patient Advisor at the Cornwall Homeless Hospital Discharge Project* is in a unique position to bridge a gap between services that want to work together but find it challenging to do so. Key members of operational staff and decision-makers, in hospitals, mental health facilities and partner agencies, are encouraged and supported to
adopt the protocol so that agreed care pathways for discharged patients are consistently followed.

- **Improving accessibility:** For example, the first point of access to Leeds No Fixed Abode Health Centre is through a daily drop-in mental health clinic that any person, once registered at the practice, can access whenever they wish to. The team also works closely with outreach agencies, to facilitate a way into appropriate interventions for those people experiencing difficulty in accessing the service.

- **Addressing language barriers:** For example, the team at HHELP has a Somali worker with a specific role to work with the Somali population. Hidden homelessness was identified as a particular issue in the Somali community and somebody who was familiar with the culture and acceptable in the local mosque was required to access this population. There are many people ostracised from the community who are sleeping in cars or sleeping out and who may be using Khat houses, who the worker has made contact with.

- **Sustained involvement with service users:** intensive support and key working are approaches found to be effective in a number of service areas including family intervention projects and homelessness. They are flexible, often delivered to the client in their own environment as well as within a service, and aim to provide help over as long a period as is necessary. The key is engagement. The Leicester Homeless Mental Health Service has adopted some of these principles. They say that, "our goal, when working with people with a history of complex trauma, is as simple and as complex as just staying in touch with them. Many are trapped in a cycle of abusive, transient relationships, aggression or substance misuse which may lead them to be excluded from hostels and back onto the streets. We try to make our service as accessible as possible by meeting people wherever it suits them".
Conclusion

The survey results presented in this interim report confirm the need to consider homeless people in the development of mental health commissioning strategy and in service delivery across sectors. Our results show that homeless people are very likely to have mental health issues including a disproportionate prevalence of serious mental health conditions such as psychosis and high rates of detention under the Mental Health Act. Homeless people are, therefore, very much the concern of the CCG and NHS services. Strategically, agencies may have to identify and respond to the needs of this particular client group if local objectives, targets and priorities are to be met. Improving mental health - and reducing the proportion of people with poor mental health by 10 per cent by 2020 - is a key objective of The Nottingham Plan, for example,\(^{54}\) and the local Health and Wellbeing strategy identifies mental health as an early intervention priority.\(^{55}\)

There are some encouraging results from the survey. There does not, for example, appear to be a significant cohort of homeless people with mental health issues in the City who are completely unknown to health services, and most of those self-reporting mental ill health have had mental health issues identified by a medical professional.

However, other results may give cause for concern. For example, it is clear that many homeless people with severe mental ill health issues are living in generic homeless hostels. These environments are likely to be inappropriate for those with serious mental ill health and can also create issues for other residents and service providers who may not be skilled in working with people with mental health issues and linking them into relevant health services. And despite evidence that homeless people with mental ill health are accessing health and mental health services, there is a significant proportion whose needs are not being met. There are those who have not accessed appropriate treatment or support, as well as those for whom the support on offer is inappropriate, inadequate or simply not intensive enough. There are also those whose diagnoses do not match their own understanding of the nature and severity of their mental health issues. Whatever the reasons, it appears that many homeless people in the City are facing barriers to accessing appropriate help, or are falling through gaps in provision.

We can perhaps illustrate some of these issues with the story of one women interviewed in depth for this study. Rosie has a long history of drug dependency and intermittent homelessness and has suffered periodic severe depression. She was evicted from her last tenancy because her violent partner, from whom she separated, damaged the property. She feels her mental health issues extend beyond depression and she would like an assessment and diagnosis. In desperation, she once ‘faked’ a crisis episode in the hope of being detained under the Mental Health Act. During a period of depression, she was referred for

\(^{54}\) [http://www.onenottingham.org.uk/?page_id=4198](http://www.onenottingham.org.uk/?page_id=4198)

talking therapy. She explained what happened when she was turned down after her initial telephone assessment:

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

Yet, later in her interview, when she talked more about her attempts to access mental health support and treatment she made the following comment

"I feel like I have got some mental health going on and I feel like I've always wanted a bit of a diagnosis as to what's going on with me, but when I've asked I've not been mental enough to access services"

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

Until we have completed Phase 2 of the study (qualitative interviews) we will not know how typical Rosie's story is, nor what specific barriers there are - for service providers and commissioners as well as for homeless people - to meeting the mental health needs of homeless people in the City. These results are not, however, particularly surprising. After all, the CCG commissioned this research precisely because of local concerns that the mental health needs of homeless people in the City were not being met adequately. In itself, that is a positive step forward towards a situation where homeless people's mental health needs will be better understood and relevant agencies will be better equipped to respond appropriately. But this journey is unlikely to be straightforward, and there may be no easy solutions. Our survey has highlighted that homeless people often have multiple and complex needs. This can include several mental health conditions as well as other support needs (poor physical health, learning disabilities, history of care and custody) with dual diagnosis particularly common. We know from studies of homelessness that it is not possible to disentangle these needs and experiences so meeting the mental health needs of homeless people is likely to demand a much broader understanding of homeless people's situations, than just their mental health.