Homeless Health Community of Practice – summary report

Homelessness and mental health provisions in London – June 14, 2021

January 2022

Overview

On June 14 2021, Healthy London Partnership (HLP) convened the first pan-London Homeless Health Community of Practice event to gather colleagues working across health, housing and the third sector to highlight the prevalence of mental health conditions among people experiencing street homelessness.

Attendees included colleagues from service providers, clinicians, commissioners, and experts by lived experience of homelessness. This event aimed to present models of service delivery and spotlight examples of good practice, discuss challenges and gaps in mental health provisions and identify desired outcomes to steer future planning and commissioning of pan-London mental health services for people experiencing homelessness.

Attendees were briefed on a recent scoping review into mental health provisions in London conducted by Public Health England (PHE) London[1] to provide a snapshot of mental health prevalence among rough sleepers. The review also mapped out the availability and accessibility of mental health services across London.

Presentations three organisations delivering or coordinating mental health provisions in London were als shared, highlightning examples of outreach work and steps taken by providers to coordinate or deliver services that were trauma-informed and co-designed with people of lived experience.

The following report summarises the presentations and discussions which took place during the event.

Pan-London mapping of mental health services

Dr Huda Yusuf presented on PHE's London's work to undertaking a mapping exercise of services across London's five ICS's including service providers, outreach, counselling and

[1] As of 1 October 2021, Public Health England was replaced by UK Health Security Agency and Office for Health Improvement and Disparities

therapy providers, Improving Access to Psychological Therapies (IAPT), self-care groups and referral pathways and their criteria.

Mapping illustrated that mental health provision in London is currently a combination of mental health trusts, services including RAMHP, EASL, STaRT/SLaM and voluntary organisations providing outreach work.

This audit identified gaps across boroughs in terms of data capture where a client's homelessness is not always recorded, as well as activity in relation to those experiencing homelessness, and funding gaps. It was noted that there are currently 11 inclusion health GPs across London.

Mental health care for people experiencing homelessness in London

The review highlighted a strong and consistent association between trauma and homelessness and recognising that being homeless itself is a traumatic experience.

Likewise, compound trauma (experiencing multiple episodes) with varying severity, frequency and range of experiences also impacts on mental health problems which creates a vicious cycle of childhood trauma, homelessness, and mental health.

Drawing on health assessments conducted by UCLH Find&Treat over 1244 people, findings showed that:

- 50% of people experiencing homelessness had depression and anxiety,
- 21% alcohol use,
- 16% drug use and
- 16% dual diagnosis of mental health and drug/alcohol use.

However, prevalence of mental health conditions is reported to be higher from studies conducted across the UK.

Studies and research highlighted that mental health issues are more prevalent among those experiencing homelessness compared with the general population, in turn highlighting stark health inequalities.

Mental health conditions among the homeless population

While psychosis is more prevalent amongst people experiencing homelessness, it was noted that severe and enduring mental illness is not the main disease category. Rather, the most prevalent conditions are anxiety and depression, complicated by complex childhood trauma and personality disorder, undiagnosed disabilities such as autism spectrum disorder, learning disability and acquired brain injury, and substance misuses.

For women specifically, homelessness and mental health may be more prominent due to experience of sexual abuse, violence, separation from children and the breakdown of relationships.

There is also an overlap between substance misuse and homelessness.

Access to assessment and treatment

In terms of challenges of access to assessment and treatment, there is limited engagement with services, potentially unpredictable behaviour such as not attending fixed appointments or maintaining a relationship with one or multiple professionals. There are additional barriers such as dual diagnosis (substance misuse and mental health), clients not being registered with a GP or lacking an address or access to a phone/internet to receive letters, calls or emails.

Evidence on mental health interventions included:

- evidence from the Housing First scheme where five schemes which operate in London have shown improvements in physical and mental health among users. 12 months on from entering the scheme, there was also a reduction in alcohol and substance misuse among users, as well as an increased social integration with friends and family
- NICE guidance on prevention, assessment and early identification, treatment, recovery and ongoing support, and end of life care also offers evidence on mental health interventions.

Findings

There was a need for coordinated and integrated care due to co-occurring mental illness and substance misuse disorders being prevalent among this population, which can result in challenges in accessing relevant medical care.

Integrated care where mental health and housing are jointly provided to homeless populations has been shown to have a greater impact than providing mental health services alone (McHugo et al., 2004).

Early intervention and outreach via street triage services/mental health assessments should be routinely provided, likewise ensuring that outreach workers, approved mental health professionals, ambulance staff, doctors and police are trained around the Mental Health Act 2005. Findings also highlighted that the training for the wider workforce should be informed by the voluntary sector organisations such as Groundswell's Peer Advocacy Service.

In terms of access to assessment and treatment, outreach teams can find it challenging to refer clients into mental health services due to the person not meeting referral criteria, providing insufficient evidence, substance misuse and some only accepting referrals from a GP. There can also be challenges due to gaps in staff knowledge and skills and understanding of the complex needs of those experiencing homelessness and providing trauma-informed care, also the challenge of rough sleepers' frequent mobility.

Service delivery models

Examples of services which illustrate what works and good practice were highlighted including, amongst others:

- EASL: outreach and mental health assessments) Enabling Assessment Service London) works with a variety of partners including St. Munhos, Thames Reach and Look Ahead and London boroughs including H&F, City of Westminster, Islington, and Newham.
- START: a specialist community MDT service provided by the South London and Maudsley NHS Foundation Trust (SLaM).

Rough Sleeping and Mental Health Programme (RAMHP), funded by the Greater London Authority (GLA) and Ministry of Housing, Communities & Local Government (MHCLG) and coordinated by Imperial College Health Partners.

Enabling Assessment Service London (EASL)

Barney Wells, Director of Enabling Assessment Service London EASL introduced the service, background on its formation and good practices which have been identified through service delivery.

EASL is a social enterprise formed in 2011/12 to provide assessments, advice and capacity building to homeless organisations working alongside them to offer support to their staff via an experienced mental health practitioner with assessments or by highlighting a client's priority need for secondary mental health support or housing needs.

Recognising the need to develop better statutory service with ongoing treatment and connections to other parts of the NHS, as well as the need to work without a threshold for assessment and working alongside an organisation a client is already working with. EASL training and resources including toolkits share learnings from the voice of lived experience.

These teams help to discuss a person's needs without need for an assessment and extends to clients who may not have engaged with mainstream services, however not having an ongoing relationship with clients means there is a challenge of ongoing support.

EASL is also commissioned to provide capacity build in some boroughs including Hammersmith & Fulham, Newham and Westminster to support homelessness services with training, case discussion and assessment work.

The service has also been commissioned by the GLA, providing assessment and advice input to outreach teams in areas in London without an NHS statutory homeless mental health service.

START: a specialist community MDT service provided by the South London and Maudsley NHS Foundation Trust (SLaM)

Dr Jenny Drife and Fran Busby from START/SLaM team presented on the team’s services and links to the third sector and local authorities.

The START team undertakes assessments and treatments for street homeless people in Lambeth, Southwark and Croydon and accepts referrals from the voluntary sector, street outreach teams, day centres and local authorities including police and A&E teams.

START works in collaboration with third sector to undertake joint outreach, support and advice, run clinics and drop-in sessions at day centres whilst also facilitating networks with housing, police, street wardens and primary care. During the Covid-19 pandemic, START provided mental health care and support to approximately 180 clients accommodated in GLA hotels.

The team will work with anyone with mental health needs which are thought to be keeping them sleeping on the streets. Clients need to be recorded on the Combined Homelessness and Information Network (CHAIN) system for the team to conduct and assessment and

suggest plans for support. CHAIN is a multi-agency database recording information about rough sleepers and the wider street population in London.

The team follows assertive outreach and consists of 18 practitioners across disciplines – medical, nursing, psychology, social work, OTs, peer support and others. The team conducts assessments, support with care planning, benefits and housing, medication, therapeutic interventions, practical and emotional support, as well as delivering MHA/MCA Care Act and safeguarding.

In terms of best practice, services are flexible and offered in a time and place which works for the client, for example on the street, via day centres, hostels or cafes. To facilitate engagement, work is trauma focused and psychologically minded, offering relational support using a key person to build up rapport with a client, practical focus, managing small caseloads and flexible drop ins.

Rough Sleeping and Mental Health Programme (RAMHP)

Christine Norman and Fiona Wallace presented on the Rough Sleeping and Mental Health Programme (RAMHP) and coordinator role of Imperial College Health Partners.

RAMHP is a two-year pilot programme funded by the GLA and MHCLG, aiming to support increased access to mental health services for people sleeping rough across 16 London boroughs by building teams of mental health practitioners who work directly with outreach services.

The RAMHP programme was established through the Mayor of London's rough sleeping strategy to help people who are sleeping rough with mental health needs and take a vital step towards a better quality of life.

The programme considers local needs and approaches of trusts and co-working with outreach teams and local stakeholders, within the area and reflecting their differing population needs. As such, the programme is co-developed with local stakeholders whilst reflecting a shared overarching strategy. Each RAMHP team is centrally coordinated by Imperial Health partners whilst being locally led.

RAMHP teams are all tailored to the local area/trust but share the following key approaches:

- assertive outreach in model of service delivery as the core referral route
- focus on navigation and advocacy
- cross-borough working
- partnership working with outreach agencies
- multi-disciplinary teams
- trauma-informed

The programme is designed around partnerships with cross-sector teams working and learning together to deliver outcomes. As a two-year pilot, this is also a learning opportunity to inform the commissioning and development of better services in the future.

Summary

Findings from the mental health provisions scoping review, presentations and attendee comments and discussions highlighted the need for consistent and stable support to clients with funding instability noted as a key challenge. Consistent and collaborative working across the health and housing sectors was also seen as key takeaway for successful service delivery.

For local systems to fill gaps in services, there is an underlying need to understand this population, who they are and what barriers they encounter when accessing care. In response to the findings of the scoping review, there is an ambition to make mental health provisions a priority across London through local leadership and community champions, integrating housing and health, transformation of services to respond to this vulnerable group.

This can be achieved through;

- flexible models of mental health care,
- expansion in primary care supported by specialist services, and MDT
- early assessment and prevention,
- establishing a pan-London clinical care pathway that avoids geographical boundaries,
- improving data capture and collection,
- activity and monitoring,
- integration of different services and organisations,
- training of staff in assessment,
- trauma-informed care and reflecting practice and,
- learning from the voice of those experiencing homelessness.

Next steps

A multi-sectoral Task and Finish group has been convened to develop the recommendations put forward in the scoping review. As of November 2021, meetings take place monthly with HLP's Homeless Health team providing secretariat support for this group.