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

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

Abstract

Purpose - This paper reports on an analysis of arrangements in English mental health trusts to meet the needs of adult homeless people. Mental ill-health is disproportionately higher amongst the homeless yet they are underrepresented in accessing mental health services. In recent years, government strategy to improve health outcomes for the homeless and practice guidance on work with this service user group has emphasised the need for NHS services to improve care pathways and service provision for the homeless, and collaborate more closely with homelessness organisations.

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

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

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

Mental Health Review Journal

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Introduction

This paper reports on a Freedom of Information Act 2000 (FOIA) based analysis of how the mental health needs of adult service users who are homeless are being addressed by English mental health NHS trusts.

Being without a home has long been associated with increased psychiatric morbidity. Homeless people are disproportionately likely to suffer depression, anxiety and serious mental illness, and to engage in self-injurious behaviour (Fazel et al., 2008, Folson and Jeste, 2002, McGiloway and Donnelly, 2001, Sims and Victor, 1999, Sundin and Baguley, 2015). Yet, they are underrepresented in accessing mental health services.

Various factors contribute to this underrepresentation (see Bhui et al., 2006, Bines, 1994, Crane and Warnes, 2001, Homeless Link/St Mungo's, 2012, Rae and Rees, 2015, Williams and Stickley, 2011 for overviews). The extent to which homeless people's social and medical needs are intertwined makes it difficult to assign responsibility for care to one professional group over another. Because of more pressing practical concerns, homeless service users do not usually seek help until health problems reach a critical stage and urgent or emergency care is required. They are often not registered with a general practitioner and can struggle to arrange and attend appointments in primary care provision through which secondary care services are accessed. They can also fall between alcohol/substance misuse and mental health services with unmet needs in one regard precluding access to the other.

Work with the homeless is, furthermore, commonly a challenging emotional labour. On account of experiences of trauma and discrimination, homeless people can present with combinations of vulnerability and volatility. They can be highly ambivalent about professional help, stimulating over- and under-identification from professionals and complicating the degree to which work with them can be reflected upon and ethical and appropriate care provided (see Scanlon and Adlam, 2006, Whittington, 2011).

Mental Health Review Journal

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Over the past six years, government strategy to improve outcomes for the homeless and practice guidance on working with the homeless in healthcare settings has emphasised the need for NHS services to utilise the expertise of homelessness organisations in local service planning and policy making (Faculty for Homeless and Inclusion Health, 2013, HM Government/Department of Health, 2011, HM Government, 2011). This guidance emphasises the need for careful consideration of care pathways between homelessness and healthcare provision and the utility of migrating clinical services closer to the homeless in the form of open-access clinics and health professionals being co-located in homeless agencies. Evidencing what works in intervention with homeless people suffering mental ill-health is a work in progress, but, overall, systematic analyses of controlled studies indicate that coordinated community provision is superior to usual care, and that good mental health and housing outcomes have been linked to 'assertive outreach' models of psychiatric care and close collaboration with housing providers (Coldwell and Bender, 2007, Hwang et al., 2005, Rees, 2009, Wright and Tompkins, 2006). Of course, this does not necessarily mean that these are the approaches implemented. As Hannigan (2013) points out, in the context of austerity and cuts to provision, it is provision with the most limited or an equivocal evidence base that has its funding withdrawn first, even if it serves vulnerable groups or a valuable community purpose.

Several secondary care services in England targeting the adult homeless population have been documented, a notable example of which are the dedicated teams established in London through the Homeless Mentally Ill Initiative 20 years ago (see Perry and Craig, 2014, Craig et al., 1994). Such initiatives are though, Hewitt and Halligan (2010) note, rarely the result of NHS and local authority commissioning and Joint Strategic Needs Assessments (JNSAs), but rather tend to be services that 'have been chiselled out by local champions, against active and passive resistance from commissioning bodies' (p. 306).

Mental Health Review Journal

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Recent studies addressing homeless people's access and use of mental health services in England depict a less than favourable situation. Crane and Warnes (2011), for example, examined access to health care services in South Yorkshire for single homeless people i.e. persons without a home, but who do not meet priority need criteria for the local authority to house them under homelessness legislation. In their study, only 26% of the homelessness staff they surveyed believed current arrangements for accessing mental health services worked well, 48% said 'yes and no' and 26% 'no', they did not work well - with long waiting times and delays in accessing treatment and advice cited by participants. Furthermore, in interviews with 61 homeless people, most (79%) volunteered that they had some form of mental health 'issue' and 57% that they had received a formal diagnosis. However, of this group, only 37% said they were currently receiving treatment.

A similar account is provided in a survey of 2590 homeless people by Homeless Link (2014). Of this sample, most (80%) reported having some form of mental health problem (diagnosed or undiagnosed) and 45% as currently having a specific diagnosis. More positively than Crane and Warnes survey, nearly half (44%) of this sample were of the opinion they had received appropriate support. At the same time, just under 20% had received no mental health input and 28% of those already receiving input would have preferred more.

Focussing on commissioning and policy making, Hutchinson et al. (2015) scrutinised the content of JSNAs and Joint Health and Wellbeing Strategies (JHWSs) for references to single homelessness. They found no correlation between the level of homelessness and the level of prioritisation by local authorities and health services. Most JSNAs (86%) referenced homelessness in some form but only 28%, provided substantial information concerning single homelessness and just 6% of JHWSs included a section dedicated to single homelessness with 61% failing to reference homelessness entirely.

Mental Health Review Journal

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

Method

FOIA legislation was used in this study because of the potential it offered to maximise the relevant data that might otherwise be obtained via conventional survey methods. Coming into force in 2005, the FOIA institutes a public 'right of access' to information held by public authorities. It obliges public authorities to publish information about their activities and enables members of the public to request information directly and free of charge.[1] Traditionally the preserve of journalists, there is a growing body of literature addressing the use of the Act in research as means of accessing diverse sets of institutional data (Bourke et al., 2012, Lee, 2005, Savage and Hyde, 2014). To date however, it has tended to be undervalued by researchers, particularly in the health and social care disciplines (for exceptions see Brooker et al., 2016, Murray, 2013, Fowler et al., 2013).

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

- A description of how the adult homeless population and their mental health needs are worked with in the trust and whether there is any provision dedicated to this population.

Mental Health Review Journal

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- If there are any specialist projects or professional roles, to describe this in as much detail as was reasonably possible, including numbers of staff and professional disciplines, particular psychiatric conditions and/or sub populations worked with, and the intervention models/approaches informing practice.
- To provide an indication of the training trust professionals have access to or undergo to improve staff awareness around, and knowledge in, working with homeless service users.

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

The traditional dichotomising of primary and secondary research to identify ethical issues in research does not transfer straightforwardly to research using freedom of information legislation (Savage and Hyde, 2014). FOIA generated data is not in the public domain when the research begins and requests are sent but becomes so when it is provided by a public authority. In this way, a FOIA based approach bears similarities with established methods of data collection such as interviews and questionnaires. However, unlike these methods, the responsibility for removing personal information and ensuring confidentiality resides with the public authority to which the request is made rather than the researcher and it does not pose ethical issues in the same way as research involving gathering data directly or

Mental Health Review Journal

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require the same level of ethical scrutiny (Savage and Hyde, 2014, pp. 310-311). For this study, following Savage and Hyde's (2014) recommendation, a protocol to respond in cases where trusts disclosed personal or sensitive information was developed.[1] Moreover, even though it is not generally expected of FOIA research, approval for the study was sought and gained from the Research Governance and Ethics Board of the university department in which most of the research team were based when the research began.

Findings

Of the 51 trusts with whom contact was made, 49 (96%) responded with information that could be utilised in the analysis. All these trusts responded within a reasonable timeframe, most within a month of receiving a request. Responses to questions varied from a single short sentence to documents of several hundred words as well as policy briefing documents and web links.

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

1. No special arrangements or services for adult homeless people as a distinct group.
2. Specific arrangements within existing universal mental health services, including referral pathways or links to local homeless agencies, which catered for the adult homeless
3. Dedicated professionals or teams delivering a service for adult homeless people.

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

Mental Health Review Journal

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No special arrangements

Fifteen trusts (31%) provided very brief responses, reporting their services were universal and oriented towards meeting the needs of all individuals equally within their geographic catchment and thus no more information could be provided.

Often these responses included an implicit or explicit rejection of a standpoint favouring dedicated or specialist service provision for the homeless, making blanket statements along the lines of '*Our trust seeks to ensure that policy development and the design and implementation and services is tailored to the diverse needs of the population we serve, and that no one group is placed at a disadvantage over others*'. The implication being, in contrast to practice guidance emphasising the need to proactively engage this service user group (Homeless Health Faculty, 2012, Keats et al., 2012), that special or dedicated provision is not only unnecessary but, in a sense, discriminatory. Another common statement in these responses was that there was no recording of information relating to homelessness within the trust. Although homeless people could be using mental health services provided by the trust, they were unable to specifically identify individuals who were by way of the information systems they had in place.

Specific arrangements

Twelve trusts (24%) indicated they had developed specific arrangements within existing services, recognising the particular needs identified as a characteristic of the homeless population. These arrangements encompassed proactive multi-agency liaison with other providers, including local authority housing or third sector organisations providing services ranging from supportive accommodation to drop-in services. They did not however involve

Mental Health Review Journal

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workers or teams with a specified or exclusive remit for addressing the mental health needs of the homeless.

Dedicated arrangements

Responses from 22 trusts (45%) indicated special arrangements in the form of dedicated provision. These trusts described close links between the trust and accommodation projects, hostels, local authority housing departments, housing forums, third sector homeless resources (including drop in centres, drug and alcohol services), and mental health charity organisations. Some responses indicated there were protocols for liaison over hospital discharge procedures, and housing allocation and support issues in place.

Twelve of the trusts with dedicated arrangements described teams dedicated to working with the homeless including case management capacity of both a short-term and long-term nature. The teams varied in size, from three to nine FTE professionals. Responses indicated team sizes were commonly closer to the lower end of this range and made up of part-time posts. Teams were multi-disciplinary with a range of professional groups represented, including psychiatrists, psychologists, social workers, occupational therapists, support workers, and most often, mental health nurses. All responses in this group stated that work was undertaken directly with adult single homeless persons, and referrals were accepted from accommodation providers and other homeless agencies. Reflecting the more developed evidence base of this approach and establishment in some areas through earlier initiatives (Coldwell and Bender, 2007, Craig et al., 1994), the majority incorporated outreach work, including assertive community treatment. This involved work on the streets, in hostel accommodation and shelters, and initial assessment and long-term support with the objective of accommodating or rehousing and reengaging service users with mental health services in

Mental Health Review Journal

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the locality. Some teams also provided psychotherapy, counselling or a group therapy element.

The 10 trusts without teams but in the dedicated arrangements grouping had professionals in posts devoted to homeless mental health. The activities of these practitioners included consultation with mental health professionals on cases involving homelessness issues and visits to accommodation projects or drop-in centres. There was also secondment, ‘crossover’ posts, and direct or liaison work with local authorities and third sector organisations, for example a psychiatric nurse working within a local authority’s housing options team. Five of the trusts in this group, spanning those with dedicated teams for meeting the mental health needs of the homeless and those without, described involvement with primary healthcare services dedicated to the homeless. In a few cases, this involved trust mental health professionals being seconded to these primary healthcare teams, and a part focus on refugees. A few trusts also reported in-house accommodation professionals who liaised with hostels and other accommodation providers.

In some responses, dedicated arrangements were reported as subject to the changing priorities and the funding capacity of the organisations engaged in partnership arrangements, clinical commissioning groups and local authorities, within which there could be differing provisions in sub-districts of a trust’s catchment area.

Training

Across the three groups of trusts, there was little evidence of organised training to improve staff awareness of, and knowledge in, working with the homeless. Of the 15 trusts with no dedicated arrangements or services in place, four services stated some training had been made available. This sometimes involved covering work with the homeless but was mostly one

Mental Health Review Journal

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element of broader training programmes professionals had access to inside and outside of the trust on matters such as accommodation, equality and diversity and risk management.

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

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

Discussion and conclusion

This study was a preliminary and exploratory consideration of the arrangements in place for adult homeless service users in English mental health trusts. It can be considered limited in terms of the level of information that could be obtained across trusts and from trust information professionals specifically, and the fact it was not linked with other data addressing local population needs and levels of homelessness. We can, for instance, note that, in general, dedicated arrangements tended to be based in trusts serving larger metropolitan areas. Also, trusts in northwest and south coast areas were more likely to have dedicated

Mental Health Review Journal

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arrangements than other parts of the country. However, the study resources and data set we worked with, prevented going beyond this and providing a more in-depth mapping of provision.

These limitations notwithstanding, this study is the most comprehensive and up-to-date analysis of its kind and has implications for policy, practice and further research - one of which is the value of freedom of information legislation for research into organisational awareness of a particular issue and the uptake of policy or practice guidance across services (see also Fowler et al. 2013, Murray, 2013).

Overall, the findings add further evidence to the argument that homeless people's needs are not being adequately considered by mental health providers in England and that a lack of suitable care pathways exist through which they may access them (Crane and Warnes, 2014, Homeless Link, 2014, Hutchinson et al., 2015). They establish that there are pockets of dedicated outreach and targeted psychotherapeutic work, and that homeless peoples' mental health needs are, at least, considered in most mental health trusts. However, arrangements can vary considerably between trusts and in a number of trusts, there are no arrangements in place at all.

Work being carried out in primary care and other services may put this variability in some degree of context. In particular, homelessness organisations themselves have been developing more sophisticated approaches to mental health needs in recent years, particularly psychological trauma, as, for example in the 'psychologically informed environments' initiative, which have been seized upon by housing services and commissioners (see, e.g. Haigh et al., 2012, Keats et al., 2012). This said, it cannot be disputed that the issue of homeless mental health should be on the agenda of all public mental health care providers if homeless people's needs are to be properly addressed. It is especially concerning that many

Mental Health Review Journal

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of the responding trusts do not just lack arrangements for the homeless and training to raise awareness of barriers homeless people face in accessing care and treatment, but also fail to monitor whether homeless people are accessing the services they provide.

Mental health trusts need to more seriously consider how they are tailoring provision to the needs of the homeless and the training trust professionals can access to work more effectively with this service user group. On the basis of what is known about what works in homeless mental health and practice guidance on working with the homeless in healthcare settings, it is specious to maintain that tailoring provision for this service user group or close working relationships with homelessness organisations are unwarranted and that homeless people remain well served by mainstream care pathways (Faculty for Homeless and Inclusion Health, 2013, Rees, 2009, Homeless Link 2014). Homeless people may make use of mainstream pathways. But they are not being discriminated against, as some trusts implied, when additional, dedicated arrangements are put in place given the many barriers they already face in accessing care and treatment and the stronger likelihood they have of suffering mental ill-health.

Finally, with regards to future research, it bears acknowledging that this analysis was undertaken at a time the NHS in England is being radically overhauled with the Health and Social Care Act 2012 devolving responsibility for decisions about local healthcare resources to clinical commissioning groups (to more closely align resource allocation and local needs and reduce health inequalities and the ‘postcode lottery’ of care, whereby a certain treatment may be available in one area but not another). Building on the analysis reported here, we have begun an analysis of information gathered from clinical commissioning groups across England regarding their activity around homeless mental health, including partnership arrangements between NHS providers, local authority housing teams and homelessness organisations. By way of this, we will be further exploring the range and scope of provision

Mental Health Review Journal

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available through primary and secondary care pathways, independent and voluntary providers and determine the prioritisation of homeless mental health by commissioners as a health inequality amongst others. There, nevertheless, remains a need for research that can supplement this that addresses awareness raising of homeless mental health, the impact of austerity measures on the availability of mental health input to the homeless population and the respective use of, and relationships between, different (NHS and non-NHS) provision at a local level.

Mental Health Review Journal

Notes

1. Outside of requests that are 'vexatious' or the amount of labour required to locate and collate information is unreasonable, and in which case, charges can be instituted.
2. This included, in the case of responses which revealed personal information, returning responses to trust representatives, querying their desire to disclose the information concerned. Some trusts publish responses to requests online, for which reason no direct quotes from responses have been included in the analysis to preserve anonymity.

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Mental Health Review Journal

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