

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

**Executive Summary**

**July 2018**



# The mental health needs of Nottingham's homeless population: an exploratory research study

## Executive Summary

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# Acknowledgements

This research was undertaken by a team from the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University on behalf of Nottingham City Clinical Commissioning Group (CCG). The Research Team would like to thank current and past members of the Research Steering Group - Rachel Illingworth, Rachael Harding, Clare Fox, Katherine Biddulph, Jane Bethea and Liz Pierce - for their ongoing support throughout the study. The research would not have been possible without the commitment of the 37 interview participants and 167 survey respondents from across housing services in the City of Nottingham who gave us their time and talked openly with us. We are particularly indebted to the many generic housing services across the City for allowing us to conduct the survey and interviews in their premises and for their efforts in helping the team facilitate participation, specifically: Framework, Opportunity Nottingham, Emmanuel House, The Arches, Nacro, YMCA, Nottingham Community Housing Association, Housing Aid, and Women's Aid.

Special thanks must also go to all the stakeholders from across the NHS (CCG and providers), Local Authority (housing, social care, and public health) and voluntary sector who gave their time to share their views and expertise with us. Thanks to Nottinghamshire Healthcare NHS Foundation Trust for support in accessing secondary data. The Research Team would also like to thank Sarah Ward and Emma Smith for their administrative support throughout this project.

# Executive Summary

This is a summary of the findings from the research. Further details can be found in the full report which is available on the CRESR website.<sup>1</sup>

## Rationale and Methodology (see Chapter 1)

Rough sleeping and homelessness have risen sharply in Nottingham in the past couple of years, reflecting nationwide trends. The relationship between health and homelessness has also increasingly been recognised, establishing homeless people as the concern of the CCG and NHS services.

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 comprised four overlapping phases:

*Phase 1: Understanding the population.* This phase of the research drew on primary research and secondary sources to profile the mental health needs of Nottingham's homeless population. 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. Survey fieldwork was conducted in a range of generic homelessness services. No specialist mental health services were included so as not to skew the results towards people with mental health issues.

*Phase 2: Understanding the citizen story.* This phase of the research comprised in-depth interviews with homeless people with mental ill health in Nottingham. The qualitative interviews with 37 homeless people with mental health needs were conducted in a smaller number of homelessness services, purposely targeted to maximise the diversity of the sample.

*Phase 3: Understanding the stakeholder perspective.* Through a series of interviews with local stakeholders this phase explored professionals' experiences of homeless people with mental ill health. Interviews were conducted with 23 stakeholders working at a strategic/policy, managerial, and front-line level in a range of organisations across the NHS, Local Authority and voluntary sector.

*Phase 4: Learning from good practice.* This phase involved a review of good practice to identify lessons that might be transferable to the Nottingham context.

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<sup>1</sup> <https://www4.shu.ac.uk/research/cresr/reports>

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:

- Homelessness. We adopted the legal definition of homelessness as set out in the Housing (Homeless Persons) Act 1977.
- Mental Health. An inclusive definition of mental ill health was employed, which ranges from mental disorder through to poor mental wellbeing. However, the survey was designed to ensure we could distinguish different types and severity of mental ill health.

## **Prevalence of mental ill health amongst homeless people in Nottingham (Chapter 2)**

A number of previous studies have identified high levels of mental ill health amongst homeless people. Mental ill health was prevalent amongst respondents to our survey in Nottingham, with three quarters indicating that they had experienced mental health issues. In addition, one in five respondents had been detained under the Mental Health Act at some point in their life. More broadly, mental health issues were associated with lower wellbeing amongst our survey sample.

## **The mental health needs and conditions of homeless people in Nottingham (Chapter 3)**

Homeless people in Nottingham are significantly more likely to have been diagnosed with all mental health conditions than the general population. Exploring respondents' mental health diagnoses in more detail reveals a picture of multiple mental health needs. Depression and anxiety were the most common mental disorders, and they were frequently diagnosed alongside other, more severe, conditions. Within our survey sample, almost two thirds of respondents with mental health issues (almost half of all respondents) had a diagnosis of a severe mental health condition (i.e. a condition other than depression and/or anxiety).

A number of broad patterns emerged relating to the onset and triggering of mental health issues amongst the homeless people interviewed for this study:

- Long-term mental health issues. Many respondents had experienced mental health issues - although not always diagnosed as such - for numerous years, often since childhood or adolescence.
- Mental health issues were typically triggered by a specific event, or ongoing trauma rather than developing independently of life experiences, and/or;
- Pre-existing but managed mental health issues were further exacerbated, or brought to crisis, by life events including stress, trauma and homelessness.

The association between mental health issues and adverse experiences in childhood signals a critical intervention opportunity. The coincidence between mental health issues and homelessness and other poor outcomes in adulthood, such as substance misuse and offending, points to a potential need for upstream preventative measures.

## **Housing situations and experiences (Chapter 4)**

Understanding how and why people become homeless and their subsequent homelessness trajectories provides insight into their wider needs. The survey data show that the most common reason for respondents with mental ill health to have first become homeless was a

relationship breakdown with their parents. Respondents with mental health issues were more likely to experience enduring homelessness.

Insights from the qualitative interviews offer a more in-depth and nuanced account of the causes and triggers of participants' homelessness. There were often considerably more complex factors at play and long chains of life events behind the single reasons captured in the survey responses. In a small number of cases, respondents had become homeless because of problems with their mental health. A number of triggers for homelessness emerged including leaving prison, leaving care, domestic violence and issues with the asylum system.

Homelessness repeated itself, as most participants lacked a secure family unit to offer a home and safety net when things went wrong; and as complex and severe needs were not met with appropriate support. Nearly all of the people we spoke to had been 'stuck' in the temporary accommodation system for years - moving in and out with only brief spells of relative stability. It is vital for future interventions to take into account the features of these homelessness pathways, and the reasons for participants' homelessness.

### **Mental ill health: cause or consequence of homelessness? (Chapter 5)**

The relationship between homelessness and mental ill health is complex. In some cases there may be a clear linear trajectory from mental ill health to homelessness, or vice versa. Often, however, there is no clear direction of causation but, rather, a mutually reinforcing relationship which is often mediated by other needs and experiences, in particular drug or alcohol abuse. It is absolutely clear that homelessness has a detrimental impact on mental health and wellbeing and can exacerbate existing conditions. With few exceptions, respondents had some form of mental health issue prior to their first episode of homelessness. However, the experience of homelessness can bring people to the point of mental health crisis.

Some of the key themes which emerged were that:

- A mental health crisis resulting in detention under the Mental Health Act presents a homelessness risk.
- Drug and alcohol use and mental ill health are usually deeply interlinked, and sometimes rooted in the same traumatic experience, and it is difficult for people with dual diagnosis to disentangle them in order to address them separately or sequentially.
- Mental ill health and homelessness (and drug or alcohol abuse) are rarely the only challenges faced by this population. This leads on to discussion of multiple, complex needs.

### **Additional support needs (Chapter 6)**

Homeless people with mental ill health might be more accurately described as having 'multiple or complex needs' or as a population facing 'multiple exclusion homelessness.' Our findings concur with the results of other studies of 'multiple exclusion homelessness' that find a high degree of overlap between experiences of homelessness and other domains of social exclusion (including mental ill health). They conclude that multiple exclusion homelessness is often positively associated with adverse life experiences particularly childhood deprivation and trauma.

We undertook logistic regression analysis of survey data and found that, within our model, homeless people were:

- 11 times more likely to have a mental health diagnosis if they had spent time in prison.
- Six times more likely to have a mental health diagnosis if they had physical health issues.
- Six times more likely to have a mental health diagnosis if they had experienced domestic violence.
- Four times more likely to have a mental health diagnosis if they were aged under 25.

The qualitative interviews strongly mirror the results from the regression model. It is rare for mental ill health and housing problems to be the only issues facing this population group. These findings suggest that certain sub-groups of homeless people may be particularly at risk of mental ill health. This has important implications for service commissioning and delivery. It presents opportunities for targeting intervention and preventative work.

### **Understanding multiple exclusion homelessness: the distinctiveness of the client group (Chapter 7)**

Distinct features of homelessness - multiple exclusion homelessness in particular - influence access to support services and people's capacity to engage. Our research highlights some of the distinctive features of homelessness, or characteristics of homeless people with complex needs:

- Daily survival is a challenge for homeless people and represents a set of priorities that most housed people don't have. As a result, mental health is not always prioritised.
- There can be a very small window to effect change that is incompatible with the slow process of accessing many services (e.g. waiting lists).
- The family circumstances of homeless people with complex needs are often chaotic, conflictual, or insecure. This means that family and friends may not represent the safe, supportive, stable environment that it does for others.
- Homeless people's previous experiences of support services often results in a lack of trust of others and/or a strong sense of self-reliance.
- This is a particularly transient population.
- Progress, and recovery can be slow.
- Low self-esteem, or feelings of hopelessness are common.

### **Patterns of service use and engagement (Chapter 8)**

The majority (over half) of homeless people with mental ill health who feel they need support or treatment, are accessing services. However, one in five respondents were receiving no support or treatment, but required it. Prescribed medication was the most common treatment, followed by help from general health providers. The following themes emerged from the research:

- A wide range of mental health services were being accessed by homeless people in Nottingham.
- The majority of respondents were also in contact with non-mental health services.
- The majority of respondents had been prescribed or offered a prescription for medication.



- No significant issues emerged with regard to accessing GPs.
- A small but important minority of respondents first received mental health support (any, or the first beneficial support) while in prison.
- The support and treatment interviewees received after a mental health crisis - i.e. suicide attempt, hospital admission, hospital or police detention under the Mental Health Act - was very variable.
- Support or treatment from mental health services in Nottingham, was sporadic, uneven, and did not always align with respondents' needs.
- There was some evidence of inappropriate use of services by interviewees. This included asking professionals to detain them under the Mental Health Act.

## **Homeless people's experiences of mental health services (Chapter 9)**

Survey responses suggest that only just over one-quarter reported receiving support or treatment that met their needs. This is not a surprise. After all, it is for this reason that Nottingham City CCG commissioned this study. The key reasons why homeless people were unable to access the support they required were:

- not having mental health needs acknowledged;
- falling between service thresholds;
- dual diagnosis;
- waiting lists;
- inappropriate or 'dead-end' referrals.

Respondents' experience of the support and treatment they received was diverse. The support and treatment itself was generally welcomed and respondents derived some benefit from it. There was a general willingness amongst respondents to engage with statutory and voluntary sector mental health services. A number of services that stakeholders singled out were working particularly well. These were the Primary Care Mental Health Service, several specific GP surgeries, a CPN to the homelessness health team and Opportunity Nottingham. However, very few respondents had received comprehensive, effective, and consistent support throughout their mental health journey.

## **Homeless people's service preferences (Chapter 10)**

Stemming from their experiences, respondents had their own ideas and suggestions about what might improve mental health services in the City. Key preferences were:

- the help of an 'advocate' or 'navigator' to access and negotiate services;
- access to mental health support at known and trusted services;
- improved communication and advertising methods;
- more 'holistic' mental health support which would be part of a wider package and would also include help with securing housing;
- to feel like they were being 'listened to' and 'cared about';
- to see more immediate-response, crisis services;



- support from someone who had been through the same experience ('formalised peer support');
- more training to improve health professionals' knowledge of homelessness;
- more continuity in services and staff (to avoid having to re-tell their story);
- longer-term, ongoing and more intensive support for mental health.

## **Barriers to meeting the mental health needs of Nottingham's homeless population (Chapter 11)**

Our research highlights the key barriers facing homeless people, and the services working with them, in meeting mental health and associated needs. There was broad consensus across stakeholders that over the last two decades mental health, homelessness and other support services had been cut in Nottingham. The national programme of austerity has affected service provision in the City. Barriers to meeting needs also operate at the individual, organisational, and structural levels, although these are not mutually exclusive. Some of the main barriers identified were:

- Insecure and inappropriate housing;
- Thresholds for services as a barrier to access;
- 'Silo' commissioning and delivery: (not) taking responsibility;
- Inflexible service models: fitting square pegs in round holes;
- Professional knowledge and training;
- Limited services able to work with people with complex needs;
- Inadequate linkages and pathways through support and treatment.

## **Learning from Good Practice (Chapter 12)**

The Big Lottery Funded 'Fulfilling Lives' programme, and the individual projects funded within that programme (of which Opportunity Nottingham is one) provide excellent examples of good practice in working with people with complex needs.

There are a number of common themes amongst those identified as potentially representing good practice:

- common single assessments;
- direct access services;
- peer support;
- having dedicated mental health workers within homelessness services;
- intensive support and key working;
- promoting partnership working;
- co-creation, design and delivery of services;
- strengths-based models which focus on facilitating people to see their own strengths.

## Conclusions and recommendations (Chapter 13)

The results from this study confirm the need to consider homeless people as a specific group in the development of mental health commissioning strategy and in service delivery across sectors.

A key conclusion from this study is that 'homeless people with mental ill health' are a population that could accurately be described as having multiple and complex needs.

There does not appear to be a significant cohort of homeless people with mental health issues in the City who are completely unknown to health services. This offers important opportunities for engagement. There have also been some positive developments locally, including:

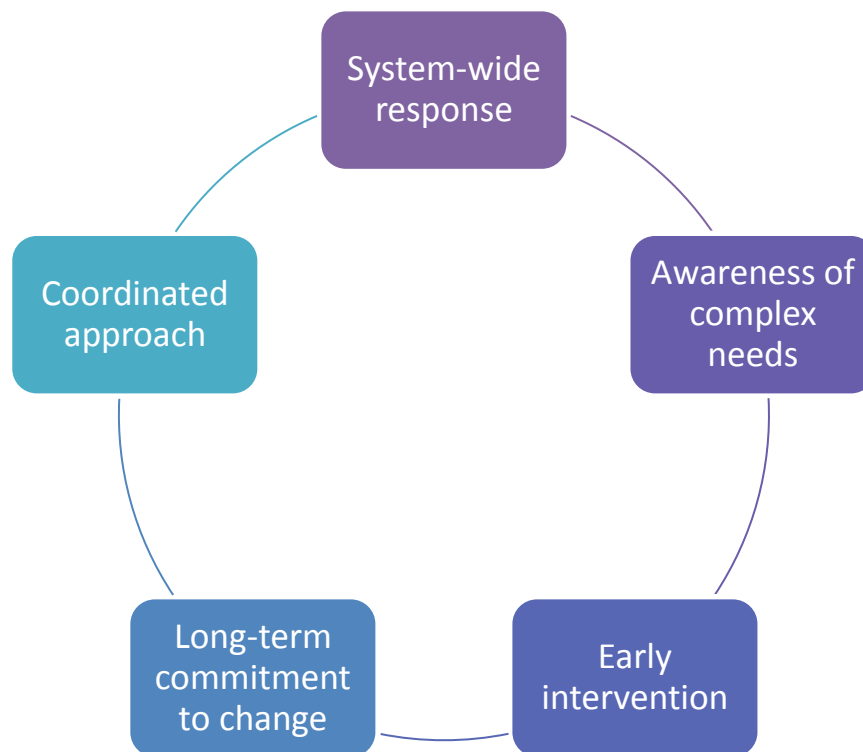
- the newly commissioned Primary Care Mental Health Team;
- the addition of the CPN to the Homeless Healthcare Team;
- Opportunity Nottingham's successful bid to the Big Lottery's Fulfilling Lives programme for a seven year project for people with complex needs that started in 2015 (a partnership, with Framework the lead delivery partner);
- As the study was drawing to a close, local partners were scoping out the potential for a Housing First approach in the City.

Despite these more positive findings, the results from the study were clear that the needs of homeless people with mental ill health are not currently being met in the City. Very few of the homeless people participating in the study were receiving appropriate, consistent support or treatment that met their needs. Issues relating to the accessibility of services were particularly prominent and very few current services are targeted at (or able to work with) people with complex needs. Issues related to the supply and appropriateness of supported accommodation for homeless people with mental health issues (and complex needs) is leaving many living in inadequate temporary accommodation that undermines recovery and, in some cases, exacerbates or engenders mental health crises.

These challenges are not unique to Nottingham and there is good practice elsewhere that local agencies can learn from, to help them design and commission provision that will better meet needs. Drawing on the findings presented in this report and the good practice review, we made a series of recommendations to Nottingham CCG and other local stakeholders within Nottingham. We believe that, if actioned, these recommendations have the potential to significantly improve homeless people's access to, and the effectiveness of, mental health and related support and treatment. These recommendations were based on five key principles.

## Recommendations

### Key Principles



- 1. System wide response.** The mental health needs of homeless people within Nottingham cannot be met by any one service. The interconnections between issues relating to housing, mental health and wider support needs mean that a range of services will need to co-ordinate their response. This may result in the integration of services and budgets. It is vital that there are clear pathways of support, particularly at points of transition (e.g. hospital discharge, leaving prison, care leavers).
- 2. Services founded on awareness of complex needs, and histories of citizens.** All commissioners and providers of support will need to ensure that they are aware of the particular difficulties faced by homeless people with mental health and other complex needs. This will include the need to ensure that staff receive training to deliver services based on Trauma Informed Principles. It will also include the need to recognise the diversity of experiences within this group (e.g. domestic violence, BME, no recourse to public funds). It also requires shifts in culture and processes to better accommodate people who are homeless through flexible, less conditional and more inclusive delivery models (i.e. rather than, or in addition to commissioning new services).
- 3. Early intervention.** The aim must be that all citizens receive the support they need in order to prevent homelessness amongst people with mental health issues (and all citizens more generally). In order to do this, there is a need to ensure that interventions take place at the earliest possible opportunity (i.e. in childhood or early adulthood). Homelessness exacerbates mental health issues so we need to do everything possible to prevent people with mental health issues reaching this point. This is needed to prevent the human cost of those who experience mental ill health and homelessness but also to prevent the financial cost to public services.

- 4. Long-term commitment to change.** An awareness of the client group and their complex support needs requires a long-term commitment to change across all sectors (Housing, Health and others). There is a need to (re)design services around long-term, intensive and non-time limited support so that staff can better meet needs and spend time building clients' trust. Long-term commitment to change also involves learning from and incorporating good practice from projects/models found to work effectively with people with complex needs. These could include peer support, common single assessments, intensive support and key working, partnership working, co-creation and delivery of services and strengths-based models.
- 5. Coordinated approach for people with complex needs (proactive broker / advisor / navigator).** The sustained involvement with service users that comes with intensive support and key working are crucial for effective treatment. There is a need to provide support to individuals in navigating often complex and fragmented systems, and in turn, helping to increase this group's engagement with healthcare services. This approach would also include a central assessment and information point where client data can be shared with other service providers (removing the need for multiple assessments and ensuring that service users do not have to tell their story to different agencies several times). It is important to place the person at the centre of this system, i.e. the person gives permission for their information to be shared across agencies.