mentalwelfare commission for scotland

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VISIT AND MONITORING REPORT

Themed visit to homeless people with mental ill health

JULY 2017

Contents

The Mental Welfare Commission for Scotland

What we do

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

We do this by

- Checking if individual care and treatment is lawful and in line with good practice.
- Empowering individuals and their carers through advice, guidance and information.
- Promoting best practice in applying mental health and incapacity law.
- Influencing legislation, policy and service development.

Executive summary

Introduction and background

The Commission carried out a small-scale project to explore how homeless people with experience of mental ill-health access and experience homeless and mental health services. We visited 43 homeless people with mental health problems in July – October 2016 in two local authority areas, one rural and one urban.

Who we visited

Of the 43 people we visited:

- Only seven (five men and two women) were experiencing homelessness for the first time.
- Thirty (68%) were male and 13 (32%) female.
- Twenty six told us they have depression, and 14 of these had recently self-harmed or had suicidal thoughts.
- Four people told us they have a bi-polar disorder.
- Eight told us they had a diagnosis that included psychosis, schizophrenia or schizo-affective disorder. Five had been detained under the Mental Health Act in the past.
- Thirteen were parents of children under 18.
- Seventeen men and two women told us they had spent some time in prison. Seven said the main reason they were homeless was as a result of being in prison.
- Fourteen (32%) had been looked after children in the care of the local authority.
- Twenty (12 male, eight female) had experienced sexual or physical abuse.
- Seventeen people told us that they currently had issues with drugs, including two with problems with both drugs and alcohol.
- Thirty six were unemployed.

Key findings

- Seventeen people felt they faced discrimination, particularly from private landlords.
- Thirty seven of the 43 people we saw were registered with a GP, but we heard about significant difficulties getting registered. Five of the 26 people who told us they have depression were not registered with a GP. Access to a

GP is crucial for mental health support and for referral to specialist services if required.

- On release from prison there is often a delay in accessing medication due to difficulties registering with a GP and GPs' reluctance to prescribe without input from a hospital consultant.
- Homeless services told us that access to psychiatric services was very difficult to arrange and there was a particular need for better arrangements out of hours.
- People with a dual diagnosis have difficulty accessing either mental health or addiction services as mental health services will not see people with addiction problems and addiction services refuse to see someone with mental health symptoms. This has been identified in the Scottish Government's new Mental Health Strategy: 2017-2027 as an area in need of improvement.
- We heard that staff in the homeless accommodation can be very helpful and offer a great deal of support, but many people experience difficulty and delays accessing psychological therapies.
- We heard from many people that the benefits system is not set up well for homeless people and in particular for people with mental health problems:
    - Personal Independence Payment (PIP) interviews are often not easily accessible for people with mental illness and sanctions are applied if appointments are missed.
    - The community care grant process is slow. This can have a major impact on people who are homeless because it can result in people having to pay rent for a tenancy, but unable to claim housing benefit because they can't move in until they receive the community care grant, which pays for essential items. This can mean people build up arrears.
- We heard that if the local authority offer a tenancy then someone in temporary accommodation is obliged to take it, which can lead to problems if the person is not ready to move on.
- The three young people we met aged 16-17 were all known to Child and Adolescent Mental Health Services (CAMHS).

Conclusion and recommendations

We found a picture of significant needs only partially met. Although some people were receiving the care and treatment they needed, others were not, or had had difficulty accessing it. We saw engaged and committed homelessness services supporting people with significant mental health needs but lacking direct referral routes to psychiatric and psychological services. We heard that the only access

route to these services was via the GP, but that there could be barriers to registering with a GP. We also heard that there is a disconnect between mental health and substance misuse services, and that people who need both may get neither.

Recommendations for supporting homeless people's mental health

NHS boards/health and social care partnerships should:

- Remove barriers experienced by people who are homeless to registering with a GP, to enable access to GP services for physical and mental health and to specialist mental health services where required, and consider linking GPs to homelessness services to facilitate access.
- Consider the needs of homeless people in the local psychiatric emergency plan and consider how mental health services can respond out of hours to crises in homelessness units.
- In line with Actions 27 and 28 of the Mental Health Strategy: 2017-2027[1], review the working of mental health and substance misuse services to ensure that individuals with dual diagnosis are fully supported.
- Require prisons-based NHS staff to:
    - Ensure that individuals who may be homeless are assisted to register with a GP prior to release, where necessary by requesting that the GP practice register the prisoner as a temporary resident. This would allow the sharing of information pre-release, so that health problems can be addressed in the community.
    - After appropriate risk assessment, ensure that all people leaving prison and requiring medication have continuity of care - for example, by providing both a small supply of medication and a prescription.

Local authorities should:

- Review and improve how they carry out their duties as corporate parents under the Children and Young People (Scotland) Act 2014, to ensure that appropriate aftercare is provided for former looked-after young people under 26 to prevent homelessness.

The Scottish Government should:

- Ensure the new Scottish agency set up to administer social security payments is fully accessible to people who are homeless.

[1] http://www.gov.scot/Publications/2016/07/7151/0 Action 27: Test and learn from better assessment and referral arrangements in a range of settings for dual diagnosis for people with problem substance use and mental health diagnosis; Action 28: Offer opportunities to pilot improved arrangements for dual diagnosis for people with problem substance use and mental health diagnosis.

- Address the links between homelessness and mental health, and the support needs of homeless people with mental health problems, in any future strategy on homelessness.

The Mental Welfare Commission will also take forward some of the issues in our own work. We will:

- Look at advocacy provision for homeless people in our new role under the Mental Health (Scotland) Act 2015 to monitor how NHS boards and local authorities carry out their duties to provide advocacy services.
- Produce new guidance on alcohol-related brain damage and the use of mental health and incapacity law.
- Review how we can include homelessness in other areas of our work, including themed visits.
- Take account of the learning from planning and carrying out this exploratory visit in any future work visiting homeless people.

1. Introduction and background

The Commission carried out a small-scale project to explore how homeless people with experience of mental ill-health access, and experience, homeless and mental health services.

Because people who experience homelessness are more likely than the general population to have mental health problems, and are in a vulnerable situation, we wanted to know whether they are able to access the right support.

We wanted to hear from people with a range of experiences and stages of homelessness. This was an exploratory project, which aimed both to visit homeless people with mental illness and to learn about how best to reach this group.

We carried out visits to 43 homeless people from July to October 2016, in two local authority areas - one rural and one urban.

Why we carried out these visits

Studies from around the UK routinely find that homeless people are much more likely to have mental health problems, as well as poorer physical health, than the general population. Crisis, a national charity for single homeless people, states that the research indicates mental health problems such as anxiety and depression are twice as common, and psychosis is between four and fifteen times more common, in the homeless population[2].

Homeless people also die much earlier and are more likely to also have co-morbid drug or alcohol problems. Levels of suicide and deliberate self-harm are also higher.[3].

Research commissioned by the Joseph Rowntree Foundation, published in 2011, found that there is a strong over-lap between the people who experience homelessness and people who have been in institutional care as children, or who have experienced traumatic childhood experiences such as abuse. Homeless people are also often known to substance misuse services and/or criminal justice services and have multiple complex needs that cannot easily be addressed by a single agency.

[2] Rees, S. Public Health Resource Unit (PHRU) (2009) *Mental Ill Health in the Adult Single Homeless Population: A review of the literature*. Crisis, London. http://www.crisis.org.uk/data/files/publications/Mental%20health%20literature%20review.pdf

[3] Thomas, B. (2012) *Homelessness kills: An analysis of the mortality of homeless people in early twenty-first century England.* Crisis, London http://www.crisis.org.uk/data/files/publications/Homelessness%20kills%20-%20full%20report.pdf

> "There needs to be an integrated response across health, housing and social care." [4]

Homelessness is also a stressful and isolating experience that can cause or exacerbate mental health problems. It is essential that homeless support services are aware of the relationship between mental health and homelessness, and have the skills and resources to respond to it. They must have close working links with mental health professionals and others who have a focus on addressing the needs of homeless people who have mental health problems.

The Scottish Government national statistics report, "Homelessness in Scotland: Bi-annual update" for April to September 2016[5] recorded that in this six month period, 10,312 unintentionally homeless households were supported to find an outcome. Four out of five of these households were found settled accommodation.

Despite the stigma attached to mental illness, 20% (n 1,974) of the applicants for support with homelessness in this period who completed the questionnaire, identified mental health problems as one reason they were unintentionally homeless. This was a 21% increase on the same six month period in the previous year. People who identified themselves as having mental health problems were marginally more likely to have a settled outcome, (83.1% rather than 80.7%), but were much less likely to be given a council tenancy (37.5% rather than 47.8%) and much more likely to be settled in non-permanent accommodation (8% rather than 1.7%)[6].

The Scottish Public Health Observatory has analysed data from 2013 local authority and acute hospital records in Fife[7], comparing healthcare use by homeless people and the general population. Among other findings, admissions related to self-harm or to injuries and poisonings were 12 times higher among homeless people. People who were homeless had a 13 times higher rate of admission to inpatient psychiatric care than the general population aged 15-64.

The Commission has not previously carried out a themed visit to homeless people with mental health problems. Homeless people are seen as "hard to reach" by health and social services. In 2008 the Commission conducted a consultation which

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[4] McDonagh, T. (2011) *Tackling homelessness and exclusion: Understanding complex lives.* Joseph Rowntree Foundation, York.
https://www.jrf.org.uk/file/40103/download?token=exQ7ROgZ&filetype=download

[5] Scottish Government, Social Security and Housing Access Statistics (2016) *Homelessness in Scotland: Bi-annual update: 1 April to 30 September 2016*
http://www.gov.scot/Resource/0051/00512952.pdf

[6] Scottish Government Social Security and Housing Access Statistics, Communities Analysis Division. Data set: Cases assessed as unintentionally homeless, securing settled accommodation and where contact was maintained to duty discharge by mental health reason for homelessness (Private communication, 08/02/17)

[7] http://www.scotpho.org.uk/life-circumstances/homelessness/data/health

identified a range of challenges for service providers in meeting the needs of homeless people with mental health problems.

The issue of how to connect with homeless individuals has also been discussed at the Commission's Advisory Group and internally. The most significant challenge in carrying out visits to homeless people was how to visit people who were actively homeless, especially those living rough, or who were "hidden homeless" such as "sofa surfers".

We worked in partnership with homeless organisations and Health and Social Care Partnerships to try to achieve this.

The legal framework

The Housing (Scotland) Act 1987, as amended, provides the legal framework for homelessness and gives rights to homeless people. It places duties on local authorities. Housing options guidance has been produced by the Scottish Government as a tool for local authorities to use when developing their approach to housing options for people who are homeless, or who are at risk of homelessness.

The guidance defines housing options as:

> "a process which starts with housing advice when someone approaches a local authority with a housing problem. This means looking at an individual's options and choices in the widest sense. This approach features early intervention and explores all possible tenure options, including council housing, registered social landlords and the private rented sector.
>
> The advice can also cover personal circumstances which may not necessarily be housing related, such as debt advice, mediation **and mental health issues**.
>
> Rather than only accepting a homelessness application, local authority homelessness services will work together with other services such as employability, **mental health**, money advice and family mediation services, etc, to assist the individual with issues from an early stage in the hope of avoiding a housing crisis."[8] (Our emphasis).

The Housing Support Services (Homelessness) (Scotland) Regulations 2012[9] came into force on 1 June 2013. These regulations changed the duties on local authorities to assess the need for housing support for every applicant assessed by the local authority as unintentionally homeless or threatened with homelessness, and

[8] Scottish Government (2016) *Housing Options Guidance* http://www.gov.scot/Resource/0049/00494940.pdf (page 6)
[9] The Housing Support Services (Homelessness) (Scotland) Regulations 2012. SSI 2012/331 http://www.legislation.gov.uk/sdsi/2012/9780111018170/contents

who the local authority has reason to believe would benefit from housing support services as prescribed in the regulations. If an assessment of a need for support is made, local authorities must ensure the housing support services are provided.

The legislation therefore requires that, from an early stage, staff with the necessary skills must be able to identify mental health problems and know how best to assist an individual to get their mental health needs met, linking in with mental health services.

Under the Mental Health (Care and Treatment) (Scotland) Act 2003 sections 25 and 26, local authorities have a duty to provide “care and support services” and “services designed to promote well-being and social development” for people who are not in hospital and who have, or have had, a mental disorder. The aim should be to “minimise the effect of the mental disorder” and give to people “the opportunity to lead lives which are as normal as possible.”

The Act further defines “care and support services” specifically to include residential accommodation. It also gives examples of what sorts of services should be designed to promote “well-being and social development” to include social, cultural and recreational activities; training; and assistance for people to obtain employment.

Under section 27, local authorities should also provide assistance for people to travel to and from these services to attend or participate in them. In our report 'Living with severe and enduring mental health problems in Scotland'[10], published in August 2016, we recommended that:

‘Local authorities and health and social care partnerships should review how they can work together to develop the provision of relevant services under ss. 25 to 27 of the Mental Health (Care and Treatment) (Scotland) Act 2003.Sections 25 to 27 of the Act are important, and should not be forgotten or overlooked.'

Objective

We wanted this project to listen to the voices of people who were homeless who had experienced mental health problems, and the views of homelessness services.

We hoped to identify potential areas of future focus and work for the Commission in relation to homelessness and mental health, and to inform how we might carry out future work.

10 http://www.mwcscot.org.uk/media/340411/living_with_severe_and_enduring_mental_illness_in_scotland_report_final_2.pdf

Scope

We aimed to visit roughly equal numbers of men and women, as we envisaged there may be different issues and factors experienced by each gender group. We also aimed to see a balance of people across the age range.

To capture how different demographic issues impacted on homelessness, we decided to meet with people in one urban area and one rural area.

The focus of the visits was intended to include:

- Access to mental health services and routes into services.
- Use of legislation: Mental Health Act and Adults with Incapacity Act.
- Exclusion from services.
- Dual diagnosis/lack of diagnosis/hidden mental health problems.
- Discrimination and disadvantage.
- Routes to recovery.
- Access to physical health services.
- Capturing diversity of experience, including:
    - ex-service personnel
    - migrants
    - women fleeing abuse
    - people who were in “looked after” care
    - ex-offenders
    - travellers
    - people with substance abuse issues
    - a range of ages

It was recognised that this was an exploratory project, and we predicted there might be other issues which would become apparent during the course of the planning and delivery.

To achieve our objective we initially planned to visit people who were in homeless hostels, or other temporary accommodation, or living rough, who had experience of a mental illness, personality disorder, alcohol related brain damage, learning disability, autism, dementia or related disorder; with or without a formal diagnosis (noting that there may not be a formal diagnosis).

We excluded from the small-scale project:

- people who have been previously homeless but are not now
- people with addictions but not mental illness
- people in hospital care

2. Planning and consultation for the themed visit

Consultation - What people told us was important to ask about

We held two focus group meetings in the rural area attended by 13 people in total.

We held one large meeting in the urban area with representatives from the majority of homeless service providers. We also held two meetings with leaders of local authority homeless housing and health and social care partnerships (eight people in total).

In the urban area we also met with three management groups of providers and seven people who were homeless.

We asked the question "What are the key issues that affect people with experience of homelessness who have also experienced mental health problems?"

The urban health and social care partnership told us that investment had been put into homelessness in recent years. The view of staff working in homeless services and some homeless people was that the system could be more helpful – for instance, a person vulnerable to mental health problems and with the stress of homelessness, may only be allowed 12 weeks in supported accommodation, and have to move on by a certain date. The impact of this is an increase in anxiety and depression, summed up by one member of staff as – "*no money, no job, a child to visit, the council on your back for service charges and rent arrears – and people will inevitably end up on anti-depressants. The system creates its own problems – you need to be very capable just to manage the system*".

Key issues from the focus groups were:

- Quick access to homeless accommodation – delays increase the problems.
- Prison staff need to engage in-reach services to help homeless people with mental health problems organise support, medication, benefits and accommodation in preparation for release.
- Registration with a GP needs to be simple for homeless people.
- Mental health and drug addiction teams need to work seamlessly.
- Mental health services need to work closely with homeless services and provide a full range of inputs, including support, advice, psychological therapies and medication.
- In particular, psychological therapies and counselling should be available and accessible to survivors of abuse and trauma in homeless accommodation.
- Mental health services should include in their psychiatric emergency plans support for homelessness services and individuals when in crisis.
- Homeless people who are given a place in a guest house should have support - life in guest houses can be very difficult.

- Accommodation offered to homeless people needs to be
    - local to their family and friends
    - up to an acceptable living standard
    - offered when they are ready to move on
- Welfare reform was noted to be having a significant impact on homeless people.
- Being listened to – with understanding and positive attitudes, and not having to repeat their history to multiple professionals.

We designed questionnaires for individuals and homeless service managers and staff based on the information given to us at the focus groups.

We contacted a number of statutory and third sector housing and homelessness support providers in the two areas selected.

Outline of how homelessness services work in the two visit areas

The urban area

In the urban area we selected there is one local authority serving a city, entirely encompassed within a health board area. At the time of our visits, the two organisations had recently set up their integration joint board.

The urban area is not a housing transfer authority and has its own housing stock. There are 10 housing associations, also known as registered social landlords (RSLs)[11]. Registered social landlords have a statutory duty to assist local authorities to house people who are homeless through Section 5 Referral under the Housing (Scotland) Act 2001. Three housing associations are part of a common housing register and common allocations policy within the area.

Homeless people have to present to the local authority housing options office (a bus journey from the centre of the city, although they can be seen at other locations on request). There is also a 24 hour homelessness out-of-hours emergency service. Where a person requires temporary accommodation, the local authority has a duty to provide accommodation immediately if the individual is roofless. An assessment of homelessness is carried out by the local authority within 28 days. If a single person is assessed as being unintentionally homeless and in need of accommodation, she or he will usually be assigned to an acute unit for short term accommodation. From these units they then can progress, usually after 28 days, to more stable rehabilitation or resettlement, depending on their need. Where an in-depth support

[11] RSLs provide a variety of accommodation and are run by professional staff and managed by a board of management made up of volunteers. These boards have overall responsibility for the work of the organisation and may include residents, representatives from local authorities and community groups, business people and politicians

assessment shows that the person would benefit from a resettlement unit, they are transferred and given support to suit their needs.

Families and pregnant women are provided with flats either from the local authority, or specialist voluntary sector agencies. Depending upon their needs, some can stay in these flats for an extended period of time, but the hope is to get them settled with an address, benefits and some stability. The ideal is then to get them a tenancy of their own, and employment.

Help is provided to access GP services, which are the only route to ongoing treatment and referral to mental health services.

There is a homeless outreach health team which has recently had a cutback in services; the mental health nurse attached to the team has only two days a week to cover the whole of the city. We were told the composition of the team is under review. The psychiatric services do not accept direct referrals from the team.

A local GP used to provide medical input into this service, but this is no longer the case.

All of the staff we spoke to in the units we visited reported difficulty in people being seen by the mental health services. In addition, individuals had to wait until medical records were sourced before GPs would prescribe their medication. This was especially true if there were also problems with addiction.

There is also a drop-in service provided by a retired nurse in a local church. She provides some health care. A dental service is available through the drop-in, and welfare rights and benefit officers attend regularly.

The rural area

The rural local authority is responsible for the needs of a large, mainly rural area, and has the same boundaries as the local health board. The population of the region is dispersed, with many people living in small villages and towns. There are four more densely populated areas.

The rural local authority does not have its own housing stock. Social housing in the area is managed by 10 RSLs, after a housing stock transfer.

The local authority is working with health and social care partners to ensure a collaborative approach to supporting people with mental health problems who present as homeless. This approach came about because the local authority was aware of “revolving door” presentations, by the same individuals, to homeless departments. This can be for a multitude of reasons, but the council is clear the most prominent issue is the lack of support available for mental health issues, accompanied by a reluctance to accept support by the individuals concerned.

There are no exclusion criteria for homeless presentations. If someone presents as homeless and the main issue centres on mental health care needs, a GP would need to make a referral to NHS mental health services. A homeless application would be taken, and early engagement with relevant services would be encouraged to identify accommodation and support requirements.

A local mental health association has accommodation and an outreach service, commissioned by the local authority.

It is recognised that individuals who are homeless are often in temporary accommodation for too long, some as long as 12 months. Recently the council says it has made good progress with RSLs to move people on more timeously to permanent accommodation. An area of difficulty reported to us by several homeless people is that the available permanent accommodation can be in poorer areas with higher levels of drug addiction.

We were also told by individuals and service providers that there are 'attitude issues' from RSLs that can sometimes prevent people from gaining housing. We were told that these issues can also mean that stays are short-lived, due to homeless people being told to leave by the RSLs if they are not deemed suitable to remain. This is important, not least because 33.3%[12] of people who identified as having mental health problems and were unintentionally homeless across Scotland in the latest available figures were settled by placement with an RSL. The council response is that, under housing legislation, RSLs cannot tell tenants to leave their accommodation as there is a legal process to follow.

The local authority and health board have set up a short life working group alongside the four locality groups to focus on the health and social care integration agenda, with one of the focuses being around homelessness. In this work there is a recognition of the need to target the prevention agenda to provide support before people become homeless. The housing options toolkit has been delayed nationally, so no work has progressed around this in the rural area as yet.

The Housing Regulator is also working closely with the council to improve their approach to the homeless population and delivery of its housing options and homelessness service.

[12] Scottish Government Social Security and Housing Access Statistics, Communities Analysis Division. Data set: Cases assessed as unintentionally homeless, securing settled accommodation and where contact was maintained to duty discharge by mental health reason for homelessness (Private communication, 01/02/17).

What we did

We visited homeless people and organisations supporting them and asked questions based on our consultations. Qualitative rather than quantitative research methods were used due to the low numbers of people being visited in this project.

We drafted three data collection sheets:

- A questionnaire concerning the individual. Part 1 consisted of largely open ended questions to be asked face-to-face; Part 2 was a detailed listing of demographic and background information, ideally to be obtained from the service provider prior to the interview with a view to being added to at the face-to-face interview with the individual.
- A questionnaire to be completed in conversation with a worker from the homeless service.
- A brief questionnaire for relative/friends/carer – to be issued with the permission of the homeless individual.

At the outset we set up an aspirational quota sheet, with the aim of guiding us towards a wide qualitative sample; we hoped to gain views from a range of individuals and a breadth of experiences across the homeless sector. The quota sheet was broadly guided by the relative population sizes of the two areas and the known relative divisions across gender and age–groups (eg 24 or under, 25 and over) cited in the national data sets.

Across these key parameters, we also aimed to gain some representation if possible from other key groups identified in the literature including: parents with children; people with experience of having been in “looked after” care; people with experience of mental health hospital care; people who have been in prison; ex-members of the armed forces; people who have survived abuse, exploitation or been trafficked; migrants or asylum seekers.

In practice we found it difficult to stick too closely to the quota sheet, largely because we could only interview those individuals who were willing to come forward on the days of our visits. Whilst we tried to be explicit with the staff in the homeless units about our criteria, sometimes these were loosely applied. We did not see homeless people who were not known to the homeless units and we did not formally interview the few “rough sleepers” seen (as they were in a drop-in). This was an exploratory themed visit project rather than formal research.

3. Arranging meetings with homeless services and individuals

We made contact with both local authority homelessness services and with the homelessness service providers in each area.

Each year, Scottish local authorities produce an annual performance report which details how they have performed in achieving their objectives for homelessness. We looked at the homelessness annual performance reports for the two areas we planned to visit. These reports gave us some information about the available services in the areas. We also had a general idea of some of the key services that exist, asked the local authority about routes for visiting homeless people, and we searched for services online.

In each area we identified services supporting homeless people and worked with them to arrange to visit people using their service. We asked each service to speak with homeless people they supported who they knew or suspected to have mental health problems, and encourage them to meet with us. We arranged times to visit each service and attempt to meet with people, using our questionnaire.

A training seminar was delivered in May 2016 by the Housing Regulator to ensure all project team members (and other Commission officers) were well informed about homelessness issues.

The rural area

We met with the local authority and with national organisations based in the rural area, APEX, Women's Aid[13] and two outreach housing support providers commissioned by the council. Most were enthusiastic to help and some managed to find many people who met our criteria and were willing to meet with us. Staff at one of these said that it was quite hard to convince clients who had a mental illness and were homeless that it would be a good idea to speak with us and go through a questionnaire.

Key to meeting seemed to be the initial phone call explaining the Commission and the themed visit in a way that made services keen to help rather than worried or anxious about the additional work it would cause.

It was very quickly made clear to us that, as we had anticipated, it would be difficult to get homeless people to attend on specific days and at specific times due to the nature of life when homeless and the conditions many people experience. We agreed that preliminary meetings would be at places where people dropped in, and

[13] www.scottishwomensaid.org.uk

that we would meet with people who were around. We chose days when people were usually expected to be there or when activities were already planned.

We asked the organisations to spread the word among their workers and homeless people who were using their services that we were coming and encourage them to speak to us.

Initial meetings were held with homeless people attending APEX Scotland services. On the whole, people were happy and sometimes eager to talk with us, but not everyone met our criteria. Because they had made contact with services and were engaging in activities, many had very recently found accommodation or had been in accommodation for some time but were struggling to keep the tenancy, rather than currently homeless. Equally, people often did not self-define as having mental illness. They identified issues such as stress, anxiety and depression, for which they might be receiving treatment, usually from a GP, but they did not necessarily associate this with having a mental health problem.

The urban area

We spent some time initially meeting with people from the council, health and social care partnership and managers. We also attended a multi-professional conference event on homelessness where all main services were represented. But the most effective route to reaching homeless people was by direct contact with the managers of the homeless hostels. The homeless support staff we spoke to, on the whole, were unfamiliar with the Mental Welfare Commission, but they were helpful and many also provided contacts with other agencies.

The people we saw had not all been through the main city centre hostel, but some had been referred straight to other direct access hostels. After initial assessment they would then progress onto longer term placements at other hostels. From here they are given support with benefits, training, employment etc with the hope that they will next move to their own tenancy. Supported accommodation can be available as an interim measure before this.

We visited the main council city centre homeless unit, another run by the Salvation Army[14], and one run by the Cyrenians[15].

In all three units the method of finding someone to speak to could be problematic. Making appointments wasn't practical and we had to rely on turning up to the unit and seeing those individuals who were available on the day,

[14] https://www.salvationarmy.org.uk/scotland-office
[15] http://cyrenians.scot

We also visited a resettlement service run by the Cyrenians, a sheltered housing scheme providing a follow-on service from the direct access units for vulnerable people, and a young persons' unit run by Action for Children[16].

Finally, we visited a drop-in centre run by a church organisation. We spoke informally to some individuals who were voluntarily sleeping rough, who said they had worked hard to get off drugs and felt the situation in most of the hostels was such that they could not hope to stay off if they went to stay there. They described shouting and aggression in the corridors at night, and constant knocking on their doors with people trying to sell drugs, or asking for money to buy their own. The hostels themselves did not describe this level of activity; although they all had a 'no drugs' policy they acknowledged this was impossible to enforce.

How we carried out the visits

We offered to meet people in any location that they felt comfortable with and at any time of the day, and found that the most straightforward option for people was to meet them in working hours at the offices of each agency.

The longest interviews lasted about 1 ½ hours, the shortest about 20 minutes. In many cases people seemed very keen to speak and said that they appreciated the opportunity to talk about their experiences.

Some people wanted to be interviewed because they thought it might make a difference for other homeless people.. Not all individuals interviewed were able to answer all the questions in the questionnaire.

Two people preferred to be interviewed at the same time so that they could support each other. This seemed to work for them quite well for them, although it may have restricted what they were willing to talk about.

Service staff also provided important insights. They could often see very real problems around such things as referrals and systems that homeless people did not raise, or were unaware of, and could often illustrate different points with real examples.

We provided direct advice to the homeless person following nine of the 43 interviews. We also gave advice to managers and staff on accessing mental health services during three interviews.

[16] https://www.actionforchildren.org.uk

4. Who we visited

We met with 48 people, 43 of whom met our criteria of being currently homeless or had been so up to the last month. Four had been homeless in the past year but were not currently homeless- these are excluded from the following counts but their stories or quotes may be used for illustration. One other was excluded on closer analysis of the data as, despite the service's opinion, the individual did not feel they had a mental health problem and we agreed.

Only seven (five men and two women) of the 43 people we saw were experiencing homelessness for the first time. Four of these seven were over 25 years old.

Gender	Rural Area	Urban Area	Total seen
Female	4 (31%)	9 (32%)	13 (32%)
Male	9 (69%)	21 (68%)	30 (68%)
Total	13	30	43

We interviewed more than double the number of men (67% 29) compared to women (33% 14). We interviewed everyone who was willing to meet with us and who met our criteria (currently homeless and with experience of mental health problems). There are more men in homeless services (55%) than women (45%)[17].

All of the homeless services we visited (eight in the urban area, four in the rural area) supported both men and women, and most reported that they usually have a majority of men, sometimes as much as 80 – 90%.

There were few communal places to spend time in at the homeless units we visited. This may reflect some of the opinions from individuals interviewed, who told us that, in the main, they did not have strong peer relationships with each other and did not necessarily seek this. This was backed up by staff, who also commented on the, at times, inappropriate mix of people in some accommodation – eg young women with a history of trauma being housed with offenders who are active drug users.

[17] Scottish Government Social Security and Housing Access Statistics, Communities Analysis Division. Data set: Applications by household type and sex of main applicant (Private communication, 08/02/17).

Mental health

The Mental Welfare Commission's remit extends to people with mental illness, dementia and learning disability, and related conditions, such as autism.

Because of this, we excluded from this themed visit project people who told us they had no mental health problems.

SELF-DIAGNOSIS	Grand Total
Depression	12
Depression and Psychosis	1
Depression and Psychosis and Other MI	1
Depression and Other MI	12
Psychosis	5
Psychosis and Other MI	1
Bi-polar	3
Bi-polar and Other MI	1
Other MI	3
Anxiety	3
Personality disorder	1
Grand Total	**43**

Of the 43 people we spoke to, 26 told us they suffered with depression. Three told us they had post-traumatic stress disorder (PTSD) as a result of childhood abuse.

> *"JQ told us she believes dysfunctional family and abuse led to her mental health problems. Her parents were drug dealers. She witnessed her mother's abuse and was sexually abused herself."*

> *"JM told us he had a 'mental breakdown' about one year ago. He was taken to hospital by his partner. He lost his job, his partner, and his house through extreme depression and anxiety. He still has anxieties regarding working and crowded spaces."*

Twelve of the 26 individuals (nine men and four women) told us relationship breakdown was the main reason they had become homeless. Nine said that it was because of a deterioration in their mental health. Fourteen of the 26 individuals also told us they had recently self-harmed or had suicidal thoughts.

Four people told us they have a bi-polar disorder.

Eight individuals, all men, told us they had a diagnosis that included psychosis, schizophrenia or schizo-affective disorder. Five of the eight told us they had been detained under the Mental Health Act in the past (though no one we saw was currently subject to measures of the Act or on guardianship in the Adults with Incapacity (Scotland) Act 2000). Four thought their mental health was the main reason they were homeless, and two identified a breakdown in relationships.

Family life

None of the individuals we spoke to were married or in a civil partnership at the time of the interview. Thirty six individuals told us they had no current partner, seven of these were single following a divorce. Three were widows or widowers. Seven people told us they had a partner.

Highlighting the impact of homelessness on more than just the individual, there were 13 parents (10 fathers and three mothers) of children under 18 in our survey with a total of 26 children (one father had six children).

Other characteristics

Ex-prisoners

People who come into contact with the criminal justice system are at a higher risk of experiencing homelessness. This may be because they lose contact with their family, or because they lose their tenancy when in prison. Nineteen (17 men and two women) of the 43 individuals interviewed told us they had spent some time in prison.

Seven told us the main reason they were homeless was as a result of being in prison.

Shelter Scotland's 2015 report Preventing Homelessness and Reducing Reoffending[18] found lack of planning around prison release put people at risk of homelessness, and that the right location for a tenancy was important in reducing the risk of reoffending.

Ex-services

Two individuals (both men) told us they had served in the armed forces.

Looked after children

Fourteen (32%) (nine men and five women) of the 43 told us they had been looked after children in the care of the local authority for some period. A child is defined as being "looked after" if they are in the care of the local authority for more than 24 hours, though most will be in care for much longer periods, sometimes until reaching adulthood. Recent data in Scotland is that 1.5% of the 0–17 age population are looked after children[19].

The Scottish Government national homelessness statistics annual report asks whether any member of an applicant household, aged under 25, was looked after as a child by their local authority[20]**.** It shows that 6% of applicant households answer yes to this question.

That almost one third of the homeless people with mental health problems who we saw had been looked after as children appears to be a much higher proportion than we might have expected, although our sample is small. However a research briefing on young homeless people published by Crisis in April 2012: "Young, hidden and homeless" found a similar situation and reported:

> "The fact that 30% of young homeless people have been in care suggests that the care system too can fail to deal with some of the support needs young people have"[21]

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[18] http://scotland.shelter.org.uk/professional_resources/policy_library/policy_library_folder/preventing_homelessness_and_reducing_reoffending_-_insights_from_service_users_of_the_supporting_prisoners_advice_network,_scotland

[19] http://www.gov.scot/Topics/Statistics/Browse/Children/PubChildrenSocialWork/CSWSAT1516 Table 2.1.

[20] Table 5 http://www.gov.scot/Resource/0050/00502077.xlsx

[21] Research briefing: Young, hidden and homeless, Crisis, 2012 http://www.crisis.org.uk/data/files/publications/Crisis%20briefing%20-%20youth%20homelessness.pdf Also see "Care leavers' transition to adulthood", National Audit Office, https://www.nao.org.uk/wp-content/uploads/2015/07/Care-leavers-transition-to-adulthood.pdf "in 2010, 25% of those who were homeless had been in care at some point in their lives"

A local authority has a range of statutory duties to "looked after" children, laid out in section 17 of the Children (Scotland) Act 1995, one of which is to provide advice and assistance with a view to preparing the child for when he or she is no longer looked after (care leavers). They must also provide advice, guidance and assistance for young people who have ceased to be looked after. There is a duty on local authorities to provide this support up to the age of 19 and a duty to assess any eligible needs up to their 26th birthday[22] [23].

For example, we met AJ, a young woman in the 18-24 age group, with a bipolar disorder. Her mother had schizophrenia and could not look after her. She told us she was looked after in care from the age of 12. When she was 14 she was sleeping rough and in and out of foster care. When she turned 18 and moved from foster care to a tenancy, she says social work said she could manage independently, but she does not feel that she can. She told us:

> *"social work said 'we are not responsible anymore because you are now over 18'"*

Her homeless support worker told us that expecting a person just leaving care to manage and budget on a monthly payment, which includes rent, does not work.

Our findings support research showing that a disproportionate number of care leavers are becoming unintentionally homeless when leaving care.

Experience of abuse

A history of abuse is thought to be a common experience for people who are homeless, but it is not appropriate to ask direct questions about this in this kind of interview. However, if the individual raised this as an aspect of their personal history, or if staff were aware of this issue as being in the individual's history, we recorded it. Of the 43 people interviewed, 20 individuals (12 male, eight female) either mentioned they had experienced abuse, either sexual or physical, or staff in the unit shared this information with us.

This shows that experience of abuse did not affect just one gender.

> "*MS stated she was neglected by her mother from a young age. Her mother was a single parent and had a drink problem and many parties at home which involved strange men frequently visiting her. MS told me she was sexually abused by a number of these men at this time. She feels her mother did not protect her."*

[22] Children and Young People (Scotland) Act 2014 section 57
[23] Scottish Government: Throughcare and Aftercare http://www.gov.scot/Topics/People/Young-People/protecting/lac/careleavers (accessed 03/03/17)

Drugs and alcohol

Just over 50% (n22) told us they had no current or past involvement with the misuse of drugs or alcohol. Five had some history, but told us they had no current problems with this.

Seventeen individuals (13 men and four women) told us that they currently had issues with drugs, which included 2 men who acknowledged having had significant problems with both drugs and alcohol. Both these men were ex-prisoners and both also experienced suicidal thoughts. But their stories showed that with the right support there was hope even in these difficult circumstances. One individual said:

> "*I am an ex user - mental health problems caused my addictions and homelessness. I am on antidepressants but I can manage myself - in the guesthouse a lot of people are off their faces - because of this I could have slipped back.*
>
> *I now work as a volunteer - this helps a lot - in prison I did a course which helped - it showed the cycle of drugs and depression. I'm ok but if something happens then there can be problems. For instance, a bill from the council caught up with me - independent living services sorted it. In the past I would have sold drugs to pay it - they are helping me pay it off in stages."*

Six individuals told us they were receiving support from an addictions team during this episode of homelessness. All but 1 of the 17 were registered with a GP. The 1 individual had been put off the GP list and told us he was waiting to be seen by the Community Mental Health Team (CMHT), but had been waiting a long time. He said:

> *"I have just started to talk about things in the last 8-10 months. I'm feeling in a good place just now. I am in contact with the drug crisis team. I don't have any mental health support but I am waiting for an outpatient appointment*."

Ethnicity

We saw no one from a minority ethnic background during the course of this project. All individuals seen were either white Scottish or white other British. This is surprising, as data (below) suggests that approaching one in 10 of the homeless population is from other ethnic groups.

Applications by Ethnicity of Main Applicant	Apr-Sept 2016	%
White Scottish	13,362	78.1
Other British	1,012	5.9
Irish	57	0.3
Other white ethnic group	405	2.4
African, African Scottish or African British	198	1.2
Caribbean, Caribbean Scottish or Caribbean British	16	0.1
Other Caribbean or Black	28	0.2
Indian, Indian Scottish or Indian British	27	0.2
Pakistani, Pakistani Scottish or Pakistani British	109	0.6
Bangladeshi, Bangladeshi Scottish or Bangladeshi British	10	0.1
Chinese, Chinese Scottish or Chinese British	21	0.1
Other Asian, Asian Scottish or Asian British	62	0.4
Mixed or multiple ethnic group	46	0.3
Other ethnic group	484	2.8
Not Known	636	3.7
Refused	130	0.8
Gypsy/ Traveller	23	0.1
Polish	286	1.7
Other African	21	0.1
Black, Black Scottish or Black British	34	0.2
Arab, Arab Scottish or Arab British	140	0.8
All	**17,107**	**100.0**

(Figures obtained from the Scottish Government Social Security and Housing Access Statistics, Communities Analysis Division. Data set: Applications by Ethnicity of Main Applicant (Private communication, 8/2/17).

Employment

Thirty-six of the 43 were unemployed. One person was in full-time employment as a care worker, two were in part-time employment and two were in full-time education. (Two people were not asked the question).

Age range

We saw people in all age groups under 65. We did not exclude older people, but we did not meet anyone in this age group during our visits.

Age Range of people interviewed	Rural Area	Urban Area	Grand Total
16-17	1	2	3 (7%)
18-24	4	10	14 (32%)
25-35	1	8	9 (23%)
36-44	2	5	7 (16%)
45-64	5	5	10 (23%)
Grand Total	**13**	**30**	**43**

5. Findings

Attitudes and stigma

People who experience homelessness also have to face the negative attitudes that some people have to this group of people. Seventeen people told us they felt they faced discrimination. When it is from ordinary members of the public it can be hurtful but we heard about problems with private landlords.

> "*If a landlord doesn't like you, you are asked to leave with nowhere to go. Because you have been evicted you have to start applying for housing all over again. Having a private landlord with that control and power over people's lives – he has no right to that power."*

In fact the council housing service told us that if a landlord wants to evict someone they must follow a process, but this individual did not feel this is how it worked in practice. Another individual told us:

> *"There is a big stigma in the guesthouses – you are seen as a 'down and out.'"*

An individual who came to one of the focus groups told us:

> "*I didn't choose this lifestyle - I take drugs because of the abuse when I was a child."*

When the homeless individual also has mental health problems they face an additional level of stigma. One individual visited told us:

> "*There is lots of stigma. When people realise that you are ill they judge you. There are a lot of negative attitudes - normal Joe public has no idea."*

> *"People treated me like dirt. Everyone thought if you were homeless you also must have a drug problem."*

But there were positive comments too, usually about homeless support staff:

> *"I feel better since being in here with support. I have started a 'hearing voices group' and am learning meditation and guitar. Because I am helping others they are putting me forward to be a befriender."*

Quality of accommodation

Whilst the supported homeless accommodation was valued and the quality of the accommodation was good, in the rural area we were told individuals may be placed in guesthouses. We were told the quality of the property varies considerably.

In the rural area one individual spoke about their experience:

> *"I found syringes in the fire place – it wasn't family or child safe – it was a wreck - I lived in one room, I couldn't afford to heat it – there was no gas in the kitchen and the fire in the sitting room didn't work."*

Shelter Scotland and the Chartered Institute of Housing Scotland publish Guidance on Standards for Temporary Accommodation[24], including physical standards on the quality of accommodation.

Access to a GP

In several focus groups problems were noted accessing GPs. GPs were refusing in one of the areas to register individuals without photographic ID. Until recently they had been accepting a photo on headed notepaper from the homeless units but they were now demanding official ID which most residents don't have and cannot afford.

People in the focus groups told us that when eventually they are allocated a GP, it is sometimes not easy to travel to the surgery. Without money they cannot afford buses to get there. We heard they are put off the GP's list if they miss two appointments.

Despite the difficulties, we heard about getting registered with a GP in the consultation, 37 of the 43 people we saw told us they were now registered. Some individuals found this contact very important as they struggled to be seen by a mental health service.

> *"I was admitted to [mental health hospital] for six months and have been mostly cared for by my GP since then".*

> *"I was under a psychiatrist and had a CPN (community psychiatric nurse), but when I moved here I missed a few appointments and was discharged. Now I see my GP every three months. I get on with him and am happy he keeps an eye on my health."*

On release from prison there is often a delay in accessing medication. If a sentence is longer than 3-6 months then they are put off the GP list and have to start again. Even if they have a GP, we were told that the GP was reluctant to prescribe anything without input from a hospital consultant, which takes time.

> *"I had to re-register with my GP following prison. I was just thrown off the list."*

A few days' medication is supposed to be given on release, but we heard from some people that this often does not happen so individuals can arrive in homeless

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24 https://scotland.shelter.org.uk/__data/assets/pdf_file/0009/322677/Temporary_Accommodation_Guidance.PDF/_nocache

accommodation already stressed and having to manage without prescribed medication.

The potential 'treatment gap' experienced by prisoners having difficulty registering with a GP was highlighted in the National Prisoner Healthcare Network's report on throughcare[25] in 2016. The report identified difficulty in pre-registering prisoners before they are released, because when a patient is registered at a GP practice their Primary Care Electronic Patient Record transfers, and is no longer available to their previous provider. However, the report notes that this is 'currently managed in some areas by requesting that the community based GP practice register the prisoner as a temporary resident allowing for the sharing of relevant information between primary care teams pre-release.'

In the urban area, we heard there was a GP who covered all the homeless units one day per week. He was part of the outreach service, but he was being "recalled" to his practice at the end of the month and there was no plan for a replacement. There is a mental health nurse on the outreach team, two days a week, but the community mental health team do not accept referrals from her.

One woman told us she attends a women's rape and sexual abuse centre but had no help from her GP with access to psychology services. When she asked her GP for a referral, she said the GP "*just laughed and said that she would not be giving out any pills.*"

Twenty-three of the 43 people we saw had a dentist. The urban area runs a mobile dental service and travels to key points in the city enabling individuals to visit this regularly without the need for an appointment.

Access to mental health services

Twenty one of the 26 individuals who told us they had depression were registered with a GP. Three had a psychiatrist; one of these and two others were also seeing a psychologist, and two had regular appointments with a community psychiatric nurse. None thought they were being supported by a community mental health team; however, individuals may not know when they are allocated to such a team..

In one case of a homeless person who told us he was depressed we were told:

> "*He had just arrived in the homeless unit one week ago. He had been in a tent for three and a half weeks. Staff have discussed him with a psychiatrist, a*

[25] *Healthcare Throughcare Workstream Report*, National Prisoner Healthcare Network, Scottish prison Service & NHS Scotland, January 2016, http://www.nphn.scot.nhs.uk/wp-content/uploads/sites/9/2015/06/20160215-NPHN-Throughcare-Report-Final-v1.0.pdf

CPN and social worker already. His depot Risperidone has been organised with them."

It is unlikely that this depot medication would be prescribed for depression and we should be cautious about accepting self-diagnosis. In this case the staff had not been asked to confirm the diagnosis.

In another:

> "She still has social work support from the through and after care team and is on a parental responsibility order with her local authority. She is still open to the CAMHS team but not active, and sees a psychiatrist every four months".

Two of the four people who told us they have a bi-polar disorder told us they have regular appointments to see a psychiatrist and a community psychiatric nurse.

Three of the eight men who told us they had a diagnosis that included psychosis, schizophrenia or schizo-affective disorder were seen in a project specifically for people with severe and enduring mental health problems.

Four of these eight told us they were abused as children. Three were looked after by the local authority as children and five had spent time in prison. Four of the 8 currently had a psychiatrist, two also had a community psychiatric nurse.

> *"I was discharged from psychiatric services as I missed appointments after I moved house. I am now only monitored by my GP, but I am happy with this*."

Access to psychiatric services was reported to us as being very difficult to arrange.

Staff in one unit described accessing mental health services as their main issue. The health outreach programme has been reduced considerably recently and two days a week of a mental health nurse for the entire area was not felt to be adequate. The general nurse has four days a week but covers all of the urban area so time is very limited. The general nurse told us she is not mental health trained.

One individual described being taken to A&E twice in one week having attempted suicide, but she was not admitted; she was told they would send a CPN to see her, but she is still waiting after seven months.

Staff have problems when they see someone who is obviously unwell and especially when the individual does not recognise this themselves. Staff feel some individuals have been masking illness for years, but once homeless and more vulnerable, it becomes more obvious.

During the day staff can sometimes speak to someone on the CMHT if someone is floridly unwell, but out of hours the advice is usually to phone the police.

The police are reluctant to attend in these situations and feel they have little to offer the individual other than putting them in a cell. Staff feel strongly that they are in a caring role, and feel it is a failure if they have to resort to getting someone arrested. In both the rural and urban areas staff said better arrangements for out of hours would help them to cope in these situations.

Another individual told us how important having support was to them:

> "*Mental health services are the only people I can talk to and open up to – they are like family to me."*

Advocacy

Some people need support to speak up, to understand what is being said and to make decisions. Many people find that when they feel unwell or upset they are not as good at saying what they want and they need support to speak up. Independent advocacy helps individuals to make their voice stronger and to have as much control as possible over their life. Independent advocates and advocacy workers are separate from services. They do not work for hospitals, social work or other services. Under the Mental Health Act, people with learning disabilities and people with a mental illness have a right to independent advocacy. They do not have to be in hospital or under any Mental Health Act order to have the right to advocacy.

The individuals we saw should have been able to have an independent advocate and/or join an advocacy group if they wanted to. None of the people we spoke with had recently used advocacy and most were not aware of it. However, most staff were aware of the right to advocacy and said it was available if needed.

Co-morbidity – drug/alcohol and mental health problems

Often individuals have a dual diagnosis and neither service – mental health or drug addiction - is prepared to take overall responsibility. Housing support staff in the urban area told us the first question when they contact the CMHT, or any psychiatric service, is whether the individual is using drink or drugs. If 'yes' they refuse to see them. Similarly we heard that drug services refuse to see someone with mental health symptoms. And we were told communication between the two services is poor. Staff are often left with no option in a crisis but to phone the police to protect other residents.

> "*I have a CPN but it is taking a long time to be seen. I have had no contact with my keyworker since being here in the hostel*."

One man in the urban area told us a more positive story:

> "*I am back on track now but I still hear voices. I am on a depot injection monthly and I see a CPN. I have a diagnosis of paranoid schizophrenia. I also have a methadone prescription. I feel well supported by staff here."*

This has been identified in the Scottish Government's new Mental Health Strategy: 2017-2027 as an area in need of improvement.

Access to psychology and counselling

Sometimes we heard that homelessness was the cause of psychological distress, but often homelessness was the result of these problems and was compounded by them. As reported above nearly half of the individuals we saw said they had experienced abuse and many had thought about or attempted deliberate self-harm or suicide.

One woman, from the rural area, told us she had been held captive for several days by a controlling ex-partner and subjected to extensive abuse. She had requested psychological help, but said she cannot access any.

One individual told us:

> "*I was referred to a psychologist but after waiting for a year had to resort to solicitors to make sure I got seen – I got a letter from the NHS thanking me for pointing out the problem in the system."*

Another individual told us his GP is his only contact. He has low moods, panic attacks and anger management problems. He was put on a waiting list for counselling and told he may have to wait 13 weeks. But he did not know where he would be living when the time comes.

> "*People mainly get medication - most people are not offered other options - and if they are, they have to wait for months and months."*

> *"Being listened to is important. You need someone who can connect with you, who can talk to you and listen and talk at the right times. No mention has been made [by the homeless support workers] of my mental illness at all – all they say is contact the drug agency."*

One individual trying to access psychological therapy told us in the consultation:

> "*I am not getting treatment because I take drugs - I have to have been dry for three months - I can think and have emotions on drugs – but no one listens - I should still get treatment."*

Staff in the homeless accommodation can be very helpful and offer a great deal of support, but this might only be a solution for a short time. One person said:

> "*I am in emergency accommodation - if you have any problems the staff know how to fix them, but I am petrified of moving on and not being able to cope, especially if I have to deal with help for my abuse while alone."*

Eleven of the 20 people with experience of abuse said they had thought about suicide or self-harm. Two individuals told us they were receiving support for their experience of abuse during this episode of homelessness. Amongst the many sad stories we heard one told us:

> "*I was in care till I was four years old then lived with my grandmother till I was ten when I was put back with my parents – they were 'smack-heads' – I was walking over needles in the house. I stopped school as I had no clothes – they spent the clothing allowance. All my family are drug users*."

Another spoke of the impact of abuse as a daily experience, and of the support she gets:

> "*I get support here and I can talk about anything to [a member of staff], she is fantastic. I see a psychiatrist once a month by video link. I need to see a counsellor to deal with the abuse - I'm now ready to face it. They tell me it is not too late - not a day goes by when I don't think about the abuse."*

The benefits system

We heard from many people that the benefits system is not set up well for homeless people and in particular for people with mental health problems. For instance, Personal Independence Payment (PIP) is a benefit set up specifically to help with some of the extra costs caused by long-term ill-health or disability for people between the ages of 16 to 64. But we heard that interviews are not easily accessible for people with mental illness and sanctions are applied if you miss appointments. It can be difficult to explain and talk about how a combination of lifelong low mood, anxiety, low self-esteem, and other mental health conditions can disable someone in every aspect of their life, but add the stress of homelessness and the interview situation is experienced as almost intolerable. One person said:

> *"Applying for benefits – if you don't present well you don't get them – where is your dignity?"*

A member of staff told us she offered to help a service user fill in a benefit application form as he didn't understand it. The benefits officer "refused to let me help saying that it was a conflict of interest, even though I explained what I do".

We also heard that the community care grant[26] only really allows for the purchase of a limited number of second-hand furniture and white goods.

> "*You end up with furniture that people do not want – but they have no choice."*

> *"I'm on* benefits *-ESA [Employment Support Allowance] and PIP. Sometimes it makes daily life difficult – it means I can't afford bills or to eat at times. Staff helped me with benefits. I am dyslexic so I have a problem with paperwork. I often use food banks."*

But even here there were positive experiences:

> "*Yes - I needed help with the forms - someone came out to me from the benefits agency - it's been okay - I got PIP, it was easy to get."*

Taking over a tenancy

One related issue we heard from several individuals and care providers occurs at the point an individual takes on a tenancy and applies for a community care grant.

A homeless individual has to sign a tenancy agreement on a property before they can apply for a community care grant. Often the tenancy is not fit to live in when they sign the agreement (with little or no furniture or white goods) and the individual plans to use the community care grant to buy the essentials and make the property fit to live in.

We heard that the rent for the tenancy is charged from the moment the tenancy agreement is signed, but the housing benefit only starts once the individual physically moves in. It can take weeks for a community care grant application to be processed and the necessary furniture and white goods to be purchased before a person moves in to their tenancy.

This results in people being in arrears even before they get to live in their tenancies. This is stressful for anyone but is even harder if the homeless person has mental health problems. On a low income it is hard to pay off the arrears. We were told some landlords are more sympathetic than others in these situations.

Rural v urban

We did not identify significant differences in people's experiences between the rural and the urban areas. We were told by some individuals that in the rural area some

[26] A community care grant of up to £700 can be made to help people on a low income live independently in the community (or to ease exceptional pressure on families). They are paid out of the Scottish Welfare Fund. They are only given in certain situations, for instance, if someone needs help to set up a home in the community after an unsettled way of life, for example, homelessness.

placements could be far away from the town familiar to the homeless individual and local to their family.

Timing

Staff in the consultations told us about the difficulty faced by homeless people if there are delays being offered support.

> "*There is a need for a quick referral, when people are at the point of wanting help and then they have to wait, they will disengage - they can't wait for help."*

An individual told us of their experience:

> "*Until a couple of weeks ago I was staying at a women's aid centre. It took two and half years for me to get a house - it was too long."*

In one case we heard an individual lost her flat because she had no money. She had been discharged from hospital without help to sort out her benefits and ended up phoning the homeless team on a Friday. By that evening she had been found temporary accommodation. Such a quick response had an immediate benefit.

> *"I have lost my house and ended up in a doss house, but I have met someone, and I am starting training. I hope to get work soon."*

Timing is not just about delays - we were told that if the local authority offer a tenancy then the person in temporary accommodation is obliged to take it whether or not they are ready – a member of staff told us sometimes it is "a disaster to be offered permanent accommodation before the individual is ready to move on".

Distance from home

More of an issue in the rural area, was the distance from your home area to the area that you were eventually offered accommodation in. If people wanted to remain in close contact with family and friends this was not always easy or possible because of the distance between some of the towns in the rural area.

> "*There are a lack of services in [the rural area] so much funding is being lost - there are wee pockets but not many people or organisations to link into*."

One individual said:

> "*You can get farmed out to [other towns] but that is no good if your family are here."*

16-17 year olds

During this project we interviewed three very young people (two male, one female). Two were in supported accommodation run by Action for Children (Scotland)[27]. One individual was in Apex supported accommodation.

All three had stories of families not being able to cope with their mental health problems. All three were known to Child and Adolescent Mental Health Services. One had bipolar disorder, one had ADHD and was seen in a children's clinic for seven years, and one had depression and a history of deliberate self-harm and currently had three-monthly appointments with a psychiatrist and had been recently discharged by a CPN. In one case the parent also had mental health problems. Two told us they had experienced abuse and in one case talked about a history of significant physical abuse. One individual had been in looked after care for a few weeks during a family crisis. One had slept rough for one night, but in general they had been sleeping on sofas and in the homes of wider family members or with friends before coming to supported homeless accommodation.

In terms of the Children (Scotland) Act 1995 a child is a person under the age of 18. The guidance to this Act highlights the role of social workers in providing support services to children and young people in need and their families. Children are also entitled to education.

None of the three mentioned being in education now (one had been excluded) and only one said they had seen a social worker during this episode of homelessness.

[27] Action for Children (Scotland) work with looked after and accommodated children and young people, young carers, children affected by parental drug and alcohol misuse and families at risk. www.actionforchildren.org.uk/what-we-do/our-work-in-scotland

6. Conclusion and recommendations

This was a project with two aims: to find out, on a small scale, more about the experiences of homeless people with mental illness, and to explore how best this group could be reached in future work.

What we found was a picture of significant needs only partially met. We found that although some people were receiving the care and treatment they needed, others were not, or had had difficulty accessing it. We saw engaged and committed homelessness services supporting people with significant mental health needs but lacking direct referral routes to psychiatric and psychological services. We heard that the only access route to these services was via the GP, but that there could be barriers to registering with a GP. We also heard that there is a disconnection between mental health and substance misuse services, and that people who need both may get neither.

Homeless people with mental health problems are at a particularly vulnerable point in their lives, and it is important that they are able to access care and treatment when they need it. We have therefore made the following recommendations.

Recommendations for supporting homeless people's mental health

NHS boards/health and social care partnerships should:

- Remove barriers experienced by people who are homeless to registering with a GP, to enable access to GP services for physical and mental health and to specialist mental health services where required, and consider linking GPs to homelessness services to facilitate access.
- Consider the needs of homeless people in the local psychiatric emergency plan and consider how mental health services can respond out of hours to crises in homelessness units.
- In line with Actions 27 and 28 of the Mental Health Strategy: 2017-2027[28], review the working of mental health and substance misuse services to ensure that individuals with dual diagnosis are fully supported.
- Require prisons-based NHS staff to:
    - Ensure that individuals who may be homeless are assisted to register with a GP prior to release, where necessary by requesting that the GP practice register the prisoner as a temporary resident. This would allow

[28] http://www.gov.scot/Publications/2016/07/7151/0 Action 27: Test and learn from better assessment and referral arrangements in a range of settings for dual diagnosis for people with problem substance use and mental health diagnosis; Action 28: Offer opportunities to pilot improved arrangements for dual diagnosis for people with problem substance use and mental health diagnosis.

the sharing of information pre-release, so that health problems can be addressed in the community.

- After appropriate risk assessment, ensure that all people leaving prison and requiring medication have continuity of care - for example, by providing both a small supply of medication and a prescription.

Local authorities should:

- Review and improve how they carry out their duties as corporate parents under the Children and Young People (Scotland) Act 2014, to ensure that appropriate aftercare is provided for former looked-after young people under 26 to prevent homelessness.

The Scottish Government should:

- Ensure the new Scottish agency set up to administer social security payments is fully accessible to people who are homeless.
- Address the links between homelessness and mental health, and the support needs of homeless people with mental health problems, in any future strategy on homelessness.

The Mental Welfare Commission will also take forward some of the issues in our own work. We will:

- Look at advocacy provision for homeless people in our new role under the Mental Health (Scotland) Act 2015 to monitor how NHS boards and local authorities carry out their duties to provide advocacy services
- Produce new guidance on alcohol-related brain damage and the use of mental health and incapacity law
- Review how we can include homelessness in other areas of our work, including themed visits.
- Take account of the learning from planning and carrying out this exploratory visit in any future work visiting homeless people.


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Mental Welfare Commission (07/17)