Mental Health in the Long Term Plan for the NHS – consultation response

About St Mungo's

St Mungo's vision is that everyone has a place to call home and can fulfil their hopes and ambitions. As a homelessness charity and housing association our clients are at the heart of what we do.

We provide a bed and support to more than 2,700 people a night who are either homeless or at risk, and work to prevent homelessness.

We support men and women through more than 300 projects including emergency, hostel and supportive housing projects, advice services and specialist physical health, mental health, skills and work services.

We work across London and the south of England, as well as managing major homelessness sector partnership projects such as StreetLink and the Combined Homelessness and Information Network (CHAIN).

St Mungo's is a champion for supporting the health needs of people who are homeless. In 2014 we launched our *Homeless Health Matters* campaign, and in 2016 we launched *Stop the Scandal*, a campaign focused on addressing the mental health problems facing people sleeping rough.

We influence and campaign nationally to help people to rebuild their lives.

This consultation response is based on a selection of questions asked by NHS England, which have been adapted to allow us to respond more effectively for our client group.

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1. What are your top three priorities for meeting the mental health needs of people sleeping rough in England? Over the next five, and ten years?

The Government's Rough Sleeping Strategy, published in August 2018, stated that the NHS Long Term Plan will include new objectives for reducing health inequalities, including for rough sleeping. The Strategy calls on the NHS 'to spend up to £30 million on health services for people who sleep rough, over the next five years'.

Our overarching priority is for the LTP to commit to improving outcomes for this client group, with a plan for how to deliver joined up services, which take account of an individual's various support needs – mental health, substance use, complex trauma, and housing. The Long Term Plan is a clear opportunity to detail how new funding, of at least £30 million, will be spent as a first step towards achieving this.

Below this, our priority calls are to:

Increase access to mainstream services in all areas – introduce greater flexibility and more proactive interventions for rough sleepers. This includes more flexible appointments and walk-ins,

reducing barriers to GP and other health registration, tackling stigma through training, taking on people with dual diagnosis, offering more effective treatment options beyond IAPT, and working more closely with homeless services.

Encourage commissioning of specialist mental health services in areas with high levels of rough sleeping – reverse the trend of cuts to specialist mental health teams for people sleeping rough in areas with high levels of rough sleeping. Specialist homeless mental health services are an invaluable means of overcoming the inaccessibility of mainstream services to rough sleepers, providing the flexibility in appointments and holistic support which is valuable to this client group.

Ensure effective treatment for people with dual diagnosis – individuals with substance use needs should not be denied mental health treatment. NHS England should pilot then roll out integrated multi-disciplinary psychological health and substance misuse treatment services, embedded in existing homelessness services. Public Health England and local authorities through the LGA should be intimately involved in this process. This approach is essential to overcoming the complex and mutually reinforcing needs of many rough sleepers.

2. What are the mental health needs of people sleeping rough?

The mental health support needs of people sleeping rough are significant and complex. Research by St Mungo's found 4 in 10 people sleeping rough have a recorded mental health problem.[1] Figures from the Combined Homelessness and Information Network (CHAIN), a multi-agency database recording information about people sleeping rough in London, managed by St Mungo's, show that people recorded as sleeping rough with an identified mental health support need has dramatically increased in recent years – from 711 in 2009-10 to 2,342 in 2014-15, and 2660 in 2017-18[2]. The proportion of rough sleepers with a registered mental health support need increased from 45% in 2014-15 to 50% in 2017-18, while the figure for substance use needs rose from 31% to 40% in the same period.

The consequences of this can be fatal – 80% of those who died sleeping rough in London last year had a mental health support need, rising from 29% in 2010.[3]

People sleeping rough with a mental health problem tend to live on the streets for longer. Many are stuck in a vicious cycle where their poor mental health is an obstacle to engaging with services that can help them move off the street, while at the same time their homelessness acts as a barrier to getting the mental health support which is desperately needed. Homelessness and poor mental health are mutually reinforcing problems, often exacerbated by substance addiction, chronic physical health problems and social exclusion.

[1] St Mungo's (2016), *Stop the Scandal* https://www.mungos.org/wp-content/uploads/2017/12/Stop_the_scandal_Feb2016-1.pdf
[2] Data from CHAIN
[3] St Mungo's (2018), *Dying on the Streets: the case for moving quickly to end rough sleeping* https://www.mungos.org/wp-content/uploads/2018/06/Dying-on-the-Streets-Report.pdf

The Department of Health has estimated that the cost of hospital treatment alone for homeless people is at least £85m a year, meaning costs of more than £2,100 compared to £525 per person among the general population[4].

3. What gaps in service provision currently exist? And how do you think the NHS should address them?

At the same time as the number of people sleeping rough with mental health problems has increased dramatically, many of the specialist services best equipped to supporting this group have been scaled back or cut entirely. At the same time, the squeeze on frontline mainstream services has led to increasing barriers being put up to this client group.

This is having a damaging impact upon an already vulnerable group. A recent survey of street outreach services, carried out for our report entitled *Dying on the streets: the case for moving quickly to end rough sleeping*, showed that services are getting increasingly difficult to access. 70% of respondents said that access to mental health support for people sleeping rough has got harder in their area during the last five years, and 42% said the same for alcohol and drugs services[5].

In the survey only a minority of respondents said important mental health services were in practice available to people sleeping rough in their area; this included assessment and on street support (28%), dual diagnosis services (32%), and talking therapies (40%)[6].

Below is an analysis of the different gaps and barriers experience of rough sleepers.

3.1 Barriers to accessing mainstream services

Mainstream mental health services are frequently unable to cater to the needs of people sleeping rough with mental health problems. This client group has particularly complex needs, which services are not designed or equipped to support. In many cases, this group are exclude by practices which limit access to services. Examples include:

- Services not working with people with 'dual diagnosis', affected by co-morbid mental health and substance use problems
- Restrictive appointment times, which are hard to make and keep for people sleeping on the street
- General Practices refusing to register individuals who do not have an address
- Difficulties getting an assessment or referral to mental health services without being registered with a GP
- Discrimination and stigma from staff, who blame mental health conditions on rough sleeping and 'lifestyle choices'

[4] Department of Communities, Housing and Local Government (2012), *Evidence review of the costs of homelessness*, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/7596/2200485.pdf

[5] St Mungo's (2018), *Dying on the Streets: the case for moving quickly to end rough sleeping* https://www.mungos.org/wp-content/uploads/2018/06/Dying-on-the-Streets-Report.pdf.

[6] Ibid.

To increase access requires both a proactive attempt to engage rough sleepers within services, and on increasing flexibility in how services can be accessed. This needs to start with primary care, which is obviously an essential gateway to accessing secondary mental health services

It is unacceptable that General Practice regularly turn down rough sleepers from registering without proof of address, and it is unacceptable that individuals with dual diagnosis of mental health and substance use are turned down for mental health treatment. Both contravene established guidance – the former in regards to the Primary Medical Care Policy and Guidance Manual, and the latter in reference to NICE guidelines[7]. NHS England should commit to ending both practices.

Elsewhere, the following interventions would increase flexibility and improve access to services:

- 'Specialised' service / post within General Practice charged with increasing access for vulnerable groups, including people sleeping rough, and carrying out mental health assessments on the streets where necessary
- Training for staff to understand needs of homeless people (discussed in more detail under question 6)
- Working with and accepting referrals from outreach referrals to secondary mental health services
- Expansion in walk-in primary care clinics and longer appointments to deal with client group's multiple needs
- Collecting data on outcomes of referrals to secondary health services, with greater transparency and justification over when and why individuals are turned down for treatment, especially in dual diagnosis cases.

The kinds of treatment available in secondary mental healthcare is often not appropriate to rough sleepers with complex needs. Talking therapies and programmes like IAPT often have limited impact for individuals with severe mental illness, especially where it is bound up with active substance use. Group sessions can also often be inappropriate for people who have experienced complex trauma. The expansion of these kinds of programmes, while beneficial for many, has sucked resources from more effective kinds of treatment aimed at more marginalised groups.

Ensuring other options are available is essential – this should include access to person-centred therapeutic environments run in non-NHS services.. The NHS should roll-out a 'social prescribing' model, to allow primary care to referrer individuals to these kinds of services, often run by the voluntary sector or local authorities. This also has the benefit of helping improve someone's capacity to take up and sustain engagement with the medical NHS treatments available.

3.2 Lack of specialist services

Specialist homeless mental health services have been an invaluable means of overcoming the inaccessibility of mainstream services to rough sleepers, bridging the gap in areas with particularly high levels of rough sleeping. They provide the flexibility in appointments and holistic support which is valuable to this client group.

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[7] Primary Medical Care and Guidance Policy Manual (2017) https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/; and NICE, *Coexisting severe mental illness and substance misuse: community health and social care services* (2016) https://www.nice.org.uk/guidance/ng58/chapter/Recommendations#first-contact-with-services

The teams accept referrals from a range of sources, including street outreach teams (unlike secondary mental health services), and work with people who are unable or unwilling to access mainstream mental health services. They undertake and coordinate various types of mental health assessments with people sleeping rough, sometimes on the street if necessary.

Several specialist homelessness mental health teams that were set up in London in the 1990s as part of the Homeless and Mentally Ill Initiative have now been disbanded. Specialist statutory teams used to but no longer cover Hammersmith and Fulham, Kensington and Chelsea, Islington and Hackney. As a result of these cuts there are now more areas, including areas with a high number of people sleeping rough, that are not covered by a specialist homelessness mental health team.

Many of those that remain have suffered deep budget cuts which have limited their ability to address mental health problems among this client group.

Specialist mental health service case studies: START and Focus

START is a specialist mental health service provided by the South London and Maudsley NHS Foundation Trust (SLaM), set up in 1990 as part of the Homeless Mentally Ill Initiative. The START team focuses on engaging with, and undertaking assessments, for street homeless people in Lambeth, Southwark and previously Lewisham. START takes referrals from a wide range of sources, including voluntary sector street outreach teams. The team is comprised of doctors, nurses, social workers, psychologists and a psychotherapist. In 2012, financial pressures meant that staffing was reduced by 50% and the team could only offer support to 130 clients in 3 boroughs rather than 200. In 2016, further pressures led to them being disinvested in one of the three boroughs so they can now only offer a service to 2 local authorities. Voluntary sector staff in the disinvested borough are forced to refer hard to engage clients to appointments at a NHS Assessment team rather than the START team attending homeless day centres and sleep sites to outreach service users. This has led to vulnerable rough sleepers with mental illness not receiving a service.

Focus in Camden is another specialist mental health service, also set up in the 1990s. The CCG is implementing a 42% cut to the £521,000 budget it gave the team this year despite local protests. One of the team's two psychiatrists and one of its six nurses will lose their jobs as a result. This is despite the fact that it is widely regarded as a model of good practice of how to reach are group who are traditionally hard to engage.

Specialist mental health services offer a tried and tested model of improving outcomes for rough sleepers with mental health problems. Cuts to such services should be reversed, and they should be rolled out in areas with high levels of rough sleeping. There is the possibility of supporting cross-boundary commissioning for such services outside of London to encourage their uptake.

These kinds of services exist as a response to high levels of rough sleeping and mental health problems; when we hopefully see substantial reductions in numbers they will need to be phased out and integrated into mainstream services (which can integrate this 'specialist' approach); or could be developed into multidisciplinary teams to respond to multiple disadvantage / complex needs more widely.

3.3 Gaps between mental health and housing / homelessness services

There is a lack of join-up between mental health and housing / homelessness services. This has two clear impacts – many people in contact with homeless services do not get their mental health needs met; and many people who have been in treatment do not get adequate housing support after discharge.

Research by the Kings College London HEARTH study found that of 900 homelessness projects (702 hostels, 198 day centres), 43.4% were linked to a specialist primary health care service, and 40.2% not linked[8]. In practice it is likely that over half of homelessness projects are not linked into specialist primary care. The lack of in-reach from health services means many of this client group will have untreated mental health problems.

On the other side of the divide, there is equally a lack of link up between mental health units and housing / homelessness service at the point of discharge. Many are forced to sleep rough after being discharged, and this is particularly prevalent in discharge from mental health services. St Mungo's carried out a survey of outreach workers across the UK in 2016, and 78 per cent of survey respondents said that in the last 12 months they had met at least one person sleeping rough who had recently been discharged from a mental health inpatient service[9]. 44 per cent of respondents said that the number of people who sleep rough soon after being discharged from a mental health inpatient service is increasing; only seven per cent said it was decreasing.

Several professionals interviewed for the report said that there is a lack of coordination between services when someone with housing needs is discharged from a mental health hospital. A referral to a street outreach or other homelessness service may be made, but in some cases this is done at or very near the point of discharge, without time for services to process the referral.

There have been efforts to address this. In 2013-14 the Department of Health invested £10 million in 52 homeless hospital discharge programmes, and some of this funding was used to support people who were discharged from mental health hospitals – St Mungo's Hospital Discharge Network was a part of this. However, most of these services were unable to secure continuation funding. Only 17 out of 41 homeless hospital discharge projects that responded to the survey reported receiving funding to continue delivering services after the central government grant expired.

The Homelessness Reduction Act and the new Duty to Refer on hospitals will hopefully instigate the change needed to stop people falling through this gap. But this should not be seen as a silver bullet – proper plans must be in place to deliver the Duty effectively, and ensure discharge to the street does not occur in practice. Achieving this requires:

- New funding for a successor to the hospital discharge programme
- Good links between hospital staff, the local authority and community-based agencies to promote involvement of appropriate agencies in the discharge process.

[8] Kings College London (2018), Mapping of specialist primary health care services in England for people who are homeless, https://www.kcl.ac.uk/sspp/policy-institute/scwru/res/hrp/hrp-studies/HEARTH/HEARTH-study-Mapping-FullReport-2018.pdf

[9] St Mungo's (2016), Stop the Scandal, https://www.mungos.org/wp-content/uploads/2017/12/Stop_the_scandal_Feb2016-1.pdf

- A specialist post or service dealing with housing problems upon admission. This individual / service should be consulting with care co-coordinators and housing providers to address housing issues before it comes to discharge, therefore reducing bed blocking and discharge accommodation.

3.4 Gaps in treatment for dual diagnosis and comorbidities

The high levels of co-morbid mental and health substance use problems among this client group is one of the major barriers to accessing and maintaining housing. This is further complicated by the high levels of complex trauma experienced by this client group, as well as the prevalence of personality disorders. Misdiagnosis is common, and this often leads to support needs going untreated and conditions worsening.

Secondary services are poorly equipped to deal with these co-morbidities. Frequently mental health teams will not work with individuals until their substance use problem is addressed, but in many cases this substance use is itself a product of unmet mental health needs. Even if a referral is made and treatment is started, many struggle to engage in structured mental health treatment or group sessions that are favoured in community recovery services before detoxification. The result is that these individuals do not get the support they need, and their conditions worsen before reaching crisis. This is partly a product of the separate funding arrangements for mental health and substance use services, and the lack of partnership between CCGs and local authorities over providing services which address both.

Responding to this requires immediate steps to improve diagnosis of co-morbid mental health, substance use, and/or personality disorders. This requires mental health and recovery teams to work collectively on clients' needs, alongside other kinds of therapeutic support. NICE guidance sets out well what this should look like, including assigning a care coordinator to develop a care plan, which involves the client and addresses the individual's mental health, substance use, and housing needs[10]. Unfortunately this is rarely adhered to in practice. Most immediately, the guidance cautions never to exclude people with dual diagnosis from secondary care mental health services – as well as from physical health, social care or housing. Again, this kind of exclusion is a frequent experience.

The priority should therefore be to ensure services never turn people away due to dual diagnosis or comorbidities. If a client's substance use makes a mental health diagnosis difficult, the mental health teams should be required to liaise with appropriate recovery agencies to create a plan for the individual – rather than rejecting the referral and sending them back to their GP. There needs to be stronger requirements to ensure this happens in practice, and clearer joint working arrangements between local authority / PHE and NHS services.

3.5 Gaps in current responses to complex trauma

While the above examples show the gaps in mental health treatment for rough sleepers, this rarely exists in isolation from other support needs. A much more 'holistic' approach is needed – which actually goes beyond dual diagnosis – and services should be built around this principle.

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[10] NICE, *Coexisting severe mental illness and substance misuse: community health and social care services* (2016) https://www.nice.org.uk/guidance/ng58/chapter/Recommendations#first-contact-with-services; and https://www.nice.org.uk/guidance/CG120/chapter/1-Guidance#primary-care

For men and women most at risk of rough sleeping, homelessness and poor mental health are mutually reinforcing problems, often exacerbated by substance addiction, chronic physical health problems and social exclusion. At the root of their problems is complex trauma resulting from adverse childhood experiences such as abuse and neglect. These have often been entrenched through repeat exposure to trauma, poverty and exclusion.

Creating sustainable solutions with a complex and ever changing heath/social care/housing system has proven to be beyond the capacity of any single actor within the system. Constant changes in one or other commissioning system or service means that landing a sustainable integrated model has proven impossible.

Service provision should reflect the complex and mutually reinforcing needs of many rough sleepers. Multi-disciplinary teams would be highly effective in delivering this approach.

We would like to see the testing of an integrated, multi-disciplinary trauma informed psychological health and substance use treatment service embedded in existing homelessness services that provides:

- Rapid mental health engagement and assessment of people sleeping rough (working with outreach teams), offering pathways into mainstream services where appropriate
- Psychological treatment including initial pre-treatment relationship building, one-to-one psychological therapy, group therapy in homelessness settings (i.e. hostels, supported housing etc.)
- Parallel and integrated substance use treatment including assessment, substitute prescribing, harm minimisation, needle exchange etc.
- Support to host services to develop psychologically informed environments / trauma informed care through reflective practice, training and clinical supervision with teams.
- Liaison and advocacy with surrounding health/care/housing systems to ensure effective move on and long term support.

This is clearly beyond the scope of the NHS alone, and to devise a pilot will require buy-in from a variety of different agencies. We believe this is an important long-term model to address the complexity of need in this client group, and this principle of multi-disciplinary teams should be recognised in the LTP.

4. What currently exists and works well? Are there examples of excellent practice that you think could be scaled-up nationally to enhance the quality of care people receive for their mental health, reduce costs and/or improve efficiency of delivery?

4.1 Specialist services

The most effective mental health interventions for people sleeping rough have a degree of 'specialism'. These can either look like a dedicated specialist mental health team for rough sleepers, or an individual post with specialism in mental health and homelessness embedded in existing teams. Which is most appropriate depends on the scale and nature of rough sleeping in a local area.

Examples of specialist mental health teams, including START and Focus, were given in the previous section, but there are multiple examples of embedded specialism in existing teams too. Thames Reach used a Homelessness Transition Fund grant to embed a specialist mental health outreach worker in street outreach teams mainly working in outer London. This was combined with spot purchasing of support from a specialist homelessness mental health team, Enabling Assessment Service (EASL), for the most challenging cases. As a result of this programme, 37 people with serious mental health issues were moved off the streets and into accommodation in two years[11].

The flip side of this is specialism embedded in mental health services themselves. This can include a responsible individual in general practice, or a designated specialist who can carry out street mental health assessments or in-reach to hostels when necessary.

Although trials are limited, there is evidence in the academic literature that coordinated treatment programmes lead to better outcomes for people who are homeless and have mental health problems[12]. This is true regardless of the kind of intervention; any active co-ordinated approach is preferable to relying on mainstream services to pick up the slack. Which should be commissioned depends on local circumstances and numbers – but specialist teams are clearly preferable in areas with high levels of rough sleeping given the capacity they offer.

4.2 Unlocking mainstream services – advocacy and communications

In the absence of specialist services and mental health outreach, advocacy and effective communications have been used to help rough sleepers unlock mainstream services.

The Healthy London Partnership have worked on an initiative to reduce the number of rough sleepers being unable to register with a GP due to lack of address. They have produced plastic cards which remind GP receptionists and other practice staff of the national patient registration guidance from NHS England, which states that people do not need a fixed address or identification to register or access treatment at GP practices. The plastic cards are designed to be carried by adults who are homeless across London, including people who sleep rough. Since December 2016, 60,000 cards have been delivered to shelters, day centres, food banks, drop in centres and other organizations across London. NHS England could be delivering this kind of internal communication themselves.

Advocacy services can also play a vital role in ensuring homeless people can access the health related services they need. Allocating a member of staff or peer volunteer to help people who are homeless remember and attend appointments, to go along with them, talk to the doctor on their behalf, and help them to understand advice, can help people overcome the fear of seeking help.

The Groundswell Homeless Health Peer Advocacy Service (HHPA) supports people experiencing homelessness to address both physical and mental health issues. The service is a good example of

[11] St Mungo's (2016), Stop the Scandal, https://www.mungos.org/wp-content/uploads/2017/12/Stop_the_scandal_Feb2016-1.pdf

[12] NHS North West London (2013) *Rough sleepers: health and healthcare A review of the health needs and healthcare costs of rough sleepers in the London boroughs of Hammersmith and Fulham, Kensington and Chelsea, and Westminster*
http://www.jsna.info/sites/default/files/Rough%20Sleepers%20Health%20and%20Healthcare%20Annex.pd

how to increase access to healthcare, particularly where specialist services are limited or non-existent. Their Peer Advocates have all experienced homelessness themselves, and work in a variety of London boroughs. Crucially, they accept referrals from anyone working in a homelessness or health service, as well as self-referrals[13]. This kind of service can and should be more widely commissioned by CCGs.

5. People with physical health problems do not always have their mental health needs addressed; and people with mental health problems do not always have their physical health needs met. How do you think we can improve this?

Many of the good practice and recommendations contained in this response can equally be applied to physical health. In fact, the overall goal of health policy should be towards holistic support for people's mental and physical health, including safeguarding, substance use and any other support needs.

To ensure this, CCGs should requires services to adopt an 'every contact counts' principle, advocated by the Healthy London Partnership among others, which includes a holistic assessment of need, covering physical health, mental health, substance use and safeguarding needs. This would ensure a continued focus on the physical health of people with mental health and complex needs. This can be done through:

- NHS screening services reaching all homeless people
- Annual primary care reviews for people with long term mental health needs
- Mental health services providing dedicated stop smoking services

6. Do you think the NHS should be doing more to prevent mental ill-health? If so, what should we do to improve this?

We know that mental health problems can be both a cause and consequence of homelessness, and that mental health problems rapidly worsen after exposure of rough sleeping. Addressing and preventing this spiral will require closer partnership between CCGs and local authorities, and recognition in local commissioning arrangements.

Health and Wellbeing Boards are tasked to improve the health of all local people, while Clinical commissioning groups have a duty to reduce inequalities in health outcomes and access to health services. They are therefore required to plan to address the poor health experienced by people who are homeless.

St Mungo's has done a lot of work in the past to ensure the needs of rough sleepers are included in Health and Wellbeing Strategies and Joint Strategic Needs Assessments. We worked with Health & Wellbeing Boards and partners to develop our Charter for Homeless Health, with those who signed the Charter pledging to:

[13] http://groundswell.org.uk/wp-content/uploads/2017/10/Saving-Lives-Saving-Money-Full-Report-Web.pdf

- **Identify need** by gathering information about homeless health and including it in local plans
- **Provide leadership** and encourage local agencies to work together
- **Commission services** that welcome people who are homeless and meet their health needs

At the last count 44 Health and Wellbeing Boards had signed the Charter, since October 2014[14]. This is almost a third of the 152 Boards across the country. It should be common practice for homeless / housing representatives to sit on these Boards, with clear commitments made to tackling rough sleeping through a partnership and preventative approach. Similarly, it is necessary for Joint Strategic Needs Assessments to include rough sleeping – previous research we carried out with Homeless Link found that only 36% of JSNAs currently make reference to single homelessness, and only a quarter include detailed information7. The health needs of single homeless people should be included in each JSNA.

Looking further upstream, there are clear social determinants for rough sleeping and complex needs which require preventative action. At the root of many problems for rough sleepers with mental ill health is complex trauma resulting from adverse childhood experiences such as abuse and neglect. These have often been entrenched through repeat exposure to trauma, poverty and exclusion. There is a role for interventions by the NHS at this much earlier stage, as well as ensuring services for adults are trauma-informed given the prevalence of these experiences among this client group.

7. How can we recruit, train and retain the workforce to deliver the changes we need, particularly to meet your priorities?

It is essential for homeless mental health services to be peer led, with experts by experience at the centre of decision making. Directly recruiting individuals with experience of both homelessness and mental ill health can play an invaluable role here, including those from non-medical backgrounds.

CCGs can achieve this by commissioning services which include people with lived experience in workforce planning, with proactive practices to increase ex-client representation. This could start with voluntary opportunities with clear pathways towards full-time paid employment further down the line.

Training is essential in reducing stigma and barriers facing rough sleepers when accessing mental health services. These training packages should be co-produced with experts by experience, and support staff to understand the issue of homelessness – turning them from gatekeepers to gateopeners. Within this should include the rights of individuals to treatment, including the expectation that no individuals are turned away due to lack of address, or for presenting with dual diagnosis.

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[14] https://www.mungos.org/wp-content/uploads/2017/07/Charter-for-Homeless-Health.pdf