I have 15 years experience providing psychological input to homeless individuals and to the services who work with them.

My submission is in relation to a small percentage of homeless individuals who are often referred to as the ‘multiply excluded homeless’, or, ‘complex needs homelessness’. This population have usually arrived at homelessness quite late on in a life that typically has had high levels of adversity in it.

**Housing Options and Homeless Prevention**

Housing options is a key area that can be used to address the needs of the multiply excluded homeless. The barriers to this tend to be a lack of understanding on the part of health services that housing can be a health intervention, and a lack of understanding on the part of housing that health has all the answers. The separate budgets are also a barrier in that when housing is providing good quality residential care to an individual they are not supported financially by health, even though they may well be saving health large sums of money.

Housing First has been shown to unequivocally be the best practice in addressing the needs of MEH individuals. A range of housing options can be derived from this basic model that would address the needs of most individuals in this area. Joining up budgets and involving health in the provision of care in a housing first setting would go a long way to integrating the two key elements of health and housing. The current split between housing and health services only serves to exacerbate the degree of exclusion that MEH individuals experience.

Health needs to recognise that there are many other staff groups who carry out care of these most complex individuals in a competent and professional manner. Rather than waiting for individuals to attend clinics designed by the health service, health staff might be better employed going to where the individual are and working with them directly or through supporting the staff who are working with them.

**Temporary Accommodation**

For many MEH individuals, good quality supported temporary accommodation that is available to them for as long as they need it is the health treatment of choice. If this is recognised then a certain proportion of temporary accommodation should be funded from health budgets as well as housing ones. Many supported
accommodation units operate de facto as residential mental health units, but are not recognised, supported or funded to do so.

**Multiple and Complex Needs**

The first step in ensuring the needs of homeless people with multiple and complex needs are met is the development of a shared understanding about what those needs are and how they have developed. Far too often MEH individual are understood through the lens of the symptoms they present with, and are directed towards services that match that symptom profile. Typically the relationship that then ensues between individual and service does not go smoothly and can often lead to the individual being discharged, barred or in some other way excluded. The language that services use around this experience is typically one of describing the individual as ‘not engaging’, when of course they are engaging – just not in the way that the service would like them to.

Psychologically informed approaches have been shown to be best practice in this area. An understanding of the psychological and emotional needs of these individuals helps explain why they might engage with services in the way that they do, and begin to describe how services might position themselves such as to offer the greatest potential of addressing the underlying needs.

I am biased, but I think that we have several models of good practice in Edinburgh where the health service (me) works closely with the third sector housing provider, through processes such as supervision, case review and reflective practice, to support staff, develop a psychologically informed approach and ultimately benefit the service user. The rate determining step in these endeavours is typically the amount of time that the individual is allowed to stay in the supported accommodation. Time is an important factor here, in that most time limits are not in any way informed by a good psychological understanding of the individual’s development. If, for example, a person experienced high levels of trauma, abuse and neglect through the first ten years of their life, then it is highly unlikely that 18 months in a supported unit will be enough to ‘change their mind’, independent of how good the care is. It just is not enough time. An understanding of realistic time frames in the provision of care to MEH individuals would go a long way in addressing the need.

There is a huge scope for improved joint working particularly across all sectors. In the third sector, competitive tendering tends to keep providers from working with and along side each other. Each becomes a brand vying for a contract. In statutory services workers too often resort to their own particular professional tribe. In both cases the different languages and understanding used by services act as a barrier to shared work. Such fragmentation and splitting is not helpful for individuals who have typically experienced high levels of fragmentation in their early relational experiences. From a psychological perspective, having coherent, joined up services
would be the first thing on your design sheet when working with people who have had fractured and incoherent upbringings.

Access to health services could be increased dramatically for MEH individuals if the health service moved away from a somewhat autistic idea that everyone can access and make use of health service in the same way. Specialist health services are often built around this basic premise, and as such any individual who does not play the part of patient properly can quickly find themselves becoming excluded and discharged. To offer a health giving relationship that is tolerant, understanding and recognises that engaging in care might evoke extreme ambivalence in some individuals would mean far more MEH individual being able to ultimately make use of care. Ironically it is often the ‘non-specialist’ keyworkers and support workers who are truly expert in the business of stickability and developing trust with those who have long histories of having their trust abused. The health service works very well for those that can use it. It requires a new, relationally based model of care if it is to address the needs of this most vulnerable population.

Housing First represents an approach that is psychologically informed and has been shown reasonably robustly to be the intervention of highest potential for MEH individuals. It should be commissioned without delay and joint funded across health, housing and social care. It provides a genuine opportunity to integrate fragmented services around an individual, or, in simpler words, to provide the coherent family group that is so often absent in the histories of this population. Too often the idea of complex needs evokes a notion that the intervention needs to be complex. It does not. All that is often required is security, stability, coherency, reliability, dependability and time. All the qualities of a good care relationship. Housing First carries the potential to provide this. And if you get this, most fundamental, part right, then the individual may well in time be able to make use of all the other aspects of life that we all take for granted.

**Rough Sleeping**

The care shelters that are provided by the churches show a good model of modified housing first for those who are often the most entrenched homeless. We should drop ideologies about what constitutes a house, get away from meaningless language about ‘encouraging’ rough sleeping, and provide good basic, low threshold shelter for those that need it. Again is about understanding and respecting the psychological and emotional needs of the individual and trying to come alongside those, rather than imposing our own views on things.

**Other**

In terms of the population that I have been describing here, it is well established that the reasons behind why they become homeless are relational in nature and have
their roots in developments characterised by high levels of adversity. Such adversity (incl. trauma, neglect and abuse) has profound and long lasting detrimental impacts upon an individual’s capacity to form relationships that have positive health outcomes. In this regard the homelessness is a relatively late emerging symptom of a much broader difficulty in emotional and psychological function. These individuals often become homeless because their relationships break down across the board, and yet they can also often struggle to be by themselves, and as such they can often be caught in a highly toxic agoraphobic / claustrophobic cycle where they both demand help (in the form of relationships with care providers), and then seem to make no use of those relationships when they are provided, or worse, get involved in abusive, neglectful and traumatic dynamics. This can lead them to become ‘multiply excluded’ from mainstream and other services.

Having integrated services who share a common understanding and language that is informed by the best available research would go some way to address these issues. In my work I have been lucky enough to work across organisational barricades and see that most people who work in this area do share a common goal. They understand the importance of a psychologically informed approach and are keen to operate in that way. Too often that goal is fragmented by funding arrangements, competitive tendering, professional preciousness, arbitrary policies and procedures, and general theoretical poverty.

I have rather rushed off this submission due to time constraints, but I would be more than happy to come and discuss any of the points I have raised in greater depth and clarity.

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The Access Point