Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar anghydraddoldebau iechyd meddwl

This response was submitted to the Health and Social Care Committee consultation on mental health inequalities

MHI 60

Ymateb gan: | Response from: The Wallich

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Mental Health Inequalities Consultation Response

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The Wallich is the trading name of Wallich Clifford Community

About The Wallich

The Wallich wants to create a Wales where people stand together to provide hope, support and solutions to end homelessness.

As Wales's largest homelessness and rough sleeping charity, The Wallich operates under three core objectives: **getting people off the streets; keeping people off the streets; and creating opportunities for people.**

Running over 70 diverse projects, across 18 local authorities, The Wallich works with more than 9,000 people experiencing homelessness every year across Wales.

Which groups of people are disproportionately affected by poor mental health in Wales? What factors contribute to worse mental health within these groups?

The Wallich supports people who are experiencing or are at risk of homelessness. Our experience is that the relationship between homelessness and poor mental health is mutually reinforcing: people who have poor mental health are disproportionately more likely to experience homelessness than the general population, and people who experience homelessness are more likely to have poorer mental health as a result.

We know that people who have experienced significant trauma, including adverse childhood experiences (ACEs), are at significantly greater risk of homelessness than those who haven't had these experiences. This can be because they develop behaviours as responses to trauma that can, for example, make it harder to maintain employment or a tenancy. Homelessness is also a greater risk to people who have poor mental health that is not necessarily related to trauma.

On the other hand, an experience of homelessness is in itself a traumatic event which is likely to cause a deterioration of one's mental health. Without support, individuals are at greater risk of social isolation, stigmatisation, and marginalisation, something that organisations like ours aim to address through our work.

Cooccurring issues

As well as these interconnections between homelessness and poor mental health, these experiences also frequently coexist with experiences of substance misuse, as well as contact with the criminal justice system. In a 2015 research paper into severe multiple disadvantage in England, Lankelly Chase Foundation found that 85 per cent of people in contact with the CJS, homelessness or substance misuse services had experienced trauma in their earlier lives (page 28 Hard Edges: Mapping Severe and Multiple Disadvantage in England – Lankelly Chase).

Whilst this is undoubtedly a compelling argument for investment in prevention services, particularly for children and young people who have had adverse childhood experiences, we particularly want to advocate on behalf of adults who have these backgrounds of disadvantage, and are consequently at much higher risk right now, of homelessness, criminalisation, substance misuse and mental ill health.

For the groups identified, what are the barriers to accessing mental health services? How effectively can existing services meet their needs, and how could their experience of using mental health services be improved?

In our experience, it is not realistic to expect the people we support to engage with general needs mental health support services. There are numerous barriers to accessing mainstream NHS provision, including difficulties with even registering for GP services without a fixed address or proof of identity. We support people experiencing homelessness to register with a GP wherever possible, but it can take time to build up a trusting relationship to allow this, particularly if individuals have had negative experiences in the past.

Further to this, we believe that there is active exclusion from mainstream services taking place, for example when individuals also struggle with substance misuse. Support and treatment pathways for 'dual diagnosis' – i.e. difficulties with mental health and substances – do exist, but they do not seem to be working effectively across all parts of Wales. Far too often people are simply barred from accessing one set of services, because their needs on the other side of that duality are considered too great. The people we support all too often fall into that gap. Rather than talking about 'dual diagnosis' which might suggest two separate diagnoses, we consider cooccurring mental health and substance misuse problems to be comorbidities which cannot be separated, as a complex response to trauma.

Capacity of crisis services

We are seriously concerned that the capacity of local crisis intervention teams is simply not up to the scale of the mental health needs in our communities. Accessing crisis support was often difficult prior to the pandemic, but since March 2020 it has been harder than ever to refer a client to the local crisis team. We have had instances of service users in severe mental distress, at risk of causing harm to themselves or others around them, and all that has been available has been support via phone call, which is simply not enough to resolve the emergencies our staff have faced.

In these situations, all too often things have deteriorated so far that the police have been called, and people in severe mental distress have ended up being detained in a police cell. We deplore the punishment and criminalisation of people simply for having an acute episode of mental illness, however we must concede that in many instances it takes contact with the criminal justice system before a mental health assessment will be carried out. **This is not a status quo that anybody should be able to accept.**

In order to address this, we would urge the Welsh Government and local health boards to consider all options. Mental Health Crisis teams need to be properly funded to provide a genuinely 24/7 service, with sufficient in-patient bedspace available to meet the need of cases that are currently routed into the police or other non-health services. We would also like to explore the possibility of embedding qualified community psychiatric nurses within housing support services in each region. Current commissioning arrangements may be prohibitive to this, but this may be a useful resource to improve integration between homelessness support and the NHS system, which can sometimes feel like it has conflicting priorities. We all need to work together to develop an evidence base for what works best to respond to mental health crisis episodes and set thresholds for different interventions appropriately.

Current guidance

We would also like to highlight that we do not feel that current guidance from NICE and the Welsh Government is being followed at present. Under the Mental Health (Wales) Measure 2010 (Code of Practice), services must offer both medication and talking therapies as appropriate, and a care plan must be developed for anybody presenting with severe symptoms such as psychosis or suicidal ideation. **It is not acceptable to turn people away simply because they are thought to be under the influence of drugs or alcohol, however we believe that this has happened in some areas of Wales.** Where our service users have managed to access services, more often than not they have been offered medication without a corresponding offer of talking therapy. We then need to pursue this independently (for example through our in-house Reflections Network of counsellors).

The NICE guidance on co-occurring mental health and substance misuse goes further, outlining not only that individuals must not be excluded from services, but that they must be actively supported, including where appointments are missed. There are often good reasons why the people we support might miss appointments, and the consequent withdrawal of support can be incredibly retraumatising and damaging to trust. Individuals must not be punished for 'failing to engage' and services must do better to engage people on their own terms. **NICE also recommends that their 'Care Coordinator' (i.e. the service with lead responsibility for treatment) should be a mental health specialist.** This is not happening at present, as our staff are typically acting as the lead care providers due to the difficulty of accessing mental health services.

A culture of cooperation

Above all we need to look at the culture of services that work in this area, as at present it is all too easy to slip into siloed ways of thinking and working. Mental health is inextricably linked with housing and homelessness, as well as substance misuse, anti-social behaviour, and criminal justice, so services must be commissioned holistically in recognition of this. At the moment there are different pots of money and different commissioning processes for these strands of work, and we feel that these need to be brought into closer alignment to encourage deeper cooperation and partnership working.

There needs to be coordination between the wellbeing work carried out by housing support workers and the clinical interventions of health services. Our support workers spend many hours with clients getting to know them, building up trust and a support network where relationships with family or friends may have broken down in the past. These relationships are vital for developing personal resilience, working to prevent an escalation to crisis-point, so mental health services need to represent a continuation of this compassionate approach. It would be much better if we were all working to prevent crises happening in the first place, rather than always working reactively as is too often the case presently. In some local authority areas, we feel that our expertise in supporting people in a trauma-informed way is not sufficiently respected by partners including the local CMHTs, but we are keen to share examples of good practice.

To what extent does Welsh Government policy recognise and address the mental health needs of these groups? Where are the policy gaps?

In order to address the challenges raised above, Welsh Government needs to break-down silos and bring policy and commissioning in particular into closer alignment. Joined up commissioning of housing support with health and social care services is essential to address the complex interconnected nature of mental health with homelessness and substance abuse. There are promising early indications of this in documents like the Welsh Government's Ending Homelessness Action Plan which outlines the importance of partnership working and developing a shared outcomes framework. But we feel that at present there is not yet sufficient levels of understanding across local health services of how trauma and ACEs impact mental health.

At present we are using other sources of funding to fill the gaps that we see in mental health provision. For example, our Reflections Network provides our clients with one-to-one sessions with trained counsellors, to explore the underlying causes of their poor mental health. This is hugely valuable to clients and the staff that support them, but it is seen as a service enhancement rather than an essential feature of support services as they are commissioned. The Reflections Network was born out of frustration that waiting times and appropriate counsellor matching was not working for our service users when going down the conventional route. We have received some funding through the WG Section 64 fund for third sector mental health services, but we must rely on charitable donations and grants in order to maintain the Network at a level commensurate with demand. We are awaiting a decision from WG on the long-term future of Section 64 funding, but ideally, we would like to see a recognition that integrated mental health support will be vital for the success of flagship programmes such as rapid rehousing. Mental health stability is essential for somebody to maintain a tenancy.

Successful joined up working across the housing and mental health sectors will depend upon developing a culture of open communication and collaboration to ensure that the right

interventions are taken at the right times, by the right people. **By conducting rigorous mental health assessments of everyone at risk of or experiencing homelessness, we can do much more to prevent mental health crises well before things deteriorate to that level.**

What further action is needed, by whom/where, to improve mental health and outcomes for the groups of people identified and reduce mental health inequalities in Wales?

We believe that Welsh Government needs to increase funding and staffing of Community Mental Health Teams, to dramatically improve their capacity to respond to mental health crises amongst the people we support who have experienced trauma. **We feel that a culture change is needed to embrace psychologically informed ways of working, to actively work against re-traumatisation through inappropriate services which are not accessible to people who have been let down so many times before.** We are ready to work together to share good practice to ensure this compassionate approach is embedded at all levels of the system.

We would also like to reiterate our call for Welsh Government to announce their succession plans for Section 64 funds for third sector mental health services as soon as possible. We believe that the success of key pillars of the Ending Homelessness Action Plan (including rapid rehousing) will only be possible if we recognise the need for dedicated mental health support services with clear pathways for assessment and treatment. The Government might also consider piloting ideas such as embedding NHS psychiatric nurses within housing support services in each region, who as well as providing clinical support for our clients could help facilitate reflective practice amongst housing support staff to mitigate their experiences of vicarious trauma through their work.

Finally, we would welcome further exploration of options for addressing substance misuse amongst people who have experienced trauma, according to principles of harm reduction principles. We have seen promising results from the prescription of Buvidal during the pandemic as an alternative form of opioid substitution therapy, and would be interested in expanding upon this through other models such as heroin-assisted treatment (HAT) or supervised consumption rooms (sometimes referred to as Enhanced Harm Reduction Centres). (Centre for Homelessness Impact – What works in drug and alcohol)

We would like to thank the Committee for the opportunity to contribute to this inquiry, and we will be happy to provide any further information with regards to the mental health challenges faced by people with experience of homelessness and trauma.