

A GOOD PRACTICE GUIDE

# GETTING THROUGH

**ACCESS TO MENTAL HEALTH SERVICES**  
FOR PEOPLE WHO ARE HOMELESS OR LIVING IN  
TEMPORARY OR INSECURE ACCOMMODATION

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# Executive summary

**SERVICE USER: HOMELESSNESS  
MENTAL HEALTH TEAM**

**“There’s not enough services for people like us on the street – we get chucked out of society. The CPN talks to me like I’m a person, it’s normal to have these thoughts. He listens to you as an individual... A lot of CPNs have only given me medication.**

**[It’s good to have] somewhere where you can just go and talk to someone, or they’ll come to you, instead of being taken to hospital and being interrogated.”**

## 1 Introduction

The purpose of this guide is to help mental health practitioners and housing and homelessness practitioners improve access to mental health services for people who are homeless or living in temporary or insecure accommodation. The guide identifies practical solutions and models of good practice, based on information from mental health and homelessness services around the country.

The following sections summarise the chapters contained in the main guide. The bullet points highlight examples of good practice.

## 2 The support needs of people who are homeless or living in temporary or insecure accommodation

Mental health problems are more prevalent among homeless people than among the general population. Mental health problems can be a contributory factor that leads to homelessness and can also arise as a result of, or be compounded by, the experience of homelessness and time spent in insecure or temporary accommodation. People who are homeless or living in temporary or insecure accommodation may also have additional support needs, which make accessing mental health services more difficult. This guide helps to develop an understanding of the needs and associated problems of such people, taking account of the different needs of different groups, for example, families, people without children, young people, rough sleepers and others.

## 3 Identifying mental health problems

Many people who are homeless or living in temporary or insecure accommodation experience difficulty in accessing mental health services. Delay in receiving support or treatment can both exacerbate their condition and put additional pressure on other services which are not designed to meet the needs of people with mental health problems. Identifying mental health problems and addressing them before there is a crisis is key to improving accessibility. This requires:

- ➔ training and support for frontline staff in identifying the symptoms of mental health problems
- ➔ ensuring that housing departments can direct people with mental health problems to support services.

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### 4 Targeting mental health services

There are a number of reasons why people who are homeless or living in temporary or insecure accommodation may have difficulty in accessing mental health services. These include problems accessing services if they have had to move to accommodation in a new area, if they are not registered with a GP, as well as fear and low expectations of services. There are a number of ways of ensuring that mental health services can reach people in these circumstances:

- ➔ health promotion activities
- ➔ care navigators
- ➔ mental health services based in homelessness agencies
- ➔ open-access mental health services
- ➔ 'street-based' services
- ➔ dedicated specialist homelessness mental health practitioners and teams.

### 5 Working together and continuity of care

People with mental health problems who are homeless or living in temporary or insecure accommodation may need support from a number of different agencies, including those in the voluntary and statutory sectors. It is essential, therefore, that these agencies work together to meet needs. This involves:

- ➔ information exchange between agencies about their services
- ➔ joint training of staff
- ➔ protocols for common procedures for assessing and referring clients, or carrying out joint assessments
- ➔ joint case conferences
- ➔ ensuring service users' case records are accessible to other agencies.

### 6 Access to primary care

Many mental health problems can be treated in primary care services, which are often also the gateway to specialist secondary care. However access to primary care, both for physical and mental health problems, can be problematic for people who are homeless or living in temporary or insecure accommodation. Primary care services can be developed in a number of ways to improve both the service itself and its accessibility to such people. These include:

- ➔ implementation of the Royal College of General Practitioners' guidance on homelessness and primary care
- ➔ Primary Care Trusts (PCTs) ensuring that local general practices will register people who do not have a settled address

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- ➔ PCTs directing enhanced services funding at services for these client groups
- ➔ specialist workers for these client groups within primary care teams
- ➔ specialist primary care teams for these client groups.

## 7 Accessing and exiting secondary care

There can be many barriers to accessing specialist mental health services for people who are homeless or living in temporary or insecure accommodation. Inadequate access to primary care, as described above, can exacerbate this problem. In addition, some services may apply restrictive criteria, which homelessness agencies may find difficult to understand. Inadequate discharge arrangements from inpatient care can lead to repeat homelessness and further mental health problems. This chapter offers examples of ways to design and manage secondary care provision to improve accessibility, such as:

- ➔ standard assessment procedures
- ➔ clear criteria for referral and eligibility
- ➔ information-sharing protocols
- ➔ protocols for homelessness agencies to make direct referrals to Community Mental Health Teams (CMHTs) and other mental health services in areas where there are no specialist services for people who are homeless or living in temporary or insecure accommodation
- ➔ directories of local mental health services
- ➔ implementing the Department of Health guidance on the discharge of homeless people from hospital
- ➔ a specific hospital admission and discharge protocol for people who are homeless or living in temporary or insecure accommodation
- ➔ specialist discharge workers to work with people who may be at risk of homelessness after hospital discharge.

## 8 Improving services for people with dual diagnosis and personality disorder

This chapter examines the complex issues that can make accessing mental health services especially difficult. It focuses on dual diagnosis of substance misuse and mental health problems and personality disorder. Their incidence amongst homeless people, particularly rough sleepers, may be higher than the general population and, combined with the other support needs, create barriers to services. Solutions include:

- ➔ increasing accessibility for those with a dual diagnosis of mental health and substance misuse, with mental health services taking responsibility for these clients
- ➔ specialist services for those with personality disorder.

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### 9 Support services for particular groups of people who are homeless or living in temporary or insecure accommodation

This chapter looks at services for specific groups of people who are homeless or living in temporary or insecure accommodation. It aims to identify additional ways of helping these groups to access mental health services. The services include:

- ➔ support for families with children
- ➔ specialist support for young people to improve access to services, family cohesion and access to education, training and employment
- ➔ support for ethnic minority communities
- ➔ diverting people with mental health problems away from the criminal justice system.

### 10 Strategic planning of accessible services

The identification and review of needs and services is a key element in plans to improve accessibility to mental health services for homeless people. This chapter describes a range of strategies and partnerships that planners may wish to consider. It also identifies measures to review arrangements to ensure they are effective. The measures include:

- ➔ collaboration between mental health services, housing, substance misuse and Supporting People commissioners
- ➔ effective arrangements for consulting and involving service users, including joint arrangements with homelessness services
- ➔ performance assessment and outcome measures.

### 11 Appendices

There are a number of appendices providing further information. They cover:

- ➔ a glossary of mental health terminology
- ➔ an outline of homelessness services
- ➔ an outline of mental health services
- ➔ main models of funding specialist primary care
- ➔ local strategies
- ➔ performance management
- ➔ the research for this guide
- ➔ contacts for Care Services Improvement Partnership (CSIP) Regional Development Centres
- ➔ references.

# 1 Introduction

## 1.1 Why is this guide needed?

The purpose of this guide is to outline models of good practice in order to help practitioners in the mental health and housing and homelessness field as well as managers, commissioners and policy makers to:

- ➔ identify local problems of access, or barriers to, mental health services for people who are homeless or living in temporary or insecure accommodation
- ➔ develop services to overcome these problems.

## 1.2 Who is the guide for?

The guide is designed primarily for mental health and homelessness agencies, but may also be helpful to other agencies which work to meet the needs of people who are homeless or living in temporary or insecure accommodation.

It contains advice for:

- ➔ policy makers and senior managers engaged in strategic planning for both mental health and homelessness services
- ➔ service commissioners
- ➔ managers and staff directly engaged in developing mental health and homelessness services, including both mainstream and specialist services.

## 1.3 How the guide is structured

Chapter 2 outlines the evidence on the range of support needs of people who are homeless or living in temporary or insecure accommodation. The following chapters examine the principles on which good practice is based and give specific examples of services that exhibit good practice. Some of these services are targeted at specific groups such as homeless people without children, but the support they provide may be relevant to other groups such as families.

More detailed information is contained in the appendices.

## 1.4 Definitions

In this guide the term *people who are homeless or living in temporary or insecure accommodation* includes:

- ➔ people sleeping rough
- ➔ individuals and families accepted as statutorily homeless and placed in temporary accommodation pending the availability of a settled home
- ➔ people staying in a hostel, refuge or bed and breakfast accommodation.

*Temporary accommodation* refers to accommodation secured by a housing authority under the homelessness legislation, pending the availability of a settled home.

## 1 Introduction

*Insecure accommodation* refers to accommodation (other than accommodation secured under the homelessness legislation) where the occupant has a low level of security of tenure (for example, a licence to occupy).

A wide definition of *mental health problems* is used in the guide including:

- ➔ severe and enduring mental health problems, including schizophrenia and bipolar affective disorder, also known as manic-depression
- ➔ common mental health problems such as anxiety, panic disorder, phobias, post-traumatic stress disorder, obsessive-compulsive disorder and depression
- ➔ personality disorders
- ➔ dual diagnosis of substance misuse and mental health problems.

See the *Glossary in Appendix 1* for definitions of these and other terms used in this guide.

### 1.5 Research for the guide

The evidence in the guide is drawn from a review of published research on mental health and homelessness, interviews with agencies working in the homelessness and mental health sectors, and service users. The guide does not report in detail on the research process, but its examples of good practice are based on research for the report, except where referenced to another publication. (See Appendix 7 for more details).

## 2 The support needs of people who are homeless or living in temporary or insecure accommodation

This chapter examines the range of support needs that people who are homeless or living in temporary or insecure accommodation may have.

Among this client group there are different categories of people who may have different needs which should be considered when planning services. This chapter looks at the particular needs of homeless people with multiple needs, people without children, including rough sleepers, families with children and people from ethnic minority communities.

### KEY MESSAGES

- ➔ Homeless people have a higher prevalence of mental health problems than the general population
- ➔ They are also more likely to have a range of other support needs that can make it difficult for them to engage with mental health services. These needs may include problems with: substance misuse, physical health, family relationships, education and sustaining independent housing. There may be complex combinations of these problems
- ➔ It is important to have an understanding of the range of local needs, so as to identify any gaps in provision and changes needed to improve access to mental health services
- ➔ There are differences in needs between families living in temporary accommodation, people without children living in insecure accommodation, young people and rough sleepers, and also between individuals within these groups. Problems with mental health and substance misuse are particularly prevalent among rough sleepers and people without children living in insecure accommodation
- ➔ Many homelessness agencies no longer exclude people with complex needs from services, but instead help them to engage with services. All agencies should consider how they can help people with mental health problems to access their services
- ➔ There are higher levels of homelessness and of mental health problems among some ethnic minority communities and planning of services should take account of the needs of different ethnic groups in the locality.

### 2.1 People with mental health problems and other support needs

Research indicates that mental health problems are more prevalent among homeless people than among the general population.<sup>1,2</sup> These problems may start early and predate homelessness, contributing to people becoming homeless and experiencing repeat homelessness. Mental health problems can also be exacerbated by the experience of homelessness and time spent living in temporary or insecure accommodation.

Besides their need for settled accommodation, people in these circumstances may have a wide range of support needs which can make it more difficult for them to access mental health services and to sustain support and treatment programmes.

## 2 The support needs of people who are homeless or living in temporary or insecure accommodation

In addition to mental health problems, the following are frequently reported:

### Health

- ➔ substance misuse problems, increasingly involving the use of Class A drugs, particularly heroin and crack cocaine, and alcohol
- ➔ physical health problems and difficulties in accessing primary health care
- ➔ homelessness following discharge from hospital.

### Family and relationships

- ➔ histories of physical and sexual abuse
- ➔ domestic violence
- ➔ a family history of homelessness
- ➔ a lack of stable and supportive relationships
- ➔ loneliness and social isolation
- ➔ teenage pregnancy.

### Education

- ➔ learning difficulties and low educational attainment
- ➔ absence or exclusion from school.

### Institutional living

- ➔ a history of local authority care
- ➔ time in prison and other contacts with the criminal justice system.
- ➔ time spent in the armed forces.

### Sustaining independent housing

- ➔ lack of understanding of the rights and responsibilities of tenants
- ➔ lack of practical skills in setting up and sustaining a home
- ➔ rent and mortgage arrears and other financial problems
- ➔ previous problems with neighbours, including anti-social behaviour, racial and other harassment in which they might be victims or perpetrators.

Many homeless people, particularly rough sleepers and people without children who are living in insecure accommodation, experience combinations of the above which both reinforce their mental health problems and make it harder to access support and treatment.

## 2 The support needs of people who are homeless or living in temporary or insecure accommodation

### GARY: MULTIPLE SUPPORT NEEDS

Gary was 30 and described his mental health diagnosis as manic depression with substance misuse. His symptoms first started when he was nine or ten years old when he was being abused by foster parents. He grew up in care and had never known his birth parents:

**“My mother was a working girl and I guess my dad was a client.”**

Drug use began in his early teens to enable him to cope with the physical abuse:

**“I started to use [drugs] when I was 13 or 14 to numb the pain.”**

He left his foster parents when he was 15 and travelled around the country, sleeping rough and staying in various forms of insecure accommodation. Gary had tried to apply for local authority housing but had never been accepted:

**“I never got nowhere. They just brushed me under the carpet or placed me in crappy B&Bs or bedsits. I had four wall syndrome so I never bothered to stay.”**

He had been receiving treatment intermittently for the past six years, but spoke of his problems at times in getting access to help when he needed it:

**“Sometimes the rules and regulations [make services] very bureaucratic. Sometimes they’re not there when I really need them. I want to speak to people and they’re not around. I find it hard to trust people, especially about personal stuff. I get angry and start wanting to use again.”**

At other times, he found services unhelpful because he felt they were pushing him before he was ready:

**“[The Alcohol and Resettlement team] expect you to do stuff there and then and you can’t because you’re suffering an illness.”**

Gary had often had problems registering with a GP:

**“Through being NFA and because you’ve got an addiction, they don’t want to know.”**

He had resorted to hospital A&E departments for his addiction or when he had self-harmed. He had served three prison sentences for drugs related offences. Gary had a seven year old daughter whose mother had died from an overdose and was now living with her grandparents. He managed to see her twice a month, but otherwise had no social contacts whom he regularly saw.

Gary had found specialist short-term accommodation for people with mental health problems through an outreach team. He was receiving support, including help from a drugs and resettlement team, was on a methadone prescription and awaiting a hospital place for detoxification. He reported that he was now generally feeling better:

**“I’m alright at the moment... I’ve got the help and support... It takes a longtime to build up trust.”**

## 2 The support needs of people who are homeless or living in temporary or insecure accommodation

Homelessness agencies reported that they either perceived or diagnosed a range of problems among their service users, including a significant incidence of anxiety and depression, personality disorder, poor anger management, self harm and Post Traumatic Stress Disorder. The combination of these problems in individuals can make it harder to access services.

An understanding of the range of needs and associated problems of the local population is required, so as to identify any gaps in provision and changes needed to improve access to mental health services.

Since 2003 all local authorities have had a homelessness strategy in place based on the levels and cause of homelessness in their area. They are required to keep these strategies under review and to produce a revised strategy within five years. Department for Communities and Local Government (DCLG) has issued a toolkit to assist local authorities with their review, and this emphasises the need to look at health issues including mental health.<sup>3</sup>

Research evidence, such as that described in later sections of this chapter, can provide useful benchmarks and can trigger questions locally, which may discover unmet needs. This analysis of needs should inform local homelessness and mental health strategies (see Chapter 10).

People who are homeless or living in temporary or insecure accommodation are not a homogenous group. There are differences in needs and circumstances between families, people without children, young people and rough sleepers and also between individuals within these groups. Rough sleepers are most likely to have complex support needs, but others within these groups may also have similar needs.

Some people, particularly many rough sleepers and those with multiple needs, require accommodation where staff can give sufficient time to support them. Without this support, people may find it difficult to sustain accommodation. Previous policies of evicting such people from hostels and banning them from day centres tended to exacerbate their problems.

Some homelessness agencies are now making great efforts not to exclude such service users and help them engage with mental health services. Mental health services need to work closely with homelessness services and other specialist support agencies, including those described in Chapter 9. An outline of the range of homelessness services is listed in *Appendix 2*.

## **2 The support needs of people who are homeless or living in temporary or insecure accommodation**

### **2.2 People without children living in insecure accommodation**

One of the largest surveys of people without children living in insecure accommodation found that among those staying in hostels, the incidence of mental health problems (self reported depression and anxiety) was eight times higher than among the general population. Among those sleeping rough the rate was 11 times higher.<sup>4</sup>

There is a high prevalence of multiple problems among rough sleepers and some people without children living in insecure accommodation. These include dual diagnosis of mental health and substance misuse, physical health problems and contacts with the criminal justice system.

A summary and review of the main British research on the range of support needs of rough sleepers and people without children living in insecure or temporary accommodation, is available at [www.crashindex.org.uk](http://www.crashindex.org.uk)

### **2.3 Families with children in temporary accommodation**

A study of families with children living in temporary accommodation in Birmingham found that 49 per cent of mothers of these families had mental health problems, a rate three times higher than among women of comparable age in the general population. Forty one per cent of children in these families had significant mental health problems, three times higher than in other comparable families.<sup>5</sup>

Although the prevalence of complex needs among families in temporary accommodation is not as high as among people sleeping rough and people without children living in insecure accommodation, staff working with families in temporary accommodation report that, in their experience, the families can have support needs that may not be recognised because agencies tend to focus on the families' housing circumstances. These needs can include depression among lone parents, domestic violence and teenage pregnancy. Some agencies also report higher incidences of substance misuse and a lack of practical skills in maintaining a home.<sup>6</sup>

In 2005 the DCLG commissioned nationally representative surveys of 2000 families with children and 500 16–17 year olds who have experienced homelessness. It also commissioned a separate survey of 500 households that had been living in temporary accommodation for more than a year. These surveys, which are the first national surveys of families with children and 16–17 years olds who are statutorily homeless, investigate the causes of homelessness and the impact of living in temporary accommodation, in particular on the health and well-being of these households, and on children's education. The surveys also investigate the impact of homelessness and temporary accommodation on access to education, training and employment, and the costs of homelessness and temporary accommodation both to the wider public sector and to homeless households themselves.

The findings from the surveys are expected to be published in the Spring of 2007.

## 2 The support needs of people who are homeless or living in temporary or insecure accommodation

### 2.4 People from ethnic minority communities

Statistics from the DCLG on people accepted by local authorities as unintentionally homeless and in priority need of accommodation, indicate that people from ethnic minorities are around three times more likely than the general population to be accepted by local authorities as owed a main homelessness duty.<sup>7</sup> There are also marked differences in the rates of homelessness acceptances between the various ethnic minority groups, with people of Black African and Black Caribbean origins being twice as likely to be accepted as owed a main homelessness duty as people of Indian, Pakistani and Bangladeshi origins. A wide range of issues is reported as causing or contributing to homelessness among ethnic minority communities and these may differ between the various ethnic groups.<sup>8</sup>

People from ethnic minority communities can have particular difficulties in accessing mental health services. Research has found that nearly half of people from ethnic minority communities who had contact with mental health services reported race discrimination.<sup>9</sup> Black people tend not to access mental health care through primary care settings. One explanation for this phenomenon is that a 'circle of fear' is developed between the services on the one hand, perceiving Black and African Caribbean service users as potentially dangerous. This results in responses dominated by a heavy reliance on medication and restriction, and on the other hand service users viewing services as harmful because of this treatment. As a result service users delay accessing services until a crisis is reached, which then often reinforces both positions.<sup>10, 11</sup>

African-Caribbean people in the UK are more likely to be given a diagnosis of severe mental illness, to be held under a section of the Mental Health Act (1983) and some research has suggested they are more likely to receive medication rather than be offered therapies such as psychotherapy.<sup>12</sup>

## 3 Identifying mental health problems

This chapter examines ways in which the mental health problems of people who are homeless or living in temporary accommodation can be identified and assessed at an early stage.

### KEY MESSAGES

The identification of the mental health and other support needs of people who are homeless or living in temporary or insecure accommodation can be improved in a number of ways.

- ➔ Frontline agencies in contact with homeless people can play a key role in identifying possible mental health problems and making referrals for specialist assessments
- ➔ These frontline staff can be trained to identify possible mental health problems
- ➔ Mental health agencies can provide expert advice and support on mental health problems for staff in homelessness agencies managing individual cases
- ➔ Mental health staff can be trained in the other support needs of homeless people and the availability of local homelessness services
- ➔ It is also helpful if at least one member of staff in each mental health service takes a specialist interest in homeless service users and receives additional training to advise and support other staff
- ➔ Staff in local authority housing departments who deal with applications from homeless people can ensure that all those with possible mental health problems are referred to agencies which can assess and support them
- ➔ Joint assessments of applicants to local authorities can be made by housing, social services and health professionals.

### 3.1 Problems when mental health needs are not identified

Delays in access to mental health services can occur if the mental health problems of people who are homeless or living in temporary or insecure accommodation are not identified by the agencies working with them.

The homelessness agencies interviewed for this guide were in areas selected because they offered a range of effective services for people with mental health problems. But they often reported difficulties in the past for many of their users in getting mental health problems recognised and in accessing mental health services (see *Appendix 7*). Most of the 55 service users interviewed also reported such problems in the past, some of which had been resolved by the agencies which were currently supporting them.

### 3 Identifying mental health problems

#### SERVICE USERS: PROBLEMS IN ACCESSING SERVICES

In her mid thirties, Debbie had been on the streets off and on since the age of 17, when mental illness ‘crept up on me’. She had been fostered throughout her childhood and had dyslexia and learning difficulties. She was not getting on with her foster mother, so left and went to London where she became involved in a chaotic lifestyle, using alcohol and drugs to cope and periodically presenting to a hospital A&E department whenever she felt she needed treatment and was unable to access services:

**“It’s harder when you’re on the streets. I went into day centres and asked them to get me into places [for treatment]. They said they can’t help me.”**

Other interviewees frequently referred to the problems of getting help through GPs, such as Sean who was in his late thirties:

**“Especially when I was on the street in [another city], no-one wanted to know. Doctors think you’re just after pills, they’re not interested.”**

Some described how their illness was itself a barrier to seeking help. For example, Tom who was 26:

**“You get so ill you lose all sense of asking for help. You’re just not well enough to ask.”**

Frontline agencies in contact with people who are homeless or living in temporary or insecure accommodation are well placed to play a key role in identifying possible mental health problems and making referrals for specialist assessments. They include voluntary and statutory agencies providing housing management, tenancy support, hostels, day centres and advice centres as well as local authority housing departments.

However, not all staff in frontline homelessness services are trained to recognise possible mental health problems. For example, residents of hostels who are withdrawn may be overlooked if they are not causing management problems. Symptoms of mental health problems, such as difficulties in managing money or anti-social behaviour, may lead to people being evicted from their homes or banned from hostels and day services. If they are evicted, they may be deemed intentionally homeless by the local authority and not entitled to the main homelessness duty.

Behaviour linked to mental health problems can also lead to involvement with the criminal justice system. This is a particular risk for homeless people who are sleeping rough and people who are staying in a hostel, because if they are exhibiting distress or challenging behaviour, it is more likely to be in a public place.

### 3 Identifying mental health problems

People without children who are homeless or living in insecure accommodation may use crisis services, such as hospital Accident & Emergency (A&E) departments, when primary care services may be more appropriate. Mental health problems can be difficult to identify in A&E, especially if symptoms are masked by substance use.<sup>13</sup> A mental health assessment and/or referral to local inpatient mental health services can be carried out if the person is in crisis, but A&E is not a suitable setting to obtain continuing care.

Delayed access to support and treatment for this client group may make it more difficult to resolve their problems and also place a strain on other services such as homelessness agencies and the criminal justice system.

#### 3.2 Staff training in mental health and homelessness problems

Hostel staff are often on site for 24 hours a day and are in a position to observe the behaviour and mental state of residents, which can feed into an assessment by a mental health worker.

Frontline staff in a wide range of agencies can be trained to identify the symptoms of mental health problems. Details of agencies providing training can be found at: <http://www.homeless.org.uk/developyourservice/training/links>

#### TRAINING IN RECOGNISING MENTAL HEALTH PROBLEMS: THE HOMELESSNESS TRAINING UNIT

The Homelessness Training Unit runs a range of courses for all staff working with homeless people. Courses are based in London or in-house, and most participants come from London and the South East. Courses include:

- ➔ understanding and recognising mental health problems
- ➔ understanding and working with personality disorder
- ➔ understanding and working with complex needs
- ➔ working with statutory mental health services
- ➔ suicide and self harm
- ➔ working with schizophrenia
- ➔ working with depression
- ➔ treatments and interventions for people with mental health problems.

The trainers are mental health professionals who have a background in working with homeless people. On some courses service users also act as trainers.

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### 3 Identifying mental health problems

Homelessness and mental health services can also make arrangements to provide frontline staff with expert advice and support on managing individual cases.

It is equally valuable if mental health staff are trained in the needs of people who are homeless or living in temporary or insecure accommodation, including the availability of local homelessness services and the importance of settled housing for successful support and treatment. It is helpful if at least one member of staff in each mental health service is designated to take a specialist interest in homelessness and housing issues, and receives additional training to advise and support other staff.

Housing authorities, homelessness agencies and mental health services can work in partnership to organise joint training, which may also be helpful for other services such as drug and alcohol agencies, primary care and health visitors.

#### 3.3 The role of housing departments in identifying mental health problems

Staff in local authority housing departments consider applications from people who seek housing assistance. It is important that this consideration is not limited to determining whether the person may be owed a duty under the homelessness legislation. The DCLG *Homelessness Code of Guidance for Local Authorities* states that:

**Advice services will need to be effectively linked to other relevant statutory and non statutory service providers... it is often a combination of factors that lead to homelessness, and housing authorities are advised to ensure that people who require advice of a wider or more specialist nature, for example, to address family and relationship breakdown, mental or physical health problems, drug and alcohol abuse, or worklessness are directed to other agencies who can provide the service they need...**

The *Code of Guidance* later emphasises that:

**Assessment of vulnerability due to mental health will require close co-operation between housing authorities, social services authorities and mental health agencies. Housing authorities should consider carrying out joint assessments or using a trained mental health practitioner as part of an assessment team. Mental Health NHS Trusts and local authorities have an express duty to implement a specifically tailored care programme (the Care Programme Approach – CPA) for all patients considered for discharge from psychiatric hospitals and all new patients accepted by the specialist psychiatric services (see *Effective care co-ordination in mental health services: modernising the care programme approach*, DH, 1999). People discharged from psychiatric hospitals and local authority hostels for people with mental health problems are likely to be vulnerable. Effective, timely, liaison between housing, social services and NHS Trusts will be essential in such cases but authorities will also need to be sensitive to direct approaches from former patients who have been discharged and may be homeless.<sup>14</sup>**

### 3 Identifying mental health problems

The joint assessments recommended by the *Code of Guidance* do not necessarily require a full-time team, but can be implemented by regular meetings of staff from the different disciplines.

Where there are significant numbers of people seeking housing assistance who may have mental health problems, a specialist team can help to assess their needs and ensure support is available.

**SUPPORTING HOMELESSNESS  
APPLICANTS WITH MENTAL HEALTH  
PROBLEMS: JOINT ASSESSMENT  
SERVICE (JAS) WESTMINSTER**

This service is funded by housing and social services to provide assessments and support for people who seek housing assistance where mental health may be a problem. Support is given by social workers with a mental health specialism. Assessments cover both housing needs and mental health needs. The team help people to engage with mainstream mental health services and stays in contact with people until this is achieved, regardless of the decision made by the Housing Options Team. The service aims to stay in contact with 95 per cent of service users for up to six months.

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## 4 Targeting mental health services

This chapter examines how access to mental health services for people who are homeless or living in temporary or insecure accommodation can be improved by designing some services to be targeted on their particular needs.

### KEY MESSAGES

There are a number of approaches which can improve access to mental health services for people who are homeless or living in temporary or insecure accommodation:

- ➔ providing mental health promotion activities within homelessness services
- ➔ frontline workers who act as advocates or 'care navigators' to help homeless people access the most suitable services and stay engaged with them
- ➔ basing some mental health services within hostels and homelessness day centres
- ➔ offering walk-in immediate access to assessment and treatment, without the need to make an appointment
- ➔ providing some street-based services in areas where there are significant numbers of people sleeping rough
- ➔ in mainstream mental health teams, ensuring there is at least one practitioner with a special interest in housing and homelessness issues, to act as a resource for other members of the team
- ➔ where there is sufficient need, employing specialist mental health practitioners for people who are homeless or living in temporary or insecure accommodation
- ➔ in areas of high need, operating multi-disciplinary mental health teams for people who are homeless or living in temporary or insecure accommodation. These provide open-access services for all potential users, along with holistic assessment and support.

### 4.1 Problems of access

There are a number of reasons why some people who are homeless or living in temporary or insecure accommodation may be reluctant to access, or have problems accessing, mental health services. Some targeting of services is required to overcome these problems. This chapter examines how this can be achieved.

In addition to the stigma attached to mental health problems, people in these circumstances may fear that admitting to problems might prejudice applications for housing.

Some homeless people distrust mental health and social services. This can be the result of previous negative experiences of services, fear of detention under the Mental Health Act, fear of enforced medication, and concern that they will lose access to substances, such as drugs or alcohol, that they are using for self-medication or on which they are dependent. In some severe cases, people who are sleeping rough have become and remained homeless because of delusions about 'authority' and a consequent refusal to engage with any services.

## 4 Targeting mental health services

### ELLA: RELUCTANCE TO ENGAGE WITH STATUTORY SERVICES

Ella was seventeen and seven months pregnant. She had not had settled accommodation for about two years. Her symptoms began when she was 14:

**“I started hearing things and seeing things. I took medication then, but medication made me feel worse.”**

Instead she used drink and drugs until she became pregnant. While she was staying in a direct access hostel she had cut her wrists:

**“[The hostel workers] told me to go to hospital when I was having problems. They said my problems were too deep, they weren’t qualified to deal with me. But if you go to hospital in a complete mess and have cut your wrists, they’re going to keep you in. I didn’t think it would be helpful. If you’re locked up it’s going to make you worse.”**

Agencies supporting families with children living in temporary accommodation report that some parents fear that their children will be taken into care if, in addition to lacking a settled home, they admit to having a mental health problem.

Many heads of such families are lone parents on low incomes, making it hard for them to attend appointments if free childcare is not available. If they are living in temporary accommodation, they may have been placed in a different area and moved away from their previous child care arrangements.

Rough sleepers and people without children living in insecure accommodation may also have low expectations of the help that is available to them, and may give low priority to seeking support and treatment, because of the wide range of other problems in their daily lives. They can also have problems in accessing primary care, which is the route into most mental health services (see *Chapter 6*).

Long waiting times for support and treatment can adversely affect their motivation and lead to them losing contact with services, because they may not be used to planning ahead, or may have learning or literacy difficulties. People with a history of sleeping rough may find it hard to keep appointments and they may be difficult to contact if they are on the streets or moving between different hostels. This can lead to loss of contact with services, which health staff may mistakenly interpret as demonstrating a lack of commitment to support and treatment.

### 4.2 Mental health promotion

Currently, there are few mental health promotion services, and very few agencies providing mental health promotion specifically for people who are homeless or living in temporary or insecure accommodation. *Healthy hostels: a guide to promoting health and well being among homeless people*, identifies a number of ways in which hostels can promote mental health.<sup>15</sup> Several of these would also be applicable in other settings such as day centres and in supported housing. They include:

## 4 Targeting mental health services

- ➔ providing opportunities for meaningful occupation
- ➔ promoting a safe and secure environment and providing privacy in single room accommodation
- ➔ tackling literacy problems to enhance self esteem and reduce the frustration and anger experienced by people with these difficulties
- ➔ group work on stress management, anger control, assertiveness training and confidence building
- ➔ ensuring staff are seen as accessible and approachable
- ➔ encouraging a balanced diet and exercise
- ➔ promoting user empowerment through participation in the management of projects.

### 4.3 Care navigators

In addition to the need to actively encourage people to engage with services, there is also a need for frontline workers to act as advocates or 'care navigators' to help rough sleepers and people without children living in insecure accommodation to access the most suitable services and to stay engaged with them. These groups can have difficulty in maintaining motivation to engage with services, to remember and ensure they get to appointments, and to sustain treatment. Care navigators can help people to attend appointments, take medication and maintain a commitment to treatment. Existing support staff within homelessness agencies can take on a care navigation role. They can build a relationship of trust with mental health agencies, which will then be more likely to work jointly with homelessness agencies to support the service user. This task might be carried out by a designated member of staff in a situation where each hostel worker might have only one or two clients with mental health problems.

#### CARE NAVIGATORS: CREATIVE SUPPORT, MANCHESTER

Street outreach workers engage with rough sleepers and link them into the Homeless Mental Health Team, Community Mental Health Teams and Assertive Outreach. Outreach workers continue to be involved with service users, providing practical support, helping them keep appointments and rebuilding family relationships.

The workers have close links with local support services and other care professionals. This gives users a gradual introduction to services which will listen to their outreach worker and take their advice on how best to work with an individual. Sometimes homeless people have a great fear of mental health services, because of past experiences. It is important that these fears are addressed. Service users may benefit from help to understand what types of support and treatment are on offer and how to negotiate support and treatment packages, so reducing distrust and anxiety and increasing their ability and willingness to engage with mental health services.

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## 4 Targeting mental health services

### 4.4 Open-access to mental health services

Open-access services can be crucial in engaging with people with chaotic lifestyles, who are the most marginalised.

Rough sleepers and people without children living in insecure accommodation may be more willing to engage initially with voluntary organisations, since these may be seen as not part of the 'system' in contrast to statutory agencies. These groups can then be helped to access statutory services.

Support and treatment for a mental health problem are more likely to be accessible to people who are homeless or living in insecure accommodation if these are available as part of the services they are already using, such as hostels and day centres. These services provide practical help and support and they may have gained the user's trust. Staff in hostels and day centres can observe a person's behaviour over an extended period and may have had an opportunity to discuss with them their support needs, including any mental health problems.

Mental health services for homeless people have found it useful to offer, at least for some of their sessions, walk-in, immediate access to assessment and treatment, without the need to make an appointment.

#### KIRSTY: MENTAL HEALTH SERVICES IN A HOMELESSNESS DAY CENTRE

Kirsty was 27 and had suffered depression and anorexia since she was aged 8. She had always found mental health services unresponsive:

**"I tried to get help with problems but no-one was offering support. I kept going to the GP and said I needed counselling but he seemed too busy... services [in that area] are very remote."**

When she and her partner were evicted from a private rented tenancy, they moved to another area where her partner had previously lived. Neither was in work and they were unable to find a private landlord to accept them as tenants. They quickly ran out of savings and slept rough for 6 months before the Council accepted them as homeless. However, becoming homeless introduced Kirsty to services via a day centre:

**"I came here and saw the doctor. She was really understanding... she's very good – I can talk to her and she takes time to sit and listen... It's been a great help coming here to [the day centre]. You get different organisations coming in, so you get opportunities here all in one place."**

The doctor helped her find another CPN as she had found the previous one unhelpful:

**"I wasn't benefiting from her. Instead of helping she was making me worse."**

She had been put in touch with the Eating Disorders Association and had been referred for bereavement counselling, as her brother had recently committed suicide:

**"I've been feeling really stressed but now I've got support I'm just starting to get somewhere."**

## 4 Targeting mental health services

### 4.5 Street-based mental health services

Some people sleeping rough may not be engaging with any homelessness or mental health services. In areas where the number of rough sleepers justifies it, there may be a need for street-based services, or at least some street sessions by mental health workers, so that assessments can be made and they can be helped to access local services.

#### **SPECIALIST STREET WORK: JOINT HOMELESSNESS TEAM WESTMINSTER**

While there is a strong emphasis on homeless people accessing care and support in building-based services, such as day centres, in Westminster, the Joint Homelessness Team recognises that engaging some people on the street is the only way they can access support.

The team consists of six social workers, three mental health nurses and two part-time psychiatrists as well as a team manager and administrative staff. They specialise in working with people who would not present to a mental health service and who are rough sleeping. Team members reach out to people in day centres and on the street to provide them with mental health care. They work with service users for as long as it takes to get them into treatment and suitable accommodation.

They work in the area which has the largest number of rough sleepers in the country and so have a large caseload of around 120 service users with 2–3 new cases a week.

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In areas with lower numbers of rough sleepers, some specialist homelessness practitioners will occasionally visit rough sleepers on the streets when it is the only way of making contact with them and undertaking an assessment, or outreach workers can act as navigators, bringing the client to services.

### 4.6 Specialist homelessness mental health practitioners

Mainstream mental health teams have found it useful to have at least one practitioner with a special interest in homelessness, to act as a resource for other members of the team.

Where there is sufficient need, it is helpful to have a dedicated specialist practitioner to work with homeless people.

#### 4 Targeting mental health services

##### MENTAL HEALTH SPECIALIST PRACTITIONER FOR HOMELESSNESS:CHESTER

This post was developed in partnership between the Mental Health Trust and the Primary Care Trust. The Mental Health Specialist Practitioner for Homelessness is a psychiatric nurse, working across a primary care and a secondary mental health setting. The post uses an assertive outreach approach.

The service sees any homeless person with any mental health concern and can provide a service for all types of mental health problems, or refer on as necessary. Service users are generally homeless people without children, including rough sleepers and people in hostels, although the service is also available to families. Approximately 25 per cent of service users have a severe and enduring mental health problem. Contact time varies, dependent on the severity of the condition, willingness to engage with mainstream services and length of stay in the area. There are approximately 10 new referrals per month.

For secondary mental health services, the nurse is based part-time in the Crisis and Home Treatment Office and therefore has daily contact with this team and can access it when required. They are always quick to respond to requests for support. In addition, there is a consultant psychiatrist who has been designated by the NHS Trust as having special responsibility for homeless people. The nurse introduces the homeless person to the psychiatrist gradually and only when they are ready.

Engagement is a key factor with this client group and the specialist is mindful to avoid being too rigid or overly prescriptive in the developmental stages of a therapeutic relationship. Practitioners do not get disheartened if people fail to attend appointments, and they are flexible when someone presents, even if it is not at the allotted time.

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In areas where there are sufficient numbers of people with mental health problems who are homeless or living in temporary or insecure accommodation, service commissioners should consider the case for a specialist team. Homelessness and mental health strategies should identify the number of people with mental health problems who fall within these categories and the likely level of demand for a specialist team.

The membership of these teams varies and may include:

- ➔ mental health nurses
- ➔ social workers
- ➔ psychologists
- ➔ counsellors
- ➔ psychiatrists
- ➔ support workers.

## 4 Targeting mental health services

These specialist teams have a number of features described below which contribute towards their success. They vary in their level of staffing and so do not all provide the same range of services.

The specialist teams have an *assertive approach to engaging* with hard to reach people, including:

- ➔ effective links with primary care services
- ➔ referral protocols with local agencies which are in contact with homeless people
- ➔ sessions-based in locations which homeless people already use such as hostels, day centres and on the streets.

They can offer *open-access* including:

- ➔ a service which is not confined to office hours
- ➔ a tolerance of missed appointments which are not regarded as a lack of commitment to treatment
- ➔ availability to users who might have dropped out of services in the past
- ➔ acceptance of all potential service users, including people with a dual diagnosis or personality disorder.

They can offer access to *holistic support* including:

- ➔ a holistic assessment of needs, not just a clinical diagnosis
- ➔ ensuring that the other health needs of patients are addressed, usually through links with primary care services
- ➔ services to help people with mild to moderate mental health problems which are impacting on their homelessness, but which may not qualify them for mainstream services
- ➔ access to a wide range of treatment, including talking therapies
- ➔ links into mainstream services once a user is fully engaged, or is detained under the Mental Health Act, or has settled accommodation
- ➔ access to generalist support by non-clinical staff for a range of needs, often in conjunction with voluntary agencies
- ➔ help for users with practical problems such as benefits and accommodation, as a way of gaining their trust and easing stress on them
- ➔ working closely with housing agencies to prevent users losing their accommodation and becoming homeless as a result of their mental health problems.

#### 4 Targeting mental health services

##### **A SPECIALIST MENTAL HEALTH TEAM FOR HOMELESS PEOPLE: LEICESTER COMMUNITY HOMELESS MENTAL HEALTH SERVICE (CHS)**

The CHS is provided by the mental health NHS trust and provides assessments, treatments, resettlement and support to homeless people in Leicester. It also helps homeless people, and families living in temporary accommodation, to access mainstream services. The team consists of:

- ➔ a team manager (mental health nurse)
- ➔ a senior practitioner (mental health nurse)
- ➔ two outreach mental health nurses
- ➔ a full-time Support Time and Recovery Worker, jointly funded by the City and County PCTs
- ➔ two half time psychologists
- ➔ a consultant psychiatrist (supervisory input)
- ➔ an associate specialist psychiatrist (sessional input).

The team spend a significant amount of time in places frequented by homeless people such as direct access hostels and drop in centres. They also take referrals from and work closely with a specialist Homeless Primary Health Care Service which operates in the same locations and with the same principles. The associate specialist in psychiatry provides sessional input (as a GP) to the Primary Health Care Team and acts as their adviser on mental health.

The CHS have an open door policy and anyone can make initial contact with the team to be interviewed. All contacts are discussed at the weekly clinical team meeting to develop an action and support plan.

People with common mental health problems are usually given informal support from any member of the team on duty during open-access sessions. People experiencing serious mental health problems, for example psychosis, clinical depression or personality disorder, are treated by the team and usually require an element of case management, risk assessment and diagnosis.

The CHS offers a range of interventions including:

- ➔ mental health assessment
- ➔ pharmacological treatments and monitoring
- ➔ brief psychological therapies, including some group work
- ➔ support for people with drug or alcohol problems
- ➔ consultation with other agencies on client management and interventions
- ➔ referral to and liaison with adult psychiatric services
- ➔ referral to voluntary agencies, for example for counselling.

CHS also offers consultation, advice and training to agencies working with homeless people.

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#### 4 Targeting mental health services

Specialist mental health services for people who are homeless or living in temporary or insecure accommodation emphasise that it is important that people are not excluded because they do not meet certain diagnostic criteria. Mental health services may focus on severe and enduring illness, but the multiple problems of some people can only be resolved by comprehensive assessment and support, not necessarily all provided by clinicians. Specialist homelessness teams have found that it is possible to assess and offer support to almost all those who approach them, including people with a dual diagnosis who are still using substances.

Chapter 7 describes three different models of improving access to secondary care, according to the scale and nature of homelessness and housing need in the area.

## 5 Working together and continuity of care

This chapter examines ways in which joint work between agencies can help people with mental health problems who have complex needs and who are homeless or living in temporary or insecure accommodation.

### KEY MESSAGES

Joint work with other agencies can help to ensure that a wide range of other support needs are met and that service users receive continuity of care. The means of achieving this include:

- ➔ information exchange between agencies about their services
- ➔ joint training of staff
- ➔ liaison between staff at both management and front line delivery levels
- ➔ protocols for common procedures for assessing and referring clients, or carrying out joint assessments
- ➔ information sharing between agencies about individuals
- ➔ multi-agency team working
- ➔ sharing information and joint research on local needs leading to joint initiatives and development plans.

### 5.1 Joint work

Specialist multi-disciplinary teams were described in the last chapter, but people with mental health problems who are homeless or living in temporary or insecure accommodation also benefit from agencies working together to address multiple or complex needs, regardless of whether they are users of primary or secondary care mental health services. Joint work is not only more effective for service users, but also more efficient for agencies, as it avoids duplication. However, people in these circumstances are likely to need more support than service users with settled accommodation. Caseloads may need to be adapted accordingly.

People in contact with secondary mental health services are supported through the Care Programme Approach (CPA) and enhanced CPA for service users with multiple needs and those who are hard to engage (see *Appendix 3*).

Joint work can take many forms, including:

- ➔ exchange of information between agencies about what services they provide and how they can be accessed, enabling more effective referrals between agencies
- ➔ joint training of staff so that they have a better understanding of each others' skills and services

## 5 Working together and continuity of care

- ➔ improving liaison through contacts between staff at both management and front line delivery levels; these personal contacts can facilitate joint work both on service development and on individual cases
- ➔ agreeing common procedures for assessing and referring clients, or carrying out joint assessments, including the use of client confidentiality protocols
- ➔ procedures for ensuring service users' case records are accessible to other agencies, with the user's consent, for example through hand-held records
- ➔ joint case conferences, resulting in plans for individuals which spell out what each agency will do
- ➔ sharing information and joint research on local needs leading to joint initiatives and development plans.

There is useful guidance on the development and use of protocols in *Families that have alcohol and mental health problems: a template for partnership working*.<sup>16</sup> Its advice is equally relevant for people with mental health problems who are homeless or living in temporary or insecure accommodation.

However, recording and sharing information, particularly risk assessments, can sometimes have negative outcomes. An adverse risk assessment can lead to a refusal of service unless there is support to work with people with more challenging needs. If support is offered and joint risk management agreed, potential users are much more likely to engage with services. Risk assessments need to be regularly reviewed and not based on information that is out of date. Gaps in support services need to be fed back to the agencies involved in commissioning care.

Further advice on multi-agency work for people who are in these client groups can be found in the *Homelessness strategies; a good practice handbook*<sup>17</sup> and the *Homelessness Code of Guidance for Local Authorities*.<sup>18</sup>

### 5.2 Continuity of care

People with known mental health problems may lose contact with their health services, including primary care and Community Mental Health Teams (CMHTs), if they experience homelessness and are provided with alternative accommodation in a different area.

This can be a particular problem in rural areas and in areas that are not well served by public transport. People who have moved may need to be referred to a new CMHT, losing continuity of care.

## 5 Working together and continuity of care

Housing and support agencies can alleviate these problems by ensuring that people access the services they need in their new area or, if preferable, are helped to reconnect with their original services.

Where people have moved areas, medical records can be slow to follow, hampering the assessment for support and treatment. This poses a particular problem for homeless people who move frequently and who may have records in many different locations. One way of reducing this problem is to ensure that users can take their own records with them.

### HAND HELD CASE RECORDS

The Health Support Team in Westminster undertakes an holistic assessment which includes housing, physical health, mental health, benefit status and problems, child protection and immigration status. This information is recorded and given to the service user as a hand held record, designed to move with them when they access other services. The assessment is available in different languages.

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## 6 Access to primary care

This chapter examines ways in which access to primary care can be improved for people with mental health problems who are homeless or living in temporary or insecure accommodation.

### KEY MESSAGES

Access to primary care for people who are homeless or living in temporary or insecure accommodation can be improved by:

- ➔ implementation of the Royal College of General Practitioners guidance: *2002 RCGP statement on homelessness and primary care*
- ➔ Primary Care Trusts (PCTs) ensuring that local general practices will register homeless people
- ➔ PCTs directing enhanced services funding at services for homeless people and for extra time spent by GPs to treat homeless people
- ➔ specialist workers for homeless people within primary care teams in areas where there is sufficient need
- ➔ specialist primary care teams for homeless people where there is sufficient need, including mental health care practitioners within the teams
- ➔ special peripatetic services for this client group.

### 6.1 Problems of access to primary care

Most mental health problems are treated by primary care services, but people who are sleeping rough, or moving in and out of insecure accommodation, or those who have moved area into temporary accommodation provided by a local authority, may not be registered with a local primary care practice or find it difficult to register. Some primary care services are reported to be reluctant to register people who have been sleeping rough or who are living in insecure accommodation.<sup>19</sup>

### 6.2 Improving access to primary care

The Royal College of General Practitioners has produced guidance on access to primary care for homeless people, which states that:<sup>20</sup>

- ➔ All people have a right to equity of access to primary care services and to receive services which enhance their dignity and independence
- ➔ Individual professional advocacy is important in homelessness at all levels, from the consultation where the quality of the practitioner-patient relationship is paramount, to local, regional and national arenas.

## 6 Access to primary care

- ➔ New service models must be developed which utilise the complementary strengths of generalist and specialist expertise. Interdisciplinary working and multi-agency partnerships, including social services, are vital to the development of effective services in order to avoid costly duplication of effort and dangerous gaps in care. The focus should be on inclusive practice, needs not diagnostic labels and solutions not problems
- ➔ Primary care practitioners should provide a welcoming and sensitive service to homeless people and enable them to access the full range of health and social services required to meet their needs
- ➔ Homeless people should be registered permanently wherever possible and integrated into all health prevention and promotion activity within the practice
- ➔ Housing agencies could be encouraged to hold advice sessions in a primary care practice setting.

The new GP contract, introduced in 2005, provides additional funding for GPs who provide enhanced services to their patient group. Enhanced services can be used to provide the extra time required to treat homeless patients with the aim of ensuring that:

- ➔ homeless people have equal access to services
- ➔ primary care services are provided by staff who have the knowledge, training and resources to enable them to deal effectively with homeless people's health needs
- ➔ primary care services are enabled to tackle homeless people's health needs holistically by working with other services such as housing and social services.

PCTs may choose to set up a service under the National Enhanced Services (NES) guidelines or to adapt them into a Locally Enhanced Service (LES). Further advice can be found in BMA guidance *National enhanced service – enhanced care for the homeless*.<sup>21</sup>

### 6.3 Specialist primary care services

In areas with a significant number of people who are homeless or living in temporary or insecure accommodation, primary care services targeted on these groups can reach those who would otherwise have difficulty in accessing mainstream services, or who make inappropriate use of A&E services. There are a number of models which can be used to provide primary care for homeless people, details of which are given in *Appendix 4*.

Models for providing specialist primary care for people in these client groups include:

- ➔ specialist workers within mainstream primary care practices
- ➔ specialist primary care teams, including mental health care.

## 6 Access to primary care

### **SPECIALIST PRIMARY CARE SERVICES FOR HOMELESS PEOPLE WITHIN A MAINSTREAM GP PRACTICE: HOMELESS ADVOCACY PROJECT, MANCHESTER**

The Homeless Advocacy Project is part of a general practice surgery. People can contact the Homeless Advocacy Project through:

- ➔ dropping into the practice, where they are encouraged to see the worker
- ➔ local day centres for homeless people
- ➔ direct access flats
- ➔ a city centre project for the under 25s
- ➔ the rough sleeping and begging team.

Anyone attending is fully registered with the GP practice. There is also a specific registration form for homeless people to help identify any physical or mental health needs. The project is designed both to work specifically with homeless people and to link them into existing services. Link workers provide non-medical advice and support and act as advocates for homeless people, helping them to access services.

Following the Homeless Advocacy workers' assessment, mental health problems can be supported via three routes depending on the severity of the problem:

- ➔ contact with the Homeless Mental Health Team
- ➔ sessions from the surgery's counsellors
- ➔ treatment from a GP and registered mental health nurse.

All continue to receive support from the Homeless Advocacy workers. All staff in the surgery have received training on homelessness and recognising mental health problems.

Contact: Jackie Heywood  
Telephone: 0161 236 6633  
Email: [jacqueline.heywood@nhs.net](mailto:jacqueline.heywood@nhs.net)

In rural areas, where people who are homeless or living in temporary or insecure accommodation may be scattered and public transport limited, consideration should be given to providing a peripatetic service. Services in rural areas are likely to be more costly. However, accessible primary care may reduce the need for high cost crisis interventions.

## 6 Access to primary care

### **SPECIALIST PRIMARY CARE TEAMS FOR HOMELESS PEOPLE: CORNWALL HEALTH FOR HOMELESS**

Cornwall Health for Homeless is a Personal Medical Service (PMS) project which provides a primary care drop-in service. The team includes two part-time GPs, one full-time nurse practitioner, one full-time CPN, as well as a project manager and administrator. Mental health is a major part of their work: 95 per cent of their male service users and 76 per cent of their female service users have mental health problems.

Their original plan was to take the service on a bus into rural areas, but they found the number of users of the bus-based service was small, because homeless people tend to gravitate to towns and those who were still in villages registered with their original GP. Health for Homeless therefore switched to surgeries in homelessness day centres in three towns in Cornwall, working closely with the voluntary agencies which run the centres. They have around 150 patients registered at any one time.

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## 7 Accessing and exiting secondary care

This chapter examines means of improving access to secondary care and the procedures for discharge from mental health inpatient units, for people who are homeless or living in temporary or insecure accommodation.

### KEY MESSAGES

Access to secondary mental health care for people who are homeless or living in temporary or insecure accommodation can be improved by:

- ➔ clear and standardised assessment procedures used by all agencies
- ➔ clear criteria for referral and eligibility for entry to mental health services
- ➔ clear criteria for priority treatment and emergency access
- ➔ training of staff, including those in homelessness agencies, to recognise symptoms and to understand the local care pathways
- ➔ development of information-sharing protocols on case records
- ➔ a system of monitoring and reviewing assessment procedures
- ➔ protocols for homelessness agencies to make direct referrals to mental health services in areas where there are no specialist services for homeless people
- ➔ directories of local mental health services
- ➔ implementing the Department of Health guidance on the discharge of homeless people from hospital
- ➔ a specific admission and discharge protocol for people who are homeless or living in temporary or insecure accommodation
- ➔ designating at least one staff member to work with people at risk of homelessness after hospital discharge
- ➔ specialist discharge workers for people who are homeless or living in temporary or insecure accommodation in hospital, in areas with sufficient need.

### 7.1 Problems of access to secondary care

There are established procedures for referring people from primary care to secondary services. However, direct referrals from homelessness agencies to mental health services can be problematic. Where there are no specialist services, or where access to mental health services is only through a referral from primary care, some people who are homeless or living in temporary or insecure accommodation may fall through the net. This problem is exacerbated if such people, particularly rough sleepers and individuals moving around different hostels, have difficulty in accessing primary care services. Further problems can arise if people in these client groups do not turn up for appointments and are removed from the patient list.

## 7 Accessing and exiting secondary care

Some secondary care mental health services are unwilling to carry out assessments for people without a fixed address, or without a referral from a GP. Homeless people are not always seen as a priority by mental health services, especially if they are not local residents. Where the mental health care of homeless people is recognised as a need by psychiatric services, it is often met by having a 'rota' of consultants on call for homeless people, which can result in poor continuity of care and dilution of skills.

By contrast, where there are specialist practitioners or teams for homeless people with mental health problems, direct referrals into other mental health services appear to be effective.

### 7.2 Improving access to secondary care

Where there are no specialist homelessness mental health teams and where access to primary care is limited, homelessness and mental health agencies can agree a local referral protocol, which allows direct referrals to mental health services by homelessness agencies. This sets out criteria, responsibilities and procedures, with timetables for actions by all parties. Improving access to primary care for homeless people can also be considered. The protocol includes:

- ➔ standardised assessment processes used across all agencies, for example, the Threshold Assessment Grid (see box below)
- ➔ criteria for referral and eligibility for entry to each part of the support and treatment system
- ➔ the sharing of information between agencies in the support and treatment system
- ➔ criteria for priority treatment and emergency access, including any priority given to homeless people.

Implementation of the protocol includes:

- ➔ training of staff, including those in homelessness agencies, to recognise symptoms and to understand the local care pathway
- ➔ a system of monitoring, auditing and review of the protocol assessment procedures.

## 7 Accessing and exiting secondary care

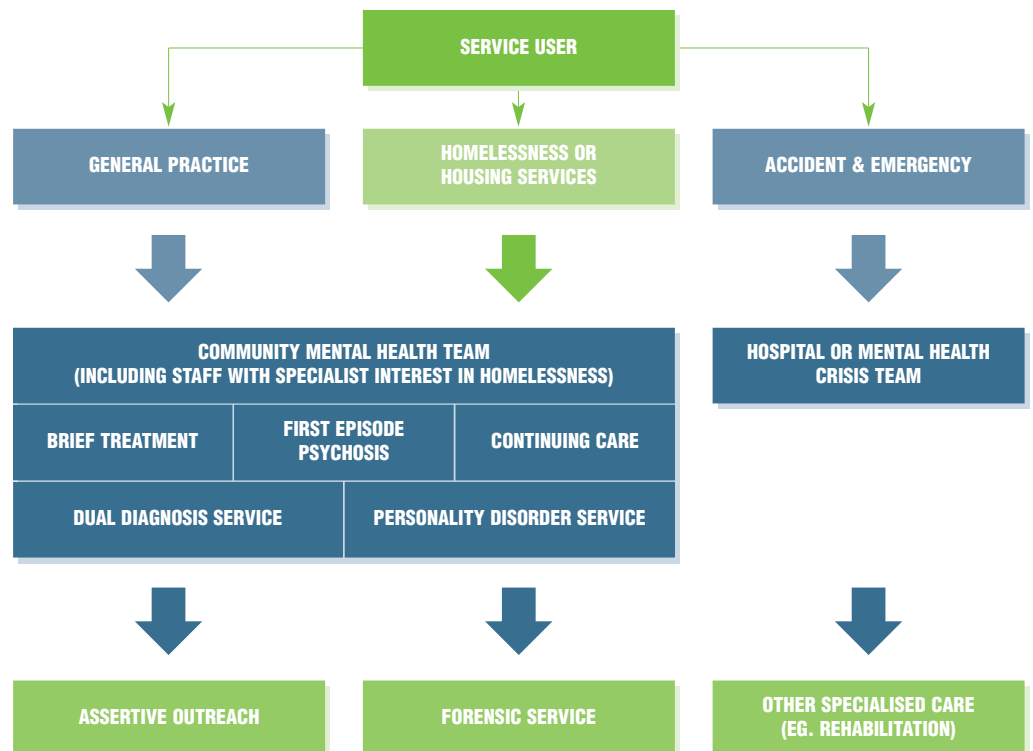
### A COMMON ASSESSMENT PROCEDURE: THE THRESHOLD ASSESSMENT GRID (TAG)

The TAG is a brief standardised assessment of the severity of mental health problems, to augment a referral letter to specialised mental health teams. It can be used by primary and secondary care staff and by non-clinical staff such as housing officers and voluntary organisations. The language and concepts are suitable for use across different agencies. The impact of TAG on improved access has been tested in a multi-site cluster randomised control trial. The results can be accessed via the TAG website (see below).

Contact: Further information can be found at [www.iop.kcl.ac.uk/prism/tag](http://www.iop.kcl.ac.uk/prism/tag)

The following charts describe access points to specialist mental health services, provided either by mainstream teams or by specialist homelessness mental health teams. The model, or adaptation of the model, which best fits each locality is likely to be based on the numbers of homeless people with mental health problems in the area. They are described as areas of low, medium and high levels of homelessness.

**FIGURE 1:** LOW LEVELS OF HOMELESSNESS WITH NO SPECIALIST HOMELESS HEALTH SERVICES



7 Accessing and exiting secondary care

FIGURE 2: MEDIUM LEVELS OF HOMELESSNESS WITH A SPECIALIST PRIMARY CARE SERVICE

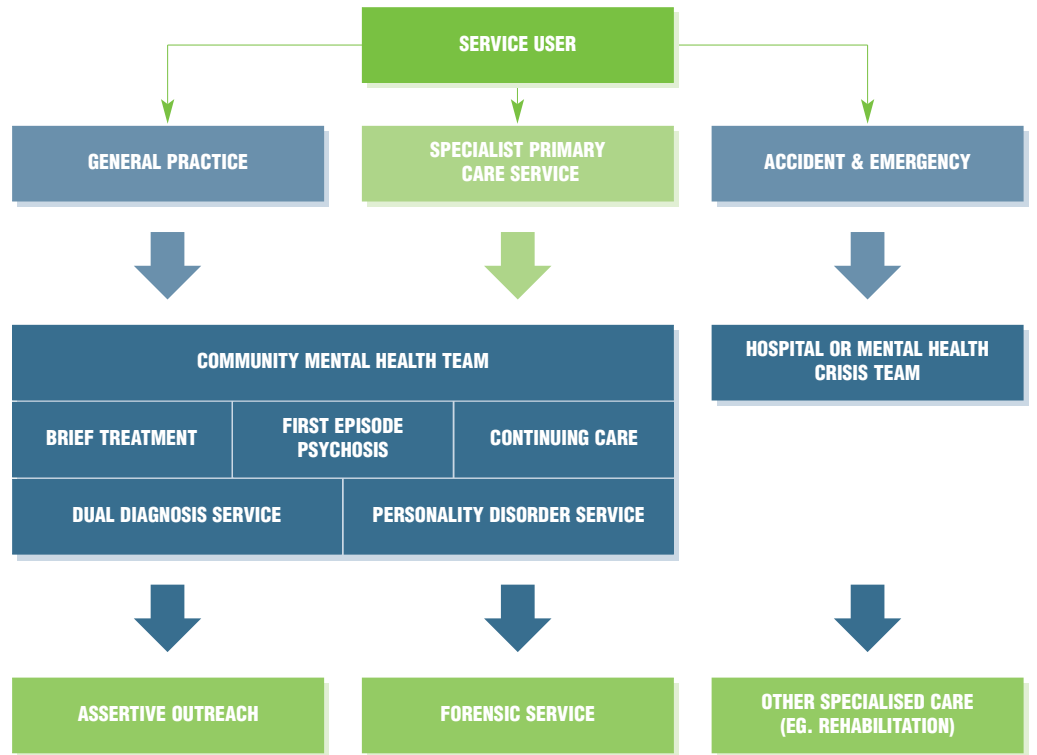
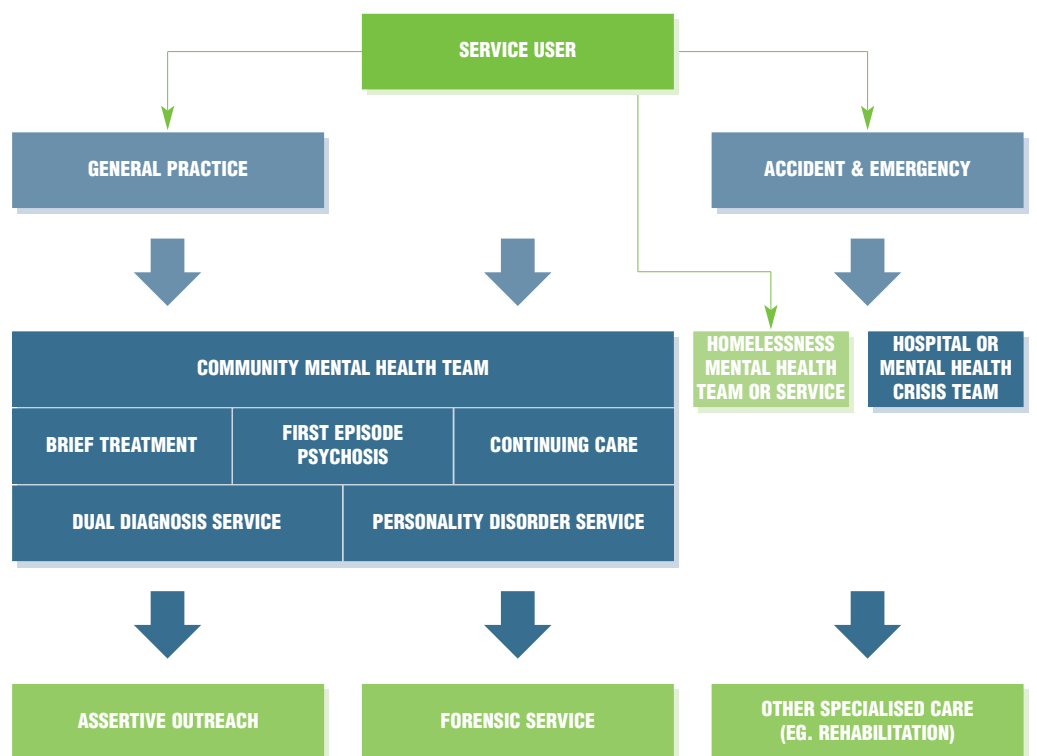


FIGURE 3: HIGH LEVELS OF HOMELESSNESS WITH A HOMELESS MENTAL HEALTH TEAM OR SERVICE



## 7 Accessing and exiting secondary care

### 7.3 Finding and choosing services

In some areas there is a wide range of different mental health and homelessness agencies. These can be hard to navigate even for professionals, as well as service users. Directories of local mental health and homelessness services, with referral criteria, are extremely useful to agencies and to service users, helping to ensure referrals are made to the most suitable agency. The need for these is reinforced by the National Service Framework for Mental Health<sup>22</sup> target to have a local service directory, which is updated at least yearly.

Inter-agency meetings, briefings and networks can also help local navigation of services, as well as providing other benefits such as peer support and information for service development.

#### **ENSURING EFFECTIVE REFERRALS: THE GUIDE TO MENTAL HEALTH SERVICES IN KENSINGTON & CHELSEA**

Kensington & Chelsea in London have produced a comprehensive guide to mental health services in the borough, with close involvement by users in its production. Written in plain English (and with access to interpreters) it includes details of:

- ➔ common forms of mental distress
- ➔ how to get help and what the different professionals and teams do
- ➔ care in hospital
- ➔ support and treatment in the community
- ➔ help for service users with other problems
- ➔ accommodation
- ➔ financial and legal help
- ➔ community groups
- ➔ work, leisure and transport
- ➔ useful contacts.

Contact: Toby Dickinson, Mental Health Commissioning Manager

Address: Royal Borough of Kensington and Chelsea Council, Town Hall, Hornton Street, London W8 7NX

## 7 Accessing and exiting secondary care

### 7.4 Discharge from mental health inpatient units

Effective hospital discharge is problematic if people have no home to which they can return. Homeless people may lose contact with mental health services if they leave inpatient units without accommodation and support.

Pressure on beds can lead to people being discharged with inappropriate referrals, for example, to the local authority housing department when there is no guarantee accommodation will be available, or to unsuitable hostel accommodation. People are also sometimes discharged prematurely from hospital because of substance misuse or chaotic behaviour. Some people discharge themselves.

Difficulties in obtaining suitable supported accommodation after discharge can also lead to a loss of contact with services.

Department of Health guidance on the discharge needs of people who are homeless states that all hospitals should ensure that people are not discharged to inappropriate accommodation, nor discharged as homeless, nor become homeless as a result of their hospital stay. Mental health inpatient units and psychiatric hospitals should draw up a post-discharge care plan with patients, well in advance of discharge, which ensures that suitable accommodation is available and that there is continuity of care following hospital discharge.<sup>23</sup> Housing needs should be assessed at the time of admission to allow the maximum time to arrange suitable accommodation on discharge.

The guidance also states that there should be a specific discharge protocol for people who are homeless, to ensure that they remain in contact with mental health and other support services and do not become homeless again. The Department of Health and the Department for Communities and Local Government, in conjunction with Homeless Link and the London Network of Nurses and Midwives, have issued joint guidelines on developing a protocol entitled *Hospital Admission and Discharge: People who are homeless or living in temporary or insecure accommodation*. The guidance is available on Homeless Link's website ([www.homeless.org.uk](http://www.homeless.org.uk)).

Specialist discharge workers in hospitals can provide the necessary expert support and advice. Areas with a sufficient number of homeless people with mental health problems may find it useful to employ such specialist workers in conjunction with local authorities and voluntary organisations. At the minimum, there should be a staff member trained to work with people at risk of homelessness after discharge.

## 7 Accessing and exiting secondary care

### **HOSPITAL DISCHARGE: JULIAN HOUSING LINK, NORFOLK**

Julian Housing Support Trust is a voluntary organisation providing housing support for people with mental health problems in Norfolk. They employ Link Workers in every acute psychiatric ward in Norfolk funded by the DCLG, the PCTs and social services. The workers provide advice and short term support to people who are homeless or have other housing problems. The workers link people to housing providers and give advice on access to housing, tenancy matters and benefits. The process is integrated into the CPA. The people in need of support are identified by nursing staff who complete a short housing questionnaire as part of the admission assessment. Link Workers can provide continuing support for up to four weeks after discharge.

A survey of 30 ward staff in all hospitals found that all reported that the scheme had led to shorter hospital stays and that it reduced stress for people who were worried about their housing. It also freed medical staff to spend more time with patients, rather than dealing with housing and social problems in which they had no expertise.

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## 8 Improving services for people with dual diagnosis and personality disorder

Access to mental health services is particularly difficult for people with dual diagnosis or personality disorder. This section examines ways of improving services for this group of people.

### KEY MESSAGES

Services for people with dual diagnosis or personality disorder can be improved by:

- ➔ integrated care within mental health services for people with a dual diagnosis
- ➔ achieving the standards set out in the Department of Health's *Dual diagnosis good practice guide*
- ➔ specialist multi-disciplinary personality disorder teams
- ➔ implementing the NIMHE guidance set out in *Personality disorder: no longer a diagnosis of exclusion. Policy implementation guidance for the development of services for people with personality disorder*
- ➔ the provision of specialist services for people with personality disorder or dual diagnosis within homelessness day centres and hostels.

### 8.1 People with dual diagnosis or personality disorder

For anyone suffering with a dual diagnosis of substance misuse and mental health problems, or from a personality disorder, accessing services can be very difficult. Agencies working with rough sleepers and people without children living in insecure accommodation reported that many of their users had such complex problems which often exacerbated the difficulties of access to services.

### 8.2 Dual diagnosis

Substance misuse can mask or mimic symptoms of mental illness, or may be used as a means of self-managing symptoms; this is sometimes termed self-medication. Substance misuse can also exacerbate mental health problems and make it harder to gain access to mental health services. Some mental health services do not accept those who are also current substance misusers for a range of reasons, including lack of an addiction specialist to resolve diagnostic and treatment problems. People with a dual diagnosis can still find themselves referred backwards and forwards between mental health and drug or alcohol services, with each believing the other should take responsibility. Department of Health Dual Diagnosis Good Practice Guide now makes it clear that mental health services should take responsibility for these clients.<sup>24</sup> It sets out standards for the provision of dual diagnosis services.

## 8 Improving services for people with dual diagnosis and personality disorder

### ACCESS TO DUAL DIAGNOSIS SERVICES FOR HOMELESS PEOPLE: MANCHESTER

In Manchester a dual diagnosis service has been set up to assist access into specialist mental health or substance misuse services. The team includes a consultant nurse, a trainer, researcher and a coordinator. Homelessness agencies, including the specialist homeless mental health team, can refer direct into the dual diagnosis team.

The team train practitioners in working with dual diagnosis service users.

The consultant nurse and trainer are available to undertake assessments of the most complex cases and develop care pathways for service users through regular clinics.

Network meetings provide a point of support, advice, skills, training and networking in a range of dual diagnosis matters.

They have produced a directory of local services to facilitate joint work with this group of service users.

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### 8.3 Personality disorder

The National Institute for Mental Health England (NIMHE) found that clinicians and mental health practitioners are often reluctant to work with people with a personality disorder. Reasons given include a lack of skills, training or resources to provide an adequate service, and a belief that there is nothing that mental health services can offer to treat the problem.<sup>25</sup>

Once acquired, a diagnosis of personality disorder can itself become a barrier to services, if practitioners' expectations are that these service users will be difficult to help and that their behaviour will be challenging. The problem of access can be compounded for homeless people by the expectation, in some services, that their commitment to treatment is likely to be poor. However, a number of specialist teams are gradually being set up around the country (see *Appendix 3*).

As with other mental health services, specialised services for people with, for example personality disorder and dual diagnosis, can be provided within a homelessness day centre or hostel to help this particularly hard to reach group.

## 8 Improving services for people with dual diagnosis and personality disorder

### **SPECIALIST SERVICES IN A DAY CENTRE: THE PASSAGE DAY CENTRE – WESTMINSTER**

#### *Dual diagnosis*

The Passage Day Centre has a specialist service for people with mental health and substance misuse problems. Following a joint bid with the Drug and Alcohol Foundation, a new complex needs worker has been employed. This service provides one-to-one counselling, group work, a specialist drop-in service, and increased information and advice on nutrition, relaxation and sexual health. The aim is to provide services but also to link people into mainstream addiction services where possible.

#### *Personality disorder*

The day centre can offer support for people with a personality disorder. The Passage employs 3 full-time Mental Health Workers whose role is to engage with and support people with mental health problems. They link people into mainstream mental health services working closely with Westminster Joint Homeless Team. In some cases where, due to legal status or a mental health problem that is not met by other local services (for example, personality disorder), the mental health workers provide on-going long term support.

Homeless Personal Medical Services for Westminster run a satellite service at the day centre, which includes a part-time counselling service. There are two counsellors who will see people with a personality disorder. The counsellors employ two approaches, one psychodynamic approach and one Cognitive Analytic Therapy. This has proved very successful especially in terms of engaging people who have previously been resistant to all services.

#### *Post-traumatic Stress Disorder*

The counsellor will work with people suffering from Post Traumatic Stress Disorder. This problem is commonly seen among ex-servicemen as well as refugees and asylum seekers. Ex-servicemen can also be linked into counselling services run by Soldiers, Sailors, Airmen and Families Association (SAAFA).

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## 9 Support services for people who are homeless or living in temporary or insecure accommodation

Different groups of people who are homeless or living in temporary or insecure accommodation may require targeted services to meet their particular mental health and other support needs. This chapter examines specialist services for families living in temporary accommodation and homeless people, including those fleeing domestic violence; young people; people from ethnic minority communities and ex-offenders.

### KEY MESSAGES

- ➔ Contact with families while they are in temporary accommodation provides an ideal opportunity to help them access support services
- ➔ Supported accommodation over a period of months may be necessary for a small number of families
- ➔ Support for people fleeing domestic violence who have mental health problems can be provided through specialist staff and voluntary agencies
- ➔ Where young people are leaving care, the authority that last cared for them must support them to access the appropriate services
- ➔ Some services can be designed to meet the specific needs of homeless young people with mental health problems
- ➔ Family mediation can help young people to return home, or at least to maintain or re-establish family relationships
- ➔ Personal Advisors from Connexions and similar services, providing information, advice and guidance and targeted support, can help homeless young people with mental health problems to engage with education and employment
- ➔ Guidance on improving access to mental health services for people from ethnic minority communities is available in the Department of Health's report, *Delivering Race Equality in Mental Health Care*<sup>26</sup>
- ➔ Guidance on improving homelessness services for people from ethnic minority communities can be found in the DCLG guide *Tackling homelessness amongst ethnic minority households; a development guide*<sup>27</sup>
- ➔ Some specialist ethnic minority support services offer specialist mental health and tenancy support for their local communities
- ➔ Services such as Diversion at Point of Arrest (DAPA) and court diversion schemes can divert homeless people away from the criminal justice system and into mental health services.

## 9 Support services for people who are homeless or living in temporary or insecure accommodation

### 9.1 Families with children living in temporary accommodation

Support for parents and children living in temporary accommodation may relieve their immediate mental health problems and help to prevent more severe mental health problems, and possibly repeat homelessness. Contact with families while they are in temporary accommodation provides an ideal opportunity to help them access mental health and other support services. Detailed good practice guidance on health services for homeless families, including mental health, can be found in: *The vital link: preventing family homelessness*.<sup>28</sup>

#### A SPECIALIST SUPPORT SERVICE FOR HOMELESS FAMILIES: LEICESTER FAMILY SUPPORT SERVICES

The Leicester Family Support Service works with families with children living in temporary accommodation and provides access to health care, including mental health care, for children and adults. It arranges other support including:

- ➔ behaviour management groups to help develop parenting skills
- ➔ ensuring children are registered at and attend school
- ➔ liaison with social services
- ➔ other training and support for parents
- ➔ activities for children
- ➔ looking after children while parents attend mental health appointments.

It also works in partnership with drug and alcohol services and with domestic violence support services.

Adults who need mental health services can be referred to the Community Homeless Mental Health Service and children to the specialist Children and Adolescent Mental Health Services (CAMHS) for difficult to engage and vulnerable young people. Both services visit the homeless families temporary accommodation and there are weekly meetings between them and the Family Support Service to discuss individual cases.

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Telephone: 0116 221 1406

Email: [Jacqui.francis@leicester.gov.uk](mailto:Jacqui.francis@leicester.gov.uk)

## 9 Support services for people who are homeless or living in temporary or insecure accommodation

### SUPPORTED ACCOMMODATION FOR HOMELESS FAMILIES: CREATIVE SUPPORT, MANCHESTER

There are two specialist family support accommodation centres in Manchester. The service takes referrals from CMHTs and Children and Families Teams. About 40 per cent of service users have severe and enduring mental health problems. The support workers help people to maintain links with mental health services and to attend appointments. They look at the impact of mental health on parenting and help people access support services. They also help with general parenting skills and refer users to Sure Start and family support workers.

The younger women at these projects frequently have emotional problems, often as a result of abuse they have suffered and may be victims or perpetrators of anti-social behaviour. They are linked in with GP services, primary care mental health services and community counselling services.

Contact: Anna Lunt

Telephone: 0161 236 0829

### 9.2 Domestic violence

There are often links between the experience of domestic violence, homelessness and mental health problems.<sup>29, 30</sup> There are support staff in many areas, often employed by women's refuges or other voluntary organisations, who work with people who are fleeing domestic violence. They may provide both emergency accommodation and support. Almost all refuges provide generalist support and many also have access to specialist support including mental health services, substance misuse and other needs. Many refuges also provide counselling or emotional support for children who have experienced domestic violence.<sup>31</sup>

### 9.3 Young people

Young people can encounter problems in making the transition between children's and adult mental health services. For example, Child and Adolescent Mental Health Services (CAMHS) may be reluctant to accept new referrals for those over 16 years. CAMHS, like adult mental health services, are often reluctant to accept service users whose needs are complicated by substance misuse. However, adult mental health services may not be best placed to work with young people where diagnosis may be difficult, due to the normal problems that adolescents can encounter as part of their transition to adulthood.<sup>32</sup>

## 9 Support services for people who are homeless or living in temporary or insecure accommodation

Agencies reported that there are sometimes inadequate links between Leaving Care Teams and CAMHS for young people at risk of homelessness. Where young people have been in local authority care and, as a result, are entitled to leaving care services, then the authority that last cared for them (the ‘responsible authority’) must continue to assess their needs and support them to access the appropriate services. This duty continues until they reach 21, or longer if they remain in an approved programme of education or training.

Young people aged 16 to 18 can fail to access services because they fall between CAMHS and adult services, and their lack of family support can make them even more vulnerable. In 2005 the Social Exclusion Unit produced a report on how services should develop to meet the needs of young people, particularly those with complex needs, and to help them make the transition from childhood to adulthood.<sup>33</sup> The five key principles of service delivery for young adults were described as:

- ➔ actively managing the transitions from youth to adult services
- ➔ taking thinking and behaviour into account, and building on it
- ➔ involving young adults (and their families and carers) in designing and delivering services
- ➔ giving effective information about services, and sharing information between services
- ➔ offering young people a trusted adult who can both challenge them and support them.

In some areas there are services specifically designed to meet the needs of young people with mental health problems who are homeless, operated by teams with skills in engaging young people with services.

## 9 Support services for people who are homeless or living in temporary or insecure accommodation

### A SPECIALIST MENTAL HEALTH AND SUBSTANCE MISUSE TEAM FOR HOMELESS YOUNG PEOPLE: CENTREPOINT HEALTH TEAM

Centrepoint works with young adults in London. They have contact with up to 1500 young adults per year, aged 16–25, in direct access services, longer term projects, foyers and rough sleeping services. The Health Needs Team consists of six professionals who are either substance misuse or mental health specialists with psychotherapy or psychology backgrounds. Primarily the young adults that come to the service have problems related to loss, depression, anxiety and other personal circumstances such as their refugee status. Referrals to the service are triggered by an initial assessment undertaken by housing service staff. Any type of mental health, emotional, substance misuse or anger management problem can trigger a referral to the Centrepoint Health Team. After referral, a team member visits the young person at a Centrepoint site, conducts an assessment and devises a management plan. The assessment process is not restricted to mental health, but also covers drug and alcohol misuse. The ethos of the service is to provide an integrated plan that addresses both mental health and substance misuse problems and does not insist on determining a primary problem. The Centrepoint Health Team works with the young adult's Support and Development worker who remains the co-ordinator of the service delivery plan. Most young adults work with a counsellor for 3–6 months. Group work and open surgeries are also held that can allow young people to access information and/or peer support on specific sessions, supported by a facilitator. Group work sessions have been held on confidence building, drug education, health issues, safe sex, and harm reduction initiatives. The Centrepoint Health Team worker also makes referrals and facilitates joint work with external agencies. This helps to introduce the young person to a new worker and ensure that the relationship is developing. At this point the Health Team worker withdraws, provided that they are satisfied that the young person will be appropriately supported. The development of service level agreements between agencies has facilitated better working relationships.

Contact: Daniel Mirea

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Email: [dmirea@centrepoint.org.uk](mailto:dmirea@centrepoint.org.uk)

## 9 Support services for people who are homeless or living in temporary or insecure accommodation

### Family mediation

Family breakdown can be associated with both homelessness and mental health problems.<sup>34</sup> Family mediation seeks to reconcile people, often young people, with their families to prevent homelessness and to enable them to stay in the family home. Even if they ultimately decide to leave home, mediation can enable them to do so in a planned manner, and to move into suitable accommodation. Family mediation can also help to maintain or re-establish family relationships where someone is unable to remain at home, so that support continues to be available.<sup>35</sup> A study of family mediation for young people without children identified a range of good practice and found that up to half of young people threatened with homelessness could be enabled to stay at home and that around 15 per cent of those already homeless could be helped to return home.<sup>36</sup>

### Connexions

Nationally, the Connexions service and equivalent services providing information advice, guidance and targeted support for young people, play a central role in identifying those at risk of homelessness and guiding them towards preventative services. The aim of these services is to guide and support all young people through their teenage years, helping them to overcome barriers to engaging with education and employment. These services are delivered primarily through a network of Personal Advisors linking in with specialist support services, including mental health services. They are drawn together from a range of existing public, private, voluntary and community sector organisations. Personal Advisors can help young people already in contact with mental health or homelessness services to access education and employment opportunities. For further information see: [www.connexions.gov.uk](http://www.connexions.gov.uk)

### 9.4 Ethnic minority communities

Some people from ethnic minority communities who are at risk of homelessness do not approach homelessness services for help.<sup>37</sup> Recent research published by DCLG identified that the main issues affecting the low take-up of homelessness services among this group include:

- ➔ the lack of a strategic approach to ethnic minority communities by local authorities which means that services do not always meet their needs
- ➔ the lack of basic knowledge about homelessness services and the assistance available among many members of ethnic minority communities
- ➔ communication problems, which mean that those who do not speak English are less likely to approach services or to receive an adequate service

## 9 Support services for people who are homeless or living in temporary or insecure accommodation

- ➔ negative images of social housing, including fear of discrimination and harassment
- ➔ fear of being accommodated away from their own community and support networks
- ➔ distrust of authority, especially amongst refugees.

DCLG has published a guide on tackling homelessness among people from ethnic minority communities. The guide provides useful information about ensuring that people from ethnic minority communities are properly represented in homelessness strategies as well as describing a number of good practice examples.<sup>38</sup>

The Department of Health's report, *Delivering Race Equality in Mental Health Care*<sup>39</sup> sets out an action plan for improving mental health services for ethnic minority communities. It has three key objectives:

- ➔ more appropriate and responsive services: achieved through action to develop organisations and the workforce, to improve clinical services and to improve services for specific groups, such as older people, asylum seekers and refugees, and children
- ➔ community engagement: delivered through healthier communities and by action to engage communities in planning services, supported by 500 new Community Development Workers
- ➔ better information: from improved monitoring of ethnicity, better dissemination of information and good practice, and improved knowledge about effective services. This will include a new regular census of mental health patients.

These two guidance documents can be used together in the strategic planning of services, to improve accessibility to mental health services for people from ethnic minority communities who are homeless or living in temporary accommodation.

Some specialist ethnic minority support services offer specialist mental health and tenancy support for their local communities. Further details can be found in the DCLG guide on tackling homelessness among ethnic minority households.<sup>40</sup>

### 9.5 Offenders

Some homeless people with mental health problems are in contact with the criminal justice system.<sup>41</sup> There are a number of services which divert people away from the criminal justice system and into mental health services.

- ➔ In some areas there are Diversion at Point of Arrest (DAPA) schemes. Where people appear to have a mental health problem, they can be speedily assessed by a mental health nurse at the police station. For minor offences, the police may decide to allow the person to be diverted to mental health services rather than be charged

## 9 Support services for people who are homeless or living in temporary or insecure accommodation

- ➔ In court diversion services, mental health staff assess people waiting to appear in court, which can result in a decision to divert the person into mental health services.

Research has found that diversion schemes achieve successful medical outcomes; improve the recognition of mental health problems four-fold; cut time from arrest to admission to treatment by a factor of seven and reduce reconviction rates by half.<sup>42</sup> There are also schemes, which provide, in addition, continuing support for this group.

### DIVERSION AND SUPPORT: REVOLVING DOORS

The Revolving Doors Agency operates community-based, multi-disciplinary teams which help less serious offenders with mental health problems gain access to the health, housing and social care they need by intervening at the point of arrest. Many clients also have drug and alcohol problems. Preventing tenancy breakdown and homelessness is a major part of their work. Where higher levels of support is needed, an orderly transfer to more supported housing is preferable to waiting until the tenancy breaks down.

Working in the local police stations, they provide support and practical help at the time of arrest. They work closely with the police and provide training for them on what the services can provide. The workload falls into three categories:

- ➔ one-off help in the police station
- ➔ short term work which involves two or three contacts, assessment and referral on to other services
- ➔ long term casework.

A major task for such projects is persuading excluded people to engage with services. The services are not forced on anyone, but persistence does pay off and they work assertively with people in their own homes, in cafés or on the streets.

The workers act as advocates and make links to help clients access local services. They continue to provide support and advice for up to two years.

Recorded offending amongst clients fell by 22 per cent following engagement with the schemes. An independent Home Office evaluation found that after engaging with the schemes, clients were arrested for less serious offences compared to people who did not engage.

Contact: Julian Corner

Telephone: 020 7253 4038

Website: [www.revolving-doors.org.uk](http://www.revolving-doors.org.uk)

## 9 Support services for people who are homeless or living in temporary or insecure accommodation

A report in 2002 from the Social Exclusion Unit suggested that 72% of male and 70% of female sentenced prisoners suffered from two or more mental health disorders.<sup>43</sup> As some of these offenders may be at risk of homelessness on release it is important to work with agencies providing support to former offenders who are homeless or at risk of homelessness. The DCLG's *Homelessness prevention: a guide to good practice* contains further advice on working with prisoners and ex-offenders to prevent homelessness.<sup>44</sup>

### HOUSING SUPPORT FOR FORMER OFFENDERS

Leicester City Council operates a range of support programmes for former offenders. Many of the service users have mental health problems and are homeless or at risk of homelessness. Services include:

- ➔ a local authority housing advice service when required in the local prison
- ➔ a tenancy support service for lower level offenders run by the Shelter Housing Aid and Research project (SHARP) in partnership with the Probation Service
- ➔ an Accommodation and Supported Housing Team (ASH) run by the Probation Service in partnership with the city council, to support high risk offenders and to manage risk and stabilise tenancies. In 2003 they had been operating for four years, supported around 40 tenancies and had only one failed tenancy and no serious incidents.

Contacts:

Local authority housing advice: Vijay Desor

Telephone: 0116 252 6915

SHARP: Dave Brazier

Telephone: 0116 254 6064

Probation: Neil Mattson

Telephone: 0116 253 6331

# 10 Strategic planning of accessible services

Effective joint work can be further enhanced by joint planning of services. This section examines joint strategic planning, user involvement in planning, and performance management.

## KEY MESSAGES

Strategic planning can be improved by:

- ➔ ensuring that health services, homelessness agencies and other social care agencies fully participate in the formulation and implementation of each others' strategies
- ➔ PCTs and Mental Health Trusts each identifying a homelessness lead officer who is responsible for strategic planning and provision for the health, including mental health, needs of people who are homeless or living in temporary or insecure accommodation
- ➔ effective arrangements for consulting and involving service users, including joint arrangements with homelessness services
- ➔ performance assessment and outcome measures for care staff in their work with individual clients, preferably common measures across local areas.

## 10.1 Strategic planning

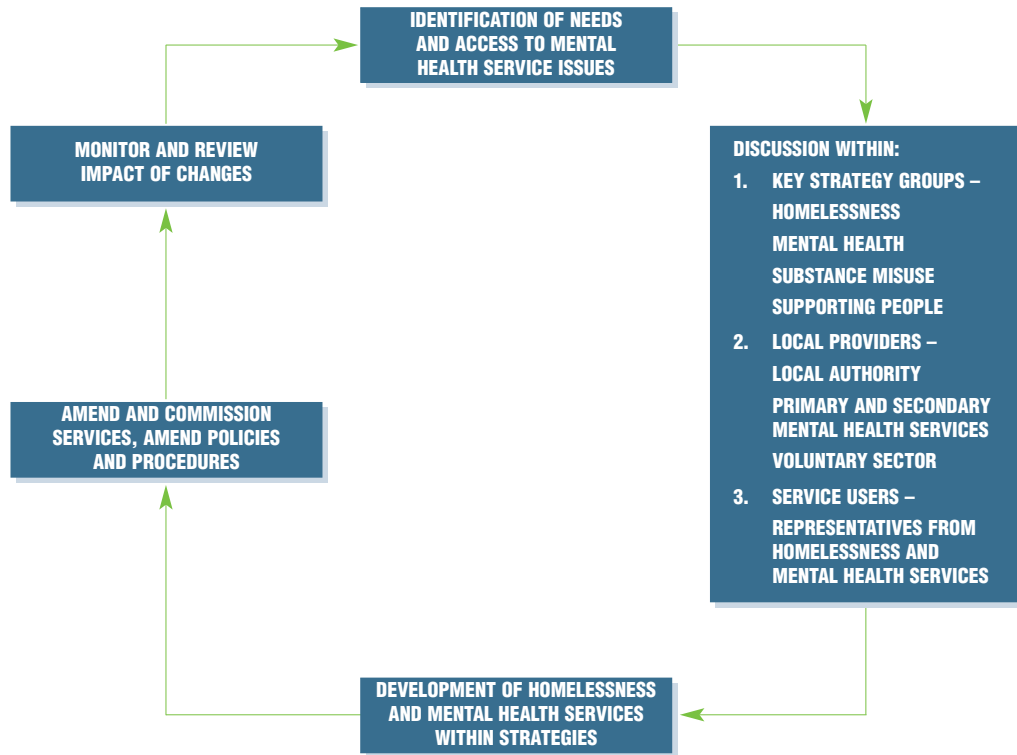
It is good practice to involve a range of people in the strategic planning of services from across disciplines. These should include not only personnel from the local authority and health sectors, but also service users and voluntary sector organisations.

The key steps in developing a plan for ensuring mental health services are accessible to homeless people are summarised in the flow diagram opposite.

It is important to ensure that agencies responsible for developing local strategies on homelessness, mental health, and substance misuse work together to consider any problems of access to mental health services for people who are homeless or living in temporary or insecure accommodation and how these can be overcome. From this, either a shared homelessness and mental health strategy can be developed, or the separate strategies can ensure that they complement and reinforce each other.

## 10 Strategic planning of accessible services

### STRATEGIC PLANNING



### 10.2 Embedding homelessness mental health services in existing strategies

There are a number of strategies, which are relevant to services for people with mental health problems who are homeless or living in temporary or insecure accommodation. The key strategies are:

- ➔ Mental health strategy
- ➔ Homelessness strategy
- ➔ Supporting People strategy
- ➔ Drug and alcohol strategy

Other mechanisms and strategies which may be relevant are:

- ➔ Local Strategic Partnership and community strategy
- ➔ Local Area Agreement (LAA)
- ➔ Learning Disability Strategy
- ➔ Crime and Disorder Strategy

## 10 Strategic planning of accessible services

- ➔ Other local authority and regional strategies: In some authorities there is a need for a joint element in strategies to cover neighbouring areas, or a whole county or region. There are a number of reasons why this need might arise:
  - some homeless people are very mobile and travel across authority boundaries
  - there might be insufficient need to justify provision of a specialist service in every authority
  - cities and towns often act as magnets for people from surrounding rural areas, sometimes because services are concentrated there.

Further details of all these strategies can be found in *Appendix 5*.

Strategic plans are needed to decide whether to concentrate joint services in certain areas, such as the main cities and towns in a county, or to set up smaller scale, scattered provision to allow people to stay in their home areas. There are groups of authorities who work together under the Supporting People programme as cross-authority groups (CAGs). CAGs might in some areas also form natural partners in homelessness strategies and mental health strategies.

### 10.3 Improving local awareness among strategic planners

Some local authorities and homelessness agencies have found it hard to involve PCTs and Mental Health Trusts in the planning of homelessness strategies. The Community Practitioners and Health Visitors Association (CPHVA) has produced a good practice guide to help PCTs to work more effectively on the health problems of families in temporary accommodation: its guidance is equally relevant to the mental health problems of homeless people.<sup>45</sup>

PCTs and Mental Health Trusts should consider having a named individual leading on homelessness who is responsible for strategic planning and provision for the health, including mental health, needs of homeless people. This may be most effectively achieved through a joint planning group.

## 10 Strategic planning of accessible services

### A JOINT PLANNING GROUP: WESTMINSTER'S HOUSING AND RELATED SUPPORT SERVICES LOCAL IMPLEMENTATION TEAM

The National Service Framework for Mental Health Implementation Team in Westminster has a sub-group called the Housing and Related Support Services Local Implementation Team (H&RSSLIT). The H&RSSLIT is a multi-agency group consisting of:

- ➔ Mental Health Provider Forum Representatives
- ➔ Supporting People Contracts Manager
- ➔ Commissioner for Mental Health Accommodation
- ➔ Placement and Resettlement Manager
- ➔ CMHT Area Managers
- ➔ Assertive Outreach Team Manager
- ➔ Service User Support Worker
- ➔ Housing Strategy and Performance Officer
- ➔ City West Homes Service Development Mental Health Lead
- ➔ Ethnic Minority Mental Health Project Manager
- ➔ Housing Needs Manager
- ➔ Temporary Accommodation Team Leader
- ➔ Joint Homelessness Team Manager
- ➔ Housing Options Manager.

The H&RSSLIT ensures that there is a range of initiatives aimed at improving access to mental health services for homeless people and that these initiatives are integrated into service provision for homeless people.

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Email: [RThorneycroft@westminster.gov.uk](mailto:RThorneycroft@westminster.gov.uk)

### 10.4 User involvement in service planning

There can be particular problems with involving rough sleepers or people living in insecure accommodation in service planning because of their transience and, for some, their high levels of need and difficulty in engaging with services. However, some hostels and day centres have arrangements for consulting and involving service users. Mental health services could tap into these consultation procedures.

## 10 Strategic planning of accessible services

Services have found that there are a number of techniques for gathering the views of homeless people which are likely to be more effective than formal committee or public meetings. These include:

- ➔ feedback from established groups, for example residents' meetings in hostels
- ➔ surveys, including any that have already been carried out by local agencies or specially commissioned
- ➔ focus groups
- ➔ visits to projects for informal discussions with users
- ➔ evaluations carried out by independent external agencies
- ➔ 'Speakouts' which are designed for homeless people to express their concerns direct to local policy makers and service providers. (For further information on Speakouts and other means of consulting homeless people contact Groundswell: [www.groundswell.org.uk](http://www.groundswell.org.uk))
- ➔ the involvement of people who have been homeless in the past, drawing on their experience of services.

Shelter have produced a guide to running focus groups for homeless people.<sup>46</sup>

### 10.5 Performance management

Standards for most mental health problems from schizophrenia to depression have been set out through National Service Framework for Mental Health and specific practice guidelines published through the National Institute for Clinical Excellence (NICE): [www.nice.org.uk](http://www.nice.org.uk). These guidelines provide detailed recommendations for best evidence-based practice, both in terms of specific treatments and for wider aspects of care.

For services working with homeless people, both performance assessment and outcome measures are necessary. These can include, for example, symptomatic remission, accommodation outcomes and user satisfaction. There are further detailed suggestions for performance assessment and outcome measures in *Appendix 6*. The specific measures can be adapted according to what the particular service aims to provide.

Performance management across a local area is improved if service providers use the same or similar outcome measures, supported by service level agreements. This allows for regular monitoring not only of the individual service but across the area, informing future planning and commissioning decisions.

Performance management can clearly contribute to improved care, particularly if greater attention is paid to the effects of interventions on outcomes that matter to service users and their carers. The routine collection of aggregated statistics may be some way off and not fully achievable until the wider introduction of electronic records, but good practice at least requires care staff to use simple outcome measures in their work with individual people.

## Appendix 1: Glossary

Descriptions of various mental health problems can be found in National Institute for Mental Health England (NIMHE) (2006) *Contact: A Directory for Mental Health published by the Department of Health* <http://www.dh.gov.uk> <http://nimhe.csip.org.uk/>

### Anxiety states

These include conditions characterised by persistent fearfulness often with panic attacks and phobic conditions such as agoraphobia where the sufferer has a morbid fear of open spaces, crowds and travelling away from home.

### Bipolar affective disorder (Manic-depressive illness)

Some people experience profound changes in their mood, with periods of severe depression and at other times periods of elation and over-activity. Some people may move from depression to elation and back in a week while others may go through this cycle once a year or less often.

### Care Programme Approach

The Care Programme Approach (CPA) was introduced in 1991 to provide a framework for effective mental health care.<sup>47</sup> Its four main elements are:

- systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services
- the formation of a care plan which identifies the health and social care required from a variety of providers
- the appointment of a key worker to keep in close touch with the service user and to monitor and co-ordinate care
- regular review and, where necessary, agreed changes to the care plan.

Two levels of the CPA were introduced in 1999, standard and enhanced.

The characteristics of people on *standard CPA* include some of the following:

- they require either the support or intervention of one agency or discipline or low key support from more than one agency or discipline
- they are more able to self-manage their mental health problems
- they have an active informal support network
- they pose little danger to themselves or others
- they are more likely to maintain appropriate contact with services.

People on *enhanced CPA* are likely to have some of the following characteristics:

- they have multiple care needs, including housing, employment etc, requiring inter-agency co-ordination
- they are only willing to co-operate with one professional or agency but they have multiple care needs

## Appendix 1: Glossary

- ➔ they may be in contact with a number of agencies (including the Criminal Justice System)
- ➔ they are likely to require more frequent and intensive interventions, perhaps with medication management
- ➔ they are more likely to have mental health problems co-existing with other problems such as substance misuse
- ➔ they are more likely to be at risk of harming themselves or others
- ➔ they are more likely to disengage from services.

Service users on enhanced CPA require, as part of their care plans, crisis and contingency plans. These plans form a key element of the care plan and must be based on the individual circumstances of the service user. It is good practice for users on standard CPA to have similar arrangements within their care plans.

### Child and Adolescent Mental Health Services (CAMHS)

In this document CAMHS is defined as specialist child and adolescent mental health services whose primary function is to provide mental health care to children and young people. They are mainly composed of a multidisciplinary workforce with specialist training in child and adolescent mental health.

### Depression

It is commonplace to talk about 'being depressed'. But depression defined by a doctor as 'clinical depression' is a severe version of this in which the sufferer experiences low mood, loss of interest and enjoyment and increased fatigability often with feelings of hopelessness, worthlessness and disturbances in sleep and appetite.

### Dual Diagnosis

The term 'dual diagnosis' covers a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently. Although typically thought of as the combination of a psychotic illness such as schizophrenia and co-occurring substance misuse, it is concerned with all severe mental health problems and the use of illicit drugs, volatile substances (such as gas or glue sniffing) and the use of alcohol, the most commonly used substance.

The nature of the relationship between these two conditions is complex. Possible mechanisms include:<sup>48</sup>

- ➔ a primary psychiatric illness precipitating or leading to substance misuse
- ➔ substance misuse worsening or altering the course of a psychiatric illness
- ➔ intoxication and/or substance dependence leading to psychological symptoms
- ➔ substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses.

## Appendix 1: Glossary

### Eating disorders

Starving to the extent of severe, sometimes life threatening, slimness is diagnosed as 'anorexia nervosa'. Compulsive eating and vomiting is known as 'bulimia nervosa'. Both behaviour patterns are often a way of coping with psychological or emotional problems.

### Personality Disorder

Despite decades of extensive research, psychiatrists and psychologists remain divided as to how these disorders can be conceptualised. At the core is the notion of deeply ingrained and enduring behaviours that are significantly different from how the average person behaves, particularly in relating to other people. For example, the International Classification of Mental and Behavioural Disorders, defines a personality disorder as: '*a severe disturbance in the characterological condition and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption*'. Similarly, the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders defines a personality disorder as: '*an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture*'.<sup>49</sup>

### Post-traumatic stress disorder (PTSD)

Post-traumatic stress disorder is a delayed and/or protracted response to an event of catastrophic proportions (eg. rape, being a victim of torture, serious accident etc). Typical symptoms include intrusive memories of the trauma ('flashbacks'), fear and avoidance of cues that remind the sufferer of the event and a sense of 'numbness' and emotional detachment.

### Psychosis

Psychiatrists use the term 'psychosis' to describe conditions in which hallucinations, and/or delusions occur making it difficult for the sufferer to distinguish clearly between what is real and what is imaginary, or what is external or internal to their own thought processes.

### Schizophrenia

Doctors use the term 'schizophrenia' to describe a particular type of psychosis involving disturbances in thinking and perception. Sufferers typically report that their most intimate thoughts are known to, or shared by, other people and experience distorted perceptions including hallucinations (particularly hearing voices). The popular understanding of the term, as describing a Jekyll and Hyde split personality, is not true. Persistent delusions, often of a persecutory nature are common as are explanations of their experiences in terms of natural or supernatural forces.

### People working in the mental health sector

There is a wide range of people working in the mental health sector. Mind produces a comprehensive fact-sheet describing the roles of these people; it includes paid and voluntary staff. (For further details: [www.mind.org.uk/information/factsheets](http://www.mind.org.uk/information/factsheets)).

## Appendix 2: Outline of homelessness services

This section gives a brief outline of homelessness services. It is designed for mental health practitioners and staff in other agencies who may want additional information on the structure and functioning of these services. More information on homelessness and copies of the DCLG publications referred to in this guidance are available at [www.communities.gov.uk](http://www.communities.gov.uk)

Research for this guide found that a misunderstanding of homelessness services by mental health practitioners has sometimes led to adverse consequences for service users. For example, there was a fairly common belief among health services practitioners that single homeless people with mental health problems would automatically be considered by local housing authorities to be vulnerable and have a priority need under the homelessness legislation and therefore be owed the main homelessness duty to secure accommodation. However, this is not always the case (see below: *Local authority housing departments*).

The provision of suitable accommodation with the appropriate level of support is essential to enable people with mental health problems to access and remain engaged with mental health services.

Some people with mental health problems require supported housing, at least for a period. The Audit Commission has found that the provision of supported housing can reduce unplanned psychiatric re-admissions.<sup>50</sup>

The *2004 National Patient Survey* found that only 48 per cent of mental health service users who wanted help with accommodation received it.<sup>51</sup> It is important to link mental health service users into suitable services for support and access to accommodation. This does not simply mean referring them to local authority housing departments, but ensuring they are referred to the most appropriate agency. In order to do this, mental health services should liaise with local agencies that work with homeless people to ensure that:

- ➔ users of mental health services who are homeless or at risk of homelessness are identified at an early stage. This involves a few simple questions about people's housing circumstances in the standard assessment
- ➔ information is available from local agencies on the accommodation and support services available for people who are homeless or at risk of homelessness. Local housing authority staff and Supporting People co-ordinators can provide this information
- ➔ referral protocols are in place with the statutory and voluntary housing agencies, including the provision of information about users' needs. There is a need for clear arrangements for liaison and joint working between mental health and housing services

## Appendix 2: Outline of homelessness services

- ➔ mental health services should work with housing authorities and voluntary agencies to plan future provision of suitable accommodation and support to meet the full range of needs of all groups including families. This can be achieved through active participation in local authority and Supporting People strategies and by joint commissioning between health and housing authorities
- ➔ continuing tenancy support is available to people who have settled housing if they need it, including some specialist support for people with mental health problems. This support is also helpful for people at risk of losing their current home and for people who may not meet care management criteria, but whose mental health problems could make it difficult for them to sustain a tenancy. Such services can be provided through a variety of sources, for example through Supporting People or Support, Time and Recovery Workers (STR) or by joint commissioning. It is essential that the support provided is sufficiently flexible that it can continue to be effective if a crisis should occur.

### Homelessness agencies

#### *Local authority housing departments*

Housing authorities have a significant role to play in homelessness prevention and can employ a range of initiatives to achieve this.<sup>14</sup>

In respect of all applications for accommodation or assistance in obtaining accommodation, where the local housing authority has reason to believe that the person may be homeless or threatened with homelessness, it is under a duty to make enquiries to satisfy itself whether the applicant is eligible for assistance and whether any duty is owed to that person under the homelessness legislation (part 7 of the Housing Act 1996).

Further, where there is an immediate reason to believe that the applicant may be homeless and have a priority need, there is a duty to provide suitable interim accommodation while those enquiries are carried out.

The main homelessness duty is a duty to ensure that suitable accommodation is available for people who are eligible for assistance, unintentionally homeless and who fall within a priority need category. Some people from abroad are ineligible.

The priority need categories include:

- ➔ people whose household includes a dependent child or a pregnant woman
- ➔ 16 and 17 year olds (with certain exceptions) and young people up to the age of 21 who were previously in care

## Appendix 2: Outline of homelessness services

- ➔ people whose household includes someone who is vulnerable as a result of:
  - old age
  - mental health problems or learning difficulties
  - physical disability
  - another special reason.
- ➔ people who are vulnerable as a result of:
  - having been in prison or custody
  - having served in the armed forces
  - having been in care earlier in their life
  - fleeing their home because of violence, or the threat of violence.

The decision whether a particular housing applicant is vulnerable is for the local housing authority to make. Guidance on the factors they should consider in reaching a decision and on the need to work with other agencies in doing so are set out in the *Homelessness Code of Guidance for Local Authorities*. The Code of Guidance states that:

**assessment of vulnerability due to mental health will require close co-operation between housing authorities, social services authorities and mental health agencies. Housing authorities should consider carrying out joint assessments or using a trained mental health practitioner as part of an assessment team... *People discharged from psychiatric hospitals and local authority hostels for people with mental health problems are likely to be vulnerable. Effective, timely liaison between housing, social services and NHS Trusts will be essential in such cases but authorities will also need to be sensitive to direct approaches from former patients who have been discharged and may be homeless.***<sup>52</sup>

However, it should not be assumed that all homeless people with mental health problems, or even all those leaving psychiatric hospitals, will be accepted by the housing authority as vulnerable and having a priority need for accommodation. Indeed there are a number of variations (outside that where the main homelessness duty will apply) into which a person seeking accommodation and assistance may fall, for example:

- ➔ in cases where the local authority are of the view that the applicant has become homeless intentionally but that he does have a priority need, they shall ensure that he has accommodation available for his occupation for such time as is reasonable for him to find alternative accommodation and they shall assess his housing needs and provide him with assistance and advice in finding that alternative accommodation
- ➔ in cases where the applicant is deemed intentionally homeless and not to have a priority need the local housing authority shall assess his housing needs and provide him with advice and assistance in finding alternative accommodation

## Appendix 2: Outline of homelessness services

- ➔ in cases where the applicant is not in priority need and is not homeless intentionally, the authority shall assess the applicants housing needs and provide him with advice and assistance in finding alternative accommodation. In addition they may secure that accommodation is available for occupation by such an applicant. Note that this is not a duty but at the discretion of the authority.

### *Housing advice services*

Local housing authorities have a statutory duty to ensure that advice and information about homelessness and the prevention of homelessness is available free of charge to everyone in their area. Some housing authorities also operate effective services to help prevent homelessness, and these should be available to people who do not necessarily fall within a priority need category. In some areas there are also voluntary agencies which provide housing advice services. In addition to specialist housing advice agencies, many other agencies may be offering housing advice to people who are homeless or at risk of homelessness including community and day centres, other voluntary agencies, accommodation agencies, social services, probation officers, and many others. While housing advice services focus specifically on the housing aspects of a person's problems, they are also encouraged to signpost clients to other advice agencies and support services.

### *Street outreach teams in areas where people sleep rough*

Homelessness street outreach teams are usually run by voluntary agencies. They aim to help rough sleepers to move off the streets, usually into a hostel as a first step, and eventually into settled accommodation. A high proportion of rough sleepers have mental health problems and street outreach teams may have contact with some who are not in touch with other services.

### *Homelessness day centres*

Day centres for homeless people can engage people who may not use hostels and other services. Traditionally, they have offered basic services such as day time shelter, food and clothing. But they also offer an opportunity to target people at risk of homelessness and some centres have developed a comprehensive range of services. For example, some host specialist primary care services for particular groups, including people with mental health, alcohol and drug problems. Some also provide a range of general advice and support services to prevent homelessness, such as life skills and employment training, benefits advice, rent deposit schemes and tenancy support.

## Supported housing

There is a range of supported housing available for people who would otherwise be homeless including:

- ➔ hostels providing emergency accommodation for homeless people
- ➔ short to medium term hostels with varying degrees of support
- ➔ transitional housing schemes, often in shared or grouped accommodation

## Appendix 2: Outline of homelessness services

- ➔ supported lodgings schemes
- ➔ registered residential care homes often for long term care.

There is further information on these options in the guide *Supporting People: Guide to accommodation and support options for homeless households*.<sup>53</sup>

There is an online Supporting People Directory of Services which provides information on local supported housing schemes, including emergency accommodation:

[www.spdirectory.org.uk](http://www.spdirectory.org.uk)

### *Hostels for homeless people without children*

Hostels vary widely from emergency accommodation for rough sleepers, to shared accommodation for students or young workers who may have no support needs. Not all hostels accommodate homeless people and it is important to identify the target group of hostels before including them in mental health services planning. As it is difficult for people sleeping rough to access or sustain mental health support and treatment without accommodation, hostels offer a major opportunity for these people to take the first steps into mental health services.

Foyers are specialist hostels for young people offering employment, training and other support as well as accommodation. More information on Foyers can be found at [www.foyer.net](http://www.foyer.net)

Hostels offer very varying degrees of general support, from minimal levels to 24 hour continuing care. Some hostels offer support for people with mental health problems provided by specialist mental health workers. It is important to ensure that the necessary level of support is available before referring homeless people with mental health problems to a hostel, in consultation with the hostel provider. In some areas, there are shortages of some types of provision, for example hostels offering high level specialist support for people with a dual diagnosis.

### *Temporary accommodation for households accepted as homeless by local housing authorities*

People accepted as homeless by a local authority may be placed in temporary accommodation until a settled home becomes available for them. Local authorities use various types of temporary accommodation for this purpose.

The vast majority of people in temporary accommodation are placed in self-contained housing with their own front door and cooking and washing facilities; this applies to families, single people and couples without children. Some people may become isolated when in temporary accommodation if it is located away from their usual support networks. Other forms of temporary accommodation are also used, including hostels and bed and breakfast hotels.

## Appendix 2: Outline of homelessness services

### *Bed and Breakfast accommodation*

Recent legislation has ensured that housing authorities cannot discharge a homelessness duty to someone with family commitments (where the household includes a dependent child or pregnant woman) by placing them in Bed and Breakfast (B&B) accommodation, except in an emergency and even then for no longer than six weeks. *The Homelessness Code of Guidance* (see chapter 17 of the Code) also make it clear that authorities should avoid the use of B&B for other clients except as a last resort. However, some people may be placed in B&B accommodation by local authorities and some may book themselves into a B&B for lack of an alternative. People in these circumstances may be isolated and not in touch with any support services. Others may use day centres for homeless people to access some support.

The Government has recently announced a commitment to end the use of bed and breakfast by local housing authorities in discharging their homelessness duty for 16 and 17 year olds, unless there is no alternative and then for no longer than 6 weeks, by 2010. This is part of a new package of measures aimed at preventing youth homelessness, which also includes plans to establish supported lodging schemes and improving access to homelessness mediation schemes across the country.

### *Refuges*

Refuges are crisis accommodation for women and children escaping domestic violence. Refuges vary, but have in common the offer of help and a safe place to stay. Most refuges have staff available during office hours to offer support, often by specialist staff trained in domestic violence. They also offer information on accommodation and other services. The shortage of longer-term accommodation may mean that women stay in a refuge for months or, in some areas of London, for up to two years. If a refuge space is not available, the housing department or social services may have a duty to ensure that women fleeing domestic violence have somewhere suitable to live.

### **Tenancy support and floating support**

Some people with mental health problems may have difficulty maintaining a tenancy without support. Agencies providing general tenancy support services have demonstrated that tenancies can be sustained even where people have high support needs, such as mental health and drug or alcohol problems. Support is provided either in special supported housing or to people with a tenancy in general needs housing. Tenancy support commonly includes help with moving in and furnishing a home, claiming benefits, budgeting and ensuring the tenant abides by the tenancy agreement. Not only can tenancy and floating support prevent homelessness, it can also avert a range of other social problems and can be extremely cost effective.<sup>54</sup> Tenancy and floating support workers do not attempt to provide all support themselves, but can arrange for support from other specialist agencies. Some tenancy and floating support teams specialise in clients with particular needs, such as mental health problems.

**Appendix 2: Outline of homelessness services****FLOATING TENANCY SUPPORT FOR PEOPLE WITH MENTAL HEALTH PROBLEMS**

Julian Housing is a voluntary agency working in Norfolk providing a range of housing support services to people with mental health problems including a floating tenancy support service, funded by Supporting People.

There is an initial needs and risk assessment. If people meet the criteria for the service, an individual support plan is drawn up in conjunction with the service user. People who do not meet the criteria are referred to other services which can help.

Julian Housing Support works to a 'strengths' model of care which focuses on the strengths, abilities and talents of clients. Continuing tenancy support is provided for up to two years.

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Email: [t.wilson@julianhousing.org](mailto:t.wilson@julianhousing.org)

Specialist tenancy support cannot be provided as a part of mainstream housing management and it needs specialist staff and separate funding administered by local authorities under the Supporting People programme. Supporting People only covers housing-related support that helps people achieve or maintain independent living, but does not cover social care or treatment for mental health problems. It funds not only supported housing, but also tenancy support provided in ordinary lettings, including private sector tenancies and home owners.

DCLG has published a series of guides to accommodation and support available under the Supporting People programme, including separate guides on options for:

- ➔ homeless households
- ➔ people with mental health problems
- ➔ households who misuse substances
- ➔ households experiencing domestic violence
- ➔ former offenders and people at risk of offending.<sup>55</sup>

## Appendix 3: Outline of mental health services

This Appendix outlines the range of mental health services provided in community settings. It is designed for staff who do not work within the mental health sector. More information about specific mental health problems can be found in the *Glossary – Appendix 1*. A useful reference is *Contact: A Directory for Mental Health*.<sup>56</sup> It contains information on mental health problems and on seeking help and treatments. It also provides a list of organisations specialising in mental health.

### Primary care

People access health services through a variety of routes, the most common being via their General Practitioner but also through NHS walk-in centres which offer quick access to some NHS services.

Primary care services can assess the needs of people with mental health problems, and know how best to access specialised mental and physical health services. Many common mental health problems including mild to moderate depression and anxiety can be adequately managed within primary care. Some larger general practices have staff dedicated to providing counselling and other psychological therapies. This provision has increased through the employment of (Graduate) Primary Care Mental Health Workers. These are usually psychology graduates trained in brief therapy techniques of known value in treating common mental health problems.

Improving partnerships between health, social and voluntary sector provision helps to ensure faster access to effective support and treatment for people with common mental health problems, faster access for people in crisis, effective care for those with stable, severe mental illness and services closer to people's homes. To enable this, some practices have introduced Gateway Workers who co-ordinate and ensure prompt access to mental health care. They work with GPs and primary care teams, as well as NHS Direct and A&E departments to respond to people who need immediate help.<sup>57</sup>

Some areas have specialist primary care for homeless people where the staff often have enhanced skills in mental health care, thus enabling the homeless person to access the care they need. There is a range of models for delivering this specialist care, which are described more fully in Chapter 6.

Occasionally, people attend A&E with mental health problems. This is not always inappropriate, but where it occurs frequently, the adequacy of primary care services needs to be reviewed.

### Appendix 3: Outline of mental health services

## Secondary care

### Crisis Resolution or Home Treatment Teams

These services are designed to serve adults suffering an acute psychiatric crisis of such severity that, without the involvement of a crisis resolution/home treatment team, hospitalisation would be necessary.

The service:

- ➔ acts as a gatekeeper to mental health services, rapidly assessing individuals with acute mental health problems
- ➔ provides immediate multi-disciplinary, community-based treatment 24 hours a day, 7 days a week
- ➔ ensures that individuals are treated in the least restrictive environment as close to home as clinically possible
- ➔ remains involved with the individual until the crisis has been resolved and the person is linked into on-going care
- ➔ if hospitalisation is necessary, is actively involved in discharge planning and provides intensive care at home to enable early discharge.

### Inpatient care

Care is provided 24 hours a day by registered nurses and support workers with multidisciplinary input. General acute wards may be on a general hospital site, part of a mental health hospital or in a separate purpose-built unit. They provide care, including residential care with intensive nursing support for patients in periods of acute psychiatric illness. Approximately 27% per cent of psychiatric hospital inpatients (this can be much higher in urban areas) are described as formal patients, in that they are detained in hospital under the Mental Health Act 1983 and subject to compulsory assessment and/or treatment for a fixed period of time.<sup>58</sup> More information about this process can be found at Mind's website: [www.mind.org.uk/Information/Legal/OGMHA.htm](http://www.mind.org.uk/Information/Legal/OGMHA.htm)

### Community Mental Health Teams

Community Mental Health Teams (CMHTs) are the mainstay of the secondary mental health system. The majority of referrals of new clients enter specialist mental health care via the CMHT. The responsibilities of CMHTs may change over time with the advent of new services; however they retain an important initial assessment and treatment role. They also continue to care for the majority of people with severe and enduring mental health problems in the community.

The CMHT provides support and treatment to several groups of people, usually through a number of specific sub-teams made up of psychiatrists, mental health nurses, occupational therapists, psychologists and social workers.

### Appendix 3: Outline of mental health services

- ➔ Brief Treatment: most people treated by the CMHT have time-limited conditions and are referred back to their GPs after a period of weeks or months when their condition has improved
- ➔ Continuing Care: a substantial minority, however, remain in specialist care for continuing support and treatment, care and monitoring for periods of several years. They include people needing specialist care for severe and persistent mental health problems associated with significant disability: predominantly psychoses such as schizophrenia and bipolar disorder where there is a significant risk of self harm or risk to others or where the level of support required exceeds that which a primary care team could offer
- ➔ First Episode Psychosis Service (also referred to as 'Early Intervention Services'): These are relatively new sub-specialisations of the CMHT that focus entirely on people aged between 14 and 35 years with a first presentation of a psychotic illness (eg. schizophrenia). Intervening early in the course of the illness can prevent initial problems and improve long term outcomes. They provide services for the first three years following initial diagnosis. These are very new service developments and their implementation varies considerably from a comprehensive replacement of traditional inpatient and CMHT services on the one hand, to the presence of one or two workers with a special interest and expertise within the local CMHT.

#### Homelessness Mental Health Teams

In some areas Homelessness Mental Health Teams have been established. They are often the first point of contact for mental health services a homeless person can access. Unlike other specialist teams a referral from a primary care team is not required. In fact, service users can access services without any referral, although contact is often made via primary care or homelessness/housing services. These teams vary widely in size and staffing, some being nurse led, others social work led. Many are multi-disciplinary. Their composition and work methods vary according to local need and service development, but all use an assertive outreach approach, focusing specifically on homeless people. The specific populations they work with are determined locally. Some teams use their own broad definitions of homelessness, which may include anyone at risk of becoming homeless or sleeping in friends' accommodation. Other teams use tighter definitions covering only rough sleepers and those living in insecure accommodation. The mental health criteria used also vary widely. Some teams encompass any mental health problem, including mild problems such as emotional distress. Other teams work specifically with people with severe and enduring mental health problems who meet the criteria for Enhanced Care Programme Approach (see Glossary).

### Appendix 3: Outline of mental health services

Homelessness Mental Health Teams or services often straddle mental health provision provided in primary and secondary care settings. Engaging homeless people with mental health problems is often the key priority rather than diagnosis or intensity of contact required. Homelessness Mental Health Teams can also facilitate access to other specialised tertiary care where it is required. Over time it is hoped that service users are able to use traditional mental health services and are helped to engage with these when it is appropriate. Length of engagement with Homelessness Mental Health Teams varies widely according to individual need, from short-term interventions to long-term engagement.

#### Tertiary care

Services in this group provide intensive, highly specialised treatments or target particular high risk groups.

#### Assertive outreach

These services are designed for adults aged between 18 and 65 who are already known to the specialist mental health service and who have:

- ➔ a severe and persistent mental health problem associated with a high level of disability
- ➔ a history of high use of inpatient or intensive home-based care (for example, more than two admissions, or more than 6 months inpatient care in the past two years)
- ➔ difficulty in maintaining lasting and consenting contact with services
- ➔ multiple, complex needs including a history of violence or persistent offending; significant risk of persistent self-harm or neglect; poor response to previous support and treatment and co-occurring serious mental illness and substance misuse. The aim of assertive outreach teams is to keep in contact with people who are difficult to engage. Provision includes day to day engagement and active health care and rehabilitation.

#### Forensic services

These services deal with people who have had contact with the criminal justice system and/or who are at particular risk of harm to others. They provide both inpatient and intensive community supervision and support.

#### Other specialist treatments/teams

In addition to these services a number of initiatives have been proposed that affect service delivery to people with mental ill health. The development of these services depends on local circumstances. Some of these initiatives are particularly relevant to homeless people. Local commissioners can provide further information.

### Appendix 3: Outline of mental health services

#### Specialist personality disorder services

The majority of people with problems related to personality disorder are managed within the CMHT. However a few people have more complex problems and for these there are now specialised individual or group-based psychological treatments available. Specialists attached to the CMHT or based in intensive day-care settings can provide these treatments.<sup>59</sup>

#### Dual diagnosis services

Dual diagnosis is a short-hand term commonly used to refer to the combination of severe mental illness and drug/alcohol misuse or dependency. People with dual diagnosis comprise up to a third of cases in the CMHT and even higher rates among users of Assertive Outreach teams and in hospital.

The *National Service Framework for Mental Health*<sup>60</sup> emphasises the importance of a number of issues in tackling dual diagnosis:

- Mental health promotion: in relation to alcohol, brief primary care interventions such as an assessment of alcohol intake with feedback can help reduce excess consumption
- In primary care, assessment of individuals with mental health problems should consider the potential role of substance misuse. Primary care clinicians should know how to access specialist services
- Secondary care should meet the needs of people with dual diagnosis through existing mental health and drug and alcohol services
- The Care Programme Approach (CPA) should be available to people with dual diagnosis whether they are located in mental health or drug and alcohol services and this must start with a proper assessment.

Historically, services for substance misuse and mental health problems have evolved separately. Clients have tended either to be treated within one service alone, which has meant that some aspects of their cluster of problems have not been dealt with as well as they might, or they have been shuttled between services, with a loss of continuity of care. There is some evidence and considerable argument in favour of integrated approaches that provide treatments for both conditions from a single team. As a result, many mental health teams now employ specialist dual diagnosis workers and run training programmes to equip staff with essential skills to manage these disorders.<sup>61</sup>

### Appendix 3: Outline of mental health services

#### Mental health promotion

Mental health promotion involves any action to enhance the mental well-being of individuals, families, organisations or communities. Mental health promotion is essentially concerned with:

- ➔ how individuals, families, organisations and communities think and feel
- ➔ the factors which influence how we think and feel, individually and collectively
- ➔ the impact that this has on overall health and well-being.

Mental health promotion has a role in preventing mental health problems, notably anxiety, depression, behavioural difficulties and can also help with drug and alcohol dependence. But it also has a wider range of health and social benefits. These include improved physical health, increased emotional resilience, greater social inclusion and participation and higher productivity. The *Mental Health National Service Framework* provides a practical guide to help local health and social care services and employers develop mental health promotion strategies.

#### Mental health services for children and young people

Like adults, children and young people will generally access primary care services for any mental health problems in the first instance. If more specialist support is required, young people up to the age of 18 can access support from Child and Adolescent Mental Health Services (CAMHS). However, new referrals after a young person has turned 16 can sometimes be difficult.

CAMHS delivers services in line with a four-tier strategic framework which is now widely accepted as the basis for planning, commissioning and delivering services. Although there is some variation in the way the framework has been developed and applied across the country, it has created a common language for describing and commissioning services.

Most children and young people with mental health problems will be seen at Tiers 1 and 2. However, it is important to bear in mind that neither services nor people fall neatly into tiers.

##### *Tier 1*

CAMHS at this level are provided by practitioners who are not mental health specialists working in universal services; this includes GPs, health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies.

Practitioners will be able to offer general advice and treatment for less severe problems, contribute towards mental health promotion, identify problems early in their development, and refer to more specialist services.

### Appendix 3: Outline of mental health services

#### *Tier 2*

Practitioners at this level tend to be CAMHS specialists working in community and primary care settings in a uni-disciplinary way (although many will also work as part of Tier 3 services). For example, this can include primary mental health workers, psychologists and counsellors working in GP practices, paediatric clinics, schools and youth services.

Practitioners offer consultation to families and other practitioners, outreach to identify severe or complex needs which require more specialist interventions, assessment (which may lead to support and treatment at a different tier), and training to practitioners at Tier 1.

#### *Tier 3*

This is usually a multi-disciplinary team or service working in a community mental health clinic or child psychiatry outpatient service, providing a specialised service for children and young people with more severe, complex and persistent disorders. Team members are likely to include child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists, art, music and drama therapists.

#### *Tier 4*

These are essential tertiary level services for children and young people with the most serious problems, such as day units, highly specialised outpatient teams and inpatient units. These can include secure forensic adolescent units, eating disorders units, specialist neuro-psychiatric teams, and other specialist teams (for children who have been sexually abused, for example), usually serving more than one district or region.

## Appendix 4: Main models of primary care provision for homeless people

There are a number of models which can be used to fund primary care for homeless people.

- ➔ Primary medical services via GP practices usually operate under either a *General Medical Services (GMS)* contract or a *Personal Medical Services (PMS) agreement*: these may be the most appropriate route in areas with low numbers of homeless people. However, GPs need to have available clear pathways for access by homeless people to specialist mental health and substance misuse services and to local housing agencies
- ➔ Specialist general practice via *Specialist Personal Medical Services (SPMS)* allows for the development of different organisational models to improve access to services, including surgery-based and outreach care in hostels, day centres or on the streets, especially in areas with relatively high levels of homelessness. In 2004 there were over 100 SPMS schemes in England providing for homeless people. Since then, some have continued within the SPMS model and others have been absorbed into their host PCT as PCTMS (see below)
- ➔ *Enhanced services attached to existing GMS or PMS practice*. In areas with significant numbers of homeless people, but not high enough to justify a full specialist service, these services provide GP registration and a level of specialist primary care, for example GP sessions in hostels or day centres, specialist nurse or health visitor provision
- ➔ *Alternative Provider Medical Services and Primary Care Trust Medical Services (PCTMS)*. PCTs can commission services from alternative providers such as voluntary organisations, not-for-profit organisations, social enterprises, other NHS bodies and commercial providers. For example, PCTs can work with voluntary organisations to provide mental health services in an accessible setting. PCTs can also provide services by employing staff directly themselves
- ➔ *Walk-in Centres*. NHS Walk-in Centres are open every day of the year and have extended opening hours. They are not specifically designed for homeless people, but can be used to improve access to services for them. Care has to be taken to ensure continuity of care for users of these centres.

## Appendix 5: Local strategies

This appendix contains details of local strategies, which are relevant to services for homeless people with mental health problems. The key strategies are:

- ➔ Mental health strategy: the National Service Framework for Mental Health (NSF) sets down key standards that mental health services, including those for homeless people, should achieve and suggests that a strategy is developed for delivering the plans set out in the NSF. [www.dh.gov.uk](http://www.dh.gov.uk)<sup>62</sup>
- ➔ Homelessness strategy: local housing authorities are required to produce a strategy, which must be a strategy for preventing homelessness and ensuring that there is, and will be, sufficient accommodation and support available for people who are homeless or at risk of homelessness. The government issued *Homelessness Strategies: A good practice handbook* in 2002 to help local authorities to produce their first homelessness strategy by 2003.<sup>63</sup> Local authorities are required to review their strategy by 2008, and DCLG has issued *Preventing Homelessness: A strategy health check* to assist them
- ➔ Supporting People strategy: local authorities are required to produce a Supporting People Strategy for housing-related support covering a wide range of vulnerable people, including homeless people with mental health problems
- ➔ Drug and alcohol strategy: treatment for drug misuse in England is organised and commissioned through local partnerships such as drug action teams (DATs) which form part of local Community Safety initiatives. These partnerships produce plans which outline how they aim to develop drug treatment services, some also co-ordinate services relating to alcohol. The National Treatment Agency for Substance Misuse (NTA) website provides links to a range of documents in relation to supporting homeless people with substance misuse problems: it is listed under *Accommodation Guidance*: [www.nta.nhs.uk](http://www.nta.nhs.uk)

Other strategies which may be relevant are:

- ➔ Local Strategic Partnerships and community strategies: every local authority has a duty to prepare a community strategy. Strategic partnerships of local government, public bodies, businesses and voluntary organisations tackle major local issues such as housing and social exclusion
- ➔ Local Area Agreement (LAA): this is a three year agreement, based on local Sustainable Community Strategies, that sets out the priorities for a local area agreed between Central Government, represented by the Government Office (GO), and a local area, represented by the local authority and other key partners through Local Strategic Partnerships (LSPs). LAAs simplify some central funding, help join up public services more effectively and allow greater flexibility for local solutions to local circumstances

**Appendix 5: Local strategies**

- ➔ Learning Disability Strategies which are prepared by Learning Disability Partnership Boards within the overall framework of Local Strategic Partnerships
- ➔ Crime and Disorder Strategy: local authorities and the police have a duty to publish three yearly crime and disorder strategies. These often involve schemes designed to tackle anti-social behaviour. For further information see: [www.crimereduction.gov.uk](http://www.crimereduction.gov.uk)
- ➔ Other local authority and regional strategies: in some authorities there is a need for a joint element in strategies to cover neighbouring areas, or a whole county or region. There are a number of reasons why this need might arise:
  - some homeless people are very mobile and travel across authority boundaries
  - there might be insufficient need to justify provision of a specialist service in every authority
  - cities and towns often act as magnets for people from surrounding rural areas, sometimes because services are concentrated there.

## Appendix 6: Performance management

This appendix gives further details of the possible performance measures discussed in Chapter 10.

### Performance assessment

This involves monitoring service activity in various ways. Indicators of particular value for homeless people that could usefully be completed at the point of intake into a particular service or programme include:

- ➔ numbers and brief characteristics (age, sex, housing status, length of time since last settled accommodation, reason for loss of last settled home, past history of contact with services) of contacts
- ➔ number (%) of those above for whom assessments were completed (may be further specified according to assessment type, for example mental health, substance use, physical health, housing need)
- ➔ number (%) with severe mental illness (diagnosis if known)
- ➔ number (%) receiving core services from this team (Housing assistance, mental health advice/treatment, substance use advice/treatment, welfare benefits advice)
- ➔ number (%) receiving services externally and type of care
- ➔ number (%) on enhanced CPA whether co-ordinated by service or externally
- ➔ time from referral to assessment
- ➔ service quality measures based on periodic user satisfaction audits.

### Outcome measures

These can ideally be measured at three monthly intervals and might include:

- ➔ number (%) of those in programme whose housing status has significantly improved since the last assessment (for example, sleeping rough ➔ temporary shelter ➔ homelessness hostel ➔ accommodation with tenure)
- ➔ number (%) who achieve settled housing in period
- ➔ number (%) of tenancies sustained over defined periods
- ➔ number (%) in employment (full/part-time)
- ➔ number (%) that misuse or are dependent on alcohol/other substances, numbers that have improved substance use status (difficult to measure but see Table A6 for suggested scales)
- ➔ number (%) with improved mental health status (also difficult to measure but see Table A6)
- ➔ number (%) discharged from service
- ➔ number (%) lost to follow-up.

## Appendix 6: Performance management

TABLE A6: EXAMPLES OF PERFORMANCE MEASURES

BROAD INDICATOR	EXAMPLE MEASURE	NSF
Categorical indicators	Number (%) with severe mental illness	✓
	Diagnosis	
Symptomatic remission	Various clinician rated (eg. HoNOS )	✓
	Various client rated (eg. DASS)	
	Alcohol use (eg. AUDIT)	
	Drug use (eg. MAP)	
Social Function	Occupational status	
	Paid employment	✓
	Education/training	
	Quality of Life measures	✓
Housing status	Accommodation status	✓
	Tenure	
	Suitability to need	
Service 'engagement'	Service user satisfaction	✓
	Care plans signed by service user	✓
Service utilisation indicators	Proportion people lost to care	✓
	Proportion discharged from follow up	✓

*Notes to table*

NSF: ✓ – recommendation within *National Service Framework* for monitoring people suffering from severe mental illness

HoNOS: *Health of the Nation Outcome Score* – Wing et al Royal College of Psychiatrists (Crown Copyright) [www.rcpsych.ac.uk/cru/honoscales/](http://www.rcpsych.ac.uk/cru/honoscales/)

DASS: *Depression Anxiety and Stress scales* – by Lovibond, S. & Lovibond P. [www.psy.unsw.edu.au/dass/](http://www.psy.unsw.edu.au/dass/)

AUDIT: *Alcohol Use Disorders Identification Test* – Saunders et al (1993) *Addiction*, 88, 791–803 [www.dass.stir.ac.uk/DRUGS/pdf/audit.pdf](http://www.dass.stir.ac.uk/DRUGS/pdf/audit.pdf)

MAP: *Maudsley Addiction Profile* – Marsden et al (1998), *The Maudsley Addiction Profile (MAP): a brief instrument for assessing treatment outcome.* *Addiction*, 93: 1857–1867 [www.dass.stir.ac.uk/DRUGS/pdf/Map.pdf](http://www.dass.stir.ac.uk/DRUGS/pdf/Map.pdf)

This list is not exhaustive, it is meant to give an indication of the range of measures available.

## Appendix 7: Research for this guide

The evidence in the guide is drawn from a review of published research on mental health and homelessness, interviews with agencies working in the homelessness and mental health sectors, and service users. The guide does not report in detail on the research process, but its examples of good practice are based on research for the report, except where referenced to another publication.

The methods used to develop this evidence base are listed below.

- ➔ A review of published research on mental health and homelessness
- ➔ Nine regional seminars attended by over 300 delegates including staff from agencies working with homeless people with mental health problems, service users and carers, organised in conjunction with the Care Services Improvement Partnership (CSIP) Regional Development Centres
- ➔ Six interviews with national agencies concerned with homelessness and with mental health services
- ➔ A postal questionnaire to local authorities and PCTs asking for contact details of local mental health services for homeless people
- ➔ A postal survey to 381 individual projects in England thought to provide specialist mental health services to homeless people. Of the 185 responses, 86 agencies were found to provide such services and gave details of their operations
- ➔ Interviews and focus groups with 73 staff in agencies in six case study areas which provided examples of innovative and effective practice
- ➔ An additional sixteen telephone interviews with specialist agencies in other areas of the country
- ➔ A review of internal and published reports produced by interviewed agencies
- ➔ In-depth qualitative interviews with 55 homeless people with mental health problems
- ➔ Expert advice from an advisory group.

Eight regional databases of agencies considered to be providing specialist mental health services to homeless people, or routes to mental health services were developed. CSIP Regional Development Centres can provide contact details of these services. See *Appendix 8* for your local CSIP Regional Development Centre.

## Appendix 8: Care Services Improvement Partnership Development Centres

### CSIP Eastern Mental Health Development Partnership

654 The Crescent  
Colchester Business Park  
Colchester  
Essex CO4 9YQ

Telephone: 01206 287541  
Email: [see website](#)  
Website: [www.eastern.csip.org.uk](http://www.eastern.csip.org.uk)

### The London Development Centre

11–13 Cavendish Square  
London W1G 0AN

Telephone: 020 7307 2431  
Fax: 020 7307 2432  
Email: [see website](#)  
Website:  
[www.londondevelopmentcentre.org](http://www.londondevelopmentcentre.org)

### CSIP North West Development Centre

Hyde Hospital, 2nd Floor  
Grange Road South  
Hyde SK14 5NY

Telephone: 0161 351 4920  
Fax: 0161 351 4936  
Email: [ask@northwest.csip.org.uk](mailto:ask@northwest.csip.org.uk)  
Website: [www.northwest.csip.org.uk](http://www.northwest.csip.org.uk)

### CSIP South West (main office)

Mallard Court  
Express Park  
Bristol Road  
Bridgwater  
Somerset TA6 4RN

Telephone: 01278 432 002  
Email: [see website](#)  
Website: [www.southwest.csip.org.uk](http://www.southwest.csip.org.uk)

### CSIP East Midlands Development Centre

3rd Floor, Mill 3  
Pleasley Vale Business Park  
Outgang Lane  
Mansfield NG19 8RL

Telephone: 01623 812943  
Email: [see website](#)  
Website: [www.eastmidlandscsip.org.uk](http://www.eastmidlandscsip.org.uk)

### North East, Yorkshire and Humber

Genesis 5  
Innovation Way, Off University Road  
Heslington  
York YO10 5DQ

Telephone: 01904 717260  
Email: [see website](#)  
Website: [www.neyh.csip.org.uk](http://www.neyh.csip.org.uk)

### South East Development Centre

Parklands Hospital  
Aldermaston Road  
Basingstoke  
Hampshire RG24 9NB

Telephone: 01256 376394  
Fax: 01256 376309  
Email: [see website](#)  
Website: [www.southeast.csip.org.uk](http://www.southeast.csip.org.uk)

### CSIP West Midlands

The Uffculme Centre  
Queensbridge Road  
Moseley  
Birmingham B13 8QY

Telephone: 0121 678 4854  
Email: [see website](#)  
Website: [www.westmidlands.csip.org.uk](http://www.westmidlands.csip.org.uk)

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