



HOMELESSNESS, MENTAL HEALTH AND WELLBEING GUIDE

**SECTION FIVE:
WORKING EFFECTIVELY WITH
EXTERNAL PARTNERS**

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- 5.1 Tips for working with mental health services
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5.1 TIPS FOR WORKING WITH STATUTORY AGENCIES

Supporting people who are homeless or vulnerable who also present with mental health or wellbeing issues can present a range of challenges for staff and managers. Mental health services can be difficult to navigate and present complex barriers for clients who need support. It can sometimes be very challenging to get the right support from mental health services, however building good relationships and understanding of how the mental health teams work is the key to getting adequate support for individuals. This section outlines a mental health team structure to help you make sense of the teams and support your clients may access. It offers tips on how to build a case for support for a client. We have also included a template joint working protocol that can be adapted to form a service level agreement between mental health services and housing providers. We have also included a developing and implementing partnership work diagram to support this process.

Improving your working relationship with statutory services

Having a working protocol or service level agreement with relevant statutory services can be extremely helpful (see 5.3), but not always possible. Informal relationships with local teams can often bring results for clients. Top tips include:

- Understanding what mental health services offer in your local area and what they can and can't do for clients
- Where formal joint working is in place, building on these links to maximize the support for clients
- Assigning a link worker
- Attending a team meeting and inviting them to yours
- Attending local forums
- Arranging joint training in homelessness and mental health issues
- Sharing skills
- Knowing the name of the person who can help when things get difficult.
- Attending care planning meetings and if you can't, sending written notes or your clients' latest support plans in advance of the meeting
- Demonstrating your professionalism, knowledge of clients and expertise
- Setting up shadowing for all new workers and reciprocating the offer so new CMHT members shadow your workers
- Keeping up to date with the mental health sector, signing up to newsletters and online forums
- Inviting mental health staff to client meetings
- Enabling informal regular communication

Understanding the pathways into mental health services

Mental health pathways will be different depending on the area you work in. Below is a table outlining possible mental health services structure that will help you understand the different teams' functionalities.

Health reforms

The way in which health services are funded, structured and delivered is currently undergoing change as part of the NHS health reforms. Local areas will have greater flexibility and local services are likely to vary, which means that the service structure outlined below is not comprehensive and could change. However you will probably have to work with GPs, health trusts, Community Mental Health Teams (CMHT), Crisis Teams (or home treatment teams), potentially specialist homelessness teams and other medical professionals within the hospital setting. It is important that you know which teams are in your local area and what pathways exist in and out of these services. It is important to understand where the decisions are made about how to get access to various provision and the routes to challenge any concerns or dissatisfaction. Teams not included in the structure below, but which may be relevant, include specific forensic teams and personality disorder services, so try and ensure you know how to access this support. However, hopefully this table of services will help you and clients to navigate services.

SERVICES	WHICH PROFESSIONAL THIS INCLUDES AND HOW TO REFER	WHAT ARE THEY FOR?	WHAT CAN THEY PROVIDE?
VOLUNTARY SECTOR SUPPORT	May include psychotherapist and psychoanalysts, counsellors, support and community workers. Referral route: Self-referral or contact local voluntary agencies on behalf of client	Can provide a range of support for mild and severe mental illness	A range of support, counselling, psychotherapy, alternative therapy, activities, treatments
PRIMARY CARE	General practitioners (GPs) and IAPT (Improved access to psychological therapies) Referral route: register with your local GP and make an appointment. Persist if you don't get the support initially	Mild to moderate mental health issues or any concern relating to mental health. GP's can be the gateway service to many other services. Stable clients should be managed by primary care	GPs may prescribe medication, refer to talking therapies such as counselling and CBT through IAPT; or refer to the CMHT (below) They may also refer you to alternative solutions such as nutrition and exercise programmes
COMMUNITY MENTAL HEALTH TEAMS (RECOVERY TEAMS)	Physiatrists Trainee, or junior psychiatrists called an SHO (senior house officer), CPN (community psychiatric nurse) Clinical psychologists Pharmacists Social workers Occupational health Additional therapists and support workers Referral route: Often via GP, however direct referral routes can be set up with homeless and housing providers if appropriate	CMHTs are responsible for residents within their locality. Their role is to provide a range of support services for people with more complex (severe) mental health issues that can't be resolved by a primary care intervention. This could include: <ul style="list-style-type: none"> - manic episodes, bipolar - delusional disorders - personality disorder - complex trauma (often with issues from childhood and homelessness) 	A whole range of support is available depending on need such as medication, psychotherapy, activities, housing and social care, hospital discharge support etc. often using what's called a care programme approach (CPA) CMHT staff work within the community from out-patient clinics, GP surgeries, day-centres, hostels and people's own homes
CRISIS RESOLUTION TEAM AND HOMETREATMENT	As above	Seek alternatives to hospital admission or long term CMHT treatment, again for people with severe mental illness.	Providing treatment within the home or providing early interventions to prevent unnecessary hospital admissions
DRUG AND ALCOHOL ACTION TEAM/ DUAL DAIGNOSIS TEAM	Specialist drug and alcohol professionals and psychiatrists	Providing mental health and substance misuse support	Often provide specialist advice, treatment, rehabilitation, detox intervention etc. For more info: http://www.drugscope.org.uk/resources/databases/helpfinder.htm
SPECIALIST HOMELESSNESS TEAM/ ASSERTIVE OUTREACH TEAM	The same professionals as the CMHT, but with a specialist knowledge in homelessness and excluded clients (only exist in some localities) Referral may come from homelessness services as working agreements are often in place.	Homeless clients, mainly rough sleepers with serious mental illness.	Specialist interventions, medication and talking therapies tailored to be specifically for homeless clients. Outreach tends to be flexible and can happen at sleep sites, hostels and day centres, however these teams are very rare
IN-PATEINT CARE	All of the professionals above, within a hospital setting Self referral, or via CMHT and approved mental health professionals, which can be the police, social workers etc.	Clients will be admitted if they consent to and would benefit from treatment and meet the criteria. Clients can also self refer. If clients do not agree to admission and are seen to be 'at risk' to themselves or others they may be admitted under the Mental Health Act (see section2)	A range of treatments and support (as above), but within a hospital setting

Where to find out about the *Mental Health Act*

As mentioned in section two it is important to understand the *Mental Health Act*. The main purpose of the *Mental Health Act* 1983 (amended 2007) is to allow compulsory action to be taken, where necessary, to make sure that people with mental illness get the care and treatment they need for their own safety or for the protection of others. Using the Act can be extremely stressful and can mean difficult decisions for clients and staff. Remember that individuals suffering with mental illness can admit themselves and can find the process useful. Being in hospital can be very distressing, however it can also be a positive place for recuperation and support. Staff and clients can work together with services to make sure an intervention is used effectively.

For more detailed information on the Mental Health Act and supervised community treatment orders (CTO) visit the department of health and website:

http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/DH_4002034

For all you need to know about the Mental Health Act and individuals' rights while detained visit:

http://www.rethink.org/living_with_mental_illness/rights_and_laws/laws_you_need_to_know_about_mental_health_act/index.html

The importance of making appropriate referrals

Making appropriate referrals will enable you to establish good working relationships with statutory mental health services. All services are stretched, so utilising them effectively is key. Remember their role is to work with people with severe and enduring mental illness; general mental health and wellbeing concerns should be referred to the GP. You may have to work hard to ensure that the mental health team delivers support for the most vulnerable as unfortunately their criteria threshold is strict and resources are limited. However they are there to provide mental health support and it may be your role to make a case for support to ensure clients get access to appropriate services.

Some advice on referrals includes:

- involve your client throughout the process
- always refer to the GP first and involve them where possible
- know the criteria thresholds for referrals for different teams and treatments
- know the pathways for clients and help them to know their possible treatment options
- understand diagnosis and treatment terms and definitions (see section 2)
- have a copy of their internal referral form (even if you can't use it)
- explain the behaviour that concerns you in detail
- if you are unsure about the referral, seek advice from the mental health team, GPs and voluntary specialists
- consider making a joint referral with another agency or practitioner
- consider whether another referral is more appropriate; it could be what we perceive to be a mental health issue actually requires interventions from voluntary projects, drug and alcohol teams, family, friends or the police such as safer neighbourhood team.

Most importantly, build informal lasting relationships with your local GP and CMHT and advocate for your clients. Encourage mental health services to be flexible in their approach/access criteria and offer them support in return. You are not expected to be a health professional, but knowing more about how it works will help you to be empowered to support clients more easily. For more information on diagnosis, treatment and definitions see section two of this guidance. Also the organisations below have extremely useful guidance:

MIND: <http://www.mind.org.uk/>

Rethink: <http://www.rethink.org/>

Royal College of psychiatry: <http://www.rcpsych.ac.uk/mentalhealthinfo/communityteam.aspx>

5.2 BUILDING A CASE FOR EXTERNAL ASSESSMENT AND SUPPORT

If you feel a client you are working with demands extra external support and is showing signs of serious mental illness you may need to build a case to effectively engage secondary support. This should be done through the GP, however clients may not always be linked in with the GP, especially if the client is rough sleeping. If you are filling in the referral form or writing a letter to ask for support, make sure it is accurate and gives as much detail as possible about the behaviour of the clients and the concerns you have regarding their mental health. Mental health secondary services are often under resourced and only able to work with high threshold clients, however if you are sure that your client is in need and meets this threshold as established in the assessment section of this guide then the tips on referrals below may help in ensuring an assessment and on-going support is established.

Top tips for filling in mental health referral forms

- Ensure you are clear and accurate about the level of need the client is facing
- Explain the behaviours that are concerning you especially if they are potentially putting the client or someone else at risk
- Fill in **all** the information you have (the forms can be long, but the more you can help the team, the more they will help you)
- Include information about GPs and other supporting agencies
- Detail is useful; think about risk and history
- Be sure to explain where things have happened on more than one occasion and be as accurate as possible about time frames, for example 'Jim has talked about suicide on more than occasion over the last week' or 'Carrie has become increasingly forgetful and has left the oven on and the door unlocked several times this month'.
- Outline any other factors that may be contributing: personal circumstances, drug and alcohol use, exploitation and vulnerability
- Explain any deterioration that you have noticed
- Consider issues such as culture and background
- Understand capacity and what it means; just because somebody is making 'unwise' choices that are potentially detrimental does not mean they have a serious mental health issue.

After the referral

If a referral is not an emergency it will usually go to a team meeting, where referrals will be discussed weekly and decisions will be made as to whether assessment is necessary. If an assessment is required then the CMHT will invite a client for an appointment, however CMHT's should be able to come out to services if necessary. If you have made a referral and the client and you are unhappy with the decision made by the CMHT for any reason you need to ensure you know the routes to express your on-going concerns. If you think a client needs support, but isn't receiving any due to lack of assessment or an insufficient assessment contact the team manager or the operation lead and explain your concerns. If you do not feel that your client is being adequately supported and they are in distress it is important that you continue to follow this up; keep an audit trail of your attempts to receive support and monitor the client to ensure you know whether the clients is improving or deteriorating. Other powers such as the safe guarding vulnerable adults may enable you to access support for a client if you still feel concerned about an individual.

For more information, please see the SCIE Report 39: Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse:
<http://www.scie.org.uk/publications/reports/report39.asp>

5.3 EXAMPLE PROTOCOL FOR WORKING WITH EXTERNAL AGENCIES

Individuals who are rough sleeping or accessing homelessness services often experience complex needs including mental health and drug and alcohol issue. It is crucial therefore that services work together to meet the needs of this vulnerable group to ensure clients do not fall through the net and be victims of complex bureaucratic systems. A range of services including local authority social care, mental health services and housing support may need a joint working protocol to ensure individuals' needs are met.

The document below has been put together as a draft protocol or service level agreement for mental health and housing agencies working together to ensure the mental health needs of homeless clients are met. We recognise that individual services will have different needs and commissioning contracts and constraints; however this should act as guide around focusing on the main issues and finding ways to work together proactively. If services build barriers between each other and do not find ways to overcome differences in approach it is clients who often lose out on receiving the appropriate support. It is the responsibility of services to work together to achieve appropriate support pathways for vulnerable people.

Possible barriers of working together

- Low resources
- Lack of understanding of capacity and expertise
- Too high/ low expectations of service delivery
- Competing outcomes
- Approach

Good practice solutions

- Joint working protocols
- Shared training and learning resources and opportunity
- Joint commissioning

Joint working protocols could include:

- Referral procedure: pathways, who can refer and how (share paperwork)
- Eligibility criteria: who can receive secondary mental health care
- Emergency protocol: what happens when someone is in crisis
- On-going support: what can you expect from staff who are supporting residents within the CMHT
- Hospital discharge: what are the forms of communication
- General support
- Informal expert support and advice
- Explicit guidelines: timescales of appointments and reviews should be known and understood by both services
- Flexibility and understanding.

See appendix one for an example protocol.

APPENDIX ONE: HOMELESSNESS AND MENTAL HEALTH TEAMS – JOINT WORKING PROTOCOL (TEMPLATE GUIDE)

Introduction

The aim of this protocol is provide clarity to both the housing providers and mental health teams about reasonable and realistic expectations and to promote good collaborative working. The document should enhance effective joint working across agencies. This protocol also aims to establish agreements around communication systems and procedures, as well as naming particular workers as points of contact in both organisations. Use appendix two to help you implement the policy effectively. Please use this protocol in conjunction with appendix two.

Referral procedure

Clients should initially be referred to mental health services via the GP, however if this is not feasible or clients are already in contact with services then clients should be referred via letter or referral form send directly to the mental health team manager. If regular meetings happen between teams then referrals should be discussed within these meetings. Referral forms should give as much detail as possible regarding the client and use appropriate language to inform staff of the client's current situation regarding their mental health. General referral forms should be responded to within 1 week (where possible) of receiving them. If referrals are not accepted, mental health teams should offer feedback to housing staff. Housing staff need to continue to support, monitor and review the client's needs and refer the client again if their situation worsens.

Eligibility criteria

A clear eligibility criteria needs to be established and communicated to the housing staff about who can access mental health services and what a serious and enduring mental health need is. This can happen via training or information days. Housing staff must only refer clients who meet this level and will make every effort to support clients in whatever way they can who are close to the threshold to prevent deterioration. Disputes about eligibility should be taken to the relevant manager or operation lead to ensure vulnerable clients are supported.

Assessments

Mental health assessments should be completed within 3 weeks of referral; if clients wish, hostel staff should be able to accompany clients during assessments. Hostel staff should have an awareness of what an assessment entails and make every effort to reassure and support clients through this process. Mental health assessments should include information and intelligence from hostel staff and any other relevant carers and practitioners. If hostel staff are not happy with the outcome of an assessment and they are concerned about the welfare of a client they should consult with their manager and present the case to the lead of the mental health team.

Emergency protocol

If a client is in crisis and is in contact with the mental health teams the local crisis intervention team need to be contacted. A&E should be a called if a client or anyone else is in danger. If a client is detained under the *Mental Health Act*, communication between staff needs to frequent and transparent. Hostel staff should have a full understanding of the Act and work with mental health teams to help ease the process for clients.

On-going support

On-going and open dialogue methods between staff need to be established and acted upon. Care plans need to be shared with housing staff and changes to care plans including medication and support hours must be communicated. Hostel staff should be invited to CPA/case conference meetings and mental health staff should be invited to key work sessions where helpful and relevant. Both professionals should update one another on any incidents concerning changes in behaviour or mood that alert concern or improvement. Client aspirations and outcomes should be discussed and planned collaboratively with the client at the heart of the decision-making. Concerns from housing staff about a client's welfare, i.e. a major change in behaviour or a sudden decline in wellbeing needs to be taken seriously by mental health teams.

Hospital discharge

This should be planned and communicated. If clients are to be released early, hostel staff should be informed so they can arrange transport where possible. Rooms should be kept available for clients even when in hospital for long periods of time. However if repeat hospital admission occurs, new housing options should be considered to meet changing client need.

Informal expert support and advice

Mental health staff should make every effort to ensure they offer informal expert advice and support to concerned hostel staff. Effective communication prevents inappropriate referrals and deteriorating mental health and wellbeing needs of clients. Joint training and work shadowing opportunities should be provided where possible.

Substance misuse

Where clients are using alcohol or drugs all professionals should work jointly towards a shared action plan. Clients should not be denied access to mental health services if substance misuse is an issue. Intelligence and information about the underlying causes of substance use must be communicated.

Approach

Ensuring that both mental health and hostel services adopt a similar approach can help collaborative working. Mental health services are all moving towards *recovery*, which dovetails with personalised responses and person-centred, outcomes-based models delivered within homelessness good practice.

Complaints

Methods to express concerns of any kind regarding support from both housing and mental health should be easily accessible and transparent. Both services need to ensure service user input is an active learning process and should never feel it may impact upon the working relationship negatively.

Key information

Both services should ensure they are aware of the following

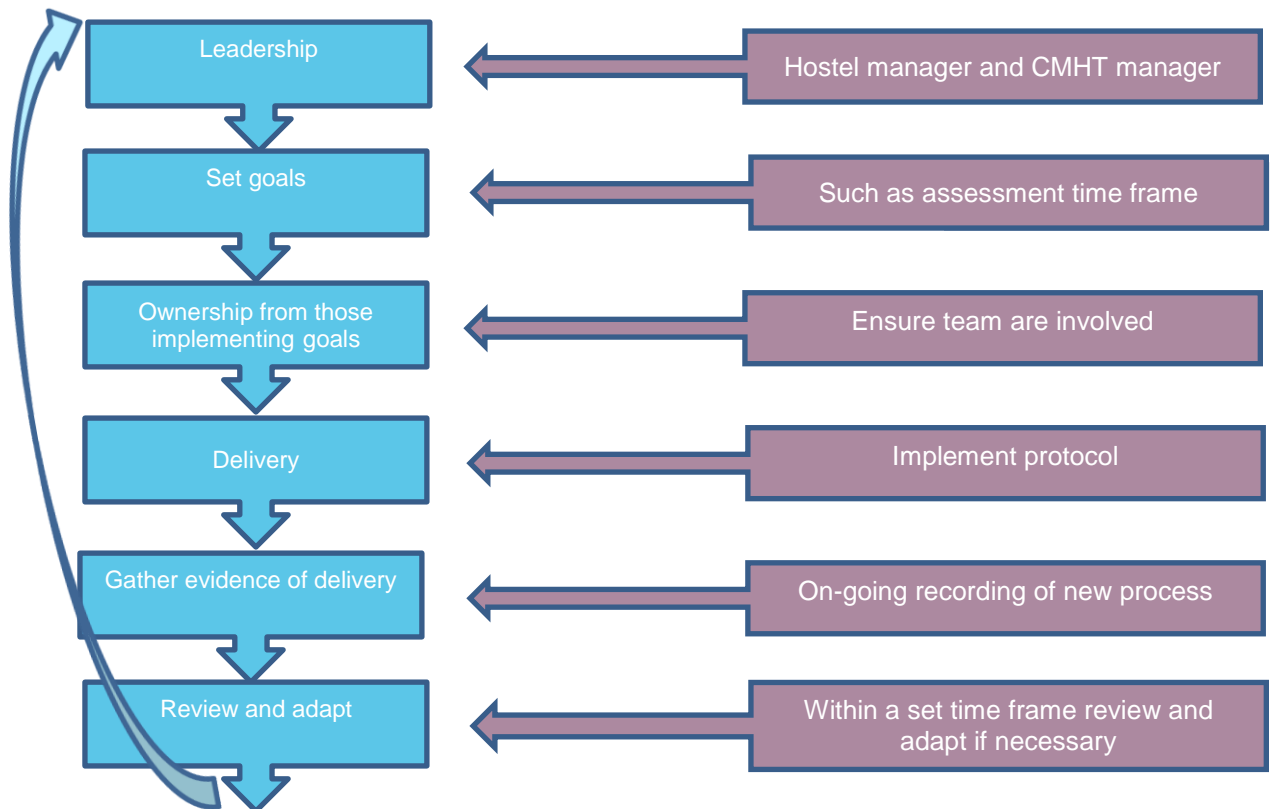
- Name of lead worker
- Capacity time allocated to work with project
- General capacity time to work with individual clients
- Length of time allocated to work with clients (example 2 year stay hostel, 6 month counselling service offered)

Other good practice includes:

- A link contact worker for advice and support when clients present with challenging behaviour
- Offer clear and transparent referral routes
- Joint training and shadowing opportunities for mental health and housing support staff
- Case workers to attend any local task and targeting rough sleepers group
- Drug and alcohol teams also work jointly and adhere to the service level agreement
- Share information on a need to know basis in a supportive and democratic way
- Gain a full understanding of what housing support services can and can't provide

APPENDIX TWO: DEVELOPING AND IMPLEMENTING PARTNERSHIP WORK DIAGRAM

Implementing new protocols or pathways within services requires leadership from managers as well as ownership from all partners delivering on the ground. This flow chart describes how implementing a partnership or protocol as outlined in section 5.3 may work and the processes you need in place to ensure it is developed accordingly.



Implementing a new protocol should include a continuous cycle of review to enable any sticking points in delivery to be raised and adapted where necessary. Team leaders or managers need to lead the process of change, however staff delivering the new protocol should be involved in its development and feel real ownership of the process. Methods to review and alter the delivery function need to be robust and delivered within a specific time frame. Once again this needs to be led by management.