Working with Statutory Mental Health Services

A Guide for housing and homelessness staff – updated 2022

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Homeless Link

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Contents

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Your work and why it matters

When you come across someone in distress, or with a mental health problem, what can you do? Start by thinking about how you can support them in the here and now. People with mental health problems are often marginalised and isolated. Just being there or helping them with a small practical problem can help them to feel less alone.

It is a myth that only specialist services can make a real difference in providing treatment and care for mental health difficulties. This is not the case – don't underestimate your value to a client. What you do will make an impact, even if they are also seeing a specialist service. It is also tempting to think that, once a client is seen by mental health services, a solution to their difficulties will be found. Unfortunately, this is often not the case. Clients can be reluctant or unable to work with services, or they may present with problems that mental health services simply cannot resolve. And if a client does accept a referral to a mental health service, you may well be needed to support them through the delays and frustrations that often happen during that process.

The best way to get a good outcome for a client with mental health difficulties is for every service involved to work collaboratively. This can create a durable and mutually supportive network for the client. We know that people with mental health difficulties need more than medication or psychotherapy. Recovery demands attention to a client's social situation, and support within their normal environment. Specialist services can usually deal with medication and psychological interventions, but social interventions can be limited within statutory services, despite these being a powerful and valued tool in a person's recovery. Thankfully, social interventions can be made by anyone, in any organisation. Supportive and trusting relationships between workers and clients can often bring about as much change as specialist interventions, although often, a holistic package of support is needed.

As in many public services, there have been drastic cuts in mental health over the past few years, which has resulted in thresholds for service provision being higher, and the length of provision often being reduced. Ten years ago, most people with complex mental health difficulties would have remained under the care of mental health services for many years, but now, it is the expectation that people will be discharged to their GP for ongoing management, often even where they continue to have significant need, or present with significant risk. As such, the need for ongoing support and monitoring often has to fall to external organisations such as homelessness services, with care being provided by non-specialist workers who already have complex and demanding caseloads. This guidance aims to support you in developing your confidence to work with people with mental health difficulties, understanding what you can do within your role, and when you might need to involve other agencies.

What can you do to help?

There are some simple things you can do to help someone with poor mental health. These include:

- Stopping to chat and taking time to check-in with people, especially where you know someone tends to try to minimise or hide their feelings.
- Offering basic support, such as suggesting a cup of tea or something to eat can be a good way to start a more in-depth conversation. Some people find it easier to talk more openly when they have a different focus.
- Asking people what help or support they might like. Many homeless people have lacked support over protracted periods and have had to learn to live with distressing feelings or symptoms. As a result, they may view these as 'normal' for them, and may not know that something can be done to help them feel better.
- Help them to register with a GP, as this is often the first step to accessing services.
- Offer to make them an appointment with their GP or clinic, or offer to accompany them there.
- Put them in touch with other services who may be able to help.

It isn't always necessary to involve another agency, especially where symptoms and risks are low, and the person doesn't want input, but if a referral is needed, try to see that as part of an extended support system rather than a replacement support system. Consistent input from a trusted person is essential, especially while people may need to tolerate fairly difficult assessments or processes in the early stages of getting specialist support.

How can you better equip yourself to help?

When you work with someone who is distressed or has mental health difficulties, it can impact on your own wellbeing. You need to feel safe and well in order to effectively support others. Many homelessness organisations have developed practices and policies which explore trauma informed care (TIC) and psychologically informed environments (PIE), both of which aim to support the wellbeing of both clients and workers. You can find out more about these approaches, and how they might best inform your practice, here:
Trauma Informed Care and Psychologically Informed Environments | Homeless Link

Some tips

- Look after yourself physically and emotionally and you will be better able to help others. Ensure you pay attention to your own needs as well as the needs of your clients.
- Working with people who have experienced trauma can, in itself, be traumatising. It is no negative reflection on you if you find this challenging, and in fact, shows empathy and compassion.
- Don't try to manage difficult situations alone. Talk with colleagues about your concerns, thoughts, and feelings, and ensure you prioritise your supervision sessions with your manager. In particularly distressing situations, it may be appropriate for your manager to make arrangements for you to have debriefing sessions, or your own psychological support or counselling through Occupational Health.
- Discuss your decisions with colleagues if you feel unsure. Feelings of helplessness and not knowing what to do to help someone with complex mental health needs are common and entirely understandable.
- Support your colleagues in their decision making. Collaborative working with colleagues can be an enormously helpful learning tool for you and for colleagues.

What else can help?

We know that people need physical safety and security, including stable accommodation, before they can heal, develop, and reach their full potential (you can look up Maslow's Hierarchy of Needs for more on how meeting basic needs is the catalyst for meeting more complex needs). Homelessness services often meet people when they are at their most vulnerable and disturbed. Those initial contacts can be absolutely crucial in laying the groundwork for developing a trusting relationship between client and worker, and consequently in a person's subsequent ability to develop other trusting working relationships.

Alongside you and your work, many other agencies and networks should, or could, be involved. It is important to work closely with them and encourage the person to do so too. These might include:

- GP
- Mental Health Teams
- Housing Department
- Job Centre/Benefits Advisory Services
- Drug and Alcohol Services
- Voluntary Agencies such as Mind
- Religious organisations
- Cultural organisations
- Family and friends

Your responsibilities

When you first start working with a client you need to ask for signed consent to share information and clearly explain that this might include making referrals to other organisations, including health services. This is far more than a signature on a piece of paper, and you should ensure that the person understands the benefits and potential risks of information sharing, in order to be sure that they can give valid consent.

Clients may refuse to give this consent or they may lack the capacity to consent, which can cause significant issues in a person accessing the care they need. You need to:

- Be aware of what the law says in terms of what you can and cannot share without consent.
- Make sure that you clearly record any decision to share or not share information, along with the justification for your decision.
- Discuss such decisions with your manager.
- Remember that if someone is unable to give their valid and informed consent as a direct result of having an impairment of, or disturbance in the functioning of their mind or brain, you would need to assess their capacity to make the decision to share information.

You can find further information and guidance about using the Mental Capacity Act here Microsoft Word - Mental Capacity Act guidance (homeless.org.uk).

The Social Care Institute for Excellence provides some useful guidance on information sharing in regard to Safeguarding Adults, but the principles and law are also applicable with regard to referrals and sharing mental health information:
Safeguarding adults: sharing information | SCIE

As a general rule, if you have serious concerns for a client's wellbeing or safety, or for the safety of others, you should not automatically take their lack of consent as a reason for not taking action. There have been many investigations and reviews which have looked at critical incidents that have occurred after a person refused consent to share information or engage with services, and fault is nearly always found in the process of determining whether that decision should be followed or not. Always ensure you discuss such situations with your manager, and carefully record the decision and rationale for the decision, paying particular attention to risk criteria and the law on information sharing.

If you do not have serious concerns, but just feel that a referral would be helpful, it is unlikely that it would be justifiable to breach a client's confidentiality. The risks of referring to a mental health service without consent (such as loss of trust and subsequent refusal to engage with you) are unlikely to outweigh a client's right to make their own decision, even if you think it is an unwise one.

Mental Health: Primary Care

Where to start

Where there does not appear to be an immediate risk to a person or to others, start by contacting the client's GP. The GP will be able to decide whether it appropriate for them to see the client to assess their needs, or whether the situation warrants a referral without that initial assessment due to the urgency or risk (this is quite rare, as mental health services will usually expect a GP to have assessed where possible).

GPs may well know a lot about the client's mental health needs and difficulties, and may feel that they can manage their needs without involvement from other services. In recent years, there has been a move towards managing people's needs in primary care where possible, so even where someone may present with significant difficulties, it may be that the GP has an appropriate plan in place to manage their needs.

In most circumstances, it is a good starting point to advise someone to discuss their mental health needs with their GP, or offering to help them to do so.

The care available

A person experiencing homelessness is far more likely than the general population to have poor physical and mental health, and to be using too much alcohol or street drugs. Ensuring that they are registered with a GP is essential in order to meet their often extensive needs. GPs often act as a hub for someone to access many other services, and may well have relationships with services that enable them to more easily access advice and support, even when the person isn't willing to accept a referral.

Many GP surgeries now have direct input in their practices from mental health workers, usually Community Psychiatric Nurses. Some clients may find accessing mental health care in their local surgery easier or less worrying than having to go to a specialist service.

Psychological input such as Cognitive Behavioural Therapy can also now be arranged in primary care services, usually through borough-wide services under the umbrella name Improving Access to Psychological Therapies (IAPT). Many IAPT services also take self-referrals, though in more complex cases, it may be more appropriate for a GP to make a referral.

These primary care services are suitable for people with mild to moderate difficulties, with lower levels of risk, who can be safely and effectively managed without more specialist input, over a brief period of time. They are unlikely to be able to meet the needs of people who have more complex needs, or who present with significant risk, such as people who are using substances to cope with their symptoms, self-harming, or experiencing suicidal thoughts.

If your client is not registered with a GP

In some areas, mental health services will say that they can only see clients who are registered with a GP in their borough or service-area (although this can be challenged, especially where there are significant risks). Always try to help someone to register with a GP when you first start working with them, as this will make it far easier and quicker to access specialist services should they be required.

Homeless people have often found it very challenging to register with a GP, as some surgeries have refused registration if a client is unable to provide certain documentation. Should this be the case, you can challenge a refusal using the information in this NHS document (section 4.9):
B0134-primary-medical-care-policy-and-guidance-manual-v3.pdf (england.nhs.uk)
This sets out that:

- GPs can use the surgery address to register someone who has no fixed abode.
- GPs cannot refuse to register someone who cannot provide identification, proof of immigration status, or proof of living within their catchment area.

For clients who do not want you to help them with registration directly, but who are struggling to register with a GP, you can print out a 'My Right to Access Healthcare' card from this web site, which reminds GP receptionists of the duty to register homeless patients:
'My right to access healthcare' resources - Healthy London Partnership Partnership

Some areas also have specialist GPs who work with homeless people.

GP surgeries have been part of Clinical Commissioning Groups for the past few years, but recent changes are seeing them subsumed into Integrated Care Systems (ICS) for different geographical areas. Each one should have systems in place for ensuring that homeless people have full access to medical care, so you should contact the ICS for your area for advice if you are refused GP registration for a client on the grounds of homelessness.

Mental Health: Secondary Care

The structure of secondary care mental health services provided by the NHS and Local Authorities varies from place to place. You will need to find out how things work in your area, but usually there will be an NHS Mental Health Trust for an area, with some involvement from the Local Authority. For many years, it has been usual for mental health teams to be integrated partnerships between health and social care, but in recent times, some teams have separated, with the main mental health service being provided by the NHS, with a separate Local Authority team with specific roles rather than for general input. This has meant that it isn't always clear where referrals should go, but in the main, most mental health referrals should go into an NHS team in the first instance.

Initial Referral

It is increasingly difficult to give generic advice on how referrals should be made into mental health services, given the now huge variation in how services are arranged. In the past, most teams covered a small geographical caseload, and provided a full range of services for differing conditions within one team. There is now an increasing trend towards having teams covering larger areas, but having much more defined roles, such as individual teams for managing initial referrals, assessment and short-term input, and long-term treatment teams.

Unfortunately, this means that it is more difficult for you to establish where referrals should go but, as a general rule, you should be able to find out by looking up 'NHS mental health service' + the area you are working in. GPs will know the referral process for their area, so if you are unable to find out, the client's surgery (if they have one), should be able to advise you.

At the point of referral, any clear needs should be identified to ensure that the client can be contacted and assessed. For example, if they require an interpreter, or are prone to aggressive behaviour, this should always be highlighted at the referral stage.

Providing clear information can help the receiving service establish whether they are the right service to assess, or whether the referral should be passed to another team. For example, if a referral identifies someone as experiencing psychotic symptoms for the first time, the generic adult mental health team would be likely to pass the referral directly to the First Episode/Early Intervention in Psychosis team.

Examples of the differing referral processes from three London Mental Health Trusts:

Ealing (under West London Mental Health Trust)
GP refers to 'MINT' (Mental Health Integrated Network Teams) which provide a single point of access for assessment and treatment within that team. The service is for those aged 18 and over.

Continued over.

Wandsworth (under South West London and St George's Mental Health NHS Trust) Referrals to a 'SPA' (single point of access team) are mainly from GPs, but they will accept referrals from other agencies where there is a clear description of serious mental health difficulties. The service is only for people aged between 18 and 74 years old. Assessments are carried out by the SPA, and onward referrals made to other specialist teams should any further interventions be required.

Westminster (under Central and North West London NHS Foundation Trust) Referrals also to a SPA for children and adults of any age, from clients and organisations. Urgency and pathway to services are established by the SPA, and if someone is felt to require an assessment, they are referred on to one of their locality Community Mental Health Teams.

Assessment

In order to establish a client's needs, mental health services will need to carry out an assessment. This usually follows a clear format, covering a person's symptoms, their physical and mental health history, social situation and history, family history, and risks. It can feel intrusive for a stranger to ask so many questions, which often need to be personal and detailed, and some clients may struggle with this, particularly those with a history of abuse and trauma. It is their right to ask for you or another trusted person to stay with them during the assessment, though an assessor may ask if they are comfortable to speak alone for a period of time.

Following the assessment, the client may be advised that they will be contacted with the next steps, as assessments, particularly of complex cases, are usually discussed within the multi-disciplinary team in order to reach a decision about what services to offer.

Longer term support

Longer term teams have a focus on recovery, with the aim of getting people to a point where they can be supported in primary care services. These teams are usually multi-disciplinary to provide a holistic range of care, and may include Psychiatrists, Community Psychiatric Nurses, Social Workers, Support Workers, Occupational Therapists, and Clinical Psychologists. Following the assessment of need, a client will usually be allocated a named Care Coordinator, who will be responsible for their care. Sometimes people only see a psychiatrist, but other people who have more complex needs, may see multiple professionals from the same team.

Clients should receive a care plan, which should include what support is going to be provided, and who will provide it. This should be regularly reviewed, and all involved agencies should be invited to attend if the client consents.

These teams may also act as gatekeepers to other specialist services that only accept referrals following a comprehensive mental health assessment. Examples of such services might be Psychotherapy or Forensic Mental Health Services.

As with all services, Care Coordinators often have very high caseloads, and may have days when they are unavailable due to covering other team business, such as carrying out Mental Health Act Assessments. This can make it difficult for you to get your client seen quickly, or to get advice on what to do. In such circumstances, if you have significant concerns, you should always ask to speak to the Duty Worker, who will be able to advise you.

Home Treatment Teams

Confusingly, these teams are often referred to as Crisis Teams or Crisis Resolution Teams, although they are not available to everyone in a crisis. They have a very specific role usually, to provide an alternative to inpatient treatment for people experiencing a mental health crisis, by providing a high level of contact and support. They will often provide intensive treatment, seeing clients once or twice a day, either to prevent admission to hospital, or to facilitate someone's early discharge from hospital.

Home treatment teams usually only accept referrals from Assessment / Referral / Recovery teams rather than from outside organisations, as their role is very specific, and they are often the gatekeepers for hospital admission. They will carry out their own assessment to determine whether they feel a client can be safely managed with their input, or whether that person should be admitted to hospital because their illness and consequent risks cannot be managed safely in the community.

Home Treatment Teams will often not be willing to assess if a person is street homeless, because of the difficulties in providing an intensive service, and monitoring risk, in an uncontrolled environment.

Although you may feel that your client is in need of a higher level of support, there are many reasons why a Home Treatment Team may not take on a client:

- Some teams are very medication-focussed in their approach, and if there is no clear need for someone to have their medication supervised every day, home treatment might not be offered.
- Clients are likely to be visited by different members of staff each day rather than the same person. Some people find this approach very difficult, especially those who struggle to build trusting relationships.
- Risks are not felt to be very high, and there is no need for daily monitoring.

- Where someone is comfortable with the support they receive from other agencies and this could be increased to provide additional support for the period of their crisis.
- Where a client has a tendency to become overly dependent on services (such as those with Dependent Personality Disorder, or some anxiety disorders), it may not be helpful for them to have intensive input, as it is likely to reinforce their belief that they can only feel better with this type of support.

Hospital Admission

There are a number of routes by which a person may be admitted to psychiatric hospital:

- If they are able to give valid and informed consent to their admission, and they do so, they can be admitted voluntarily.
- Under the Mental Capacity Act (MCA). If someone is unable to give their consent (due to 'an impairment of, or disturbance in, the functioning of the mind or brain'), they could be assessed as lacking capacity to make that decision, and a Best Interests decision made to admit them. This option is only available in cases where the client has no identifiable objection to admission or treatment.
- Under the Deprivation of Liberty Safeguards (DoLS) part of the Mental Capacity Act. This is relatively rarely used in acute psychiatric hospitals, but is possible for those identified above as being admitted in their Best Interests due to lacking capacity to consent, but for whom the restrictions on them amount to a deprivation of liberty. This requires specialist assessments to be carried out. NB the Deprivation of Liberty Safeguards are soon to be replaced by the Liberty Protection Safeguards, though these will have similar powers for inpatients.
- Under The Mental Health Act (MHA). This is used to formally detain people who are felt to require hospital admission, but are unwilling to consent to this (or unable to consent but object), or who consent but are very likely to change their mind. The MHA can only be used by specially trained staff. People often refer to 'being sectioned', but professionals will usually use the term 'detained'.

The Mental Health Act

For someone to be detained under the MHA, they need to have a mental disorder which is of a 'nature and/or degree' which warrants their detention in hospital, and present with risks to their health or safety, or risks to others, which warrant their detention.

In order to be detained, a person needs to have an MHA assessment. These are usually carried out by:

- An Approved Mental Health Professional (AMHP).
- A section 12 approved Doctor, with special training and experience in psychiatry.

- Another Doctor, preferably the GP (though this is very rare), but usually an independent Psychiatrist.
- The Home Treatment Team.

MHA assessments can take place wherever the person is, although sometimes, for safety reasons, a person may be bought to a place of safety for assessment, usually by the police (if the correct legal procedures are in place).

The team have the complex job of assessing the person's need for treatment, risk management, and care, against their right to decide for themselves whether to go to hospital, in order to reach a conclusion as to whether they meet the high threshold for detention. To detain someone is a very serious act, which can be highly distressing for clients, so is a decision never taken lightly. There could be a number of outcomes of an MHA assessment:

- No follow-up.
- GP follow-up.
- Follow-up from a community mental health team.
- Intensive treatment from the Home Treatment Team.
- Informal/Voluntary admission with the person's consent.
- Admission under the Mental Capacity Act if the person lacks capacity to consent to admission, but doesn't object.
- Admission under the MHA.

It can be worrying if your client is not admitted to hospital following an assessment. The AMHP who carried out the assessment should be able to explain the rationale for the decision taken, and talk to you about what might be helpful in terms of what you, and other services, can provide on an on-going basis.

The Role of the Police

In an emergency, when you cannot wait to speak to mental health services for advice, the police should be called. This would be when a person is presenting with severe symptoms or distress, and with immediate and severe risk of harm to themselves or others. It is important to remember that, while the police are not mental health professionals, they often play a vital role in keeping someone safe when they are acutely unwell and at risk of serious harm. The police have training in working with people in mental health problems, and are often very good at treating the person with sensitivity and compassion.

It is most likely that the police will contain a dangerous situation and then call in support from mental health services. If the person is already under a team, it would be helpful to call them and alert them to what is happening, so that they can take appropriate action if required.

The police have a range of powers they might use if someone is behaving aggressively or in a way that might cause immediate harm to themselves or others:

- They can intervene to prevent a breach of the peace, which might just be taking the person aside and speaking with them about what is happening.
- If they believe the person has committed a crime, they might arrest them. However, this is much less common than it used to be if a person is presenting with symptoms of mental disorder, due to a long-awaited move towards diverting people experiencing mental disorder away from the criminal justice system.
- If they feel that the person is in need of urgent mental health care, they might suggest that they take them to a hospital A&E department or to the person's mental health team if the person is willing (or if they lack capacity to make the decision but don't object).
- If the person is unwilling to attend hospital, and they are presenting as being mentally disordered and in need of urgent 'care or control', the police can use their powers under section 136 of the MHA to take them to a place of safety where they can be assessed. These are usually specialist rooms in psychiatric units, usually referred to as 136 Suites, or POS (Place of Safety) Suites. Using section 136 is only an option open to the police if the person is in a place 'to which the public have access' – they cannot remove a person from their property using this section.

There will be times where you have concerns for a person but the police do not feel that they meet the threshold for use of their legal powers, such as when the person has calmed down before the police arrive. In such situations, you should ask the police for their reasons for not taking the person for assessment, and then speak with the GP or local mental health team in order for them to facilitate assessment.

Referring to Mental Health Services

As highlighted earlier in this guidance, the mode of referral very much depends on your area. You may be able to make a referral via telephone, but some Trusts will require a written referral. It is preferable to ensure that you have reviewed and written down the information in this section, if you are referring by phone, so you ensure that nothing is missed out that might delay the referral or affect the decision of the mental health team.

If the person is able, and the local service allows for self-referral, try to encourage this where possible. This will help the person feel more involved in their care, and encourages them to take responsibility for their needs. They may well need support to do this, but try to make them as much of an active participant as possible. Even small steps can be helpful, such as encouraging them to make an appointment with their GP at a time they feel they can manage. Many people feel out of control when they are experiencing mental health difficulties, and it is important to support them in a way which gives them as much of a sense of control as possible.

When talking with your client, think carefully about how you frame a referral to mental health services. It can be tempting to 'sell' a referral, because you think they might otherwise refuse to accept it, but giving people unrealistic or overly positive information means that they are not truly giving informed consent. It also means that people may be disappointed if their expectations are not met, and their relationship with you may suffer if they feel they have been misled. Instead, try to clearly explain the possible outcomes of a referral, and help people to explore any worries they might have about being referred. If people understand that a service may not accept the referral, but that you will speak to them to help them plan another way forward, they may feel less concerned.

What to include in your referral

Whatever the referral process is in your local area, preparing your referral carefully is key. Many mental health services are over-stretched, and need to make decisions quickly about who needs to be seen and when, which means that they rely on the referrer to provide all the relevant information. It is often the case that services have many more referrals than they have available appointments, and they have to prioritise appointments based on the needs and risks identified in the referral.

When referrals are rejected or delayed, it is sometimes because the mental health service did not have access to the relevant information. Wherever possible, the referral should be made by the person who knows the client best so that they can clearly outline the concerns and, if necessary, answer any questions.

There is a detailed checklist to refer to in the Appendix to this guidance, which outlines what should be included in a referral. In summary, this should include:

- Client's name, date of birth, last known address, current location and how long they have been there (if street homeless).
- A contact number for the client and for you, and detail as to the best way to contact the person if they don't have a phone.
- Client's consent to share information (or explanation as to why obtaining consent wasn't possible).
- Client's GP details and any recent appointments.
- Client's medical history (as far as you can establish):
    - Medication prescribed and whether they are taking it.
    - Allergies.
    - Medical conditions.
    - Drug or alcohol use.
    - Previous mental health service contact and any known diagnosis.
- Your concerns.
- Risk issues to self and/or others.
- The level of support you are providing, and details of any other agencies providing support.
- Level of urgency.

If you believe that your client may be unable to make some of their own decisions, it may be appropriate to reference the Mental Capacity Act Screening tool. This would be especially relevant if you feel that they lack capacity to consent to the referral being made or to accept support with their mental health problems due to a lack of insight. The toolkit is available here:
Mental-Capacity-Act-screening-tool-for-out-reach-workers.pdf (pathway.org.uk)

There will always be situations where you simply don't have all the information you would want or need, usually when the client is new to your service, or when they are reticent to disclose much. Try to get all the information you can, and if you cannot get it, explain why in the referral, as this may be helpful information in itself, such as if a person seems very guarded or suspicious about your motives for asking questions.

What language to use

It is normal to feel anxious when working with someone who appears very mentally unwell, and this can lead us into using overly-dramatic language. Try to ensure that your language accurately portrays the person, and be specific about what you think might be of benefit to them. For example, if you feel concerned about the possibility of self-harm, ensure you explain why you believe this to be likely. Is it because they have showed you their injuries? If so, what is the type and seriousness of these injuries? Self-harm takes many forms from entirely superficial (such as repeatedly making scratches with fingernails) to extremely dangerous (such as swallowing needles). If someone has injured themselves in a potentially serious way, ensure you detail what medical attention, if any, has been provided. Without the detail of the self-harm, services will be unable to make an accurate decision as to the urgency of the situation.

Similarly, be cautious about making statements you cannot justify. For example, describing someone as 'dangerous' would need to be backed up by clear explanations and examples of what they have done to make you believe this. Referrals to mental health services become part of someone's health record, and statements must be accurate because they can have an on-going impact on risk assessments, and on the care that can or cannot be provided. For example, some services, such as some primary care services, will have criteria that excludes people who have a history of harm to others. Given words such as 'dangerous' have a habit of being repeated, even when there is a lack of evidence to support them, they could be excluded from accessing some services without any real reason.

Avoid generic terms and phases. Mental health services frequently receive requests for clients to be 'monitored' or 'supported', which are too vague and do not help them to identify what the client needs. In your experience of the person, are there things that are helpful or unhelpful? Does the person find regular telephone check-ins help them to reduce their anxiety or distress, or do they find it more helpful to have a longer meeting face to face?

Use language that you feel comfortable with. You don't need to use medical terminology. It is more confusing for services to decipher referrals where someone has used medical terms without fully understanding them or being able to describe them. For example, your client might be speaking incredibly quickly and loudly, without pauses to let you speak. Mental health workers may refer to this as pressure of speech, but your plain English description of how their speech is coming out will be entirely sufficient for a mental health worker to know what you mean.

Sometimes referrers will try to summarise their concerns by using umbrella terms such as 'psychosis' or 'depression', rather than describing symptoms. Unfortunately, this is rarely helpful because there is a vast range of severity in presentations; one person with psychosis might be able to function quite normally, and another might need to be admitted under the Mental Health Act due to the risk associated with their symptoms. You are far better off outlining the way that the person is talking and behaving, as this is likely to provide a far clearer depiction of their difficulties.

Some example referrals are included at the end of this guidance.

Making effective referrals

When services are overstretched, relationships between services can become quite fraught, and this is often the case between homelessness and mental health services. Having a positive relationship with your local team can expedite referrals and ensure that any issues are dealt with in a timely manner. Here are some ways to build a positive relationship through making effective referrals:

- Build a reputation as being reliable in your own assessments. Some workers mark all their referrals as urgent, rather than identifying where someone could wait a little longer to be seen. This means that services then have to attempt to triage urgency based on what information they have, and this takes time. As such, this practice creates delays for actual urgent and emergency cases. Be reasonable and fair in your assessment of urgency, and you are far more likely to have emergency referrals offered rapid appointments.
- Ensure your referrals are appropriate and go to the right place. For example, if someone is going to be moving out of area in a week, and the situation isn't urgent, there is little point referring them to a service in their current area as only urgent referrals are likely to be seen within a week. If you know where they are moving to, even if you only know the rough area rather than an exact address, you should be able to refer into a service there, with an assurance to provide an address within a few days.
- Make sure your referrals are made in a timely fashion. If you have had serious concerns about a client for a week, but leave making a referral until Friday afternoon, this is unlikely to be helpful for your relationship with the team. Most mental health services are open Monday to Friday, from 9 am to 5 pm, with limited, emergency only services outside these times. It takes time to

arrange assessments and care, especially when someone is acutely unwell and may need admission to hospital. If you are really concerned about someone, prioritise making the referral straight away.
- Ensure your referrals are clear and provide comprehensive information (outlined in the Appendix).
- Identify key areas of concern. When we are concerned about someone, we tend to become caught up in the minutiae of their situation, and that can make it difficult for workers just getting involved to understand the critical information. Try to divide your concerns in to key areas and provide additional specifics for each one.
- Mental health teams may respond to referrals in ways that you feel don't meet your client's needs, which can be frustrating for everyone. Try to speak with the practitioner who made the decision and ensure that they have fully understood your concerns. If you feel they haven't and they are unwilling to review their decision, you can speak with your line manager about escalating the issue within mental health services. Alternatively, they may be able to provide a clear rationale for their decision and give you some more detailed advice about what the next steps could be, or what else might help a person.

Why a referral might be rejected

As detailed previously, mental health services do not offer a service to every person with a mental health issue, and it is very common for referrals to be turned down or for clients to be discharged after just an assessment. Common reasons for this include:

- Drug or alcohol misuse. It can be very challenging to assess someone's mental health needs when they are heavily intoxicated with alcohol or drugs because their intoxication can mask their symptoms, or actually cause symptoms of mental disorder that would resolve if they stopped using. This can include serious symptoms such as hallucinations or delusions. It may be more appropriate for the client to be supported by Drug and Alcohol services in the first instance (NB these services are often led by Psychiatrists and Community Psychiatric Nurses who are well versed in managing co-morbid substance misuse and mental health problems). There are always exceptions to this, and it is sometimes appropriate for two services to work together, but if the primary issue is felt to be substance misuse, mental health services may recommend referral to drug and alcohol services in the first instance.
- People with personality disorders. While a diagnosis of personality disorder should never automatically exclude a client from services, it can be a long process to effectively engage someone with personality difficulties. The main treatments for these difficulties are talking therapies, although medication may also have a role, and it can take many attempts for someone to feel ready to engage meaningfully. The work that you do with a client, in building trusting relationships, and providing safety and stability is the absolutely crucial first step for someone to start working towards more structured therapeutic work.

Mental health services may well need to provide crisis interventions along this often slow and difficult path, but may discharge after only a brief period of time if the person isn't showing signs of being able to engage more deeply.

- People who already have appropriate treatment or support. Many people are already receiving excellent care and support from other services, and adding additional mental health services may be confusing or overwhelming for them. Unless there is a specific role for mental health services, they may advise continuing with the existing care plan and either turn down a referral or discharge a client from their service. For some people, it can be highly therapeutic to not be felt to require formal mental health services, because they see this as signifying that they are doing well and recovering. Lack of input is too often viewed as negative, rather than sometimes being indicative of someone being ready to move on and no longer needing specialist support.
- People who have needs that do not meet the threshold for secondary care services. In general, secondary care mental health services are commissioned to provide services for people with moderate to severe or enduring mental health problems. If the team you are referring in to feel that this threshold is not met, they may recommend your client speaks to their GP in the first instance, or self-refers to primary care mental health services.

Building partnerships with mental health services

When communicating with mental health services, the key is to work together to build a care plan that supports the person. This should incorporate the work that you are doing that that person. Often, there are things that you are intuitively doing with clients that you might not recognise as an intervention, but which can be very helpful and therapeutic. Ensure the work you are doing is known to the team, so that they can build it in to the care plan and more effectively plan for future care.

If you feel your local team doesn't know or understand what your service does, please do enlighten them! You are doing valuable work, and need to be able to access services for clients in a timely manner, as well as keeping those services involved for as long as the client needs. If the local service knows who you are, and the work you are doing, they are more likely to have realistic expectations of what you are able to provide. For example, if you work in a hostel, some mental health teams might lower the priority of your referral because they were not aware that you are not a specialist mental health hostel and cannot provide the level of intervention they might expect. Staff turnover is often quite high in mental health services, so it is important to revisit this regularly to ensure that they know what your service does.

There may be specific functions of the mental health service that your team are not aware of. Ask your local team if they might be able to provide some input to help you and your colleagues to better meet the needs of the people you are jointly working with. They may be able to provide some advice, training, or learning materials around

working with people with specific conditions, such as personality disorders, or about the legal parts of their roles (such as about the Mental Health Act).

Partnership working when a client is in hospital

If one of your clients is admitted to psychiatric hospital, try to maintain contact with the ward staff. Wards can be very chaotic, and nursing staff don't always have time to make sure everyone involved with a client is aware of what is happening. Most wards will have a ward round every few days at least, and it is best practice for all involved workers to attend, so that everyone is aware of the care plan. This is particularly important in the time leading up to a client being discharged from the ward, as community services need to ensure that a coherent and joined up care plan is in place to support the person when they leave. The period of time following discharge can be higher risk for clients, especially now that pressure on wards means that people are often discharged earlier than is ideal. If you have information that suggests risk will increase significantly on discharge (especially if the inpatient team might not be aware of it), ensure that you attend ward round to discuss this with the Consultant Psychiatrist and their team.

You can put together a hospital admission plan detailing what you can (and importantly, what you cannot) provide during admission and following discharge. This is very important, particularly for those with nowhere to go on discharge. Wards can sometimes see that a homelessness worker is involved and presume that this means accommodation will automatically be provided, which may well not be the case. If the ward is aware that they would be discharging a person to the streets, they may well reconsider how early a patient is discharged, or what on-going support will be needed from their community mental health services.

Partnership working after referral

It is important to remain in contact with mental health services once they have accepted a client. Your feedback is very important and helps them to better tailor the client's treatment plan. Where you might be having difficulty in working with a client, they might be able to provide support and advice (and vice versa), and potentially change aspects of the care plan to better meet the patient's needs.

Examples might include:

- You might be working with someone who is engaging poorly because they are suspicious of you and your motives for being involved. It might be that this is one of their symptoms of psychosis, and a small adjustment in their medication might help them to feel less suspicious and more able to work with you.
- You might have a client with acute anxiety, such as about going outside. Your natural reaction to their anxiety might be to provide them with reassurance and do things for them so that they don't have to go out as much. Psychologically, however, this can be counter-productive, as it tends to

reinforce that there is something serious for them to be anxious about, and this can make their prognosis worse in the long term. The mental health team may be able to draw up a plan with you to help you work more therapeutically with them.

- You might be working with someone who is 'splitting' – saying one thing to one worker, and something else to another. They may well talk negatively about some staff members to other staff members, or to clients, or attempt to form closer bonds with some staff by telling them about how much better they are than other staff. Sometimes this also happens where whole teams are portrayed negatively. This is particularly common behaviour in people with personality disorders, and it can be very difficult, upsetting and destructive for a team. It is often hard to know how best to manage such behaviour. The mental health team might be able to give you some support or resources in learning how to manage such difficulties, or meet jointly with you and the client to discuss the behaviour, so it is openly acknowledged. This can be the first step towards reducing splitting behaviour.

In Summary

Mental Health services are, despite efforts towards accessibility, often very complex to navigate. For example, according to their current web site, South London and Maudsley NHS Trust covers four south London boroughs, providing care in those boroughs through over two hundred and forty teams, as well as running over fifty specialist services across the UK. In developing this guidance, we reviewed the web sites of several NHS trusts and found it often very difficult to establish what the first step towards accessing a service would be. This is a great shame for clients and for services supporting clients as, for those who may already be reticent about seeking help, any barrier can be the difference between accepting and rejecting a referral. For this reason, and to avoid unnecessary delays, it is recommended that you always phone the team you intend to refer in to, and double-check that:

1) They are the right service for what you are seeking for the client.
2) They will accept a referral from you directly, rather than from the GP.
3) They cover the area where the person is (some primary care services go by where the GP is rather than where the person is, but secondary care services usually go by where the person is).
4) Whether they will accept a phone referral, whether they require a specific form to be completed, or whether they will accept a referral letter.

Appendix 1: What to include for an effective referral.

Client details	Full name (and any aliases, also known as, or previous names), date of birth, last known address, where they currently are and how long they have been there (to aid services in trying to track down any previous records). Most importantly, a contact number for them, and your contact number.
GP information	The client's GP details, and information about whether the GP has been asked to see the client, and if not, why not. Has the GP been asked to provide the client's medical history, and can this be passed to the mental health service (ask for client's consent).
Your concerns	The specifics of your concerns. You don't need to use technical language but should explain in detail why you think the person needs mental health team input. E.g. 1: Rather than state you believe the person is depressed, describe their symptoms, such as seeming low in mood, crying a lot, isolating themselves, not eating or sleeping, poor self-care, little communication, thoughts of harming themselves. E.g. 2: If the person talks about feeling suicidal, you must provide significant information about what they have said (and take immediate action by telephone rather than by written referral if you think the person is in imminent danger). Include details of any plan to harm themselves that they may have spoken about, any past history of self-harm or suicide attempts (and the details of these as there is a major difference between someone taking five paracetamol and immediately calling an ambulance, and someone who has taken fifty paracetamol and been discovered by someone entirely by chance). E.g. 3: If someone is aggressive, you should detail any triggers, whether they have a history of violence/weapons, and whether their behaviour has necessitated contacting the police. NB, if someone has made direct threats against a specific person, this is an immediate matter for the police, although a mental health referral may also be appropriate.

Medication, allergies, and medical problems	Is the client prescribed any medication and are they taking it? Include physical and mental health medication (names and dosage where possible, ideally the medication list from the GP). Does the client have any known allergies or severe medical problems (again, include the GP medical summary where possible). This information is very important to try to obtain in case the client requires urgent mental health medications, as some may be contra-indicated with certain conditions or other medications.
Risk	Is there any known risk history, to themselves or others, and what are the details of these risks? Are there any current risks in terms of harm to self, or behaviour that may cause harm to others?
Drug and Alcohol use	Is the person currently using substances, and if so, what are they using and how much? How long have they been using for in their current pattern, and is their history of substance misuse different to their current use? Again, because of medications that may be prescribed, and because of the difficulties in assessing mental health symptoms when someone is using, this information is vital.
Previous treatment	Have they had mental health treatment in the past and, if so, where and when was that treatment? This will enable the mental health service to obtain more comprehensive records than the GP might have.
Your support	How have you been supporting the person and for how long? How well has the person responded to your input, and have there been any particular issues in engaging them? Be clear about how long you can continue to provide input for and at what level. If you are unable to continue to provide what you are providing currently, ensure this is clear so that any potential shortfalls in meeting the client's needs can be identified.
Urgency	How urgent do you feel the referral is? If you feel the client needs to be seen quickly, be clear about why this is. What are the risks if they are not seen quickly? It is also very helpful to say if you think the person might be able to wait a while, and if so, for how long, as this helps the team prioritise referrals more effectively.

Appendix 2: Case examples

You will see from the first case study below that you don't need to know everything about a person to make a referral, but that it is best to acknowledge where they are gaps in your knowledge. This is so that it doesn't seem you have simply left out information. In Joe's case, the lack of information may actually be quite informative. It shows he is quite guarded, which may be due to his mental state.

In the second case study, Mary, acknowledging the difficulties around engagement and her changeable responses to accepting help is likely to be useful to the mental health service in thinking about how they could engage with her.

Case study 1: Joe B

Dear Colleague

Re: Joe Bloggins. DoB 01/02/1960.
Previously of 1 Abbots Close, NH7 PKY. Thought to have been rough sleeping under Cobbins Bridge since 2014.
No contact telephone number or email, but can be contacted through my service as we see him regularly. This is my number …

I would like to refer Joe to your service. We have been seeing him on and off for the past three years. He has always maintained that he does not want to move to settled accommodation and appeared to be making an informed decision to refuse our help.

Over the past three months, we have become increasingly worried about his behaviour, and more so in the past week or so. He seemed at his worst ever yesterday, hence the reason for the referral now. He seems more erratic, and often doesn't attend appointments, which is very unusual for him. He often appears fearful, and talks about how 'they' want to harm him, but he can't explain who 'they' are, or why they want to hurt him. He has been speaking about how he is a Hollywood movie star, fallen on hard times, but there is no evidence that this is the case – he has insisted we google him, but nothing comes up. We have seen him talking animatedly to himself regularly, but he denies this when we ask who he was talking to. He speaks very loudly and is far more irritable than usual. He usually eats well, but has been refusing meals over the past few weeks, and appears visibly much thinner. His self-care, which has always been somewhat poor, has noticeable declined, and he has pungent body odour and very dirty clothes. He is usually a cheerful person, but he seems really low, and seems despondent about the future now.

We helped Joe to register with a GP when he first came to our attention three years ago, and had hoped to get him seen by them now. However, he has refused, and they have told us that they have never seen him since his registration appointment. He isn't

on any prescribed medication and the GP said he didn't disclose any medical problems on registration, though this isn't confirmed as they were never able to obtain his previous medical records. We suspect that Joe has previously been under mental health service care, but he has always refused to discuss this, so we can't be sure.

Joe hasn't talked at all about wanting to hurt himself or other people, and there is nothing in his current or historical (last three years) behaviour that suggests these are risks. However, we are very worried about his rapidly declining mental health and his poor self-care, and feel he is very likely to deteriorate further unless something is done soon.

We have never known Joe to use alcohol or drugs, and he has always said that they are 'poison' to him. It is therefore very out of character that we have seen him obviously intoxicated and smelling of alcohol several times in the last few weeks. He denies it when we ask if he has been drinking.
We are doing our best to keep engaging with Joe, although it is becoming increasingly difficult, as he isn't attending appointments regularly, and often isn't in his usual spot (again, unusual for him) when we try to visit him. We will continue to try to see him, and are trying to encourage him to eat, and use the washing facilities we can offer, but we haven't been very successful in this recently.

We feel very worried for Joe's wellbeing. Although there doesn't seem to be an immediate risk of him coming to harm, he is clearly deteriorating, and is likely to continue to do so, so we do feel he needs to be seen quite quickly as it seems likely he will need some medication and support to stop him getting any worse. It is also getting very cold, and Joe doesn't appear to be recognising the change in the weather. He hasn't changed the way he dresses, despite a massive drop in temperatures, and we see him walking around without a coat. He is leaving his sleeping bag exposed to the elements, although he used to tie it up somewhere dry, and we saw him sleeping in it despite it being wet through.

Because Joe seems quite confused at times, we are worried about his ability to recognise when he might be at risk from others, and to protect himself from harm. Because he is very irritable with people now, we are also worried he might be at risk of retaliation if he is irritable or aggressive to the wrong person.

We have been trying to work with Joe to see if he will agree to being referred, but as he is now largely disengaging, and there seems to have been a very recent and significant decline in his mental health, we have decided to refer at this point.

Joe can be very difficult to track down, so it's probably best to call me on my mobile number (provided above), and I will be able to suggest some times and places where it might be possible to see him. He knows me very well so it might be less stressful for him if I am there when he is assessed. He doesn't know yet that I have made this

referral, but I will tell him as soon as I can find him, and will ask him if I can be there at his appointment.

Case study 2: Mary J

Dear Colleague

Re: Mary Jones. DoB 01/02/1980. Room 3, Star Hostel, Barrow Road (a supported project for people who we are helping to access more permanent accommodation). Her mobile number is 07938..., but she often doesn't answer, and said she is happy for you to contact us for more information or to make an appointment.

We would be grateful if you could please offer Mary an appointment.

Mary has a long history of substance misuse problems and traumatic life events. She has been with us for about two months, and we have become worried about her functioning and her self-harm.

Mary tends to become very distressed and angry when she perceives her needs are not being met, or she is being judged in some way, even when we are trying to help her as best we can. Her behaviour has become increasingly erratic, and when she is upset she makes very frequent (daily) threats to end her life. We have noticed some cuts to her arm, which she says she did with a razor because we had told her that she would need to find some more documents to help her housing application, and she said she didn't have these. The cuts didn't appear that deep and she declined to go and have them looked at. She has also started banging herself on the head with her fist repeatedly when she gets angry. Mary's threats to end her life are usually along the lines of "I may as well go and walk in front of a bus", rather than anything very specific in terms of when and where. She usually comes back an hour or so later, and denies any intention to harm herself, but it is alarming for staff and other residents at the time.

Mary often talks about feeling very lonely, and not having any friends, but her erratic behaviour means that other residents are wary of her, and tend to keep their distance. She is estranged from her family, and says she hasn't seen any of them for several years. She has very little in terms of meaningful activity in her life, and tends to spend lots of time walking around on her own.

Mary is currently trying to modify her substance use. She has denied any current drug use (she previously used to smoke cannabis daily, and use cocaine when people offered it to her). She is drinking about two cans of strong lager a day, which is a big reduction for her compared to four months ago, when she was drinking about six cans a day. She is keen to reduce it further, but doesn't want any specialist help to do so.

Mary has told us that she was physically and sexually abused by a close family member as a child, and that this was ignored by her wider family despite it being common

knowledge. She has been in several abusive relationships in her adult life, both in terms of her being a victim of violence, and being a perpetrator of violence. She isn't currently in a relationship but has spoken a lot about how she is going to find someone to have sex with because she wants a baby. We feel very worried for her, as this doesn't appear to be a good idea for her at her current stage in life. She doesn't recognise that such behaviour could be dangerous to her safety or her health, or that it would be difficult to raise a child alone. She just says she would 'cope', though this seems unlikely as she really seems to struggle with most aspects of her life.

We have spoken with Mary's GP who feels a referral would be helpful. She doesn't really know Mary but said that she thinks it is likely that she has some personality difficulties. The GP doesn't feel any medication should be prescribed in primary care, but said it might be helpful for a psychiatrist to see Mary. She felt it would be better for the referral to come from us, as we have more knowledge of Mary than she does.

We are currently needing to provide a lot of help to Mary to stop her angry outbursts escalating. But we are finding this very difficult to manage, both in terms of knowing what would really help her, and also in terms of our staffing levels because she is needing so much more support than other residents, and this is taking support time away from other people. Her behaviour is so distressing to others that we are going to have to give her notice to leave if we can't do something to contain her better. The situation is really quite urgent, as we feel she is vulnerable and don't want to see her on the streets, but we may be left with little option if things don't improve in the next week or so.

I am not really sure how receptive Mary is going to be to this referral if I am honest. At times, she is very keen for help and has said she will take anything she is offered. At other times, she says she has no problems, and she doesn't want people interfering with her life. She might be more receptive if I offer to come with her.

I would be very grateful if you could please offer Mary an appointment as soon as you are able. I don't think this is an emergency situation, but as I have outlined above, we are really struggling with her, and she would be very vulnerable if she was out on the streets, so there is some urgency to her situation.

What We Do

Homeless Link is the national membership charity for frontline homelessness services. We work to improve services through research, guidance and learning, and campaign for policy change that will ensure everyone has a place to call home and the support they need to keep it.

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