



homeless link

MENTAL HEALTH AND WELLBEING GUIDE



HOMELESSNESS, MENTAL HEALTH AND WELLBEING GUIDE

SECTION ONE: INTRODUCTION AND POLICY CONTEXT

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Section 1: Introduction and policy context

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PURPOSE OF THIS GUIDE

We have developed this guide to support frontline staff and managers of homelessness services to work successfully with clients who present with various mental health and wellbeing needs. The aim of the guide is to give staff and managers the confidence to work with a range of complex needs in a personalised and dynamic way, enabling clients to receive the appropriate support they need to live happy and fulfilled lives.

WHO IT IS FOR

This guide is for generic and specialist mental health homelessness services. This includes hostels (both first and second stage), day services, and outreach teams. It is crucial that managers and staff across all levels including night workers have an understanding and awareness of mental health and wellbeing issues that affect homeless people.

WHY IT IS IMPORTANT

Our health needs audit¹ revealed that:

Homelessness services play a large part in stabilising and preventing more serious mental health problems by offering emotional and psychological support to vulnerable people. They work with individuals at an extremely fraught and complex time and can offer essential support to those in need. They also play a key role in guiding people through statutory and voluntary support services.

WHAT THIS RESOURCE WILL HELP YOU WITH

This guide will enable workers to recognise the importance of your work and build on your skills to assess and support people's mental health and wellbeing proactively. It has been divided into helpful sections and offers top tips to navigate services and support clients successfully within a range of projects.

- **over 70% of people using homelessness services report having experience of mental distress**
- **over 45% feel they need more support in coping with their mental health needs**

WHAT IT IS NOT

This guide is not a psychological framework or assessment tool to diagnose clients. While we encourage organisations to become increasingly psychologically aware, train staff and use psychologically-informed tools and approaches, it is also important that staff know where their role starts and stops. Homelessness services are not there to replace statutory mental health support or, necessarily, to deliver counselling or additional psychological services (although some do this excellently and such partnerships should be encouraged). Homelessness services need to ensure they can work effectively alongside mental health services in a joined up and cohesive way, which puts the client at the centre.

¹ <http://homeless.org.uk/health-needs-audit>

The guide will

- explain the policy context of health and wellbeing
- help you to understand the complex language that exists in the mental health field, especially around diagnosis and treatment
- provide practical tools and advice for working with challenging people on a day-to-day basis
- enable you to work with external services that can offer more intensive support for those most in need
- provide solutions for working with complex individuals

USING THIS GUIDE

It has been divided into five sections. For each section there is signposting to further resources to increase your knowledge and understanding of mental health and wellbeing issues. There are good practice case studies and top tips throughout to help in your work. All resources can continue to be updated with more good practice examples, so please contact jessica.plant@homelesslink.org.uk if you would like to add any examples or you would like to suggest any additional resources that could be included.

POLICY CONTEXT

Health reforms are currently on-going, the way mental health services are structured is likely to change significantly in the next few years. Mental health services are increasingly likely to be commissioned locally with a focus on *recovery*. Homeless Link will be working in this area to try and ensure homeless people needs are recognised within the new commissioning structures. It is helpful to be aware of the following documents:

In July 2010 the government launched the white paper; **Equity and excellence: liberating the NHS**

This outlines the major health reforms proposed by the government and the second consultation has recently closed. For more information visit the Department of health website:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

In February 2011 the Coalition launched its new mental health; **No health without mental health: a cross-government mental health outcomes strategy for people of all age**

To read more about it, please visit the Department of Health website:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766

In November 2010 the White Paper; **Healthy Lives, Healthy People: Our strategy for public health in England** was launched.

This White Paper sets out the Government's long-term vision for the future of public health in England. The aim is to create a 'wellness' service (Public Health England) and to strengthen both national and local leadership.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941

Homeless Link's policy pages

To find out more about mental health policy and how affects the needs of homeless people, please visit our website: <http://homeless.org.uk/mental-health-policy-context>

Also see Homeless Links consultation responses: <http://www.homeless.org.uk/closed-consultations>



HOMELESSNESS, MENTAL HEALTH AND WELLBEING GUIDE

**SECTION TWO:
UNDERSTANDING HOMELESSNESS,
MENTAL HEALTH AND WELLBEING**

HOMELESSNESS, MENTAL HEALTH AND WELLBEING GUIDE

SECTION TWO: UNDERSTANDING HOMELESSNESS, MENTAL HEALTH AND WELLBEING

2.1 What is mental health and wellbeing

2.2 Homelessness and mental health: key statistics

2.3 Common diagnoses among homeless people

2.4 Understanding treatment and support options

2.5 Street homelessness and mental health

2.1 UNDERSTANDING MENTAL HEALTH AND WELLBEING

Nearly 70% of people accessing homelessness services state they have a mental health issue of some kind. Poor mental health is both a cause and consequence of homelessness. Understanding what we mean by mental health and wellbeing can improve our working relationship with clients and external agencies, it can also help to reduce stigma and help staff to feel more confident about supporting individuals with various needs.

A high proportion of people within services will need support with a range of issues, from mild depression and anxiety to severe and enduring issues such as schizophrenia. As government policy states, there is: **“no health without mental health”**

Thinking about mental health in a similar way to how we view physical health problems can be useful when approaching how to support people. Mental, like physical health issues exist on a continuum of severity and are interlinked. The severity of the issue, the impact it has on our lives, the treatments available, as well as individual responses to poor health of any kind, are varied and complex. Remember that people can and do make full recoveries from mental ill health. The key definitions of mental health and wellbeing as well as common diagnosis and the symptoms are outlined below. Gaining an understanding of these terms will enable you to respond effectively to clients needs and get the right referrals to external services for the people you support.

USEFUL DEFINITIONS OF MENTAL HEALTH

The World Health Organisation

“A state of complete physical, mental and social wellbeing, and not merely the absence of disease. It is related to the promotion of wellbeing, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders.”

A mental illness is a psychological or behavioural pattern that someone experiences which causes them distress or disability.”

The Mental Health Foundation

“Being mentally healthy doesn’t just mean that you don’t have a mental health problem. If you’re in good mental health, you can:

- *Make the most of your potential*
- *Cope with life*
- *Play a full part in your family, workplace, community and among friends*

Some people call mental health ‘emotional health’ or ‘wellbeing’ and it is just as important as good physical health.”

Mind

“You care about yourself and you care for yourself. You love yourself, not hate yourself. You look after your physical health – eat well, sleep well, exercise and enjoy yourself.

You see yourself as being a valuable person in your own right. You don’t have to earn the right to exist. You exist, so you have the right to exist.

You judge yourself on reasonable standards. You don’t set yourself impossible goals, such as ‘I have to be perfect in everything I do’, and then punish yourself when you don’t reach those goals.”

UNDERSTANDING MENTAL HEALTH

Understanding the difference between severe mental illness and more common diagnoses can help us to support clients (table one overleaf outlines these definitions). If someone has a serious mental illness it does not necessarily mean they have poor mental health, as they may have found appropriate ways to treat and cope with the illness. Many individuals can have a serious mental illness and manage their lives well, taking appropriate medication and seeing doctors regularly to help them manage their illness. Other individuals may not have a diagnosis of any kind, but are making extremely unwise choices that are having a negative effect on their wellbeing resulting in poor mental health. In both instances support will need to be in place to help that individual within homeless services. Using the outcome star, a tool developed for effective key working can support this process. To access this tool visit: <http://homeless.org.uk/outcomes-star>. Axis 7 (shown below) of the star can help us to understand this more:

7. Emotional and mental health

This ladder is about how you are feeling. How aware you are of your emotional health, how often you feel low, depressed, stressed or anxious or experience panic attacks. Is self-harm an issue for you? You may have symptoms of post-traumatic stress or a diagnosed or suspected mental health issue that needs medication or treatment. This journey is about how aware you are of these issues and how well you manage them.

Where are you on your journey?



TABLE ONE: DEFINITIONS

This table outlines terms and definitions within the mental health field. It also outlines some important aspects of mental health and the law¹. Having an understanding of this terminology can inform our work and support clients.

TERM	MEANING	ADDITIONAL NOTES
Common mental illness	This term refers to mental distress rooted in 'everyday' human emotions, but when they become unmanageable or difficult for an individual. Reality and insight are retained, but responses can still be extreme and distressing for individuals.	This includes problems such as depression, anxiety and phobias.
Mental illness/ mental disorder – sometimes called severe mental illness (SMI)	<p>This includes diagnoses such as schizophrenia, bipolar, drug induced psychosis. It refers to diagnoses that mean people's experiences are outside of 'normal or everyday' human experience; it can mean someone's reality is changed and insight is lost.</p> <p>Diagnosis of a SMI can only be issued by a qualified professional in the field. They use the DSM-IV statistical diagnostic manual to guide their diagnosis. Having a severe mental illness diagnosis means individuals will get support from statutory services.</p>	DSM-IV is published by the American Psychiatric Association and covers all mental health disorders for both children and adults. (Version V is likely to be out soon, but this is a highly contentious manual with serious consequences) It works across 5 areas and more information can be found here: http://allpsych.com/disorders/dsm.html
Wellbeing	A term used more and more to talk about a holistic wellness, both physical and mental. Public policy currently tries to measure wellbeing within society to improve practice. Improving wellbeing can include looking at exercise, social networks and social inclusion for example.	See definitions from various organisations above. Also see New Economic Foundation for more information: http://www.neweconomics.org/programmes/wellbeing
Psychiatry	This is a branch of medicine that specialises in treating mental illness.	
The Mental Capacity Act (2005)	The Act states that everyone should be treated as able to make their own decisions until it is shown that they are not. A person's capacity to make a decision will be established at the time that a decision needs to be made. A lack of capacity could be because of a severe learning disability, dementia, mental health problem, a brain injury, a stroke or unconsciousness due to an anaesthetic or a sudden accident. The Act also makes it a criminal offence to neglect or ill-treat a person who lacks capacity. The act safeguards both individuals and professionals and carers.	For more information on the mental capacity act: http://www.nhs.uk/CarersDirect/moneyandlegal/legal/Pages/MentalCapacityAct.aspx For useful training regarding mental incapacity: issues in supported housing, download Lemos and Crane's free briefing: http://lemosandcrane.co.uk/home/index.php?id=213501&emailid=2:82:0
The Mental Health Act (1983, amended 2007)	The amended Mental Health Act came into force in England and Wales in 2007. The act allows people with a mental disorder to be admitted and detained in hospital against their will and be given treatment to alleviate symptoms to prevent harm to themselves or others.	People may be admitted to hospital under different sections of the Act. People can either be voluntary (informal) or involuntary (formal) patients.

¹ Definitions adapted from the mental health Care website, for more details see: http://www.mentalhealthcare.org.uk/mental_health_act. In addition, the *Happy, health sorted tool kit* produced by the Foundation Foyer and definitions also adapted from the MIND website were extremely useful in putting this resource together.

<p><u>Sections of the mental health act</u> Civil (compulsory) admission to psychiatric hospital</p>	<p>When someone lacks capacity and they are in fact causing an immediate risk to themselves or someone else they can be admitted to hospital against their will. Individuals can also make a voluntary admission if they feel they or someone else may be at risk.</p>	<p>Section 2 is an assessment order. Under section 2 an approved mental health professional or someone's nearest relative can apply for someone who has a mental disorder to be admitted to hospital. If admitted under section 2 one can be detained for up to 28 days for assessment and treatment and it cannot be renewed.</p> <p>Section 3 is a treatment order. This allows people who have a mental disorder to be admitted for treatment for up to 6 months if appropriate treatment is available. Again an approved professional or a nearest relative can apply for admission and two doctors have to agree.</p> <p>Section 4 can be used in an emergency if someone is causing harm to themselves or others and there isn't time to use section 2 or 3. People can be admitted for up to 72 hours.</p>
<p>Aftercare</p>	<p>If people are detained under section 3 of the Mental Health Act there is a duty of care to provide aftercare support.</p>	<p>Section 117 is the section of the Mental Health Act which states that in the case of persons who are detained under certain treatment orders, the primary care trust and local authority have a duty to provide aftercare services, in co-operation with voluntary agencies, until such time as they are satisfied that the person is no longer in need of such services. This can be extremely useful for ensuring people get the right level of support.</p>
<p>Police powers</p>	<p>The police have certain powers to take someone from a public place or a private residency to a place of safety for health and safety reasons.</p>	<p>Section 136 this part of the Mental Health Act allows people to be removed from a public space and held for up to 72 hours, usually in a hospital to prevent harm. They may then be held under section 2 or 3 or discharged.</p> <p>Section 135 allows police to gain entry into someone's premises to allow assessment under the Mental Health Act. A warrant from the magistrate's court is required for this power to be used.</p>
<p>Community treatment orders (CTOs)</p>	<p>A legal order that allows a patient to be discharged from formal detention onto supervised community treatment i.e. receive treatment in the community.</p>	
<p>Approved mental health professional (AMHP)</p>	<p>These are professional such as social workers, psychologists, doctors and nurse who can make the decision that someone can be detained under the Mental Health Act.</p>	<p>AMHPs undergo specific training and should always seek alternatives to hospitalisation.</p>
<p>Safeguarding vulnerable adults</p>	<p>Individuals with mental health issues can be victims of abuse and mistreatment. If you feel someone is at risk, safeguarding vulnerable adult powers can be another route to gain statutory support if someone is at risk</p>	<p>London's multi-agency task group has recently reviewed: <i>Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse</i>. To read more visit: http://www.scie.org.uk/publications/reports/report39.asp</p>

Useful resources for understanding the law and mental health

Lemos and Crane published an 8 page briefing written by Dr Helen Carr on Mental incapacity: issues in supported housing. This document is free to download if you register on their website at <http://lemosandcrane.co.uk/home/index.php?id=213501&emailid=2:82:0>.

Dr. Carr looks at how the Mental Capacity Act works, assessing capacity under the Act, acting in someone's best interests and under what circumstances a mentally incapacitated person may lawfully be restrained. They also offer online training resources that can up-skill staff.

2.2 HOMELESSNESS AND MENTAL HEALTH: KEY STATISTICS

Our recent research into the health needs of homeless people, the Health Needs Audit (2011), indicates that:

Seven out of ten homeless people experience mental distress, compared to one in four of the general population

The connection between homelessness and mental health issues is complicated, it has been found to be both a cause of long term rough sleeping as well as a symptom of the experience of becoming and remaining homeless. There are complex associations with issues such as trauma in childhood, drug and alcohol misuse, domestic abuse, violence, and neglect and relationship breakdown.

Mental health issues have had a long association with stigma and discrimination, therefore homeless people with mental health problems run the risk of been multiply excluded and falling between the cracks in services. Individuals' wellbeing can be seriously affected by the experience of being homeless and people who have less resilience to ensure they protect their own wellbeing may be more likely to become homeless. It is therefore crucial that all homelessness services have a full understanding of the current levels of need relating to mental health and wellbeing and know how to respond effectively. Homelessness services play a key role in promoting good mental health and wellbeing across all the work they do, as well as ensuring that if mental health becomes unmanageable for an individual they can access the help and support they require in a timely way.

HEALTH NEEDS AUDIT

Through the health needs audit that took place this year (2011), we spoke to more than 900 people from hostels, day services and those in contact with outreach teams. This revealed that:

Levels of need

- 72% of clients said they had one or more mental health need
- 45% said they had one or more long-term mental health need (61% of all those with a mental health need)
- 35% of those with a mental health need said that they would like more support with their mental health
- Other research also found that 60% of people in homelessness services have been found to be affected by complex trauma or personality disorder.

Currently

- 44% of those with a mental health problem said they self-medicate with drugs or alcohol
- 14% of clients stated that they self-harm, compared with 4% of the population
- One fifth of clients who had recently attended A&E had done so because of either mental health or self harm
- Only 10% of clients have additional support from mental health services

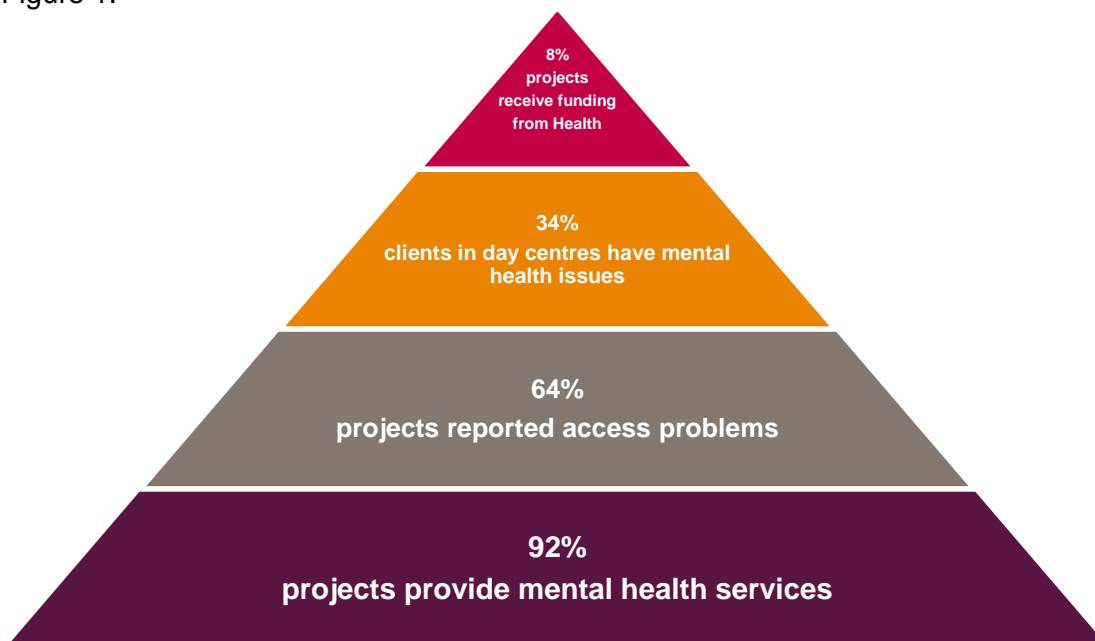
The table on the following page summarises the findings regarding mental health diagnosis, comparing the needs of homeless people with those of the general population. This table may assist you when trying to make a case for homeless and mental health services to work more effectively together. For further information on how the health needs audit can help you to influence commissioning decisions, see: <http://homeless.org.uk/health-needs-audit>.

	General population	Homeless population
% with mental distress	30%	72%
Proportion with diagnosable mental health problem at any one time	16%	70%
% of people who experience depression	10%	47% mild, 17% severe (49% with either severity)
% of people who experience anxiety	4.7%	41%
% personality disorder	-	-
% bipolar disorder	1-2% lifetime prevalence	5%
% people who experience sleep problems	29%	50%
% schizophrenia	0.2%	4%
% people who self-harm	4%	14%

Survey of Needs and Provision (SNAP)

Homeless Link's Survey of Needs and Provision (SNAP) 2011 provides an overview of the homelessness sector, offering insights into the sustainability and range of services available in England. Each year the survey is carried out to look at the needs of single homeless people and the service provision they receive. It's in its fourth year and to collect the data, 500 projects were surveyed including day centres, direct access hostels and 2nd stage accommodation projects. One of the more surprising findings of this year's survey was the fact that a large number of services still do not receive any funding from a number of specific sources, despite most projects delivering such services. Figure 1 illustrates this:

Figure 1.



For more details visit: <http://homeless.org.uk/snap-2011>.

2.3 COMMON DIAGNOSES AMONG HOMELESS PEOPLE

This section outlines some of the main diagnoses and mental health issues homeless people are likely to face taken from the health needs audit findings. This section also draws on information from a 2010 good practice paper issued by the DCLG and the National Mental health development unit, *Mental health good practice guide: meeting the emotional and psychological needs of homeless people*, which focuses on recent research done looking at the links between complex trauma and homelessness. See the research here: <http://www.nmhdu.org.uk/complextrauma>

The common diagnoses and mental health issues this guide covers are as follows:

SERIOUS MENTAL HEALTH ISSUES
2.3.1 Complex trauma and personality disorder
2.3.2 Bi-polar disorder
2.3.3 Schizophrenia
2.3.4 Depression
2.3.5 Anxiety
2.3.6 Suicidality
2.3.7 Self-harm
OTHER MENTAL HEALTH ISSUES RELATING TO HOMELESSNESS
2.3.8 Dual diagnosis
2.3.9 Sleep problems
2.3.10 Anger management

References

The description of the various mental illnesses, common signs and symptoms has been put together using a number of sources including the MIND, the Royal College of Psychiatry, NHS Live Well, and Rethink websites. These have proved invaluable sources of information for this guide, and we recommend strongly that you refer to these resources for further information. They all produce excellent easy access guides that can support clients and staff to deal with mental ill health and wellbeing issues. Using their websites will help you understand the issues further. John O'Niel, the Training Manager specialising in homelessness and mental health, from the Outreach team at SLaM NHS Foundation has also overseen this document and offered invaluable expertise.



TOP TIP

Having a good understanding of terms used, signs and symptoms will enhance your working relationship with external agencies and enable you to support clients. A top tip is to allocate a lead mental health worker who is responsible for resources and information on mental health. Also, having presentations on different diagnoses at team meeting can be highly informative and motivating. Understanding behaviour that various mental illnesses can lead to can support us to tolerate and work with challenging individuals in a more appropriate, supportive way.

Notes on guidance

This is not an assessment tool and while various symptoms may be easy to recognise unless you are a trained professional you cannot diagnose individuals. This information is meant to support you to understand the causes and symptoms to support those in need prevent poor mental health and recognise when external intervention is necessary.

SERIOUS MENTAL HEALTH ISSUES

2.3.1 COMPLEX TRAUMA AND PERSONALITY DISORDER

Personality disorder, which is sometimes – and perhaps more helpfully – understood as complex trauma is found to be common among homeless people. Recent research by the former National Mental Health Development Unit and the DCLG suggests that up to 60% of individuals living in hostel accommodation and accessing homelessness have experienced complex trauma or have an undiagnosed form of personality disorder: <http://www.nmhdu.org.uk/complextrauma>

People who have complex trauma who have experienced homelessness may display a range of behaviours that suggest underlying difficulties with relationships or with managing their own emotions. The idea that personality disorder is formed in childhood and often makes attachment extremely difficult can be easily recognisable in homeless clients. The recent research acknowledges that the process of being homeless itself is extremely traumatic and distressing and can contribute to the development of personality disorder or complex trauma. Definitions of personality disorder include:

“Personality traits which are extreme, inflexible and cause significant distress to the bearer would indicate the person suffers from abnormality.”

“An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.”

Personality disorder is very often rooted in childhood abuse, deprivation, neglect or trauma, which results in an inability to function effectively as an individual or in society. Someone with a personality disorder is impaired in attaining the instinctive goals of having:

- A stable self-system (self-identity)
- Stable functioning in satisfying personal needs (attachment, intimacy and integration)
- Stable relationships (with groups and society)

Personality disorder is not usually diagnosed during childhood but emerging personality disorder in adolescents is increasingly being recognised. People with personality disorder may present with a range of physical, mental health and social problems such as substance misuse, depression and suicide risk, housing problems, offending and long-standing interpersonal problems (Mind 2011).

Some people who have personality disorder may for example:

- self-harm or have an uncontrolled drug and/or alcohol problem
- appear impulsive and not consider the consequences of their actions
- appear withdrawn or socially isolated and reluctant to engage with help that is offered
- exhibit anti-social or aggressive behaviour
- lack any structure or regular daily routine
- not have been in work or education for a significant period of time
- have come to the attention of the criminal justice system due to offending

Types of personality disorder

There are different types of personality disorder, which can have a range of impacts and effects on people’s lives. They can be divided in to three clusters: Cluster A (paranoid/schizoid), Cluster B (anti-social or borderline) and Cluster C (avoidant, dependent and obsessive compulsive). See the Mind website for more information:

http://www.mind.org.uk/help/diagnoses_and_conditions/personality_disorders

Support

This client group often gets very little support from external services due to historical criteria and notions that nothing can be done with this group. Personality disorder and complex trauma should not be a barrier to support; there are successful treatment and support options and statutory mental health teams do have a duty to this client group. However, hostel staff are often extremely skilled at working with this client group because of experience and this on-going support and boundary-setting can be highly effective. High tolerance, good boundaries and understanding is demanded to appreciate that usual patterns of behavioural adjustment are not always possible for people with personality disorder.

TOP TIP

The Department of Health issues useful guidance for practitioners working with this group, for spotting diagnosis and supporting clients:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124319.pdf

Recent training to work with this client group has also been made available for practitioners. Visit the Institute of Mental Health's website for further information:
<http://www.institutemh.org.uk/-education-/the-knowledge-and-understanding-framework>

Help for personality disorder can be:

- Talking therapies
- Therapeutic communities
- Some medication

The high levels of personality disorder and or complex trauma found among homeless groups means that adopting a 'psychologically informed environment' within homelessness setting is crucial. To find more visit section four of this guide.

Further resources and training available

Personality disorder website: <http://www.personalitydisorder.org.uk/>

The Institute of Mental health: Knowledge and understanding Framework:
<http://www.institutemh.org.uk/-education-/the-knowledge-and-understanding-framework>

Department of Health guide to working with personality disorder:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124319.pdf

2.3.2 BIPOLAR DISORDER (PREVIOUSLY KNOWN AS MANIC DEPRESSION)

Bipolar is likely to affect around 5% of people accessing homelessness services, compared with 1-2% in the general population. People diagnosed with bipolar disorder often experience extreme mood swings from one overactive state referred to as mania, to another low deep depression. Moods can last for several weeks, however there can be long periods of stability for people with bipolar disorder. These are much more extreme than the general ups and downs of daily life and can be very distressing, especially if this is compounded by an unstable living environment. People who suffer from bipolar can also have visual and or auditory hallucinations or strange beliefs referred to as delusions.

Common signs of bipolar could be:

Highs (mania)	Lows – deep depression
<ul style="list-style-type: none">• extreme mood swings• intense highs	<ul style="list-style-type: none">• a sense of hopelessness• feeling empty emotionally

- talking very fast
- little concentration
- poor judgement
- risky behaviours

- feeling guilty
- feeling worthless
- suicidal feeling
- chronic fatigue
- difficulty sleeping or sleeping too much
- weight loss or gain/changes in appetite
- loss of interest in daily life
- lack of concentration
- being forgetful

Causes

Most sources (MIND, Rethink, NHS) conclude that a mixture of chemical imbalances, genetic and environmental factors are thought to be the cause of bipolar disorder.

Support available can include:

If you think a client accessing your project is suffering from bipolar it is important that an assessment is done. This can happen via the GP or through a Community Mental Health Team. They will probably be referred to a psychiatrist and get support from them. Read more about working with statutory services in section five. Bipolar is usually helped by medication along with additional support to help recognise triggers and reduce the impact of manic episodes and depression. Medication can be used to help stabilise moods; the most common are

- lithium carbonate
- anti-convulsant medicines
- anti-psychotic medicines

To find out more about treatment for bipolar disorder, please follow the link to the NHS website and NICE guidelines below:

<http://www.nhs.uk/Conditions/Bipolar-disorder/Pages/Treatment.aspx>

<http://guidance.nice.org.uk/CG38>

Other help available includes:

- Self-help groups
- General wellbeing advice
- Information about treatment - <http://guidance.nice.org.uk/CG38>
- Talking therapies

Further information

Hypomania can be less severe than mania and people may feel intense creativity or have periods of productivity. This can be useful and valuable to people, however if left untreated it can lead to more severe symptoms. There are also many different types of bipolar, to find out more about them visit the Mind website:

http://www.mind.org.uk/help/diagnoses_and_conditions/bipolar_disorder_manic_depression#what

To watch video clips that may help you understand bipolar more, visit the NHS website:

<http://www.nhs.uk/Conditions/Bipolar-disorder/Pages/Introduction.aspx>

2.3.3 SCHIZOPHRENIA

It is likely that around 4% of people accessing homelessness services will be affected by schizophrenia, and although this isn't that high it is significantly higher than in the general population. Schizophrenia can be referred to a psychotic illness or a chronic serious brain disorder. Evidence suggests that homeless clients find it hard to get appropriate treatment. Key-workers play a vital role in brokering and establishing the right support for individuals with mental health issues, especially as trigger factors for various issues could be exacerbated by homelessness.

Commons signs

- Delusional thoughts
- Hearing voices (auditory hallucinations)
- Often an inability to distinguish internal thoughts and imaginings from reality
- A sense of being controlled by outside forces
- Withdrawn
- Muddled view
- Hallucinations
- Changes in behaviour
- Unwilling to accept help (as the delusions are strong, so they cannot see what the problem is. Remember unless they are likely to harm themselves or anyone else this doesn't mean they will be guaranteed support.)
- Flattening of emotions and loss of motivation

There are many different views about schizophrenia, thus causes and treatment is a complex process for all those involved.

Causes

There are no clear answers as to what causes schizophrenia, however there is some evidence that it is genetic. Head injury or infection and brain development are also possible causes of schizophrenia. To find out more visit the NHS website. Triggers such as major life events, stress and drug use are also said to contribute to the onset of various severe mental health issues.

People who are homeless are more likely to have had stressful life events, but less likely to receive treatment around complex mental health issues. For more information on causes visit:

<http://www.nhs.uk/Conditions/Schizophrenia/Pages/Causes.aspx>

<http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/schizophrenia/schizophrenia.aspx>

Further information

There is a lot of stigma around schizophrenia as it is thought to be associated with violent crime, when in fact very few violent crimes are committed by people with a schizophrenic or a psychotic diagnosis. Visit the Time To Change website for more information on myth busters

<http://www.time-to-change.org.uk/>. Schizophrenia has more recently been associated with a strong breed of cannabis referred to as skunk; to find out more about mental health and cannabis use visit the Royal College of Psychiatrists website.

<http://www.rcpsych.ac.uk/mentalhealthinfoforall.aspx>

Other useful websites include:

<http://www.nhs.uk/conditions/schizophrenia/pages/introduction.aspx>

<http://www.sane.org.uk/>

http://www.mind.org.uk/help/diagnoses_and_conditions/schizophrenia#useful

2.3.4 DEPRESSION

Depression is likely to affect nearly 50% of the clients accessing homelessness services, compared with 10% of the general population. Depression can be difficult to diagnose and understand because of its breadth of severity. It can be mild, moderate or severe to the point of debilitating and individuals can fluctuate between diagnoses. Homelessness is likely to compound feelings of depression, low mood and anxiety, especially as homelessness may be a result of another distressing life event, such as relationship breakdown, job loss, bereavement or debt. However, it is extremely important that a depression that incorporates long lasting low moods, impairs the abilities to function properly, feel pleasure or enjoy things is recognised and treated appropriately.

Commons signs (feeling the below on a regular basis, bot just one off)

- Feeling of helplessness and hopelessness
- Poor concentration and reduced attention
- Self-hatred, questioning and a need for reassurance

- Low motivation and energy

More serious cases:

- Suicidal thoughts and fears (or suicidal ideation)
- Issues with food
- Delusions and or hallucinations

TOP TIP

If individuals disclose more serious symptoms such as suicidal thoughts it is crucial to seek external support from the GP, community mental health teams, or other experts.

Causes

Depression can be caused by a number of issues including brain chemistry, social and environmental factors as well as genetic makeup. It is thought that issues that often affect homeless people such as adverse childhood experiences, poor relationships, neglect, and loss of a job or partner can affect a person's ability to cope and lead to depression. Lifestyle factors such as diet, exercise and substance misuse can also have an impact on depression. Physical illness (which is likely to be higher among homeless people) and medication may also contribute towards depression. It can be difficult to get support for someone who is suffering from depression within the homelessness sector as often the life circumstances can be seen as the main cause of the depression. However depression may have in fact led someone to become homeless, i.e. they have lost their home and job because of their depression and need long-term on-going support with this to enable them to live in more settled accommodation.

Support

Remember it is important to look at someone's support needs holistically and establish appropriate support that addresses all of their needs. Some activities that might help with depression include:

- Accessing self-help groups
- Learning about depression and ways to fight it
- Physical activity
- Visiting your GP
- Alternative therapies such as reflexology massage and breathing exercises
- Medical treatment such as anti-depressants
- Talking therapies including counselling, cognitive behavioural and psychodynamic therapies
- Exercise and nutrition.

Further information

Different types of depression can occur at certain types of our lives or year, such as post natal depression or seasonal affective disorder. For more information on depression, visit the Rethink website: [http://www.rethink.org/about mental illness/mental illnesses and disorders/depression/](http://www.rethink.org/about_mental_illness/mental_illnesses_and_disorders/depression/)

You can also find out tips to help with depression and take a depression test on the NHS website if are unsure how severe your problem is:

<http://www.nhs.uk/livewell/depression/pages/depressionhome.aspx>

2.3.5 ANXIETY

Anxiety is likely to affect 40% of the homeless population compared with around 4% of the general population. Social factors to do with being homeless such as instability, lack of earnings, low self-esteem, shared living and substance misuse can impact upon anxiety. It is important to understand what anxiety is and how people can seek help rather than simply viewing it as a symptom of homelessness and lifestyle. Someone's lack of emotional resilience and anxiety may have led them to become homeless in first place and therefore may need addressing before someone can move on.

Anxiety is often a normal feeling associated with change, new situations, feeling threatened or worried; this can happen when we start a new job or have something intimidating starting in our lives. Anxiety can sometimes be a useful feeling to help us deal with complex situations. However if individuals start to feel anxious a lot of the time for no obvious reason it can become problematic and difficult to deal with. Anxiety can have psychological and physical effects on individuals. When you feel anxious all the time this can be referred to as GAD – general anxiety disorder.

Commons signs of GAD

- Feeling very worried all the time
- Tiredness and an inability to concentrate
- Poor sleep
- Feeling depressed or stressed
- Feeling irritable

More serious cases could include issues such as:

- Panic attacks (shortness of breath and a irregular heart beat)
- Phobias

Causes

Anxiety can be caused by a complex range of issues such as genes, trauma, drug use and other mental and physical health problems. Current and past circumstances that have led to an individual becoming homeless may contribute to increased anxiety. Living on the streets may also have an impact: feeling isolated, in danger and weary can continue even after people leave the streets.

Support can include:

- Talking about the problem
- Self-help groups
- Seek counselling or support from your GP
- Learning to relax (breathing exercises or mindfulness techniques)
- Healthy eating and exercise
- Medication
- Assertiveness training: http://www.mind.org.uk/help/treatments/how_to_assert_yourself

More information on anxiety

Anxiety can be a really useful feeling that gives us adrenalin at times when we need it. However if it becomes too much and unmanageable it is important to get the right help. For more information and downloadable leaflets visit Mind, or the anxiety alliance websites:

http://www.mind.org.uk/help/diagnoses_and_conditions/anxiety

<http://www.anxietyalliance.org.uk/>

2.3.6 SUICIDE

Unfortunately people who are homeless are a high risk group in relation to suicide. This can be a stressful and tense environment for individuals at risk and those around them. Samaritans research shows that 85% of calls are about a multitude of problems rather than one thing in particular, suggesting that compounding factors lead to suicide. They suggest the kinds of reason people may attempt to take their lives include:

- Recent loss or the breakup of a close relationship
- An actual or expected unhappy change in circumstances
- Painful and/or disabling physical illness
- Heavy use of, or dependency on alcohol/other drugs
- History of earlier suicide attempts or self-harming
- History of suicide in the family
- Depression

Risks include

- Suicide is thought to be higher among the socially deprived, the depressed, those with severe illness, and those who are isolated or live alone
- Most (75%) of those who kill themselves have not been in touch with mental health services in the previous 12 months. Many fear stigma or hospital, especially a psychiatric ward
- Research suggests that individuals with certain types of personality disorder are at higher risk of committing suicide and self-harming. There is evidence that suggests up to 60% of people who are homeless or living within a hostel environment could be diagnosed with personality disorder. Therefore services need to be prepared to deal with these complex needs and high risks groups

Read more about who might be at risk:

http://www.samaritans.org/your_emotional_health/about_suicide/helping_others_at_risk.aspx

Things the Samaritans suggest to reduce the risk of suicide include:

- open and frank dialogue about issues that may be affecting someone
- talking generally about your feelings
- reducing stigma around accessing support for mental health issues

Good practice example

One organisation has formed links with the local Samaritans to offer free confidential sessions in-house. This offers a space outside of key work to receive one-to-one support in a safe environment.

Support

Risk assessment and support plans often include sections about suicide and self-harm; this can be hard for staff to ask about, however staff need to ask the right questions to reduce risk. Training and support should be provided to help people feel confident in asking the right questions about suicide but this doesn't have to be costly; practising in team meetings and shadowing opportunities can really help. Staff should ask questions sensitively and in the right environment, but should not shy away for fear of upsetting people. It can be explained that you are simply asking a standard form to gain an understanding to support them as best you can. If you think about going to the doctors this often happens and while it can feel a little uncomfortable it is necessary to understand someone's issues. It is very important that a staff member is concerned that someone is suicidal either because a client has disclosed this information or they have concerns about an individual that they tell someone. Staff must inform their manager and then a GP or CMHT must be involved.

Other resources to help with support around self-harm and suicide include:

NHS Direct: <http://www.nhsdirect.nhs.uk/>

Maytree <http://www.maytree.org.uk/index.php>

Samaritans:

http://www.samaritans.org/your_emotional_health/about_suicide.aspx?qclid=CJK_m4Le1qoCFZRc4Qodu3ha5w

More information

National mental health development unit - <http://www.nshn.co.uk/>

Young people and self harm <http://www.thesite.org/healthandwellbeing/mentalhealth/selfharm>

MIND http://www.mind.org.uk/help/diagnoses_and_conditions/self-harm

2.3.7 SELF-HARM

Self-harm is likely to affect 14% of people accessing homeless services, compared with 4% of the general population. Self-harm is difficult to understand and can be extremely distressing for those self-harming and the people around them. Many people who self-harm, are not attempting to commit suicide and are in fact using self-harm as a method of release from emotional pain, or a

coping mechanism rather than attempt to end their life. However self-harming is obviously a high risk behaviour and individuals who do self-harm are potentially putting their lives at risk. Self-harm is a broad term that covers lots of behaviours and actions, Mind describe self-harm as:

“Self-harm is a broad term. People may injure or poison themselves by scratching, cutting or burning their skin, by hitting themselves against objects, taking a drug overdose, or swallowing or putting other things inside themselves. It may also take less obvious forms, including unnecessary risks, staying in an abusive relationship, developing an eating problem (such as anorexia or bulimia), being addicted to alcohol or drugs, or someone simply not looking after their own emotional or physical needs.

Talking about self-harm may alleviate some of the associated stigma and discrimination towards this behaviour. It's often viewed as attention seeking behaviour, this is over simplistic. For most people self-harm is a private act and individuals make a lot of effort to hide it from others. People who self-harm are often in deep distress; it may be a way to communicate this pain and should always be taken seriously. Trying to ensure people feel comfortable talking to keyworkers and their GP about such issues means that measures can be put in place to support people reduce self-harming and also reduce the risks of self-harming. Therefore questions about self-harm should be built into risk assessments. Remember if you are concerned about someone's safety and wellbeing always tell someone, contact your manager and seek additional support from GP's, CMHT or A&E in an emergency.

Resources on self-harm:

Working with people who self-harm, do's and don'ts:

<http://counseling.uchicago.edu/vpc/uchicago/self-injury.html#tips>

Other resources:

http://www.rethink.org/living_with_mental_illness/coping_in_a_crisis/suicide_self_harm/

<http://handbooks.homeless.org.uk/resettlement/risks/seriousincident/suicide>

<http://www.thesite.org/healthandwellbeing/mentalhealth/selfharm>

<http://www.selfharm.net/>

http://www.mind.org.uk/help/diagnoses_and_conditions/self-harm

<http://www.nshn.co.uk/misconceptions.html>

Homeless Link also offer training on self-harm, for more information;

<http://www.homeless.org.uk/training-suicidal-clients>

COMMON MENTAL HEALTH ISSUES RELATING TO HOMELESSNESS

2.3.8 DUAL DIAGNOSIS

This term comes from psychiatry; it is a focus on mental health and health and literally means two diagnoses. Dual diagnosis is a term that refers to people who have both a diagnosed mental health illness and addiction issue or two different types of mental health diagnoses. Within mental health services and drug and alcohol services this is very specific and refers to individuals who have a primary:

- psychiatric illness leading to substance misuse
- substance use worsening or altering the course of a psychiatric illness
- Intoxication and/or dependency leading to psychological symptoms
- Substance use and/or withdrawal leading to psychiatric symptoms

This is an area fraught with contention and diagnostic dilemmas for practitioners, and is prominent within the homeless client group. Services are stretched and trying to establish the primary need can often mean individuals are passed between services. *The symptoms of psychosis brought on*

by drug use (“drug-induced psychosis”) and psychotic illness can overlap and even mask each other making an accurate diagnosis difficult (Rethink website 2011).

Hostels play a key role here in helping individuals navigate the services and working out how the support needs can be dealt with holistically. If dual diagnosis services don’t exist in your area, then staff play an important role in assuring support is joined up. Support agencies need to work together to support your client, and utilise the expertise out there. Establishing which need is the primary concern either drugs and alcohol or a mental health issue, monitoring behaviour and then making a case for support based on knowledge and evidence will help you to get the right support for an individual.

It can be very challenging working with this client group, as clients who are making unwise decisions around drug and alcohol use can be distressing and exhibit harmful and challenging behaviour. Having a clear understanding of the *Mental Health Act* can assist you with understanding how mental health diagnosis stands relating to addiction and the ‘unwise’ decisions individuals often make.

Resources on dual diagnosis:

[http://www.patient.co.uk/doctor/Dual-Diagnosis-\(Drug-abuse-with-other-psychiatric-conditions\).htm](http://www.patient.co.uk/doctor/Dual-Diagnosis-(Drug-abuse-with-other-psychiatric-conditions).htm)
<http://users.erols.com/ksciacca/>
<http://www.dualdiagnosis.co.uk/>
<http://www.turning-point.co.uk/inthenews/Documents/DualDiagnosisGoodPracticeHandbook.pdf>
http://www.mind.org.uk/help/diagnoses_and_conditions/dealing_with_anger#useful
<http://www.rethink.org/dualdiagnosis/>

TOP TIP

Turning point and Rethink have produced a dual diagnosis toolkit that can support the work you do. Ensure you support clients to navigate statutory services that can offer support and expertise. See: <http://www.turning-point.co.uk/inthenews/Documents/DualDiagnosisGoodPracticeHandbook.pdf>

2.3.9 SLEEP PROBLEMS

Unsurprisingly, not getting enough sleep was found to be a common issue among people accessing homelessness services, affecting nearly 50% of those surveyed in the health needs audit. Sleep can have a serious impact on mental health, mood and our ability to manage situations rationally. Sleep can be affected by noise, light, the use of substances, mental health issues, medication, the food we eat, stress levels, and partners. All of these issues can be addressed within hostels and should be taken seriously.

- This sample drugs policy and guidance notes contains detailed information about the effects of sleep on mood and mental health. It also offers top tips around how substance misuse and the food we eat affect sleep. It offers some very practical resources that can be used with individuals on a one-to-one basis or for group discussions.

<http://homeless.org.uk/evictions-abandonment-toolkit-sample-drugs-policy>

The mental health foundation has also recently published lots of useful information and guidelines on sleep: <http://www.mentalhealth.org.uk/our-work/mhaw/>

2.3.10 ANGER

Anger is a common and frustrating emotion, especially for people living in homelessness services who may feel frustrations linked to their current housing situation. Anger can be expressed in shouting, threatening or violent behaviour as well as silence, withdrawal and passive aggressive actions. Anger can be challenging to deal with as it can be threatening and potentially dangerous.

Some people need extra support in finding ways to effectively express anger. Remember anger is a horrible emotion to experience and some people find it extremely hard to control and cannot see the potential consequences of their behaviour. People with complex trauma or personality disorder may have difficulty controlling their anger due to emotional deregulation. This means they may lack the ability to regulate their emotions in the way other people can and therefore lash out in unpredictable ways seemingly never learning from their mistakes.

Also people's individual circumstances may lead them to feel extreme anger and this can be a useful emotion to help people take control and want to change their lives, however if anger becomes increasingly a problem, is threatening, or creates a risk then steps need to be taken to work with this individual. It may be useful to work with someone around what triggers their anger and help someone manage these triggers. Increasing self-awareness and offering alternative coping mechanisms may be useful. If anger becomes problematic people can be referred to the GP for extra support.



**TOP
TIP**

Help clients to understand the feeling of anger and look at finding ways to reduce this. You could run a simple workshop, just by using useful online information. Check out the calm zone:

<http://www.thecalmzone.net/talk/issues/anger/?gclid=COX28sSH96oCFUdTfAod0wIZLQ>

More resources on dealing with anger include:

MIND leaflet on how to deal with anger:

http://www.mind.org.uk/help/diagnoses_and_conditions/dealing_with_anger

Mental health foundation:

<http://www.mentalhealth.org.uk/help-information/mental-health-a-z/A/anger/>

2.4 UNDERSTANDING TREATMENT AND SUPPORT OPTIONS

Treatment and support for various mental health issues is once again a contentious and complex area. A multitude of medical treatments, talking therapies and alternative treatment and support options are available. However access to these various forms of treatment and support may vary depending on where you live and your local health services' approach. This section outlines the various approaches to treatment and support that are available, while section four and five will offer more practical ways to implement support.

The table below outlines some of the treatment and support options available to clients with varying needs. This section also introduces some key terms that it may be helpful to be familiar with. Understanding what approaches there are to treating mental ill health and wellbeing issues will enable you to support clients effectively and ask for extra support from agencies if you feel someone is not being supported adequately.

TOP TIP

Evidence suggests that counselling and psychotherapy can have great results working with homeless and ex homeless clients who have underlying problems related to childhood abuse or neglect.

Some understanding of the terms used within primary and secondary support will be helpful for supporting individuals. Below is a table to help you:

Treatment and support	When appropriate and who can provide it	Benefits	Risks
Hospital treatment (psychiatric ward)	Only an approved mental health professional can admit someone to hospital, although sometimes people can self-refer if they feel they are at risk to themselves or others	Safe and secure Offers respite Get immediate support	Previous negative experiences May remove choice and control (if a secure unit)
Medication	Only an approved mental health professional can prescribe and administer controlled substances	Can provide immediate relief Can be stabilising Can offer long term solutions if reviewed and monitored	Various side effects, depending on type of medication. For more information visit the Mind website.
Talking therapies, such as counselling and or psychotherapy	Psychotherapists, counsellors with suitable training and supervision in place	Can get to the route of the problem Equips people with long lasting coping mechanisms	May make things temporarily worse before they get better
CBT/DBT - Cognitive or dialectical behavioural therapies	People who have received appropriate levels of training. (Keyworkers should have some skills associated with talking therapies such as an introduction to CBT methods or motivational interviewing)	Can have relatively quick results Equips people with long lasting coping mechanisms	Can't always address more deep rooted issues and not always sufficient
Relaxation techniques	For low level stress and anxiety and generally to help build resilience and coping strategies	Can be done taught easily using online tools	As above
Alternative treatments such as massage, reflexology, homeopathy	Trained professionals in various fields. Can help with a range of issues, especially around stress and anxiety	Avoid hospital treatment Can be relatively cheap (although not always available via the NHS)	As above

There are many more forms of treatment and support available. To find a comprehensive A-Z list please visit the MIND website as well as the NHS guide to treatment for mental health issues: http://www.mind.org.uk/help/medical_and_alternative_care

Approaches to be aware of when working with clients with MH and wellbeing needs

Useful terms	Brief explanation
Personalisation	An approach developed in the social care sector mostly, but becoming increasingly good practice across the board. Involves working with clients individual needs in a personalised way and providing opportunities for choice and control around care and treatment. For more information please visit our website: http://homeless.org.uk/personalisation
Care programme approach	An approach adopted in the late nineties within mental health and is around continuous and on-going support for people with diagnosed mental health issues. It demands clients' treatment is reviewed regularly and people's changing needs are met. Most people currently receiving support from mental health teams will be under the care programme approach.
Recovery	Recovery from a mental health problems means different things for different people depending on the issue. However more and more services are focusing on ensuring people recover and find meaningful and fulfilled lives regardless of poor mental health experiences. Recovery or the recovery approach is a new initiative therefore, which is currently being implemented in mental health teams across the country. It is outlined within the 'No health without mental health strategy' 2011. The focus is on a cultural change within mental health teams to adopt the recovery model. Some agencies are leading the way with the Implementing Recovery Organisational Change (ImROC) Project To find out more see: http://www.nhsconfed.org/NETWORKS/MENTALHEALTH/OURWORK/Pages/NMHDU-Implementing-Recovery-Organisational-Change-Project.aspx
Safe guarding/ SOVA	Other powers may ensure you get the necessary support for a homeless client at risk. If you believe a client is the victim of abuse (e.g. physical, financial, sexual, psychological, neglect) you should raise an alert with the local authority's Safeguarding of Vulnerable Adults lead, who will often work in Social Services or the CMHT. You will need to provide details of the suspected incident(s) of abuse and why the client is vulnerable. The SOVA lead will assess the client's vulnerability and the evidence of abuse. If the answer is yes to both, they will call a case conference of professionals to agree what support is required to safeguard the client and implement an action plan. SCIE have put together some guide lines on; Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse http://www.scie.org.uk/publications/reports/report39.asp
IAPT (improving access to talking therapies) programme	This is a national programme aimed at increasing the amount of talking therapies (counselling, psychotherapy and Cognitive behavioural therapy CBT) available to people with mental health and wellbeing needs. To find out more about services in your area see: http://www.iapt.nhs.uk/

2.5 STREET HOMELESSNESS AND MENTAL HEALTH

Teams working with rough sleepers can face challenging situations in which they feel a person clearly lacks capacity to make wise choices and is neglecting themselves in a way that is likely to cause harm in the long run. Having a good understanding of the *Mental Health Act* and the *Capacity Act* is crucial to get the appropriate support for individuals. Statutory services can work in different ways across the country depending on resources, which means people can get very different responses depending on where they are found rough sleeping, however the Mental Health Act is there to protect individuals from harming themselves and other people.

Below are two case studies that illustrate that rough sleeping in itself can be a reason to utilise the *Mental Health Act* and admit individuals to hospital for more care and support. These may enable you to work with your local authority around developing such an approach, however remember that these powers can have serious implications for individuals and everyone's case will need to be dealt with on a case by case basis. Homelessness services that develop successful working relationships with mental health teams appear to work best at delivering effective support for individuals. The specialist homelessness mental health team worked for nearly ten years to develop a more proactive approach to the hospitalisation of rough sleepers, it required effective multi-agency work to have beneficial results and constantly requires reviewing.

Using the Mental Health Act – an example from the Joint Homelessness Team

The Westminster Joint Homelessness Team was set up to work with rough sleepers in Westminster. Through intensive work and on-going evaluation it became apparent that firstly, compulsory admission was indeed often an effective form of intervention. (It often resulted in permanent improvements in the quality of life of rough sleeping clients). Secondly, definite patterns emerged to explain why they ended up detaining some people under the Mental Health Act and not others, which the team sought to address.

Certain triggers were needed to prompt the team to taking the steps towards assessing the client under the Mental Health Act. A group of people who did not present with these triggers did not get assessed and were neglected. It was difficult to identify the characteristics which distinguished those who had been housed without the need for compulsory admission. However the quantitative study showed that a willingness to engage early on generally indicated that progress could be made without compulsory intervention. The team felt that in both groups the availability of suitable housing that was acceptable to the clients and offered a flexible level of support was essential to achieving a positive outcome.

The team felt that their instincts were validated: with people who were clearly mentally ill and refusing all offers of help, a more assertive approach was necessary, and adopting a planned approach to compulsory admission rather than waiting for a crisis to present was the way forward.

The JHT used the evidence based they had collected around this approach to ensure the hospital staff understood the long term benefits of admission and treatment for rough sleepers. They continue to work effectively with rough sleepers applying these more proactive methods towards assessment and hospitalisation of rough sleepers with excellent results

Another recent development in Westminster has seen the setting up of training and support sessions by the local personality disorder service, to give expert advice and guidance to those working with homelessness agencies and help meet the needs of their service users with personality disorders. To read more about this see the case study in SECTION FOUR.

Rough sleeper refusing shelter

Craig was first found by the outreach team mid-November in 2010, he reported that he been rough sleeping for 20 years in various locations across the country. The team had immediate concerns for his mental health and referred him to the local Community Mental Health Team (CMHT) for an assessment. Craig also presented with poor physical health including scabies. Craig refused to engage with any services and refused any medical attention. The outreach team arranged for services such as the St John Ambulance to visit him on his sleep site. They also involved the local police team who also used a targeted approach to try and engage with Craig on a regular basis. Some weeks later Craig was assessed under the Mental Health Act. He was not found to be detainable. Craig however was still extremely unwell, showing signs of deterioration and continued to refuse all offers of accommodation, despite the plummeting temperatures.

Discussions continued between all the teams involved; outreach, CMHT, the drug and alcohol action team and the police regarding Craig's safety and wellbeing. Services considered the options available to maintain his safety in cold weather if he continued to refuse accommodation. These options included repeat mental health assessments and the use of the Vagrancy Act. The Vagrancy Act could be used to arrest a rough sleeper following refusal of accommodation, allowing the police to keep Craig in custody overnight if all other options fail and there is genuine concern regarding potential loss of life.

Staff worked hard to put forward the risk that Craig presented to himself and demonstrated their concerns by illustrating his behaviour to the CMHT in an accurate way. Craig was assessed under the Mental Health Act again one week later and this time Craig was detained under Section 2. Craig was therefore taken to hospital where he received appropriate treatment and support. Craig has since stabilised, receiving support from a partnership of agencies: he takes his medication regularly and is maintaining accommodation accessed through mental health services. His physical health has greatly improved and he is planning for his future.

Lessons learnt

Craig was extremely unwell and homelessness services fought hard to ensure he got the support he was entitled to. Mental health services needed to ensure his human rights were protected and he was correctly diagnosed, which can take time and it means presenting cases in-depth. The joint working and intelligence use of external services and the law meant that Craig got the response he required. The use of the Vagrancy Act wasn't necessary in the end, but understanding it meant the agencies had options to protect the individual if they felt the wrong decision had been made by the CMHT. Through this complex case working, relationships between the various teams have been forged and well enable future cases to be addressed in a joined up way.



HOMELESSNESS, MENTAL HEALTH AND WELLBEING GUIDE

**SECTION THREE:
HOW TO SUPPORT HOMELESS PEOPLE
WITH MENTAL HEALTH AND WELLBEING
ISSUES**

HOMELESSNESS, MENTAL HEALTH AND WELLBEING GUIDE

SECTION THREE: HOW TO SUPPORT HOMELESS PEOPLE WITH MENTAL HEALTH AND WELLBEING ISSUES

3.1 Putting theory into practice	
3.2 Assessing the mental health and wellbeing needs of clients	
3.3 Support options	

3.1 PUTTING THEORY INTO PRACTICE

Understanding individuals' mental health and wellbeing issues, and the treatment available, as outlined in section two, will give you a good grounding in knowing how to go on and support clients. This section has been put together to enable you to identify what the best approach might be for your clients. Individual's mental health and wellbeing will vary incredibly in terms of severity across your service and the level of intervention required will also be very different.

You will need to develop ways of effectively assessing and monitoring individuals to ensure you get the right level of support in place and can respond to changes in level of need. This section looks at how you may appropriately assess individuals within your service and outlines the support pathways your organisation should have available.

Remember tools can be useful, but knowing clients circumstances well and having a common sense approach to risk and support needs will ensure you support individuals effectively. Tools should always be used alongside discussion, expert opinion and consultation with clients and other services.

3.2 ASSESSING THE MENTAL HEALTH NEEDS OF CLIENTS

BUILDING A RELATIONSHIP WITH CLIENTS

Whatever kind of support you think an individual may need, it is crucial that you establish a way to work with people. Living in a hostel may exacerbate the likelihood of mental health issues becoming more serious, so monitoring and on-going support is crucial to ensure clients who are 'down' or 'distressed' do not deteriorate. Support workers and housing staff play a large role in improving wellbeing of clients and helping them through key work and informal contact to build resilience and responsibility. The chart below gives some examples and methods of how you can support people through practical on-going support in-house as well as through external referrals. Three key areas to work with clients who cannot or will not get secondary support include resilience, responsibility and engagement:

- **Resilience** – evidence suggests that people who have stronger coping strategies and have developed resilience are more likely to build strong and happy futures for themselves. Many people who become homeless and excluded have not been able to build these skills for many reasons. Resources to help you support clients build resilience include:
<http://www.centreforconfidence.co.uk/pp/overview.php?p=c2lkPTU=>
http://www.bitc.org.uk/community/employability/homelessness/emotional_resilience.html
- **Responsibility** – helping clients to learn how to take responsibility for themselves is a key part to any support worker's role. Life skills workers need to ensure they look at ways to build people's sense of responsibility for themselves.
- **Engagement** – The voluntary sector prides itself in being able to work with hard to reach clients in imaginative ways, however we occasionally feel we have exhausted all opportunities. There are always new ways to try to help individuals make changes. Ensure you celebrate and reward all successes however small they may seem. Keep sharing good practice and supporting one another across various agencies to work together. If people are living in your service or accessing your drop-in they are in one way or another engaging, so make every effort to build on any steps that are taken in the right direction. Your acceptance and tolerance will slowly build trust and hope, which allows people to slowly make positive changes.

Top tip - service user groups

Remember to utilise mental health service user or patient groups as a way to offer extra support to clients and influence the way services are delivered. They may offer advocacy for clients and help you and clients to find out more about how mental services in your area work.

Patient care: <http://www.patientopinion.org.uk/>

ASSESSING NEED

Assessing the mental and emotional support needs of clients is an on-going challenge for support workers. Assessment is important with regards to managing risk, providing suitable support internally and making appropriate external referrals. Assessing need should be an on-going process and should be in conjunction with partner agencies. It is important to remember that it is not support workers' roles to diagnose individuals unless you are suitably trained and working with appropriate supervision in a specifically funded role. However carrying out assessments that establish support needs and indicate risk will enable you to work safely and provide appropriate support to clients. Accurate assessment is an important and skilled aspect of support workers' roles. Time should be dedicated in supervisions, training and team meetings to ensure staff can confidently carry out meaningful assessments. The information in section two of this guide on common diagnosis should help you to learn more about various mental health issues and the impact they can have on individuals.

What should we be asking to assess need?

You will need to make sure you ask appropriate questions about mental health and wellbeing during initial assessments, support planning and risk assessment. You need to feel confident to ask difficult questions if you are going to be an effective support worker. Remember your job is not to diagnose or treat, but to offer the right level of support and referral pathways. Questions areas to incorporate into this paper work include.

- How someone is feeling
- Significant events including relationship breakdown
- Coping abilities
- History of mental health issues
- Sleep
- Food
- Substance misuse
- What someone is doing with their time
- Suicidal thoughts
- Anger
- Lowliness and isolation
- Medication

The Outcomes Star is an example of a tool that provides a great means to start asking about these complex issues, without feeling intrusive. For more information visit:

<http://homeless.org.uk/outcomes-star>

IDENTIFYING APPROPRIATE SUPPORT

Brief screening and referral tool

The tool at appendix one has been put together to establish what we can refer to as *indicative thresholds*, i.e. what various thresholds people have to meet to gain access to various different types of support both external and in-house. Please note this is not a diagnostic tool, but a chart to help you establish what thresholds people meet and the level of intervention an individual may need. The chart by no means covers all individual cases as people's circumstances require personalised responses that do not fit neatly into boxes. However, hopefully the tool will enable staff to decide what direction to start supporting clients in and will help staff feel more confident in their key working sessions. You may wish to develop your own more in-depth tool that is specific to your own organisation.

National Health Service (NHS) tools

There are tools available online that can help you with assessment and supporting clients in-house. For example, the NHS has developed a number of quick online assessments for issues such as stress, depression and anxiety. They may help clients establish whether their needs require support from the GP or an external professional or whether there are lifestyle changes that can be made with your support to reduce the symptoms they are experiencing. Please visit the [NHS website to carry out these simple trials:](http://www.nhs.uk/Tools/Pages/depression.aspx?Tag=Health+assessments)

<http://www.nhs.uk/Tools/Pages/depression.aspx?Tag=Health+assessments>

TAG assessment form

The TAG tool has been put together by King's University and is a quick assessment tool to establish whether someone meets the statutory requirements for mental health support. It is used by GPs and other mental health providers, but may also be useful in a housing setting to help assess need around mental health. This was developed because many services fail to refer to mental health adequately, including GPs, police and voluntary sector organisations. You can also use this tool to help with risk assessment. It may help you to establishing a case for external support by helping you to use language and terminology with which mental health services are familiar.

It assesses need in 3 different areas and may allow you build a case for support from secondary services. The areas it covers include:

- a) SAFETY assesses the level of concern about intentional self-harm (domain 1) and unintentional self-harm (domain 2)
- b) RISK identifies the risk from others (domain 3) and to others (domain 4)
- c) NEEDS AND DISABILITIES assesses survival (domain 5), psychological (domain 6) and social (domain 7) difficulties in the patient's life

To download the TAG resources and accompany documents please visit the website:

<http://www.iop.kcl.ac.uk/projects/?id=10274>

The Recovery Star

The Mental Health Recovery Star is a tool developed by Triangle consultancy and is currently administered by the Mental Health Providers' Forum. It works in a similar way to the Outcomes Star developed for homelessness services, but focuses entirely on mental health and wellbeing recovery. It has 10 different focus areas and can be used as an assessment and key work tool. As mental health services move towards recovery, this will be a complementary tool to use with clients who are engaged in the mental health and homelessness services. It is also likely to be used by charity organisations such as MIND. For more information visit:

<http://www.mhpf.org.uk/recoveryStarApproach.asp>

Good practice example:

Redbridge Places of Change Partnership – Homelessness Common Assessment Form

Redbridge Places of Change Partnership in east London has developed a homelessness common assessment form to enable agencies to work together more effectively with homeless people in the borough, particularly around their health needs (including mental health). The form was designed in partnership with all organisations that are part of the newly developed pathway, from street outreach to second tier accommodation. A Common Assessment Form has obvious benefits in saving time and unnecessary duplication for both staff and clients. The questions around mental health are brief and concise and effectively pull out the main issues that may need to be addressed. The important work is ensuring all agencies are asking the same questions and can therefore use the information in a joined-up way effectively supporting clients. Please find the common assessment framework as appendix three.

ON-GOING SUPPORT AND MONITORING

Clients you support may not show any signs of mental health or wellbeing issues in their initial assessment, however people may need support around dealing with their current circumstances and new emerging issues, so assessments and case reviews need to be done regularly with a focus on mental health and wellbeing. You will also need to put measures in place to offer on-going support and monitoring to ensure if individuals circumstances improve or worsen that you can respond effectively. Using the outcomes star and effective support planning paperwork will help you to monitor how people are doing within your service.

3.3 SUPPORT OPTIONS

As outlined in the tool as appendix one, there are three main options for support:

OPTION 1 – IN-HOUSE SUPPORT

This includes delivering effective key working, looking at what services and support can be offered in-house such as wellbeing activities, sport, exercise, healthy eating, and client involvement. This also includes delivery of awareness-raising work and inviting external partners in to support the work you do.

OPTION 2 - REFER TO PRIMARY CARE

This mainly means referring to the GP, however good practice services may have nurses and doctors onsite who can deliver primary care responses in-house. You will need to be aware of what primary care options your GP has and referral options to effectively support clients to engage with the support available. This will include talking therapies, counselling and CBT. It may also include gym membership, nutrition advice and some types of medication. GPs can also advise on referrals to secondary care provision so relationships and communication is vital.

OPTION 3 - SECONDARY CARE

This includes support from statutory mental health services, where a package of care can be developed for individuals who require this level of support. This may include medication and one-to-one support for a Community Psychiatric Nurse (CPN) or a social worker. This may also mean hospital admission is required as well as support from psychiatrist and doctors.

The next sections of this document outline good practice in how you can:

Implement OPTION 1 IN-HOUSE SUPPORT

Section four: Looks at how to; Develop your internal responses to create a psychologically informed environment.

Implement OPTION 2 and 3 REFER TO PRIMARY CARE AND SECONDARY CARE

Section five: looks at how to; Develop excellent working relationship with providers of primary and secondary care.

APPENDIX ONE: BRIEF SCREENING AND REFERRAL TOOL

This is a mental health referral and screening tool for organisations working with homeless people. Workers can ask questions based around the signs and symptoms listed below. The severity of the issue will identify the support intervention the client may require.

Client	Referral and support options
<p>Sometimes feeling low and isolated (for example spending a bit too much time in your room)</p> <p>Not always interested in seeing other people</p> <p>Occasionally having problems sleeping</p> <p>Feeling sad and low about your current circumstances</p> <p>Not very motivated to change circumstances</p> <p>Don't want to engage in activities in or outside the hostel</p> <p>Occasionally using substances as a way to cope</p>	<p><u>OPTION 1 – INTENSIVE IN-HOUSE SUPPORT</u> Internal support around social networks, exercise diet and support</p> <p>Use support planning tools – make personalised action plans to address wellbeing issues</p> <p>Continue to monitor and ensure client does not deteriorate</p> <p>Use a team approach to check in with client regularly</p> <p>Use tools such as CBT, motivational interviewing and a person-centred approach</p> <p>Ensure they are given information about mental health support, including anti-stigma</p>
<p>Feeling low and isolated a lot of the time (for example spending lots of time in your room)</p> <p>Hardly interested in seeing other people</p> <p>Over or under-eating</p> <p>Having problems sleeping</p> <p>Feeling helpless about current circumstances</p> <p>Very unmotivated to change circumstances</p> <p>Occasionally having suicidal thoughts</p> <p>Using substances often as a way to cope</p>	<p><u>OPTION 2 - REFER TO PRIMARY CARE</u></p> <p>Refer to GP – be aware of the support options they can provide such as counselling, other talking therapies, gym passes, alternative therapies and medication</p> <p>Work with client around utilising GP support; help them to explain how they are feeling before the appointment, perhaps getting individual to write it down. Give clients a copy of any support plans to take with them to the GP</p> <p>Refer to in-house talking or psychological therapies such as CBT if available</p> <p>Plus continue with OPTION 1 support</p>
<p>Displaying behaviour that puts you or other people at immediate risk including self-harm</p> <p>Expressing suicidal thoughts</p> <p>Hearing voices</p> <p>Barely sleeping or eating and showing signs of self-neglect</p> <p>Stopped complying with medication or previous mental health interventions</p> <p>Showing signs of developing a serious mental illness, such as schizophrenia, psychosis and personality disorder (see more detail in section 1)</p> <p>Substance misuse becoming unmanageable</p>	<p><u>OPTION 3 SECONDARY CARE</u></p> <p>Refer to statutory mental health services such as community mental health or recovery teams, the crisis team and in emergency call 999</p> <p>Ensure on-going multi-agency work is embedded in work practice including case reviews.</p> <p>Plus continue with OPTIONS 1 and 2</p> <p>*For more details on making a case for external support see section 5</p>

APPENDIX TWO: REDBRIDGE COMMON ASSESSMENT FORM

Client Details				
Name				
Known as:				
Date of Birth		Age		Estimated? Yes/No
Gender	Female <input type="checkbox"/>	Male <input type="checkbox"/>	Transgender <input type="checkbox"/>	Prefer not to say <input type="checkbox"/>
NI Number			Mobile. No	
Email address				
CHAIN Number if appropriate		Verified?	Yes / No	
Preferred Language			Nationality	
Spoken English Ability	High		Medium	Low
Borough:				
Address/Sleeping site:				
Ethnicity:				
White British <input type="checkbox"/>	White Irish <input type="checkbox"/>	Other white background <input type="checkbox"/>	Chinese <input type="checkbox"/>	
White European <input type="checkbox"/>	Black Caribbean <input type="checkbox"/>	White & African <input type="checkbox"/>	Middle Eastern <input type="checkbox"/>	
Asian British <input type="checkbox"/>	Black African <input type="checkbox"/>	White & Asian <input type="checkbox"/>	Latin American <input type="checkbox"/>	
Asian Pakistani <input type="checkbox"/>	Other Black background <input type="checkbox"/>	Other mixed background <input type="checkbox"/>	Any other group <input type="checkbox"/>	
Asian Indian <input type="checkbox"/>	Black British <input type="checkbox"/>	Gypsy/Romany/Traveller <input type="checkbox"/>		
Asian Bangladeshi <input type="checkbox"/>	Mixed Ethnicity <input type="checkbox"/>	Any other Asian background <input type="checkbox"/>	Declined <input type="checkbox"/>	
Religion:			Prefer Not to say:	<input type="checkbox"/>
Sexuality: Heterosexual <input type="checkbox"/>	Gay <input type="checkbox"/>	Bisexual <input type="checkbox"/>		
Lesbian <input type="checkbox"/>	Other <input type="checkbox"/>	Prefer Not to say <input type="checkbox"/>		

List benefit type, current income, weekly amount and date received from		
Type of Income	Weekly Amount	Dates received from
	£	
	£	
	£	
	£	
What ID do you have? If None, why not? (eg No recourse to public funds, failed claim, failed HRT)		
If claiming, which office?		
Does the client have any outstanding loans/debt?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

<i>(If 'yes' complete below)</i>	

Immigration Status:			
Asylum Appellant	<input type="checkbox"/>	Asylum Seeker	<input type="checkbox"/>
Exceptional Leave	<input type="checkbox"/>	Failed Asylum Seeker	<input type="checkbox"/>
Illegal Entrant	<input type="checkbox"/>	Indefinite Leave to Remain	<input type="checkbox"/>
Other	<input type="checkbox"/>	Overstayer	<input type="checkbox"/>
Not Known	<input type="checkbox"/>		
		Discretionary Leave	<input type="checkbox"/>
		Failed HRT	<input type="checkbox"/>
		N/A	<input type="checkbox"/>
		Refugee	<input type="checkbox"/>

Have you approached a local council? Yes <input type="checkbox"/> No <input type="checkbox"/> Which Council?:				
Housing History – at least the last 5 years				
Address	From	To	Accommodation type	Reason for leaving Please provide details of abandonments and evictions
				How did you become homeless?
Is there any type of accommodation or particular area that you would not consider and if so, why? (eg fleeing violence, family links, ASBO, restraining order)				
Have you been a victim of domestic violence or are you currently fleeing domestic violence?				
When?			Reported to Police?	
Used refuge accommodation?			Details:	
Did you leave your home as a result of a court order or due to an accusation of domestic violence?			Please give details:	

Institutional History

Address	Yes/No	Date of leaving
Armed forces:		
Care:		
Last Prison:		
<p>List of offences that may affect housing options: (eg violent offences, sex offence, arson, known to MAPPA or on supervision/probation order) - type of licence and end date:</p>		
<p>Probation Officer: Name/Office</p>		<p>Contact details:</p>

Links to Other Agencies		
Agency	Name of Worker/Office	Contact Details
Drug/Alcohol Worker/Counsellor		
Advice service (eg. Daycentre, CAB, immigration etc)		
Other: (eg Social worker, keyworker, housing worker)		

Needs Assessment		
Subject	Yes/No	Details
Gambling Problems		
Dog Owner		
Couple		
Anti-Social Behaviour; Do you have an ASBO?		

Physical and Mental Health Issues (specify the client's physical health needs)

Hearing impairment <input type="checkbox"/> Stroke <input type="checkbox"/> TB <input type="checkbox"/> Blind/Sight impairment <input type="checkbox"/> Mobility difficulties <input type="checkbox"/> Out-patient hospital treatment <input type="checkbox"/> Other <input type="checkbox"/>	Notes of physical health needs and details of current treatment:
---	---

Are you currently linked in with mental health services? Yes / No

Have you ever been linked into mental health services? Yes / No

Please give details below of any experiences of mental health problems including any formal diagnosed illness, history of suicide attempts or self harm? (Include details of prescribed medication)

Details of GP and/or other healthcare professionals (eg CPN, psychiatrist, consultant) :

Substance Dependency Issues

	Name of drug/alcohol	Age first used	Frequency of use	Amount used (£/weight/units)	Ever injected (Y/N)	Currently injecting (Y/N)
Problem Substance 1						
Problem Substance 2						
Problem Substance 3						

Comments

Are you prescribed methadone or other treatment? Yes No
Where are you scripted?
What is the script for?

Do you have any health needs in relation to your substance use (eg Hep C)?

Have you been linked to any drug or alcohol support services not mentioned above? Please provide details:

Additional Notes (include information on detox and rehab treatment)

Next of Kin Details

Name	
Phone Number	
Address	
Relationship	

Any further information?

When and what was your last job? (For CEE nationals, were you registered on the Workers Registration Scheme?)

Client Consent and Information Disclosure Form

_____ (name of organisation) needs to collect information about you and whatever involvement we have with you and work we do on your behalf to make sure we have a proper record of our work. We may also share this information with other agencies responsible for providing services for homeless people, to help you get the services you need and provide important statistics.

Declaration:

I consent to _____ (name of organisation) staff and their agents collating and storing information about me and, when appropriate, sharing, keeping and receiving information with the individuals, agencies and statutory bodies. I understand that I am entitled to see any information kept about me and register my views about anything which I believe to be incorrect.

Name: _____

DOB: _____

Signed _____

Date _____

Birth Certificate Details (if applicable)			
Surname at birth		Clients Forename(s)	
Mothers Maiden Name		Fathers Surname	
Mothers First Name(s)		Fathers First Name(s)	
Date of Birth		Place of Birth *	

Assessor Details			
Name			
Agency Name & Address			
Tel. No.		Fax No.	
Email address		Date completed	

Initial Risk Assessment

Name:

DoB:

Worker's name:

Agency:

1. Are there currently any concerns to indicate immediate risk to self or others?

2. Risk assessment History:

- History of violence
- History of Domestic violence
- History of Suicide attempts
- History of self harm
- History of self neglect
- History of arson
- Recently left – prison
- Recently left – hospital
- History of sex offences
- History of incidents involving the police
- History of mental health difficulties
- Other history [please state]

3. Risk Behaviour:

- Accidental harm
- Heavy alcohol use
- Drug use
- Overdose
- Non compliance with medication
- Self neglect
- Inappropriate sexual behaviour
- Violence toward staff or members of the public
- Violence to other clients
- Abandonment
- Other [please state]

If you tick any box then please give details below.

4. Are there any concerns about potential risks?

5. Are you lacking information/unable to assess for other reasons? Any follow up action required?

Signed by person completing the assessment:

Date completed:

Risk Management Plan and Follow-up notes:	
Please state measures to manage risks identified in Initial risk assessment (who is at risk, from what, by whom and steps to lessen the risk)	Done Y/N
Who needs to be informed:	
Any follow up work/information: Date:	Signed:

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Actions to be completed (e.g. obtain ID, benefits, referral to rolling shelter, hostel etc)	
1.	
2.	
3.	
4.	
5.	



HOMELESSNESS, MENTAL HEALTH AND WELLBEING GUIDE

SECTION FOUR: DEVELOPING INTERNAL RESPONSES

SECTION FOUR: DEVELOPING GOOD PRACTICE WITHIN YOUR SERVICE

This section is to help you deliver excellent in-house responses to promote wellbeing and prevent mental health deteriorating among people accessing homeless services. This section offers guidance around implementing good practice by developing excellent frameworks and introducing activities such as sport, art and getting out into nature. It then moves on to look at how you can develop a psychologically informed environments (PIE's), a good practice model that focuses on reflective practice within a hostel setting.

4.1 Mental health and wellbeing impact assessment	
4.2 Wellbeing and social networks	
4.3 Improving wellbeing through client involvement	
4.4 Wellbeing, exercise and sport	
4.5 Wellbeing and engaging in the arts	
4.6 Wellbeing and nature	
4.7 Wellbeing and nutrition	
4.8 Reducing stigma and raising awareness	
4.9 Looking after number 1	
4.10 Creating psychologically informed environments	

4.1 MENTAL WELLBEING IMPACT ASSESSMENT

The Mental Wellbeing Impact Assessment (MWIA) tool has been put together to help organisations ensure that all the activities they do have a positive impact on wellbeing. The tool is useful in planning and reviewing services in terms of how they may impact upon individuals' sense of wellbeing. It can support reducing stigma and discrimination and give a new focus and attention to this often over shadowed issue.

MWIA uses a combination of methods, procedures and tools to assess the potential for a policy, service, programme or project to impact on the mental wellbeing of a population. MWIA makes evidence-based recommendations to strengthen the positive and mitigate against the negative impacts, and encourages a process to develop indicators to measure impacts.

For more information about the tool see: <http://www.apho.org.uk/default.aspx?RID=70494>

4.2 WELLBEING AND SOCIAL NETWORKS

Social networks are essential for us all to live happy and fulfilled lives. Projects, while offering support, can often stigmatise people and remove them from everyday social networks of family and friends. Homelessness can often stem from relationship breakdown and negative relationships. Equipping individuals with skills to build positive relationships with people and communities is an essential part of any key workers role. Building social networks should be an active part of people's individual support plans as well as ensuring it is built into planning and development for the project. Building social networks if you are homeless and experiencing mental health or wellbeing issues can be particularly difficult and every effort needs to be made to ensure people aren't isolated and opportunities are available. This may require that your organisation takes a different approach and makes sure that it isn't isolated from the local community, but engaged and connected to the people and activities around it. The activities and approach outlined throughout this section will help individuals to build social capital.

Social capital

This is a term you may hear used more and more as we begin to realise that people who do well in life have a lot of social capital. The idea is that social capital is what holds communities together: shared beliefs and actions that change things encourage people to invest in their local communities. There are three main types of social capital described in a Joseph Rowntree Foundation research paper.

Bonding

Relates to common identity, for example ties among people who are similar to each other. Type of participation: within communities. Role in civil society: shared common purpose, for example members of families, ethnic groups, and clubs.

Bridging

Relates to diversity, for example ties among people who are different from one another. Type of participation: across communities. Role in civil society: dialogue between different interests and views in the public sphere, for example associations, fellowships, trade unions.

Linking

Relates to power, for example ties with those in authority or between different social classes. Type of participation: between communities and organisations and with structures outside communities. Role in civil society: access to power institutions and decision making processes, for example local authorities, representatives on LSPs.

Our role in hostels and homelessness services is to provide as many opportunities for these types of social capital to be built across neighbourhoods, groups and virtual forums to ensure individuals have a stake in their communities.

Ideas you project can develop include:

- Working with individuals to rebuild relationships with estranged family and friends
- Counselling and support from services such as Relate
- A focus on bullying and behavioural change
- Personal development courses for clients in - self-awareness, confidence building, anger management, working with other people
- Encourage group work between residents
- Parenting skills
- Working with external partners such as Relate and family groups
- Client involvement
- Using social media tools
- Awareness raising events about your project and aims
- Community projects
- Engage with local voluntary sector orgs
- Setting up befriending and mentoring schemes

Good practice tools and examples

Lemos and Crane have put together a tool to help workers in promoting relationships, positive identity and interests, and independence: <http://www.lemosandcrane.co.uk/rise/login.php?>

Information on social networks –

- Social capital <http://www.statistics.gov.uk/CCI/nugget.asp?ID=314>
- <http://www.idea.gov.uk/idk/core/page.do?pagelId=1347434>

For more information on activities visit our website:

- Meaningful Occupation: <http://www.homeless.org.uk/meaningful-occupation>
- Education, training and employment: <http://www.homeless.org.uk/education-training-employment>

4.3 IMPROVING WELLBEING THROUGH CLIENT INVOLVEMENT

Research from the new economics foundation states that there are five ways to improve wellbeing through:

- Being active
- Giving
- Keeping learning
- Taking notice
- Connecting

<http://www.neweconomics.org/projects/five-ways-wellbeing>

These five factors can easily be established within your service through having active client involvement embedded in all the work your service does. Effective client involvement means working in partnership with clients to find sustainable solutions for homeless and vulnerable people. Homelessness services need to provide opportunities for clients to be involved across all aspects of service delivery, from their own individual support plans through to decision making at board level. Implementing client involvement isn't always easy, it needs real investment, enthusiasm and a dynamic approach. Please view our good practice tips and resources to support you and your organisation:

- Involve clients in their own support:
<http://www.homeless.org.uk/Involving-clients-in-their-support>
- Involve clients in services
<http://www.homeless.org.uk/client-involvement-services>
- Involve clients in the wider community
<http://www.homeless.org.uk/involving-clients-wider-community>

St Mungo's has recently produced a new briefing on involving client invigorating services and the recovery approach: http://www.mungos.org/about/clients/client_involvement.

Personalisation is about giving individuals more choice and control around the decisions that affect them. It has been developed in the mental health fields and homelessness organisations are now also beginning to implement these types of changes. It is another key way to ensure clients are empowered and live fulfilling lives.

- Find out more about mental health and personalisation
<http://www.scie.org.uk/publications/atagance/atagance18.asp>
- Visit our website to use our How to implement personalisation within you service tool
<http://www.homeless.org.uk/personalisation-how-to>

Ensuring affective client involvement will allow activities such as art, sport and getting into nature be more easily implemented.

4.4 WELLBEING AND SPORTS

Exercise is proven to increase our wellbeing and reduce mental health issues. It can help us in recovery and preventing mental health illness and can protect our physical health as well as our mental wellbeing. Implementing sports and exercise within homelessness services can be tricky with limited resources and expertise. However, Homeless Link has developed specific tools to enable you to develop sport provision for this much-needed activity within the homelessness setting. Sport can raise self-esteem, improve our health and even help to raise funds. To find out more about getting started, so please visit our website:

- Aiming high sports for all <http://www.homeless.org.uk/sport-for-all>
- Resources for sports projects: <http://www.homeless.org.uk/sports-resources>
- Funding for sports projects: <http://www.homeless.org.uk/sports-funding>

Sport can also be a way to reduce stigma around mental health and get people involved who wouldn't necessarily think about their mental health.

For information on free mental health training for sports visit:

<http://www.time-to-change.org.uk/about/what-are-we-doing/tackling-stigma-through-football/training-sports-coaches>

More information on sports and wellbeing

http://www.sportanddev.org/learnmore/sport_and_health/index.cfm?qclid=CP2V8snCrqoCFRAKtAodYjNhVg

Good practice projects: <http://www.homeless.org.uk/connect/articles/both-hands-in>
<http://www.lemosandcrane.co.uk/rise/login.php?>

Top tip

Remember that setting up any activity is hard to get off the ground, even if only 1 client attends initially it is worth doing. Make sure you are consistent and reliable; it can take time to build up groups and build trust. Set an example and be a positive role model as this will encourage clients to attend if they can see other people getting something from an activity. Be the change you hope to inspire!

4.5 WELLBEING AND ENGAGING IN THE ARTS

Artistic and creative endeavours have been found to have a significant impact on improving mental wellbeing. Ensuring there are opportunities to engage with the arts in a range of different ways can help people gain confidence and resilience. Engaging in art practices including photography, film making, singing, craft, theatre and visual arts can help people find creative outlets and enable them to live more fulfilling and happy lives. Increasing access to arts and cultural activities can also help reduce isolation and assist with engaging in local community activities and offer ways to help 'contain' distress.

Setting up in-house arts groups

Ideas for low cost and easy to run groups include arts and crafts, digital photography, sewing, mobile phone projects, drama groups, and music groups. Encourage staff and clients with expertise to set up in-house groups that take place weekly. Engage local artists and musicians trying to gain experience of community arts settings to help. You can also utilise the adult learning settings, by accessing teachers who need to build up hours teaching experience in order to get their qualifications.

Simple things to organise could include recruiting a dedicated art volunteer to run activities for creative projects such as t-shirt making or photography. But, could you think bigger and take on an artist in residence, or apply for longer term funding for a larger creative project such as short film, play or a large-scale mural or social media project. It's worth remembering that this is not art therapy, but simply client involvement that can have brilliant results.

Good practice:

- Involve clients in planning and organising the activity
- Apply to local business for donations of materials
- Make sure once the activity is set up that it runs regularly
- Provide space and materials for people to work unsupervised, this can help if people are nervous about working in groups
- Have an end goal, such as an exhibition or performance screening
- Monitor and evaluate the work

Working with external partners

Working with local community artists and art groups can allow you to share resources and gather expertise. It can also raise the profile of your project and help the work exist in a more mainstream environment, helping build social networks and reduce social isolation. Organisations that may be able to help:

- The local authority (contact the community outreach worker for arts or culture)
- Adult education colleges
- Community arts groups
- The arts council
- Local artists and musicians
- Local museums
- Institutions such as the theatre, cinemas, dance studios, music studios (many of which may have outcomes to work with excluded groups).

Increasing access to mainstream arts

Increasing equality of access to the arts more broadly is important; not everyone wants to be involved in arts activities specifically for excluded groups. What mainstream activities exist within the community that people can become more involved in? Can you make links to help break down barriers and stigma? Can you access tickets for the theatre, or help someone access a free book group, or support a client start a creative or design course at college course, or seek arts based employment?

Some inspiring examples of arts activities are below:

- **Art Space** at Connections at St Martins have set up an inspiring art Facebook page and regularly hold exhibitions with established venues, visit their page for ideas: <http://www.facebook.com/homelessart>
- **CoolTan arts** provide creative activities for people with mental health issues pan London, visit their website to find out about their services: <http://www.cooltanarts.org.uk>
- **Vision impossible** – Homeless provider Thames Reach has an arts project that seeks to provide workshops and opportunities for artists experiencing homelessness, visit their website: <http://www.thamesreach.org.uk/what-we-do/training-and-work/arts-project/>
- **Streetwise Opera** runs a weekly music Workshop Programme in 11 homeless centres around the country: <http://www.streetwiseopera.org/>
- **Cardboard Citizens** changes the lives of homeless and displaced people through theatre and the performing arts; <http://www.cardboardcitizens.org.uk>
- **Arts save lives** is an creative organisations that works on a variety of creative endeavours that support socially marginalised groups and art: <http://artsaveslives.co.uk/>
- **The choir with no name** is a singing group made up of people with experiences of homelessness and promotes and performs a wide range of diverse music across London. To find out more about how to get involved: www.choirwithnoname.org

Read this interesting report from the arts council about art and the impact on our health:

<http://www.artscouncil.org.uk/media/uploads/phpC1AcLv.pdf>

Top tip art project idea

Why not combine an art project and a wellbeing project like Chester Aid to the Homeless did by getting clients to design positive mental health posters? This extremely successful project promotes key good mental health and wellbeing issues through creating some innovative art work. Visit their website: <http://cath.org.uk>

Tools and resources

Tools for working with arts and vulnerable people:

<http://thamesvalleypartnership.org.uk/somethingbrilliant/>

Inspiring members: <http://www.homeless.org.uk/connect/articles/both-hands-in>

Lemos and Crane Create-Ability: the changing meaning of art and artistry

<http://www.lemosandcrane.co.uk/home/index.php?id=213533&emailid=2:103:0>

Arts for wellbeing

http://www.artscouncil.org.uk/publication_archive/the-arts-health-and-wellbeing/

4.6 WELLBEING, NATURE AND THE GREAT OUTDOORS

Getting outdoors and into nature can have a very positive impact on people's wellbeing; a recent study about 'green care'¹ links time spent outdoors in nature to improved mental wellbeing. Having time outdoors away from everyday life and reconnecting with nature, animals and plants can give people a different perspective and improve wellbeing. You can also find ways to get into nature in the city, so don't let the urban landscape put you off. It can also be a way to exercise, be involved in the community and meet new people

Many inspiring projects have had a therapeutic impact on individuals with drug, alcohol and homelessness experiences. Project ideas include:

- Walking groups
- Gardening
- Growing healthy food – check out city leaf: <http://www.cityleaf.co.uk/links/>
- Angling
- Local history walks
- Nature trails: share knowledge about trees, birds and vegetation in your area
- Volunteering to help manage and maintain local nature reserves
- City farms can provide excellent opportunities
- Residential walking and camping trips
- Bee keeping
- Outdoor pursuits such as climbing and canoeing
- Camping.

Examples of getting into nature projects working with homeless people:

Often what works best with people a history of drug or alcohol abuse is something that takes people out of their environment and its distractions. Thames Reach's Farm and Conservation Project in London, gives residents - many of whom have alcohol problems - the opportunity to work on an organic farm in the Sussex countryside. They get up early, are focused and sober for a day (alcohol is not allowed on the farm), work as part of a team, achieve things and have fun

As part of an ambitious collaboration between national regeneration agency the Homes and Communities Agency (HCA), Communities and Local Government (CLG), the Eden Project, the national membership charity Homeless Link, and the London Employer Accord an award winning garden was created, to find out more visit our website: <http://www.homeless.org.uk/news/places-change-garden/places-change-wins-silver-500-homeless-and-disadvantaged-gardeners-chelsea>



The Harrogate Homeless project runs a gardening club for clients at their day centre, read more about the project:

<http://www.harrogate-homeless-project.org.uk/garden-club/>

St Mungo's – putting down roots provides outdoor gardening opportunities for clients of all abilities, visit their website for more information project:

<http://www.mungos.org/pdr/>

Thames Reach – farm project offer opportunities for rehabilitation in the countryside: Find out more:

<http://www.thamesreach.org.uk/what-we-do/training-and-work/farm-and-conservation/>

¹ http://www.greenexercise.org/Green_Care.html

Trips and residential programmes

Day trips and residential programmes such as visiting the countryside or the seaside, cities, museums and art galleries can all have a positive effect on people's self-esteem and outlook. The results of such trips can be astounding and entrenched rough sleepers have been seen to turn their lives around as a result of accessing residential programmes. This can be especially effective for people with substance misuse issues.

Tip:

Use client involvement groups to get ideas about what clients want and where they would like to go, it can be a great way to get people involved who wouldn't otherwise engage. For a successful example of a project running residential trips for rough sleepers is the Basement drop in centre in Liverpool, visit their website: <http://www.basementdropin.org.uk/>

4.7 WELLBEING AND NUTRITION

Food and mood are linked inextricably: “you are what you eat”. Eating healthily on a budget is difficult, but services need to ensure that if they are catering for people they provide a healthy balanced diet, that allows people to get the vitamins and minerals required. If services are supporting people to cook independently then thought and time should be devoted to ensure life skills incorporates healthy eating advice and tips. You do not have to be a nutrition expert and there are resources, recipes and blogs online to help you with ideas and offer advice.

If you are working with drug users, thinking about nutrition is important as people may not prioritise this enough. Kevin Felmen has put together some really useful guidance around food and for drug users.

Food (taken from *Working With Drug Use In Housing Settings V1.06*)

It's harder to go to sleep on an empty stomach but, at the same time, a full stomach can disrupt sleep. In supported housing, flexible meal provision can help make sure that people get some food in side them before trying to get some sleep. Even something as humble as wheat cereal with some warm milk can help to promote sleep.

In non-supported housing setting, supporting budgeting and shopping that includes sleep promoting food stuffs will be beneficial.

FOODS THAT HELP YOU SLEEP

What you eat affects how you sleep. One of the keys to a restful night's sleep is to get your brain calmed rather than revved up. Some foods contribute to restful sleep; other foods keep you awake. We call them *sleepers* and *wakers*. Sleepers are tryptophan-containing foods, because tryptophan is the amino acid that the body uses to make serotonin, the neurotransmitter that slows down nerve traffic so your brain isn't so busy. Wakers are foods that stimulate neurochemicals that perk up the brain.

Tryptophan is a precursor of the sleep-inducing substances serotonin and melatonin. This means tryptophan is the raw material that the brain uses to build these relaxing neurotransmitters. Making more tryptophan available, either by eating foods that contain this substance or by seeing to it that more tryptophan gets to the brain, will help to make you sleepy. On the other hand, nutrients that make tryptophan less available can disturb sleep.

Eating carbohydrates with tryptophan-containing foods makes this calming amino acid more available to the brain. A high carbohydrate meal stimulates the release of insulin, which helps clear from the bloodstream those amino acids that compete with tryptophan, allowing more of this natural sleep-inducing amino acid to enter the brain and manufacture sleep-inducing substances, such as serotonin and melatonin. Eating a high-protein meal without accompanying carbohydrates may keep you awake, since protein-rich foods also contain the amino acid, tyrosine, which perks up the brain.

To understand how tryptophan and carbohydrates work together to relax you, picture the various amino acids from protein foods as passengers on a bus. A busload containing tryptophan and tyrosine arrives at the brain cells. If more tyrosine "passengers" get off the bus and enter the brain cells, neuroactivity will rev up. If more tryptophan amino acids get off the bus, the brain will calm down. Along comes some insulin which has been stalking carbohydrates in the bloodstream. Insulin keeps the tyrosine amino acids on the bus, allowing the brain-calming tryptophan effect to be higher than the effect of the brain-revving tyrosine.

You can take advantage of this biochemical quirk by choosing protein or carbohydrate-rich meals, depending on whether you want to perk up or slow down your brain. For students and working adults, high protein, medium carbohydrate meals are best eaten for breakfast and lunch. For dinner and bedtime snacks, eat a meal or snack that is high in complex carbohydrates, with a small amount of protein that contains just enough tryptophan to relax the brain.

An all-carbohydrate snack, especially one high in junk sugars, is less likely to help you sleep. You'll miss out on the sleep-inducing effects of tryptophan, and you may set off the roller-coaster effect of plummeting blood sugar followed by the release of stress hormones that will keep you awake. The best bedtime snack is one that has both complex carbohydrates and protein, and perhaps some calcium. Calcium helps the brain use the tryptophan to manufacture melatonin. This explains why dairy products, which contain both tryptophan and calcium, are one of the top sleep-inducing foods.

SNOOZE FOODS

These are foods high in the sleep-inducing amino acid tryptophan:

Working With Drug Users in Housing Settings 82 Draft 10/06

- Dairy products: cottage cheese, cheese, milk
- Soy products: soy milk, tofu, soybean nuts
- Seafood
- Meats
- Poultry
- Whole grains
- Beans
- Rice
- Houmous
- Lentils
- Hazelnuts, Peanuts
- Eggs
- Sesame seeds, sunflower seeds

BEST BEDTIME SNACKS

Foods that are high in carbohydrates and calcium, and medium-to-low in protein also make ideal sleep-inducing bedtime snacks. Some examples:

- apple pie and ice cream
- whole-grain cereal with milk
- hazelnuts and tofu
- oatmeal and raisin cookies, and a glass of milk
- peanut butter sandwich, ground sesame seeds

(It takes around one hour for the tryptophan in the foods to reach the brain, so don't wait until right before bedtime to have your snack.)

BEST DINNERS FOR SLEEP

Meals that are high in carbohydrates and low-to-medium in protein will help you relax in the evening and set you up for a good night's sleep. Try the following "dinners for sleep":

- pasta with parmesan cheese
- scrambled eggs and cheese
- tofu stir-fry
- houmous with whole wheat pita bread
- seafood, pasta, and cottage cheese
- meats and poultry with veggies
- tuna salad sandwich
- chilli with beans, not spicy
- sesame seeds (rich in tryptophan) sprinkled on salad with tuna chunks
- and whole wheat crackers

Lighter meals are more likely to give you a restful night's sleep. High-fat meals and

large servings prolong the work your digestive system needs to do, and all the gas production and rumblings may keep you awake.
Some people find that highly-seasoned foods (e.g., hot peppers and garlic) interfere with sleep, especially if you suffer from heartburn.
Going to bed with a full stomach does not, for most people, promote a restful night's sleep. While you may fall asleep faster, all the intestinal work required to digest a big meal is likely to cause frequent waking and a poorer quality of sleep.
Eat your evening meal early.
[source: Ask Dr. Sears.com]

For more information on nutrition see:

- NHS live well plates look at how devise health meals
<http://www.nhs.uk/livewell/goodfood/pages/eatwell-plate.aspx>
- Diet and mental health: <http://www.mentalhealth.org.uk/help-information/mental-health-a-z/D/diet/>
- Food and mood from MIND: <http://www.mind.org.uk/foodandmood>

4.8 REDUCING STIGMA

Mental health stigma and discrimination is still unfortunately very much an issue and can have serious consequences for people. Individuals often do not seek support because of fear of prejudice from family, friends and society more widely. Common areas of discrimination include employment and access to health care treatment. Discrimination can make people feel isolated and excluded, which when compounded with homelessness can leave people extremely vulnerable and disengaged from support networks.

The *Time to Change* campaign has been working hard over the last two and half years to raise awareness and reduce discriminative practices at work and in the public realm. This has included challenging how mental health issues are portrayed on the television and in the press. Stereotypes about treatment and support can also be a barrier to individuals seeking help; be sure your working practices seek to dispel negative stereotyping and work with mental health practitioners and public health promotion teams. This will mean developing positive relationship with nurses, doctors, public health promotional workers and social workers. There are many simple ways you can help reduce stigma around mental health issues within your project:

- Hold a Time to change event: <http://www.time-to-change.org.uk>
- Ensure you have Time to Change materials displayed within your project and use their quiz to gauge opinions
- Engage with world mental health day – 1st October
- Invite guest speakers with an experience of mental illness to come and talk to residents
- Ensure your HR and recruitment policies do not discriminate against people with a history of mental health issues
- Challenge discriminative language throughout the project
- Provide training for staff and clients on mental health awareness
- Engage people via other methods such as sports, art and cookery
- Ensure you have links with advocacy and or service user groups to help empower individuals who are facing discrimination
- Tackle stigma in the work place:
http://www.bbc.co.uk/health/emotional_health/mental_health/stigma.shtml
- Practical educational tools to use in groups: <http://apt.rcpsych.org/content/6/1/65.full>

Stigma associated with mental health is still a huge barrier in a variety of ways including access to health and employment, social networks and social capital more generally. Encouraging individuals to understand mental health issues rather than stigmatise mental health is a key aspect of your role. It is a main barrier as to why individuals do not seek help for mental health issues and as professionals working in the supported housing sector, reducing stigma around mental health should be developed into work planning, to increase engagement and to increase uptake of support.

4.9 LOOKING AFTER NUMBER 1 TOOLKIT AND RESOURCES

Looking after our wellbeing is not always easy, especially if you are homeless or living in temporary accommodation. Below are 10 top tips devised by clients and Homeless Link members about seeking support, diet, exercise, sleep and much more, to help individuals focus on how we can make small changes that have a big impact. The resources aim to encourage individuals to learn about how they can improve and look after their own wellbeing and mental health by developing knowledge and accessing services.

You can download the postcards to print off and use as flyers around your project. You can also download a promotional poster to promote positive wellbeing messages. The resources can also be used to conduct group work with staff or peer facilitators. They are also suitable for use in one-to-one sessions with clients.

Please look at the workshop guide to use alongside the postcards in a group setting.

The looking after number one resources have been put together with the help of staff and clients from a variety of our members with additional support from Dr Philip Timms from SLaM South London & Maudsley NHS Foundation.

To access the Looking after number one resources, visit: <http://www.homeless.org.uk/looking-after-number-1>

4.10 PSYCHOLOGICALLY INFORMED ENVIRONMENTS

Creating positive relationships

Building positive and healthy relationships with clients is one of the key aspects and sometimes most rewarding parts of working with homeless people. Staff can be positive role models for individuals with chaotic lifestyles. Being reliable and offering support and guidance in a trusting environment where others have previously failed them is when a real difference can be made. Key work and informal contact should always be viewed as an opportunity to be a positive influence, build self-esteem and discuss and challenge negative and harmful behaviours. The environment itself plays an important role in enabling individuals to develop; by this we mean both the physical environment i.e. the building, but also the attitudinal approach of all staff and other clients living in the space. Hostels can often be complex settings, so maintaining a positive and nurturing environment is a major challenge, but one that should be aspired to at all times.

One of the key ways to do this is to ensure homelessness services are psychologically informed environments (PIEs). Building psychologically informed environments is a model that developed from the *Meeting the Emotional and Psychological Needs of Homeless People* report published in 2010 by the National Mental Health Development Unit.

This means creating the kind of environment that fosters positive change in individuals by adopting a person-centred approach, which is tailored to meet individual need. Homelessness services work with some of the highest need people and our staff, buildings and methods of support need to reflect this. The evidence from practitioners and recent research suggests that people with a history of complex trauma are likely to have on-going difficulties related to issues such as attachment and loss, emotional regulation, impulse, dependence, avoidance, rejection, mistrust and hostility. Services need to provide top quality support that incorporates reflective practice and self-directed support that seeks to meet these needs.

What could a psychologically informed environment look like?

Here are some ideas to consider:

- The Royal College of Psychiatrists describe it as an 'enabling environment'
- An environment that allows people to feel 'emotionally safe'
- A focus on understanding challenging behaviour
- Working with clients to help them take responsibility
- Increased engagement, but on the clients' own terms
- Careful and appropriate pacing of interventions
- Making good use of peer support and working with the informal social networks created by a shared living environment
- User-led services
- Personalised services

This guide should be used as a tool to help you identify how you may develop a PIE, as well as being a source of tips and support as to the kind of policies that may need to be put in place to do this effectively. PIEs can also be referred to as **enabling environments** – the core principles of these have been outlined by Robin Johnson, *Consultant, RJA Consultancy*. He suggests a positively enabling environment would be one:

- In which the nature and the quality of relationships between participants or members would be recognised and highly valued
- where the participants share some measure of responsibility for the environment as a whole, and especially for their own part in it
- where all participants – staff, volunteers and service users alike – are equally valued and supported in their particular contribution
- where engagement and purposeful activity is encouraged
- where there are opportunities for creativity and initiative, whether spontaneous or shared and planned

- where decision-making is transparent, and both formal and informal leadership roles are acknowledged
- where power or authority is clearly accountable and open to discussion
- where any formal rules or informal expectations of behaviour are clear; or if unclear, there is good reason for it
- where behaviour, even when potentially disruptive, is seen as meaningful, as a communication to be understood².

There are 5 key elements to implementing a PIE, these are:

1. Developing a psychological framework
2. The physical environment
3. Staff training and support
4. Managing relationships
5. Evaluation of outcomes.

1. Developing a psychological approach

Approaches you could adopt to ensure this kind of PIE is created at your service are listed below. You could try a combination of approaches and get guidance from external agencies such as your local mental health teams, MIND or your GP and counselling services. They may be able to offer training and support around implementation. The crucial thing is that the psychological approach you adopt is implemented across the organisation with strong leadership and suitable staff training and support. The approach adopted needs to be in line with your core aims and objectives as an organisation and helps you develop psychologically informed guiding principles. Thames Reach and Look Ahead both give practical examples of how they changed policies and procedures to bring about a culture change in approach, which saw a huge change in outcomes, for more information please visit our website: <http://homeless.org.uk/Personalisation-pilots>

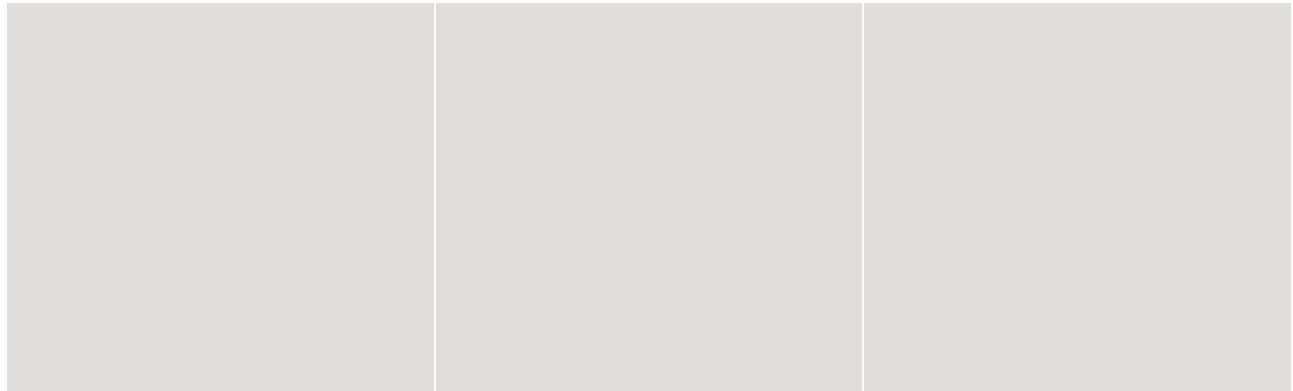
Possible approaches include:

- A cognitive behavioural therapy (CBT) or dialectic behavioural therapy (DBT) approach
- Humanistic approach
- Psychodynamic
- A person-centred approach

When thinking about adopting a psychological approach across your organisation, please take a time to note what additional things might need to be in place and what resources you may need and who need to be on board to make the changes happen. You may also want to identify any possible barriers you may face and how you might overcome them.

What key things need to happen?	What extra resources and information do you need?	What barriers may you face and how might you overcome them
<p><i>Example: we need to research different psychological environments and decide which is most appropriate for our client group</i></p> <p>Please write your actions below.....</p>	<p><i>Information about various psychological approaches, professional input, time to discuss them and training in the approach</i></p>	<p><i>Time and management buy in from management, may need a dedicated worker or a working group</i></p>

² Source: Social psychiatry and social policy for the 21st century: new concepts for new needs – the 'Enabling Environments' initiative Robin Johnson Consultant, RJA Consultancy, UK R ex Haigh Consultant Psychotherapist, UK



ST MUNGO'S LIFE WORKS PSYCHOTHERAPY SERVICE LEARNING & DEVELOPMENT

St Mungo's Life Works Psychotherapy Service provides individual medium-term psychodynamic psychotherapy to people who experience homelessness and complex needs and use St. Mungo's and partner agencies (START and Clapham SPMS). There is a significant lack of, and inaccessibility to, 'talking therapies' for this group because of common active substance use, likely not being 'in the (mental health) system', the perceived cost and effectiveness of therapy and long waiting lists for statutory provision. That which is on offer through IAPT of CBT is invariably short-term, and geared towards low level anxiety and depression which is insufficient for people who often have long-held and multiple difficulties of complex trauma. It is clear from Life Works' experience that people want to talk, with the service receiving over 500 referrals in 2½ years, and when given the chance they take it. Of all who expressed an interest two-thirds attended for the initial sessions and of them 85% went on to use the service in a meaningful and on-going way, a very positive rate of engagement for people often viewed as not being reliable in attendance or wanting or able to achieve change. Of those that didn't, common difficulties of homelessness often intervened, such as hospitalisation, imprisonment, and eviction. Life Works worked flexibly with people individually agreeing how they used their 25 sessions and the partners appreciated the greater possibility of trust we represented for people as a non-statutory service and our flexibility in working with anyone who wanted to talk. The service was evaluated through several means, finding notable successes and learning.

- Improved resilience in the areas of emotional wellbeing, feeling more able to trust others and feeling better able to make healthy choices (Mental Wellbeing Impact Assessment)
- Greater progress across all areas of the Outcomes Star, than control, especially Social Networks & Relationships, Mental Wellbeing and Meaningful Use of Time (the latter significant for a service that only engaged people for max. 50 minutes per week)
- Demonstrating Talking Therapies as a Catalyst for Change not just sustaining one. Most people's change in area from the 'Inactive to Active' stages in the cycle of change.
- Greater use of services by people who tend to avoid services and not get their needs met and a cost saving in the type of services used e.g. GPs and Outpatients rather than Ambulances and A & E.

St Mungo's is collating the learning gained from Life Works and emerging thoughts elsewhere in the field to develop 'psychologically informed approaches' across seven pilot projects. This is to complement statutory provision not replace it and encompasses access to psychotherapy for clients, clinical supervision, reflective practice and training for staff and developed client co-production.

Some quotes from those who used the service:

"I didn't want to go initially, thought 'I don't need to see a shrink', I gave it a go and the first few sessions were very informal and unthreatening. I grew to trust her and told her things I haven't told anyone else and I won't talk about here. A lot of tears were shed, she didn't drag it out of me, she listened. I got shit out of my system that I'd been carrying around a long time. There was an underlying burden in my heart that she knew what to do with. Everything I said wasn't written down

and I loved that. It was properly confidential. It was a hard one but a good one and if it wasn't for her I'd be floating down the Thames now."

"I couldn't trust anyone and I learned to trust my therapist. I realised not everyone is out to stab me in the back."

"I fall into the trap of feeling judged and taking something personally. Before I kicked the bus if I missed it, now I wave it goodbye."

"I have been going out to more groups, not staying in all the time, getting involved in more activities and meeting new friends and people."

2. Physical environment

This may include things such as reception space, soft furnishings, decorating in a personalised way, giving people choice over how they keep their own space. Communal spaces and rules, plants and animals, radio and TVs may all need to be considered in how they affect the environment.

Use the table below to help you develop your service:

What key things need to happen?	What extra resources and information do you need?	What barriers may you face and how might you overcome them
<p><i>Apply for funding to redecorate communal area</i></p> <p><i>Involve clients in design</i></p>		

3. Staff training and support

To ensure that services run affectively and achieve positive outcomes for clients, staff need on-going training and support. This is around two main areas:

- Staff are skilled and knowledgeable about mental health
- Staff are supported around their emotional wellbeing.

Staff are skilled and knowledgeable about mental health

To do this a comprehensive training schedule needs to be developed internally to embed knowledge of mental health and wellbeing across service delivery. This guide can support you with

this. This should include training around mental health awareness, the *Mental Health Act* and the law. Training programmes should also include some knowledge of psychological framework such as person-centred approaches motivational interviewing and/or effective key working that has a basis in psychological understanding.

Other good practice to increase knowledge may include:

- Use good practice guides such as this one
- Use websites such as Rethink and Mind to up-skill yourself and your staff team
- Employ professionals from the mental health sector
- Sign up to relevant journals and magazines
- Form working partnerships with local mental health teams, for work shadowing and joint training opportunities.

Staff are supported around their emotional wellbeing.

This can be done through a range of mechanisms:

- Reflective practice is implemented within the team (see PIE and case studies for examples). Models include receiving clinical supervision from trained psychologists or group supervision from local charities such as MIND to support this process.
- An effective support and supervision structure is in place
- Free external counselling service is available for staff
- Open and reflective team meetings are held
- Channels of communication are open and there is suitable space and time to off-load
- Health and safety policies are up-to-date and adhered to
- Culture of “*I can handle anything*” is discouraged
- Incidents are openly discussed and solutions shared and worked on as a team
- A team approach is adopted
- Staff room facilities are available and kept in good working order
- Incidents to do with bullying, aggression and violence are openly discussed and solutions shared
- Decision making processes about sanctions and approaches to clients are discussed across the team
- Alternative stress-busting perks such as massage, exercise and relaxation sessions are available for staff
- Breaks are properly implemented
- Literature about reducing stress at work is available.

What key things need to happen?	What extra resources and information do you need?	What barriers may you face and how might you overcome them
<p><i>New staff training schedule Implementing reflective Practice</i></p>		

WATERVIEW PERSONALITY DISORDER – CASE DISCUSSION PILOT

Central and North West London NHS Foundation Trust Waterview Centre offers an evidence-based treatment programme designed to treat clients with personality difficulties/disorder, in the boroughs of Westminster and Kensington & Chelsea. The aim of this treatment is to enable people to reduce maladaptive ways of coping, to establish a more stable sense of self, to help people engage in more constructive interpersonal relationships and behaviours, and to enhance their level of involvement in the community.

Because the Waterview Centre is targeted at non substance-using patients, only a handful of rough sleepers had ever utilised this service and there were few links between Waterview and rough sleeping services. As a first step, a discussion pilot was developed to offer teams the opportunity to present and discuss clients with personality disorders with the Waterview Service.

In November 2010 funding was agreed for Waterview to provide two hours clinical supervision/action learning sets for staff working across the rough sleeping outreach and hostel teams. The two-hour sessions were facilitated by the Waterview Manager (and Deputy when available) on a fortnightly basis.

The outreach and hostel teams were invited to propose clients with suspected or diagnosed personality disorders who they thought it would be useful to discuss in this forum and suggest workers interested in attending.

“I think these sessions are invaluable...having an understanding of how clients may be feeling and developing different approaches should be in everyone's toolkit” (support worker feedback).

Developments for the pilot's next stages

The pilot will operate on a 3 month cycle, opening with a two-hour presentation on personality and personality disorders, then using the next 5 fortnightly sessions for case presentations and discussion. Each cycle will have 10 places and workers will book and commit to all 6 sessions, with each person having one slot to discuss a case. The Waterview will provide a certificate to all those completing the sessions.

GOOD PRACTICE NOTE: SETTING UP REFLECTIVE PRACTICE IN A HOSTEL SETTING

Hostels and homeless projects require staff to work with complex needs individuals at often extremely fractions points in people lives. It is therefore important that staff feel supported, confident and emotionally well equipped to cope with what comes at them in any given working day. Much of this can be achieved by making sure staff have the right training and support. Supervisions in terms of an effective line management support structure, which offer opportunities to reflect and off-load concerns is also necessary. This also requires an effective team meeting structure, where cases and decisions about client's behaviour and possible support or potential sanctions can be discussed openly. An additional method, which allows staff a further avenue for support and supervision, is a reflective practice model.

LEARNING FROM PILOT PROJECTS

The City Bridge Trust have funded Homeless Link to work to improve the mental health of homeless people in London. Therefore as part of the City Bridge work we helped to set up three pilot models in three hostels in London, which are currently underway. All three partnerships are set up with local MIND charities acting as the lead on the monthly group staff sessions, 2 of the projects are using a group supervision model and one is using a clinical reflective practice model.

HOW TO SET THEM UP

Building good relationships with external agencies including local charities such as MIND as well as statutory mental health teams is the key in providing excellent mental health and wellbeing pathways for complex needs clients. In all three partnerships mentioned above, good relationships were forged via meetings with managers and teams who went on to share expertise, skills and resources. Teams and managers from both organisations were invited to attend team meetings and joint training was offered from the housing provider to encourage the local MIND services to

provide the support. In one of the pilots a small fee was arranged to pay for the sessions. Terms of reference were established outlining the purpose and scope of the sessions alongside a simple monitoring and evaluation process. For more information, please contact Jessica.plant@homelesslink.org.uk

FEEDBACK

The feedback so far suggests the sessions are having a positive impact on staff and clients, with staff reporting an increased knowledge and understanding of mental health. The reflective sessions have provided new ways to work with clients and have helped staff effectively deal with their own emotional reactions. When asked what was useful, staff participants' commented:

"Better understanding as a group to work consistently together with all clients even if you are not key working them"

"Better team working"

"Discussing a case and getting feedback"

"Listening to a professional's hints and tips of how to maintain time manipulation"

"I am more aware about personal boundaries"

"It has given me a better understanding of people who self-harm and how to assist them"

"It has been tailored to our scheme and with some of our clients to use as case evidence"

"The chance to reflect on the work we do day to day you stop and think about it and discuss best practice"

"Knowing how to deal with clients that are suffering with mental health"

"I am more confident about tackling my concerns about clients in a direct manner and I have noticed a difference in the way clients respond to me"

"I have used the time theory when clients tend to talk a lot, but not about specific things"

"I feel less stressed about difficult cases and less emotionally affected when for example recently a client was sectioned"

"I feel more confident about giving staff tips in supervision about how to approach particular clients"

OTHER SCHEMES

It is not necessarily a new idea for external teams either charities or statutory services to provide support around mental health and wellbeing for housing and support staff. Many partnerships run successfully between projects as either part of their joint contracts or they have simply developed organically through a mutually beneficial relationship between services. It is more common to find such models in place in specific mental health/housing schemes that have a pre-existing relationship in terms of referrals from hospital and other services. However more recently since it has been revealed that high levels of mental health and complex needs exist in generic projects so more models have been put in place to support outreach and generic hostel teams. For example the SORT team in Lambeth, support the outreach teams through a clinical supervision model. For more information contact: John.ONeil@slam.nhs.uk

4. Managing relationships

Complex behaviour can be prevalent in homelessness services; this means relationships between staff and clients, as well as residents' relationships with each other, need to be managed effectively to nurture and promote positive behaviour. This section is about ensuring staff deliver an effective and consistent approach to individuals through effective use of rules and sanctions. This does not mean creating blanket rules, but having a creative policy that enables individual responses to be carried out in a consistent way. Please see resources and good practice around rule and sanctions at <http://www.homeless.org.uk/evictions-abandonment-toolkit-behaviour-criteria>. Good practice includes:

- Developing behaviour contracts with clients that focus on change
- Consistently reviewing policies and including clients' views and opinions on any changes
- Providing opportunities for ownership and confidence building
- Developing a framework to underpin the approach
- Providing training for staff to ensure they are confident in dealing with conflict

What key things need to happen?	What extra resources and information do you need?	What barriers may you face and how might you overcome them
<p><i>We need to develop of a consistent reward and sanctions to help maintain effective relationships with clients</i></p> <p><i>Review evictions protocol</i></p>		

5. Evaluation of outcomes

Evaluation of outcomes relating to mental health and wellbeing should be undertaken across all levels of the service, from top line policy targets, which may be about what your service aims to do, to more specific targets around your particular service. Also individual targets need to be identified and measured to ensure your service is being effective. For more support around developing an outcomes approach please visit our website:

<http://www.homeless.org.uk/outcomes>.

Also you can use the table below to develop a plan moving forward:

What key things need to happen?	What extra resources and information do you need?	What barriers may you face and how might you overcome them
<i>At policy level</i>		
<i>At service level</i>		
<i>For individuals</i>		



HOMELESSNESS, MENTAL HEALTH AND WELLBEING GUIDE

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

HOMELESSNESS, MENTAL HEALTH AND WELLBEING GUIDE

SECTION FIVE: WORKING WITH EXTERNAL PARTNERS

- 5.1 Tips for working with mental health services
- 5.2 Building a case for support
- 5.3 Example joint working protocol

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

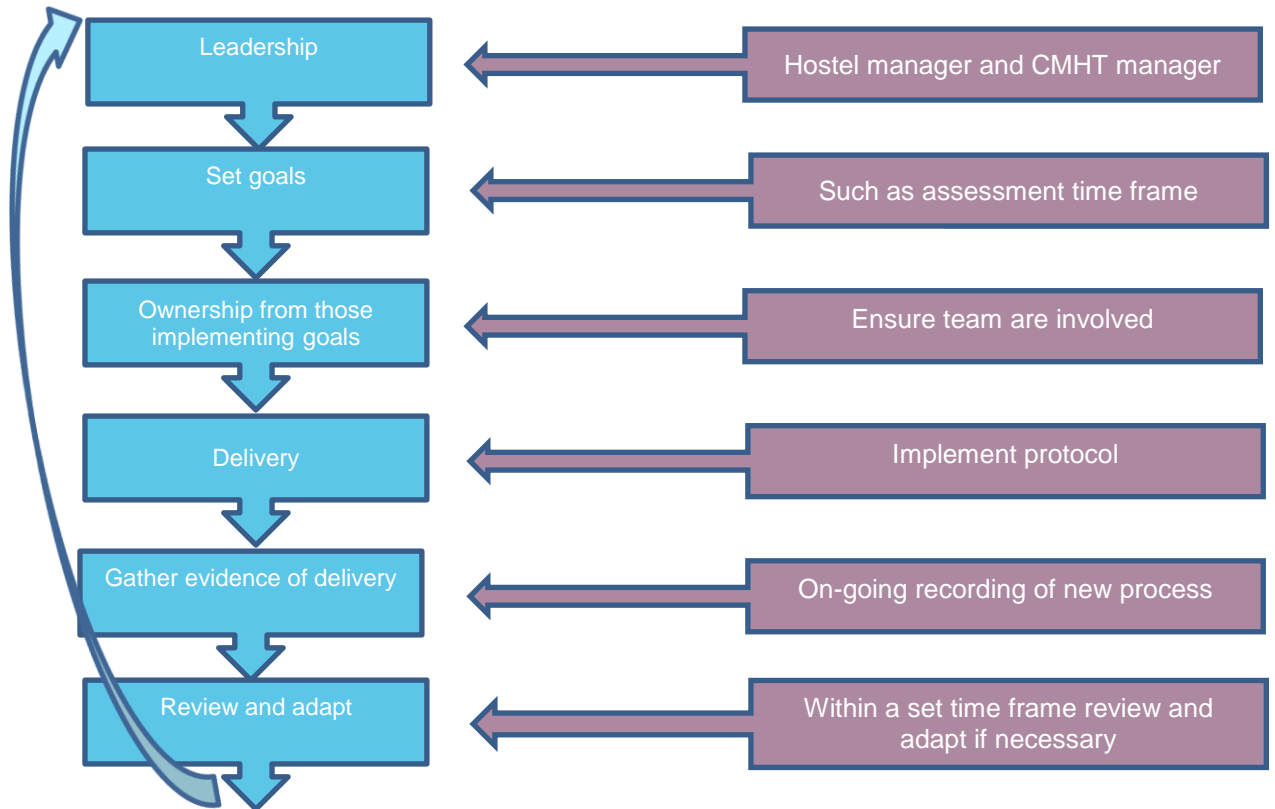
- Name of lead worker
- Capacity time allocated to work with project
- General capacity time to work with individual clients
- Length of time allocated to work with clients (example 2 year stay hostel, 6 month counselling service offered)

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.