Humber Teaching
NHS Foundation Trust

# STANDARD OPERATING PROCEDURE
# HOMELESS MENTAL HEALTH TEAM

## SOP currently under review – please continue to use this version until it is replaced by the next approved version

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| **Author/Lead**<br>**Job Title** | Paula Ashton, Clinical Lead<br>Dan Southall, Clinical Psychologist |
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| *1.0* | *Sept 2023* | *New SOP. Approved at MH Clinical Governance meeting (via Practice Network, 6 September 2023) with agreed next review deadline of June 2024.* |
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## Contents

## 1. Introduction

The Homeless Mental Health Team (HMHT) has been commissioned to provide mental health services to people who are homeless, on the edge of homelessness or whose tenancy is at risk of breaking down. The main aim of the service is to provide evidence-based assessment and interventions to individuals without unnecessary barriers or referral criteria.

Tenancy loss through eviction or abandonment is a recurring issue for people with mental health needs. Losing a tenancy can be devastating. Life on the streets, or in temporary and/or insecure accommodation, can exacerbate existing mental health problems. This limits a person's ability to access and maintain accommodation, while compounding their experiences of social exclusion, hopelessness, and powerlessness.

Many people experiencing homelessness are mistrustful of services, lead chaotic lifestyles, have substance misuse issues and have a substantial history of trauma - usually starting in childhood and continuing into adulthood (HM Government, 2018; The King's Fund, 2020). The Homeless Mental Team (HMHT) has been established as part of the larger initiative established and run by Hull City Council in response to the Homelessness Reduction Act (HM Government, 2017). The service works closely with local stakeholders to identify and provide mental health assessment and intervention to individuals who are street homeless, living in hostels or are at risk of homelessness. This also includes those who have tenancies that are at risk as a result of ongoing mental health issues.

There are two HMHT pathways: *Sustainability Pathway* and *Homeless Pathway.* The Sustainability pathway works with people who have either a Hull City Council or private rented tenancy, but whose tenancy may be impacted because of mental health issues. The Homeless Pathway is for individuals who fall under the Rough Sleepers Initiative which is led by Hull City Council. The band 7 Clinical Lead holds responsibility for both pathways of the service. Each pathway is funded separately and has a different staffing profile.

This Standard Operating Policy aims to outline the procedures within the service to provide high quality, easily accessible, flexible care to people who are homeless or at risk of homelessness.

## 2. Scope

This policy is aimed at all staff working in HMHT and who may have contact with people who fall under the HMHT caseload. It does not override the sections set out in the Mental Health Crisis Intervention Team (MHCIT) for urgent and crisis services and if someone presents as requiring a crisis/urgent response, then the MHCIT pathway should be followed.

## 3. Duties and Responsibilities

### The Board of Directors

The Board of Directors is responsible for ensuring that the organisation consistently follows the principles of good governance applicable to NHS organisations. This includes the development of systems and processes for clinical risk assessment and management.

### Chief Executive

The Board of Directors delegates to the chief executive the overall responsibility for ensuring the trust employs a comprehensive strategy to support the management of risk, including clinical risks associated with patient care.

**Service managers/Senior Clinical Lead**
Service managers have overarching responsibility for:

- Familiarising themselves with the scope of this SOP.
- The running of the service and ensuring key performance indicators are met
- Overseeing any incident investigation and complaints procedures associated with the service.
- Delegation of day to day running of the service to the clinical leads.

**Clinical Lead**
The Clinical Lead is responsible for the co-ordination of the service. Specific roles and responsibilities include:

- Acting as main point of contact for both the Sustainability and Homeless pathways
- Organising and chairing MDT reviews
- Attending meetings outside of the direct clinical area, service development and commissioning meetings
- Ensuring regular contact with other local agencies to maintain effective partnership working
- Responsibility for all elements of operational practices such as policy writing, complaints investigation, auditing, allocating new referrals and monitoring caseload numbers to ensure the caseload is evenly shared
- Ensuring the process of accurate data collection is undertaken and ensuring relevant partners receive this information when required
- Evaluation of the effectiveness of the service and the development of the team
- Providing clinical leadership and supporting decision making
- Providing clinical supervision for HMHT practitioners and managerial supervision across the team
- Networking and ensuring regular contact with partnership agencies to maintain effective partnership working which is a key part to meeting the complex needs of homelessness.
- Assessment, engagement, care planning, treatment and delivery of intervention to a limited caseload of service-users
- Supporting planning and development of the citywide Psychologically Informed Environment jointly with the HMHT practitioner psychologists

## 4. Hours of Operation and Contact Details

The HMHT operate in the main Monday to Friday between 9am and 5pm and it is not a 7 day service. Additional evenings and weekends may be offered to meet the demands of the service and to be flexible to meet the needs of the service users.

Outside of these hours, patients can be supported by the Mental Health Crisis Intervention Team.

A service offer leaflet for both the Sustainability Pathway and the Homeless Pathway are available on the intranet, on the internet and are accessable for patients and carers clearly outlining the HMHT offer.

The team can be contacted by sending an email to hnf-tr.hmht@nhs.net or by contacting the professional enquiry line on 01482 216624. Service users can contact the Mental Health Support and Advice line on 0800 138 0900 to leave a message for the team. HMHT staff may decide that providing a service user with their direct work mobile number is necessary, however this decision should be made on a case-by-case basis with an informal assessment of the possible risks e.g. misuse of the number, high level of crisis calls, possibly for misinterpretation of the relational connotations. If it is deemed that contact is becoming inappropriate via the mobile phone, it should be included in their care plan with a clear outline of the agreed contact method.

## 5. Sustainability Pathway (Housing Support)

The service provides dedicated specialist support for people whose mental health issues/problems are impacting upon their housing. This includes a combination of advice to residents in all tenures to enable appropriate sign posting and guidance on specific cases., This will be done by conducting a telephone triage and/or face to face assessments with service users in relation to their mental health. By developing an integrated approach with teams across Neighbourhoods, Housing and beyond to improve partnership working and build inter agency knowledge between the provider, Hull City Council, housing associations and the private rented sector. The team adopt a flexible approach and provide an integrated service to people whose tenancies are impacted due to poor mental health. The overall aim is to sustain tenancies and reduce instances of homelessness.

The Sustainability Pathway is commissioned for three members of staff comprising of two Band 6 Mental Health Practitioners and a Band 3 Healthcare Assistant. The aim is to prevent people losing their tenancies due to a mental health difficulty and to provide a flexible and responsive service. The Sustainability Pathway supports both Hull City Council tenants and private sector tenants.

### 5.1. Mental Health Practitioner (Band 6)

The Band 6 Mental Health Practitioner is responsible for receiving and accepting referrals. They are responsible for the following clinical duties:

- Assessment
- Engagement
- Care planning and ongoing reviews
- Coordinate the delivery of interventions
- Referrals on to necessary services

The individual in this role is also responsible for escalating clinical concerns to the Band 7 Clinical Lead and for providing clinical guidance and clinical supervision to the Band 3 Healthcare Assistant. The Mental Health Practitioner is part of the multi-disciplinary team (MDT) approach to provide support and education to the housing staff around mental health and to be the point of contact for housing staff. One Band 6 Mental Health Practitioner is allocated to the Hull City Council Tenancy Officers and the other Band 6 Mental Health Practitioner is allocated to the private tenancies that are connected to Hull City Council.

### 5.2. Healthcare Assistant (Band 3)

The Band 3 Healthcare Assistant is responsible for providing support and brief psychosocial interventions such as anxiety management, working with people who hoard, activity scheduling and graded exposure. The individual in this role is also expected to support access to appointments when agreed in the care plan designated by the Band 6 Mental Health Practitioners. The Band 6 Mental Health Practitioners will identify people for the Band 3 to support and this will be based on the provision of a specific piece of work. It is the Band 3 Healthcare Assistant's responsibility to provide feedback to the Band 6 Mental Health Practitioners on the interventions carried out and for raising concerns in areas of service user risk. The Band 3 Healthcare Assistant is also responsible for maintaining data collection and the appropriate recording of outcomes for this pathway.

### 5.3. Medical Provision or Medical Prescribing

There is not a dedicated Medical Provision or Medical Prescriber within the Sustainability Pathway. If there is a need for this provision, then the practitioner is to consider if this can be managed via primary care routes such as via the individual's GP or a referral to the Community Mental Health Team (CMHT) if the individual meets the criteria for CMHT. If the patient does not meet the criteria for a CMHT, or would be outside the remit of patient's GP, a discussion can be held with the medical provision or nurse prescribers within the Mental Health Crisis Intervention Team (MHCIT), or the consultant psychiatrist within the Homeless Pathway within the HMHT.

## 6. Sustainability Pathway Procedures

### 6.1. Referrals

Referrals can only be made by Hull City Council Tenancy officers or specific Hull City Council workers associated with private tenancies, by sending a completed Housing Support Referral (Appendix 1) to the HMHT email address:hnf-tr.hmht@nhs.net. Hull Tenancy officers can refer to the housing support pathway when someone is experiencing a mental health problem which is impacting on their tenancy and they would not be appropriate for mainstream mental health services e.g., they would find it difficult to attend appointments or use of substances might affect engagement. The referral is dependent upon the consent of the individual and this is to be recorded on the referral form. This will be uploaded to the clinical system (Lorenzo) and the Band 6 Mental Health practitioner will review it via the dashboard on Lorenzo. The Band 6 then reviews the referral and makes contact within 5 working days of accepting the referral if appropriate for the sustainability pathway.

If a referral is received that indicates high levels of current risk or the individual is presenting in crisis/acutely psychotic this referral will be escalated to MHCIT, using the risk matrix for decision making within Urgent Care (Appendix 2). A risk matrix is a tool that can help you understand the risks faced, and their overall likelihood and severity, in a visual way.

Referrals for individuals already under the care of another mental health service such as the Community Mental Health Team (CMHT), PSYPHER or Complex Emotional Needs Service (CENS)will be declined. In the event that this occurs then the Band 6 will contact the original referrer with details about how to contact the appropriate service. The referral will also be sent via Lorenzo to the team responsible for the service user's care.

If it is felt that the referral is not appropriate, for example, the service user presents with high and imminent risk to the safety of self and others, the Band 6 will make contact with the referrer to discuss further. At this time a decision will be made about whether they need this service or redirect to alternative services.

The central contact point for HMHT is Mental Health Crisis Intervention Team (MHCIT), Miranda House, Gladstone St, Hull, HU3 2RT. 0800 138 0990 or via the team email on hnf-tr.hmht@nhs.net.

### 6.2. Assessment

If the criteria for an appropriate referral is met, then an initial assessment is required; this will be arranged at a time and place convenient for the service user within 14 days of triage. The assessment will be documented on the Humber Mental Health Trust Initial Assessment Form on Lorenzo. This process also includes completing a FACE Risk Assessment, AUDIT, DAST, ReQol, mental health clustering tool, Friends and Family Test. Following completion of the paperwork, the assessment will be shared with the GP. The PHQ9 and GAD7 assessments will need to be completed if a referral is to be made to Talking Therapies. Consent should be obtained from the service user and if in agreement the assessment is to be shared with Hull City Council as well. The referrer will be updated following the initial assessment. All assessments should include the following steps:

- Review of the reason for referral
- Review of any other clinically relevant records, time permitting and at the assessor's discretion
- Contact with the patient via agreed medium at the correct date and time
- Completion of a holistic assessment with the service user and any other professional, carer or family member as appropriate, within 14 days of accepting the referral.
- Completed with the patient monitoring scales including AUDIT, DAST, ReQoL, and PHQ9 and GAD7 if referral is likely to be sent on to Talking Therapies; Improving Access to Psychological Therapies (IAPT).

- Completion of the Initial Mental Health Assessment Form, FACE Risk Assessment and the mental health cluster tool
- Agreement of the outcome with the patient
- A contact needs to be recorded on Lorenzo
- Appropriate referrals made via the Mental Health Practitioner if required
- Outcome shared with the referrer with consent and distributed to the GP for their records

Many individuals who would typically be appropriate for assessment by the Homeless Mental Health Team may struggle to engage in an intensive manner expected by other services – for example, an appointment lasting for the typical 60 minutes may be difficult to tolerate. Individuals may have previously experienced multiple assessments from services leaving them feeling dismissed and unheard by professionals. Due to past traumatic experience the individual may be wary of people in positions of authority. For this reason, it may be the case that service users are unable to complete an assessment in a single session and the assessing practitioner should respond with respect, sensitivity, and flexibility. Due to the clinical characteristics of this service user population and recognised difficulties in engagement, an assessment could be completed over a number of sessions and the reasons for this should be reflected within the clinical documentation.

### 6.3. Assessment DNA

If the service user does not attend for their appointment, the practitioner should review the information and make a risk assessment if the service user should be offered a further appointment. This cohort of individuals may need to be offered more than one offer for an initial appointment, due to the service user group characteristics. It is at the discretion of the assessing practitioner, with or without discussion with the clinical lead/MDT as to whether a further appointment is offered. This decision should be based upon presenting issues, referral and triage information, risk and previous engagement levels. The practitioner should consider potential barriers to accessing support and work creatively to overcome these. For example, it would be appropriate to cold call as a way of introduction and promoting positive engagement to an individual who is at risk of eviction due to failed gas/electricity checks as the result of a hoarded property,

The rationale for any decision whether to offer a further assessment or discharge from the team should be clearly documented in the clinical record.

Should the patient contact the team following the DNA and request a further appointment for assessment, this should be completed at the discretion of the clinical lead on duty as to whether a further appointment is offered, considering the points above to support decision making.

If a further appointment is not indicated, a standard letter advising of failed contact with the Homeless Mental Health Team should be sent to the service user.

### 6.4. Interpreter Requirements

The team have access to Language Line which is a telephone interpretation service. Should there be a preference or requirement of a face to interpretation services then this can be arranged.

### 6.5. Carers

The team identify carers and offer signposting, advice and support. The carer is to be offered a referral to the Carers Support Service and they are to be noted as a carer on Lorenzo.

### 6.6. Intervention:

Following the Initial Mental Health Assessment, if the service user meets the criteria for either primary care or secondary care then onward referrals to the relevant service will be completed at the earliest opportunity. Onward referrals following Initial Mental Health Assessment are the responsibility of the assessing practitioner and can be supported by admin from MHCIT on hnf-tr.MHCIT@nhs.net. Humber Teaching NHS Foundation Trust internal services each have different criteria and requirements of referral, therefore the assessing practitioner should make themselves

aware of any requirements for the referral before discharging the patient from the Homeless Mental Health Team (HMHT). Referrals to the CMHT following initial assessment are completed under the 'trusted assessor' framework and do not require direct discussion with the team unless this would be of added value to the onward referral. Not all internal services work with the 'trusted assessor' framework and will potentially require a discussion with the team before the referral is made. Assessors are responsible for ensuring all requirements are met before closing the referral to the HMHT.

Some service users will not meet the criteria for another service but have mental health needs that require specialist assessment and intervention from professionals with expertise in this area, for example mental health difficulties relating to hoarding. In this instance these service users will be added to the Housing Support caseload and will receive interventions as outlined below.

The Band 6 will complete a care plan in collaboration with the service user, where appropriate give direction to the Band 3, and liaise with other services. Interventions provided by the sustainability pathway include:

- Building engagement with service users, families, and carers.
- Anxiety management
- Graded exposure
- Practical assistance with activities of daily living/clearing living space (hoarders).
- Education and help in understanding issues related to their mental health
- Education and support for relatives and carers, family work and/or carer involvement.
- Assessment of substance misuse/dual diagnosis
- Problem solving
- Stress management
- Support to access local community
- On-going risk assessment
- On-going needs assessment
- Promote positive choices in relation to concordance with prescribed medications
- Psychological formulation (where appropriate and available)
- Occupational Therapist consultation (where appropriate and available)
- Specific work around the reasons they may lose their tenancy
- Liaison with housing to try and support tenancy sustainment
- MDT review and discussion around care
- Psychoeducation

Lorenzo documentation is to be completed following every visit, per Humber NHS record keeping policy, Records Management policy and Data Quality policy, including:

- Clinical note
- Clinical contact
- Updating FACE risk assessment documentation (if required)

The Band 3 within the team will keep the performance spreadsheet updated and maintained which informs a service report audit/performance report every 3 months, collated by the Band 7 Clinical Lead, which goes to the stakeholders. The report includes information set out in the service specification and outlined below:

| | |
|---|---|
| Access | Percentage of people contacted within 5 days of referral |
| Patient Experience | Friends & Family Test |
| Outcome | Number of People with their tenancy sustained |

| | |
|---|---|
| Access | Number of Referrals Received |
| Access | Number of Referrals Accepted |
| Assessment | Number of Assessments |
| Caseload | Number of people on active case load |
| Intervention | Number of people receiving intervention |

| | |
|---|---|
| Intervention | Average number of visits for intervention |
| Outcome | Outcomes to be reported |
| Discharge | Number of people discharged from service with NFA |
| Discharge | Number of people discharged into another service |

### 6.7. Multi-Disciplinary Team Meetings (MDT)

The Sustainability Pathway MDT occurs on a fortnightly basis. MDT meetings are attended by all members of the relevant team when possible.
The main aims of the MDT are to:

- Review care and formulation to agree purpose of involvement, review progress and interventions.
- Review for discharge from service
- Review and agree if medic/psychologist input is required.
- Review if onward referrals are required
- Make decisions on actions required to ensure timely and appropriate onward referrals
- Identify and escalate barriers to onward referrals
- Identify safeguarding issues and agree actions
- Discuss new referrals and allocate

The MDT will aim to discuss each service user on caseload at least once a month. There may be occasions where an MDT decision is required outside of the scheduled MDT. When this occurs the staff member will discuss with all available members of the team. MDT discussions/decisions will be documented on Lorenzo.

### 6.8. Onward referrals and Discharge:

Following the process of referral, assessment, and/or completion of a specific intervention, a service user may be deemed to no longer require the service of sustainability pathway for a number of reasons, e.g.

- support from another provider may be more appropriate for the service user and an onward referral has been made
- the service user's mental health issues are no longer impacting on their tenancy
- an intervention (brief psychosocial intervention, joint therapeutic work, psychological therapy) has been completed
- no longer has clear mental health needs
- the service user decides they no longer wish to work with the team

At any point in the service user's care that any of these criteria are met they will be considered for discharge.

Onward referrals might be completed by the practitioner rather than asking people to self-refer to ensure the onward referral is submitted for people who ordinarily would struggle to engage with services.

At the point of discharge or in preparation for discharge, there will be a discussion with the service user and their friends/families (if appropriate) around discharge, what this means, how they feel about it, if they have any unmet needs and how to contact services or seek re-referral to Mental Health Service should they need to. A request to complete the Friends and Family Test will be made and the service user, their friends/families will be given appropriate crisis support numbers e.g., Mental Health Advice and Support Line.

The discharge will be discussed within the MDT which takes place every two weeks. If there are any outstanding actions from the MDT these will be completed prior to discharge. If discharge is agreed in MDT, the Band 6 Mental Health Practitioner will ensure that a letter is sent to GP to update involvement and current presentation, the original referrer is to be updated and the referral is to be closed in Lorenzo.

### 6.9. Disengagement:

If the service user does not engage in planned interventions (e.g. does not attend appointments or respond to attempts to make contact) then the Band 6 is to review risk and mental health history, taking into consideration the individuals mental state and capacity. The Band 6 will provide evidence that proactive attempts to engage the service user have been exhausted including letters, phone calls and attending the property.

The service user should be sent a discharge letter highlighting the disengagement and advising of the Mental Health Advice and Support Line number for them to contact should they wish to access support in the future. These actions should be logged on a Lorenzo communication sheet on the service user record and the outcome should be shared with the GP as standard.

If someone disengages and there is evidence that the person lacks capacity to make the decision to engage with mental health services, there is significant risk associated with disengagement, or acute mental illness which will deteriorate further if disengagement occurs, then discussion should take place – either in fortnightly MDT or in ad-hoc discussion with the clinical lead - to consider other actions that could be taken to manage the risk and ensure the safety of the service user. Consideration may need to include the legal framework under the Mental Capacity Act 2005, or the Mental Health Act 1983, and the decision recorded on Lorenzo.

## 7. Homeless Pathway – Rough Sleepers

The Homeless Pathway is part of a citywide multidisciplinary system in Hull which includes other organisations and charities that work with homeless individuals. The Homeless Pathway is a project that is jointly funded for 5 years, until 2025, by NHS England, the Integrated Care Board, Changing Futures and by Hull City Council. After 2025 it will go into recurrent funding.

The Homeless Pathway supports people from the age of 16, who are street homeless or rough sleeping, living within a hostel, or on the edge of homelessness. The service aims to offer mental health support to individuals who have difficulties accessing mainstream services. This population is often marginalised by society and are excluded by mainstream mental health services, and this is the primary focus of the team's work. The service users may have had negative experiences from mental health services in the past and the HMHT is a support service with the aim of supporting service users to be able to access the mainstream mental health services after a period of building trust and stability. It aims to build relationships that will eventually lead to assessments and gathering information that avoids re-traumatisation.

This group of individuals present with multiple and complex needs, and the HMHT work closely with other local agencies to develop an understanding of the impact of past traumatic events and adverse childhood experiences (ACE's) on current behaviour and coping strategies. The team recognise that individuals in this group may not be ready to contemplate change or to engage with mental health services and a Pre-treatment Approach is taken that focuses on relationship building, the development of a common language with service users and the collaborative assessment of safety needs (Levy, 2021). The team employ a Trauma Informed Care (TIC) approach in order to build a therapeutic relationship built on trust, hope, honesty and partnership working to enhance wellbeing and resilience (Scottish Government, 2021).

Individuals who experience homelessness may have poor physical and mental health, often in the context of adverse upbringing, which may be untreated for long periods of time. Difficulties can include:

- Substance misuse and addiction
- Relationship difficulties (including mistrust of services)
- Sex working
- Criminal justice or history of offending
- Hopelessness, impulsivity and deliberate self-harm
- Intense and overwhelming emotions, negative thoughts and distressing memories

## 8. Homeless Pathway Duties and Responsibilities

(For description of the Board of Directors, Chief Executive, and Service Manager, please refer to Section 3). The Homeless Pathway is commissioned for the following members of staff:

- 2 x Band 7 Clinical Lead
- 2 x Band 6 Mental Health Practitioners
- 1x Band 6 Dual Diagnosis Nurse
- 1 x Band 3 Healthcare Assistant
- 1 x Band 8a Practitioner Psychologist
- 1 x Band 7 Practitioner Psychologist
- 1 x Consultant Psychiatrist (2 sessions per week)
- 1 x Peer Support worker employed by MIND
- Consultation input from Occupational Therapy for the MHCIT

### 8.1. Mental Health Practitioner (Band 6)

The Mental Health Practitioners are responsible for the assessment, engagement, care planning, treatment, and delivery of intervention to service users as described within the clinical model. They are responsible for escalating concerns to the Clinical Lead and providing clinical support and supervision to the Health Care Support Worker They will introduce a psychoeducational approach e.g., around the impact of psychological trauma, substance use and addiction. The Mental Health Practitioners follow the assessment process as documented in section 4.1 of the SOP.

### 8.2. Health Care Support Worker (Band 3)

The Band 3 Healthcare Assistant provides initial support and relational stability for service-users as per the clinical model. The Healthcare Assistant will help to facilitate the Drop-ins within the hostel environments. They also provide support and education to partnership organisations around mental health and trauma-informed approaches. The individual in this role may support service users to engage with other providers to reduce health inequalities and facilitate access to appointments when agreed in the care plan designated by the Band 6 Mental Health Practitioner.

The Band 6 Mental Health Practitioner will identify people for the Band 3 to support and this will be based on the provision of a specific piece of work. The Band 3 Healthcare Assistant will provide feedback to the Band 6 Mental Health Practitioner on the interventions carried out and for raising concerns in areas of service user risk.

The Healthcare Assistant is also responsible for maintaining data collection and appropriate recording of outcomes for this pathway. The Band 3 has administrative duties; including maintaining the Rough Sleeper Initiative (RSI) spreadsheet, collating information for audits/reports, ensuring stationary stock is ordered and maintained.

Performance indicators to be recorded by Band 3 Healthcare Assistant which the Clinical Lead shares with the stakeholders:

| | |
|---|---|
| Access | Percentage of people contacted within 5 days of referral |
| Patient Experience | Friends & Family Test |
| Outcome | Number of People Supported into Housing (MEAM/Rough Sleepers) |
| Access | Number of referrals received |
| Access | Number of referrals accepted |
| Assessment | Number of assessments completed |
| Intervention | Number of ongoing visits made |
| Outcome | Outcome of assessments by category |
| Outcome | Number of cases resulting in retention of accommodation for 3 months or more |
| Discharge | Number of people discharged from service with NFA |
| Discharge | Number of people discharged into another service |

### 8.3. Practitioner Psychologist Band 8a and Band 7

The role of the psychologist is to provide psychological assessment, formulation and intervention to service users on the caseload. Individual cases are discussed in the weekly MDT and those service users appropriate for psychological input (which might include Pre-treatment work) will be added to the psychologist's caseload. The psychologist will provide clinical and professional supervision for other psychologists within the trust, assistant psychologists and clinical psychology trainees as appropriate. Case clinical supervision will be available to HMHT practitioners as required.

A large part of the role of the psychologist in this team is providing psychological understanding in terms of consultation, assessment and formulation and supervision in relation to service users on both a formal basis and in terms of informal psychological support and guidance. Many service users will not require direct contact with a psychologist, but other professionals may require support in terms of psychological formulation, relationship building and timely offering of interventions and support. These types of activities may extend to practitioners outside of the team and could include colleagues from other homeless health services, partnership agencies such as Hull City Council, probation and housing providers.

As part of the ongoing process of working towards the development of Hull as a 'trauma-informed city', some time will be allocated to the development of the Psychologically Informed Environment (Haigh, Harrison, Johnson, Paget, & Williams, 2012). This work focuses on providing the skills and support to professionals working with individuals with a focus on understanding how histories of adversity and multiple social exclusion might impact on thoughts, feelings, behaviours and personalities. Activities in this respect include service planning, teaching and training, reflective practice, informal supervision and consultation.

(The Band 7 psychologist has 2-year funding from the Changing Futures Initiative and has been commissioned to provide clinical psychology input to service users on the MEAM caseload and to support the development of the PIE within Changing Futures).

### 8.4. Consultant Psychiatrist - 2 sessions per week

The role of the consultant psychiatrist is to provide medical diagnosis and overview, treatment and consultation for service users where a referral has been made. The consultant psychiatrist will contribute to the weekly or ad-hoc MDT, provide consultation and develop good working relationships with partner services. The person in this role will support the development and evaluation of the service in terms of quality improvement to demonstrate success and to inform future provision. The consultant psychiatrist would be expected to work flexibly within the demands of the service user population and as per the clinical model.

### 8.5. Partner agencies and networks

The Homeless Pathway within HMHT work closely with other local organisations including, but not restricted to:

- Local hostels (The Crossings, Westbourne House)
- Hull City Council Rough Sleepers Initiative
- Teams under the Changing Futures Project
- The Multi Agency Homeless Assessment Hub commissioned by Hull City Council
- Hull City Council Housing Team
- Hull City Council MEAM (Making Every Adult Matter) team
- Modality Health Inequalities – Hospital Pathways Discharge Team
- Humberside Police
- Probation
- Hull City Council Domestic Violence service
- CGL Renew
- Lighthouse project

## 9. Homeless Pathway Procedures

### 9.1. Referral Criteria

Access to the Homeless Pathway is 'barrierless' – this means that there are no specific criteria for referrals other than:

- Individuals are homeless or sofa-surfing
- Are experiencing mental health distress.
- Would not be suitable for other mainstream mental health services, either because criteria for referral are not met OR because difficulties in engagement would preclude this
- Individuals are not excluded if they use alcohol or illicit substances.
- Consent from the individual (except in exception circumstances as detailed in Section 10)
- Where a referral doesn't identify this criterion, the referral will be returned to the referrer.

### 9.2. Exclusion Criteria

- Referrals will not be accepted if the person has been determined to lack capacity and in such cases the referrer would be advised to approach the appropriate service such as Ambulance, Police, Mental Health Liaison Service, Mental Health Crisis Intervention Team, with the options to consider the use of appropriate legislation such as the Mental Capacity Act 2005 or the Mental Health Act 1983. The person may have variable capacity and further assessment may be required to decide if they meet this exclusion criteria.
- Referrals will not be accepted for people who are already open to another mental health service, the referrer will be informed of this following the referral meeting and responsible team informed of referral.
- If a referral is received that indicates imminent or high levels of current risk, or presenting in crisis/acutely psychotic, this referral will be declined, and the referrer advised to escalate the referral to the appropriate crisis service.

Referrals can be made by:

- Partnership organisations including Hull City Council; (housing teams, MEAM) hostels, homeless hospital discharge service and the Changing Futures group
- Service users themselves at any of the Mental Health Drop-in clinics
- Referral forms (Appendix 3) for formal referrals should be completed and emailed to hnf-tr.hmht@nhs.net.
- Mental health Services where a mental health assessment or triage has been completed and it is evident that they would not be able to engage with mainstream mental health services.

### 9.3. Process for Referrals

The HMHT accept self-referrals from people living within the hostels, and from people who have previously been under the HMHT and disengaged from the service and who remain precariously housed. When this occurs, the practitioner receiving the contact either in person at a drop-in, or via the telephone, will ensure the following admin tasks are completed:

- Clinical note on Lorenzo
- Open a referral to the team
- An initial generic Drop In care plan (Appendix 4) or Rough Sleepers care plan (Appendix 5) to be added to Lorenzo to capture the team's involvement. The practitioner to note in the care plan that the service user has not contributed to the development of the plan and has not signed the care plan. A more individual care plan is completed if the person continues to engage, and when they are able to contribute to the content.

When a referral is discussed and deemed appropriate in the weekly team MDT, the service user will be allocated an identified worker at the point of accepting the referral. An allocated member of the team will ensure the following admin tasks are completed:

- Clinical note completed
- Original referrer has been updated to the status of the referral

- Referral form uploaded to Lorenzo and the referral opened.

In view of the regular presentation at the Emergency Department for people who are homeless, the Homeless Pathway consider referrals from Mental Health Liaison Service. For this service to be able to refer to the team the following tasks to be completed by the referring team:

- Initial assessment paperwork completed including FACE, Cluster and ReQol
- Discussion with the Homeless Pathway to take place and if the referral is accepted MHLS to task the referral on Lorenzo to the HMHT.
- MHLS to send an email to hnf-tr.hmht@nhs.net if they have directed someone to the Mental Health Drop In provision within a hostel, as per the self-referral route.

All individuals referred for one-to-one support will be contacted either by telephone or face to face . Mobile phone contact may not be appropriate for a number of reasons (phones are easily lost or damaged, individuals may struggle to keep their phone charged, their lifestyles may mean individuals do not regularly check their phones), therefore every effort should be made to see the service user in person. Because of the often-impermanent nature of accommodation placements and because information can change quickly, it should not be assumed that a last-known address or location for a referral is accurate. Referrals will often be received but the service user may be difficult to locate. Every effort should be made to locate the service user via liaison with street outreach teams, partner agencies, liaising with hostels and Hull City Council housing staff. If this isn't successful and contact with the service user cannot be established after all options are exhausted, then the referral will be closed until they re-present or are re-referred to the HMHT.
If a service user on the HMHT caseload presents with fluctuating capacity (e.g., due to substance use or high levels of emotional distress), then the team would wait until the person regained capacity to offer an intervention. HMHT and the other agencies involved with the service user at the time, to consider if the use of powers under the Mental Capacity Act 2005, or the Mental Health Act 1983 would be appropriate.

### 9.4. Multi-Disciplinary Team Meeting MDT

The Homeless Mental Health Team MDT occurs on a weekly basis. Please refer to the content in Section 6.7 for the roles and responsibilities of those attending the MDT.

### 9.5. Assessments

It is recognised that individuals on caseload may struggle to engage in mainstream assessments and they would benefit from a Pre-treatment approach where relationship and building trust is the main intervention. The service user may only be able to tolerate short sessions with the team and a therapeutic relationship would need to be fostered before the routine initial assessment documentation could be completed. Information is gathered by the team over a number of sessions which may takes weeks or months to build upon. Once sufficient information has been gathered then the Mental Health Practitioner within the Homeless Pathway to follow the procedure outline in Section 5.2 and complete the documentation without the physical presence of the service user. The assessment steps are outlined in the following sections under the Homeless Care Pathway.

## 10. Homeless Care Pathway

Two clinical pathways operate within the Homeless Pathway (See Appendix 6 for the Care Pathway):

- **Support pathway:** this is the care pathway for service users who are able to engage, are willing to access support via drop-in services, 1:1 sessions or groups and are open to the prospect of undertaking therapeutic work
- **Consultation pathway**: this is the care pathway for service users:
  a) who cannot or refuse to engage, either due to high levels of distress, unable to form a therapeutic relationship with mental health services, and they may present with challenging behaviour.
  b) would not benefit from 1:1 input but would require consultation, psychological formulation,

informal supervision provided to the partnership agencies supporting them
c) are presenting with high levels of demand on crisis services such as attendance at Accident and Emergency, Crisis Mental Health Support and the police.

### 10.1. Support/Consultation pathway

As many as 80% of homeless people have experienced childhood adversity, social exclusion and insecure/disorganised attachment patterns that might be categorised as complex trauma (Maguire, Johnson, Vostanis, Keats, & Remington, 2009; Radcliff, Crouch, & Strompolis, 2019; Conolly, personal communication). This places individuals at significantly higher risk of developing psychological difficulties and physical health issues than the rest of the population. Furthermore, homeless people have often experienced histories of 'toxic help' – care that has often been dismissing, blaming or which has inadvertently re-triggered historical trauma which leads to mistrust, distress and frustration when they come into contact with healthcare professionals. This results in a paradoxical situation where chaotic attempts to rebalance distress and seek safety and support is often inadvertently categorised as challenging behaviour (Herman, 2015; Maguire, Johnson, Vostanis, 2010). Homeless mental health services must therefore be responsible for creating the optimal conditions in which people can engage (Williamson & Taylor 2015; John Conolly, personal communication). This focuses on:

- reducing the imbalance of power and encouraging development of mutual treatment goals
- allowing service users to engage on their own terms and recognising the need to adapt engagement style according to the needs of the individual
- recognising that formal and/or in-depth mental health assessment can be overwhelming and distressing, and therefore ensuring that all engagement is concordant with trauma-informed care principles (see section on Provision below)

A service adapted to the needs of service users with histories of complex trauma enables mental health professionals to offer a different experience of care and thus rescript their experiences of mental health support, develop trust and begin the process of providing a narrative of their experiences (Levy, 2021).

All clinical activity is underpinned by trauma-informed care principles. These principles suggest that services should have a detailed understanding of the impact of psychological trauma and how it can affect an individual's social functioning, wellbeing and physical and mental health (Harris & Fallot, 2001). Furthermore, we have adopted key principles of trauma-informed care across the service in all our interactions (Scottish Government, 2021):

1. **Safety** – ensuring all efforts are made to ensure the physical and emotional safety of service-users and staff, including measures to ensure individuals are not exposed to re-traumatising interactions.
2. **Trustworthiness** – making efforts to develop transparency and clarity in an organisations' policies and procedures to enable relationships with service users and staff to be built on trusting foundations.
3. **Choice** - service-users and staff should have the ability to make choices and have their voices heard in decision-making processes in organisations.
4. **Collaboration** – recognising the valuable contribution of service-users and staff in improving the system, and this should include peer-support and mutual self-help.
5. **Empowerment** – efforts should be made to share power and provide service users and staff with the opportunity to make changes at the service delivery level.

**Provision**

Mental Health Drop-in clinics, tailored 1:1 sessions and group work is offered within the Support Pathway. Individuals can access any of the three services at any time, but drop-in may be the first point of access. Following referral and MDT, those referred will be signposted to the next available drop-in that operates at Hull hostels, Renew breakfast club or in the city centre (e.g., at the Hub on King Edward Street). If at any point individuals disengage or decline support they can re-engage at drop-in at any time.

**i) Mental Health Drop-in Clinics**

- The main function of Mental Health Drop-ins is to focus on the establishment of a therapeutic relationship based on safety, equality and mutual trust. Drop-in practitioners are advised to be mindful of trauma-informed care principles.
- Clinics are offered on either a weekly, fortnightly or monthly frequency basis depending on demand. Drop-in clinics are facilitated by two members of staff.
- Whilst it is recognised that a thorough mental health assessment and/or psychological formulation would be a function of engagement for many mainstream services, at this stage formal assessment is not attempted due to possibility of re-traumatisation and risk of disengagement.
- Lorenzo referrals are opened but relevant assessment documentation (see section 4.2) is not attempted immediately and are progressed as relevant clinical information is gained. A clinical note should be completed at every attendance as per other clinical interactions, and reasons given in the clinical note explaining why assessment documentation has not been completed.
- It is advised that practitioners explicitly state the function of the Drop-in clinic with a statement that attendees should not explicitly describe adverse childhood experiences/attachment difficulties/other trauma experiences due to the likelihood of destabilisation
- It is advised that practitioners explicitly state that sessions are generally 5 – 25 mins long; attendees are reminded of this five minutes before the end so that the session can be brought to a gentle close.
- A focus on strengths and functional coping skills is recommended as well as discussion of difficulties.
- It is recognised that not all individuals referred will move on to further interventions following initial attendance at Drop-in clinics. If service users do not at this stage engage on a fortnightly basis, the discharge criteria should be followed.
- If significant risk is identified or becomes apparent via other sources then documentation can be updated and information shared with partnership agencies in the appropriate manner.
- If an assessment/intervention plan for a service user is deemed complex and requires wider clinical discussion within the team (e.g., psychological consultation, occupational therapy, etc), then the service user is to be added to the next MDT discussion list.

**ii) 1:1 sessions**

- 1:1 sessions should roughly incorporate the stages outlined in Pre-treatment therapy, beginning with a focus on engagement and trust within the relationship
- Assessment/formulations can be developed with the service user as engagement increases
- Pre-treatment recommends that, rather than focusing on narrow and restrictive terms such as mental health terminology, practitioner and service user develop a ‘common language’ based on the service user’s own experience
- Practitioner and service user begin to gently develop an understanding of mental health difficulties and coping strategies that are framed within the person’s life history and experiences
- The development of the attachment relationship and gradual working through the service user’s life is also an opportunity to begin naming, categorising and understanding of previously dysregulated emotions
- Once these stages have been completed, practitioner and service user may jointly explore formal goals and further mental health treatment work
- 1:1 sessions should be undertaken by qualified practitioners

**iii) Group sessions**

- Mentalisation-Based Therapy framework (to be offered in 2024 pending staff training)
- Offered in conjunction with drop in and 1:1 sessions
- Process-focused groups e.g., ‘anger and discussion’
- Other groups to be offered to support mentalisation including creative activities, food, games, etc.

## 10.2. Consultation Pathway

Within the population of homeless service users there will be a small proportion of individuals referred to HMHT who clearly have high levels of mental health distress but who will not be able to engage on a 1:1 basis, either due to declining a referral for drop-in or being unable to engage due to levels of distress. This pathway aims to provide a service to professionals in partnership agencies already working with the service user to think about how best to provide support. The professional requesting the consultation must still seek to gain consent unless this would increase the risk to the individual, professional or others.

In the majority of cases, these individuals typically present with difficulties that would indicate a profile of complex trauma underpinned by insecure attachments and adverse childhood histories. For this reason, prior to any formal treatment goals, the focus is on engagement and stabilisation (see Herman, 2015). This group of individuals present with high impact on local services in terms of multiple attendances and referrals to A&E, Mental Health Liaison, Mental Health Crisis Intervention Team, etc. Attendance at crisis services and chaotic behaviour can be understood as highly rigid yet maladaptive ways of trying to cope and seek safety. As a result of instability in childhood individuals present with multiple and complex needs including:

- Emotional, cognitive, and interpersonal difficulties
- Poor physical health
- Substance misuse and addiction
- History of offending and contact with probation and/or the justice system
- High levels of risk e.g., risk to self as a result of suicidal ideation, risk to others due to intense emotions

Individuals often present with histories of ‘toxic help’ in which traumatised individuals and their threat-based responses are deemed by professionals as being problematic behaviour leading to individuals being misunderstood, discharged without appropriate care and leaving them feeling rejected and unworthy (The King’s Fund, 2020). Understanding of the impact of complex post-traumatic stress disorder in terms of ACEs, attachment, psychological experiences emotions and interpersonal difficulties are not recognised.

- Individuals are often highly vulnerable and at risk of premature death
- Individuals have significant impact on staff (e.g., vicarious trauma, burnout, compassion fatigue)
- History of multiple evictions from hostels and housing providers

It would not be appropriate for these individuals to access services in the Support Pathway (drop-in, 1:1 sessions, group work) at this point if:

- Individuals are experiencing high levels of distress that would negate ‘verbal’ assessments or support sessions (for example as a result of dissociation, flashbacks, emotion dysregulation)
- Individuals decline to engage.

### Provision

The primary aim of this pathway is to develop a trauma-informed psychological understanding of the individual in order to link chaotic presentation to history of trauma. The formulation approach aims to provide a wraparound service that includes input from all services working with that individual (e.g. hostels, Hospital Discharge Pathways Discharge Team, Hull City Council, substance misuse services, etc.) The formulation supports the wider team to understand how the individuals’ chaotic presentation can be understood as a maladaptive way of eliciting care within the context of complex trauma and opportunities to intervene.

- Important to establish from the outset that the service is consultation-based, does not involve 1:1 support at this stage and is not a crisis service

- Lorenzo and paper notes review to gather information about history, exposure to ACEs, interaction with other services (with consent unless it was in the Public Interest)
- Indirect assessment of history and presentation with information from a variety of sources (including review of notes and staff interactions), including brief introduction to the structure, theory and benefits of psychological formulation
- Team formulation sessions (1 hour) to synthesise all available information for the individual
- Formulation to be shared with clear depiction of triggers and opportunities for intervention
- Reflective practice to support staff with impact of challenging work
- Formulation approach to be followed up (e.g. after a month, three months) to review developments

## 11. When the service user moves into their own property

It is recognised that moving into accommodation can be a difficult time for service users and may result in a decline in their mental health. Once the service user has an actual or proposed move on to their own property, HMHT will discuss the service user in the weekly MDT. This is to consider the purpose of continued support, agree a proposed timeline for that support and the possibility of planned discharge from the team. This support should be incorporated in the care plan with the agreement of the service user. Purpose of continued support may include:

- Time limited ongoing emotional and practical support to reduce the likelihood of repeated homelessness
- Support whilst the service user transitions to other support, e.g. community mental health teams (CMHT), external practical support or referral to psychological therapy.
- To complete interventions that the service user may have already started, such as detailed psychological formulation, trauma stabilisation work or 1:1 psychological therapy.

## 12. Onward Referrals and Discharge on the Support/Consultation Pathway

It is expected that some individuals attending the Mental Health Drop-in, which is the route of access and first point of contact with the service, will not attend regularly and will not need to be retained on caseload if they disengage. Homeless individuals often lead chaotic lifestyles, leave accommodation and forget appointments. A flexible, adaptable approach is crucial to engagement and attendance at sessions should be supported within this context.

Disengagement would be classed as two consecutive non-attendances at either Mental Health Drop-in Clinic or 1:1 session. Disengagement would result in the case being listed on the RSI spreadsheet for discussion in the next available MDT and if the MDT considers discharge to be appropriate (e.g. there is no salient clinical reason to retain the individual on HMHT caseload) then inform GP and close referral on Lorenzo. If there are concerns that disengagement is:

- due to evidence that the person lacks capacity to make the decision to engage with mental health services
- associated with high level of risk to self or others
- as a result of mental illness or deterioration in mental health which will deteriorate further if disengages

Then this would also warrant discussion within the MDT for crisis management or consideration for the next appropriate actions. If a service user disengages but then then wishes to re-engage, they can access the service again by attendance at Mental Health Drop-in Clinic or by informing any of the partner agencies who can re refer on their behalf.

When an individual has been deemed appropriate for planned discharge the caseworker (e.g. Band 6 Mental Health Practitioner) would arrange a meeting with service user and their friends/families if appropriate, to explore the process of discharge, including:

- what discharge means and how they feel about it
- if any goals or needs have not been addressed
- how to access Mental Health Services should they need to following discharge
- opportunity to complete a Friends and Family Test

## 13. Onward Referrals and Discharge on the Support/Consultation Pathway:

The HMHT does not hold clinical responsibility for service users in the Support/Consultation pathway, therefore discharge from the team would be explored on a case-by-case basis. Discharge would be deemed appropriate when:

- assessments and intervention plans are completed
- it is deemed that challenging behaviour and risks have reduced and/or mental health has improved
- no further input is required from the service
- the individual is no longer homeless
- a discussion has taken place with the referrer.

## 14. Disengagement

Please refer to the process outlined in Section **6.9**

## 15. Psychologically Informed Environments (PIE)

The Homeless Mental Health Team is commissioned to promote Psychologically Informed Environments amongst the homeless community, including consultation and teaching across the partnership agencies. This includes:

- **Psychological awareness.** Promoting psychological understanding of the psychological needs of our service users with the adoption of a specific psychological model, for example mentalisation-based therapy or MBT (Bateman & Fonagy, 2016)
- **Staff training and support.** Delivering training on specific knowledge and skills so that teams can meet the emotional and psychological needs of their service users, including how staff are supported to work with homeless individuals
- **Spaces of opportunity.** Developing both the physical spaces in which workers meet service users as well as considering other ‘spaces’ such as local networks, wider networks, organisational systems and pathways (e.g. for referrals)
- **Rules, roles and responsiveness.** ‘The Three R’s’ refers to the day-to-day running of the organisation, including the rules of our service and how they are communicated, roles that are available within a service for both staff and service-users, and the responsiveness to events (e.g. incidents, risk occurrences) that might shape the culture of a service
- **Learning and enquiry.** Finally, within a psychologically informed environment there should be consideration to how the organisation learns from its experiences, how evidence about the effectiveness of the service is generated, and how learning might be maintained through reflective practice.

Further information about Psychologically Informed Environments can be found at http://pielink.net/

## 16. Staff Support

HMHT work with service users who may present a number of challenges, have complex emotional needs and engage in harmful behaviours such as self-harm, drug use and rough sleeping. This can be emotionally difficult for the staff involved in their care.
Regular reflective practice to be facilitated by a psychologist outside of the direct clinical area. This provides reflective practice that benefits the whole team. There are weekly reflective practices within the wider MHCIT which HMHT can also access.

Supervision is in line with the Trust Supervision Policy. Staff within HMHT will receive monthly managerial supervision, monthly clinical supervision and ad hoc peer supervision as and when is needed.

## 17. References


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**Appendix 1 – Housing Referral Form**

Humber NHS
NHS Foundation Trust

Hull City Council

HULL 2017 UK City of Culture

# Housing and Mental Health Worker Referral Form

| | | |
|---|---|---|
| Name: (including any previous names/aliases) | Title: | Date of Birth: |
| Address:<br><br>Post code:<br>E-mail: | | |
| Telephone number: | Preferred contact: i.e. mobile phone/letter/email<br><br>Can a message be left: Yes / No | Emergency Contact: |
| Gender: | Council/Private Tenant? | |

| | |
|---|---|
| Spoken Language:<br><br>Interpreter required: Yes / No | GP details, including practice: (if known)<br><br>Tel Number: |
| Is the patient aware of and consenting to the referral?<br>Yes/No<br><br>(Please note, if answered no, the referral will be rejected. If the patient does not have capacity to consent to the referral, please contact the service by email for advice on how to access support) | |
| **Referrer Details:**<br>Name:<br>Role:<br>Work Base:<br>Email Address:<br>Tel Number: | |

**What are the mental health concerns?** Think about current presentations. What difficulties are being experienced?

**Has the person had any past or current involvement with mental health services?** Lets Talk, CMHT, MIND, etc.

| **Please indicate the support you and/or the person being referred is seeking?** |
|---|
| |
| **Have you made any referrals to other agencies?** i.e. safeguarding, social care, environmental health.<br>If yes, please provide brief details and dates: |
| |

| Risk to Visiting | Yes | No | Unknown |
|---|---|---|---|
| Would this person pose a risk to staff? | | | |
| Are there any safety concerns around the home? i.e., hoarding, pets, aggressive visitors | | | |
| Is there a risk to self?<br>i.e., self-harm, substances, self-neglect, suicidality | | | |
| Is there a risk to the tenancy?<br>i.e., court dates, ASB, compliance issues | | | |
| If yes to any of the above, please provide more information: | | | |

**Please send this referral form via secure email to hnf-tr.hmht@nhs.net and ensure you cc the practice management team: practice.management@hullcc.gov.uk**

## Appendix 2 – Risk Matrix

| Urgency | Typical presentation | Response type/time | Additional considerations |
|---|---|---|---|
| High risk of harm to self or others and/or high distress, especially in absence of capable supports.<br><br>Significant deterioration in mental health, which is highly likely to deteriorate without imminent intervention or treatment | • Active suicidal ideation with plan/partial plan and/or history of suicidal ideation<br><br>• Rapidly increasing/developing symptoms of psychosis and/or severe mood disorder<br><br>• High risk behaviour associated with perceptual/thought disturbance, delirium, dementia, or impaired impulse control, including risk of harm to self or others<br><br>• Unable to care for self or dependents or perform activities of daily living due to acute mental health presentation<br><br>• Known service-user requiring urgent intervention to prevent or contain relapse<br><br>• Where peoples physical health is significantly at risk due to their mental health i.e. not eating/drinking due to belief food is poisoned. | **Ensure a qualified member of staff is involved in the call and supporting the staff member and a plan of action is agreed.**<br>**If the staff member is a Band 3 and cannot access a qualified member of staff then they are to call 999.**<br>**Assessment maybe required within 4 hours.**<br>**Develop a collaborative safety plan** | • Known to services<br><br>• Safeguarding<br><br>• Physical screening required<br><br>• Substance misuse<br><br>• Obtain additional/corroborating information from relevant others including family, friends other services.<br><br>• If in service liaison with the relevant team |
| Moderate risk of harm and/or significant distress<br><br>evidence of mental illness which is likely to deteriorate without intervention/treatment in a timely manner. | - Significant service-user/carer distress associated with serious mental illness (including mood/anxiety disorder) but not actively suicidal<br>- Early symptoms of psychosis<br>- Requires priority face-to-face assessment in order to clarify diagnostic status for treatment purposes<br>- Known service-user requiring priority treatment or review<br>- Any moderate/severe scores or an overall score of more than 7 on the TAG score as part of the triage form. | **Clinical triage to determine response time:**<br><br>**Either urgent (up to 48 hour response) or Non-urgent assessment depending on risk and presentation**<br><br>**Follow up appointment within 14 days** | As above |

| | | | |
|---|---|---|---|
| | | | |
| Low risk of harm in short term or moderate risk with high support/ stabilising factors<br><br>evidence of mental health needs that are not manageable/treatable within a primary care setting long term | • Requires specialist mental health assessment and treatment but is stable and at low risk of harm in waiting period<br>• Other service providers able to manage the person until MHS appointment (with or without MHS phone support)<br>• Known service-user requiring non-urgent review, treatment or follow-up<br>• Early cognitive changes in an older person<br>Has long term complex needs, which require multiple professionals/service involvement.<br>Cluster 5 and above<br>A mixture of mild /moderate scores or an overall score of more than 7 on the TAG score as part of the triage form. | **Follow up review**<br><br>**Non-urgent assessment** | As above<br><br>Ensure service required is provided in area such as ADHD assessment. |
| Referral not requiring face-to-face response from MHS in this instance<br>Advice or information only/ Service provider consultation | - Other services (e.g. GPs, primary care, voluntary sector) more appropriate to person's current needs such as prescribing of antidepressants when need is not complex.<br>- Symptoms of mild to moderate depression, anxiety, adjustment, behavioural disorder, particularly when primary care hasn't already been accessed.<br>- Service-user/carer requiring advice or opportunity to talk<br>- Service provider requiring telephone consultation/advice<br>- Issue not requiring mental health but require other services such as housing, finances, benefits.<br>Cluster 1-4<br>Mainly scoring mild scores or an overall score of below 7 on the TAG score as part of the triage. | **Not appropriate for secondary MH services:**<br><br>Signpost to primary care, IAPT, voluntary services<br><br>Professional/advice from clinical triage staff | |

## Appendix 3 – Homeless Pathway Referral Form

NHS
Humber Teaching
NHS Foundation Trust

| | |
|---|---|
| **First name:**<br><br>Preferred name if different: | **Last name:**<br><br>Preferred name if different: |
| **NHS Number:** | **Date of birth:** |
| **Current Address of patient:** | **Patients telephone/mobile telephone:**<br><br>(Please ensure this number is working and able to receive calls) |
| **Next of kin:** | **Is the patient aware of and consenting to the referral?**<br><br>(Please note, if answered no, the referral may be rejected. If the patient does not have capacity to consent to the referral, please contact the service by phone) |
| **Referrer details**<br>Name:<br>Role:<br>Contact address and Telephone Number: | **GP details (if different from referrer)** |

**Date of referral:**
**Service being referred for** **Adult Mental Health** ☐ **Older Peoples MH Services** ☐

**Referrer priority status**

**Please use referral from for routine referrals only. If you referral is urgent, you must contact the team directly to refer on 0800 138 0990**

**Mental health presentation (include signs and symptoms, including historical presentation)**

| |
|---|
| **Risk of harm to self (include intentional/unintentional harm)** |
| **Social Factors( include social network, employment, children)** |
| **Relevant physical health needs and all prescribed medication** |
| **Please indicate the support you and/or the person being referred is seeking** |
| **Any other relevant information/other agencies involved** |

## Appendix 4 – Generic Care Plan for Drop-in

Suggested phrases to add into a care plan document on Lorenzo. Service user specific details to be added.

**Goal** To support relationship building and identify support needs.

**Professionals View**: Drop-in sessions offered to build trust and offer informal support in the hope of promoting engagement.

**How we are going to get there**:

XX has accessed drop-in sessions offered by the Homeless Mental Health Team (HMHT) and a referral has been opened to the team on Lorenzo. There is no obligation to attend, and XX can take opportunity to access further support via this means as they wish.

Should XX continue to attend drop-ins with the team then engagement will be reviewed within the Homeless Mental Health Team's MDT to ascertain if they may benefit from caseload allocation or onward referral.

It is intended to begin to work with XX in a trauma-informed way, to build a trusting and therapeutic relationship, to foster the necessary hope and empowerment central to their recovery, on their terms, and in their timeframe, in an attempt for them to understand and make sense of their complex experiences.

Should XX choose not to attend for a period of over a month then engagement will again be reviewed, and consideration given to closing their referral. The Homeless Mental Health Team is not a crisis service; routes to support from the Crisis and Intervention Team are provided at point of first contact where need is identified.

Due to XX current circumstances this care plan has not been signed by them.

## Appendix 5 – Generic Care Plan for Rough Sleepers/Outreach

Suggested phrases to add into a care plan document on Lorenzo. Service user specific details to be added.

**Goal** To support relationship building and identify support needs.

**Professionals View**: Outreach offered to build trust and offer informal support in the hope of promoting engagement.

**How we are going to get there**:

XX has been accepted onto the Homeless Mental Health Team's caseload and is currently sleeping on the streets and/or occasional nights in emergency beds at the Hostels.

It is recognised that XX may not be able to engage with mental health intervention and support whilst they are without access to their basic needs, including shelter. The Homeless Mental Health Team's intervention is to begin to work with XX in a trauma-informed way, to build a trusting and therapeutic relationship, to foster the necessary hope and empowerment central to their recovery, on their terms, and in their timeframe, in an attempt for them to understand and make sense of their complex experiences.

The Homeless Mental Health Team, with the goal of building trust, recognise that the interventions may only brief or fleeting. Therefore, this care plan has not been shared with XX.

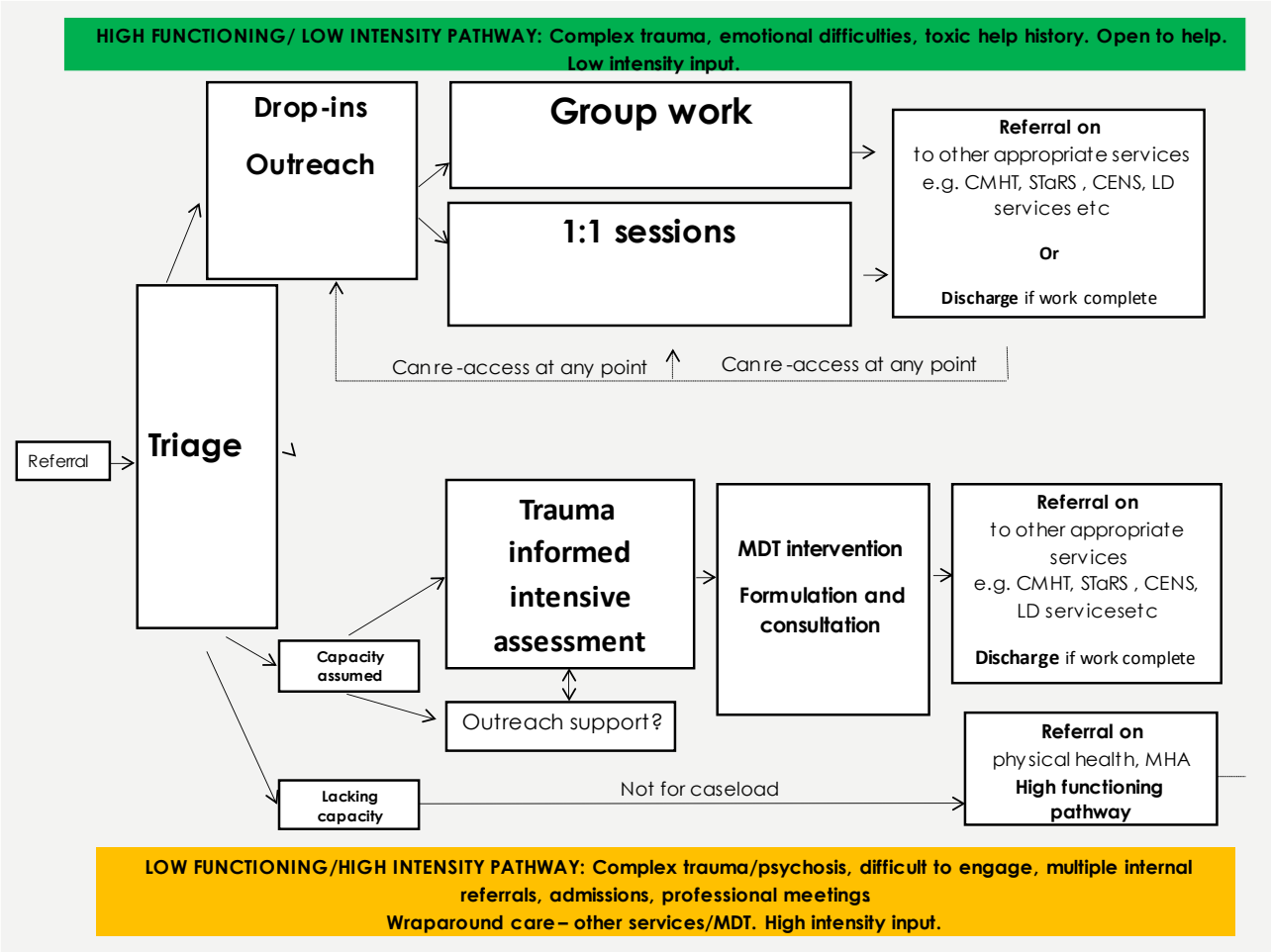
The Homeless Mental Health Team are unable to react to crisis interventions and XX should be directed towards the most appropriate crisis service at such times.

Due to XX current circumstances this care plan has not been signed by them.

The Homeless Mental Health Team will begin to work alongside other relevant agencies, to provide effective advice regarding XX mental health, as well as to meet and support them.

Whilst XX remains rough sleeping the Homeless Mental Health Team will work with a pre-treatment model.

## Appendix 6 – Care Pathway



## Appendix 7 – Lone Working Procedure/Agile Working

The HMHT are set up to be based within the community they serve. They are currently based within Miranda House, Gladstone Street in Hull, however there is a likelihood that the team will agile work. As agile workers, lone working is a significant part of the job.

When considering lone working risks should be identified at the point of receipt of referral, in regard to risk to the member of staff. These risks can be personal (directly from the service user) from a carer or known associate, or may be environmental. Due to risks posed by service user contact within a hospital and community setting, lone working procedures should always be adhered too. Please see HFTT Lone working policy.

Local protocols from lone working are as follows:

- When risk to visiting is identified, this should be recorded as an alert on Lorenzo and documented within the clinical note any decisions made around visiting.
- When risks to visiting are identified, the preference would be to see the service user at a team base and where possible, Miranda House. This is not always possible due to service-user being mistrustful and presentation and in these instances the following should be adhered to:
    - The staff member should organise a second person to attend with them. Where someone is homeless make the hostel staff aware of the risk posed to staff and ensure an appropriate room is allocated to see someone in and request hostel staff observe the room at regular intervals (to be negotiated with the staff team).
    - When this is a private residence, staff member to inform the clinical lead or in their absence another member of the team of the visit, informing them of approximate time of visit and expected length of visit. The staff member should ring a nominated colleague before they enter the property and when exiting.
- In certain circumstances, the staff member may not be able to contact the nominated colleague due to presentation of the service-user and in these instances should follow the Humber Trusts Lone Working Policy and escalate the situation as required.
- All staff members are to keep in their mobile phone under the name AAA the MHCIT emergency phone number which is 01482 336145. If unable to contact someone on this number, the staff member should contact 999 in an emergency situation.
- Local procedure dictates that when the emergency phone rings, that staff on shift immediately cease other activity and answer the phone as soon as possible, as this is an emergency situation.
- Should the staff member not return to site and be uncontactable, the clinical lead on duty will consider the use of contacting next of kin and the police.
- When seeing a service user on a trust site, lone working procedures should continue to be adhered to.
    - Service-user should be seen in an appropriate room on the site.
    - Staff member should ensure they have surveyed their environment before inviting in the service user and take note of exits, chair positioning and alarm systems.
    - Staff member should always remain in close proximity to the entrance to the room and any alarm points available
    - Should risk escalate, the staff member should attempt de-escalation if appropriate and/or remove themselves from the room to protect their safety. Staff to use the alarm points to contact for help as required.
    - When seeing a service user at Miranda House; the 136 suite and interview rooms are fitted with the pinpoint alarm system. Staff should ensure they have acquired a pool alarm kit from reception before seeing the service-user. The staff member should ensure they test the key fob to ensure it is working correctly and carry this with them at all times during their consultation. This fob is to be activated as required and assistance will be provided

from MHCIT and ward-based staff. Once the consultation is complete, the key fob should be returned and signed back in at reception for further use.

- Staff should ensure they have enquired about and adhere to all local procedures at other sites they may be working from.

Any incidents of aggression should be documented on Lorenzo, including creating an alert, inform the shift coordinator/clinical lead, report via datix, consider report to the police as required. Staff who witness or are subject to physical or verbal aggression should be offered supervision and a de-brief session at the earliest opportunity.

## Appendix 8 – Interface With Other Agencies

**Hull Homeless Assessment Hub**
The Hub is a multi-agency short term assessment Hub where a homeless person can access holistic assessment of their needs. This includes support and assessment for mental health, physical health, financial assessments and accessing benefits, housing options, substance and alcohol services and Occupational Health assessments.

**Making Every Adult Matter (MEAM)/Changing Futures**
Representatives from the HMHT attend the weekly Changing Futures operational meeting. People facing multiple disadvantages experience a combination of problems including homelessness, substance misuse, contact with the criminal justice system and mental ill health. They fall through the gaps between services and systems, making it harder for them to address their problems and lead fulfilling lives.

The MEAM Approach helps local areas design and deliver better coordinated services for people experiencing multiple disadvantage considering the seven principles, which they adapt to local needs and circumstances.

These meetings enable representatives from multi-agencies to discuss people deemed as vulnerable, experiencing multi exclusions and who do not engage with mainstream services. The meeting consists of Hull City Council, Safeguarding, Humberside Police, Renew, Probation, Mental Health and Health. This approach allows for those who present the biggest challenges within the city to be discussed at length in an holistic manner to formulate a plan of support.

**Housing and Mental Health Review Meeting**
This meeting is set up to continuously review the joint working between housing and mental health, to ensure the projects are on track and providing what they are meant to. To address any performance issues and discuss continued development of the service and to share examples of good practice. It consists of Hull City Council Housing, Hull CCG, MHCIT and HMHT.

**Hostels**
The homeless pathway work closely with hostel staff. This is not only to promote a shared understanding of service users within the hostel but to also offer reflective practice and support to staff. On every attendance at the hostel, HMHT staff will meet with hostel staff informally, to have a discussion about how they are feeling and how things are generally within the hostel. Where someone identified a greater need then additional support will be offered. Building positive relationships with the staff teams within the hostel is essential to the work HMHT do in order to help establish Psychologically Informed Environments. This allows for staff members to feel comfortable discussing service-users with HMHT, to build confidence working in this arena and to be able to understand the service-users better which improves service-user experience and increases the chance of them not returning to street homelessness.

**MHCIT**
The HMHT is part of the wider Mental Health Crisis Intervention Team. The HMHT works closely with the wider service to educate the teams around working with marginalised people, the team work with the wider service to escalate referrals if the risk is considered too high to manage within HMHT, for example, someone who is suicidal with plan and intent or where someone needs a more intensive response, for example, someone who is acutely psychotic.

When someone is assessed and requires either home based treatment or an inpatient service then the service user will be discharged as their need is too high for HMHT and the expectation is that the service user then meets the criteria for mainstream services. The exception for this is if either of these services are accessed due to risk but the persons mental health need can still be met within HMHT When this occurs, HMHT will continue to work jointly with the other service.

**CMHT**

The HMHT will liaise with CMHT when one of their service users is within the homeless community and there is anything that requires their attention that they may not be aware of. HMHT will also link other agencies in with their allocated care co-ordinator, for example, housing where there is a concern about mental health. HMHT will follow the process set out within MHCIT SOP for referrals into CMHT.