Rough Sleeping and Mental Health Programme

Evaluation

June 2022

Acknowledgements

This report was written by Beth Coyne, George Garrad, Sara Sekelj and Jenny Shand, supported by Ian Canadine, Johanna Cooper, David Orton and RAMHP Service Managers. Qualitative research and analysis was conducted by Beth Coyne, Spike Hudson and Lauren Reid. Many thanks to Hilary Neal, Rikke Albert, Sue Tatch, Jennifer Beharry, Okechukwu Okorafor, Merwaan Chaudhry and Paul Fielder, who have supported with data collection and analysis.

The report was produced with insights gathered from many professionals from the following organisations:

- Greater London Authority
- West London NHS Trust
- Central and West London NHS Foundation Trust
- North East London NHS Foundation Trust
- East London NHS Foundation Trust
- St Mungo's
- Thames Reach
- Change Grow Live
- Single Homeless Project
- Imperial College Health Partners
- London Borough of Brent
- London Borough of Kensington and Chelsea
- London Borough of Harrow
- London Borough of Hillingdon
- London Borough of Westminster
- London Borough of Ealing
- London Borough of Hammersmith and Fulham
- London Borough of Hounslow
- London Borough of Barking and Dagenham
- London Borough of Havering
- London Borough of Redbridge
- London Borough of Waltham Forest
- London Borough of Hackney
- London Borough of Newham
- London Borough of Tower Hamlets

Contents

Executive summary

Analysis conducted by the Greater London Authority (GLA) as part of the Mayor's 'plan of action' for rough sleeping in 2018 concluded that there was a lack of adequate support for people sleeping rough with mental health problems. As a result of this analysis, the GLA and the Department of Levelling Up, Housing and Communities chose to invest in a two year Rough Sleeping and Mental Health Programme (RAMHP) pilot, which was set up to help people take a vital step towards a better quality of life by supporting access to mental health services. It operated for two years across 15 London boroughs and directly commissioned four different NHS mental health Trusts and continues to be operational in all trusts. The intended outcomes for the programme were:

- Mental ill health doesn't contribute to rough sleeping
- Rough sleeping doesn't prevent people from accessing mental health services
- Mental ill health doesn't prevent people from moving off the streets or sustaining a settled lifestyle

To try and assess whether the programme had been successful in its aims, the GLA commissioned UCLPartners to conduct an evaluation of RAMHP. Over the last seven months, UCLPartners have conducted a mixed method, quantitative and qualitative, evaluation of the programme and identified the following three key themes:

- RAMHP and the lives of people sleeping rough
- RAMHP – service access and shared learning
- Factors that contributed to RAMHPs perceived success

There were significant limitations in the quantitative element of the evaluation, mostly focused on inconsistent data collection, which has meant it is difficult to assess the true impact of RAMHP. However, by augmenting the quantitative with qualitative insights, the following findings were identified:

RAMHP and the lives of people sleeping rough

- There was some indication that the mental health of people sleeping rough was stable or improved. This was measured using the HoNOS scale, a clinician rated instrument comprising 12 simple scales measuring behaviour, impairment, symptoms and social functioning. However, due to data capture issues, it is difficult to say categorically
- Over 70% of people who received support from RAMHP services were not seen rough sleeping again within 12 months of discharge from the service

RAMHP – service access and shared learning

- Registration at GP surgeries for rough sleepers was consistently high for services that collected enough data
- From the interviews, there was evidence of skills transfer and significant learning between the rough sleeping and health sectors that led to more joined up working
- There was some evidence of better access to mental health services for people sleeping rough, due to the bespoke nature of how RAMHP is commissioned. However, barriers continue to exist for people sleeping rough accessing other mental health services

Factors that contributed to RAMHPs perceived success

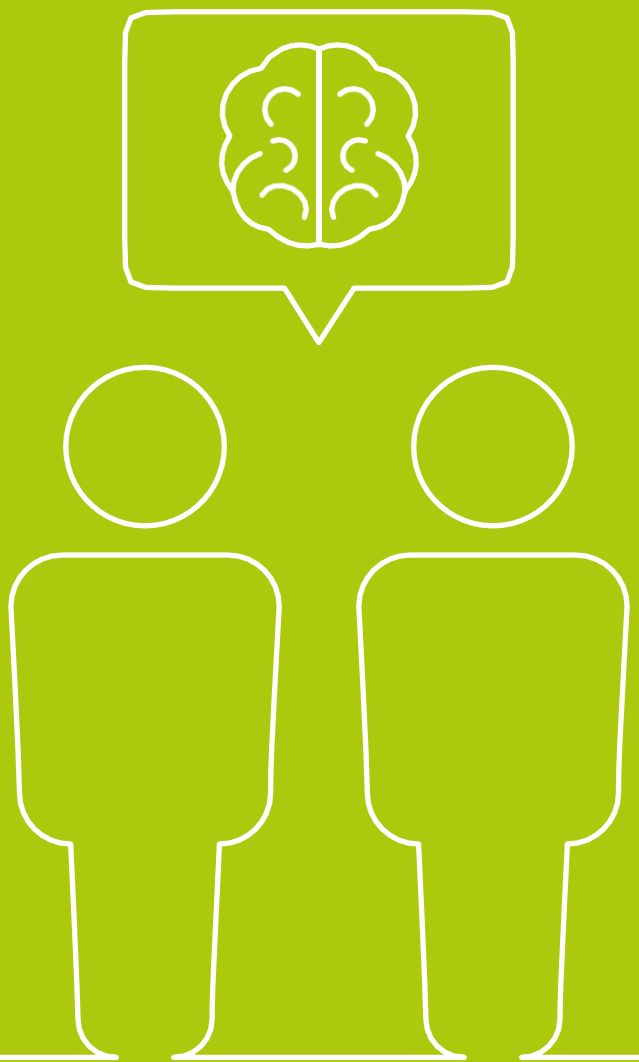
- The fact that funded services were located within the NHS, but delivered in partnership, was crucial to RAMHP success
- RAMHP services are flexible and personalised in how they are delivered and have a diverse staff team with a range of expertise
- Lived experience was embedded throughout RAMHP, specifically the co-design advisory group and some services employing Peer Support Workers

Reflections and recommendations

When considering the wider commissioning/extension of RAMHP and RAMHP like services, it is recommended that careful consideration is put on the following:

- Invest in good quality data capture
- Prioritise the role of partnership to ensure good cross sector skills transfer and learning takes place
- Continue to commission NHS services, but insist they deliver in partnership with the third sector and local authorities
- Consider the influence on the wider pathway of offering bespoke services for people sleeping rough; there is a danger of excluding them from mainstream access
- RAMHP services should always be flexible and personalised, fitting around the lives of people sleeping rough, rather than the services themselves
- Embed lived experience within the programme, with Peer Support Workers and lived experience advisory groups being crucial to the success of the programme

Introduction to RAMHP and context for evaluation



Introduction to RAMHP and context for evaluation

In 2019, the Greater London Authority (GLA) conducted a review of the mental health needs of people sleeping rough in London. They found that of the 71% of London's people sleeping rough that were assessed for health needs in 2017/2018, 50% had a mental health need (Figure 1). Staff from both the NHS and homelessness charities have described significant barriers for people sleeping rough accessing mental health services, with many people being excluded by referral criteria, or their itinerant status preventing proper assessment and engagement.

London analysis 2017/2018

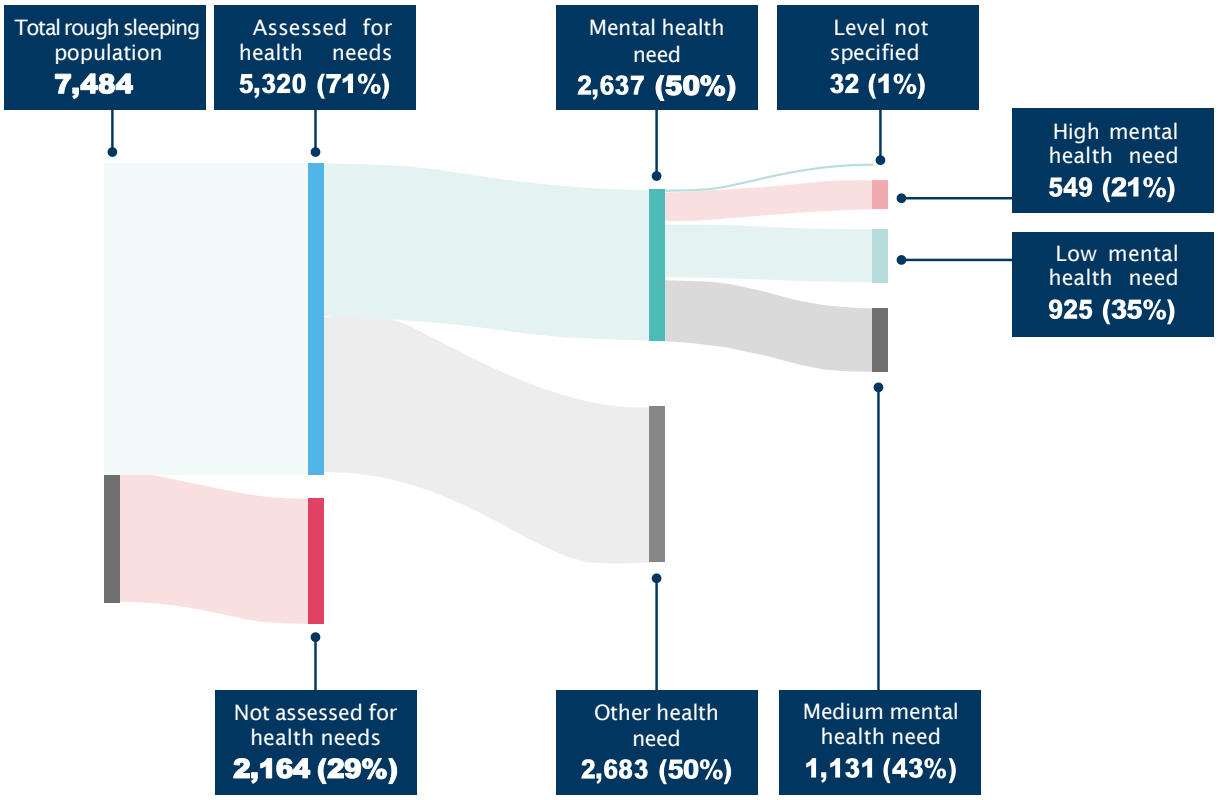


Figure 1: Needs of people sleeping rough in 2017/2018, © Imperial College Health Partners

This analysis and wider feedback from the health and rough sleeping sector informed the set up of a Rough Sleeping and Mental Health Programme (RAMHP), which was designed to help people take a vital step towards a better quality of life by supporting access to mental health services. It was launched as a two-year pilot funded jointly by the Mayor of London's Office and the then Ministry for Housing, Communities and Local Government. Four NHS trusts received funding to create specialist teams of mental health professionals, who worked collaboratively with Homeless Street Outreach Teams and Local Authorities to support individuals across 15 boroughs in London. Imperial College Health Partners was commissioned as the Programme Coordinator to facilitate programme design, support mobilisation, and to support sustainability and spread.

When it was designed, the GLA and programme partners had three intended outcomes for the RAMHP:

- Mental ill health doesn't contribute to rough sleeping
- Rough sleeping doesn't prevent people from accessing mental health services
- Mental ill health doesn't prevent people from moving off the streets or sustaining a settled lifestyle

It sought to achieve these aims by mental health practitioners undertaking outreach with people sleeping rough; and through increasing collaboration between homelessness outreach and mental health providers. The kind of activities RAMHP practitioners undertook in their day-to-day work included:

- Conducting regular joint outreach shifts with homelessness outreach teams
- Meeting people sleeping rough and building relationships over time
- Assessing the mental health needs of people sleeping rough and discussing treatment and support options
- Attending multi-disciplinary and strategic meetings with partners
- Facilitating access into mental health services for people sleeping rough
- Evaluating progress and being responsive to changing circumstances
- Delivering a range of treatment options
- Supporting homelessness and local authority colleagues to find the most appropriate accommodation options
- Continuing to provide support, discharging or making onward referrals as required

Crucially, from the outset, RAMHP has been guided by people with lived experience of sleeping rough and having mental health needs. The programme Codesign Advisory Group of experts by experience influenced both the design and delivery at a service and programme level throughout the pilot.

By operating in this way, it was hoped that providers and their staff would have an increased understanding of the needs of people with mental health needs who are sleeping rough, and they would feel able to try out new ways to make their services more appropriate and accessible to them. Figure 2 below illustrates how the different RAMHP services were set up and ran by the different providers. Whilst there are subtle differences between the Trusts, there are more commonalities than differences. For example, all services:

- Have mental health practitioners in the team
- Are predominantly located in the NHS
- Have strong links with local authorities and outreach teams

It should be noted that the FTEs, bands and posted listed below were accurate at the start of the programme and have iterated over time.

Local RAMHP teams

Central and North West London					
Boroughs	Brent	Kensington & Chelsea	Harrow	Hillingdon	Westminster
Trust (Dept)	Central and North West London NHS Foundation Trust (Community Mental Health Teams)				
Outreach Teams	St Mungo's Brent	St Mungo's Kensington & Chelsea	LSR Harrow	LSR Hillingdon	
CNWL RAMHP Team	Brent	Kensington & Chelsea	Harrow & Hillingdon		Westminster
	Mental Health Practitioner (Band 6)	0.5 Mental Health Practitioner (Band 6)	Mental Health Practitioner (Band 7)		Service review/ research
			[TBC] x Mental Health Practitioner (Band 7)		

North East London				
Boroughs	Barking & Dagenham	Havering	Redbridge	Waltham Forest
Trust	North East London NHS Foundation Trust (Access, Assessment & Brief Intervention team)			
Outreach Teams	LSR Barking & Dagenham	LSR & Local SORT Havering	SHP Redbridge	CGL Waltham Forest
NELFT RAMHP Team	0.2 Psychologist (Band 8a)			
	Mental Health Practitioner (Band 7)	Mental Health Practitioner (Band 6)	Mental Health Practitioner (Band 6)	

West London			
Boroughs	Ealing	Hammersmith & Fulham	Hounslow
Trust (Dept)	West London NHS Trust (Community and Recovery Team)		
Outreach Teams	St Mungo's Ealing	St Mungo's Hammersmith & Fulham	St Mungo's Hounslow
WLT RAMHP Team	0.5 x Management		0.4 x Admin
	0.2 x Consultant Psychiatrist		0.1 x Psychologist
	Mental Health Practitioner (Band 6)	Mental Health Practitioner (Band 6)	Mental Health Practitioner (Band 6)

East London				
Boroughs	City	Hackney	Newham	Tower Hamlets
Trust (Dept)	East London NHS Foundation Trust (Crisis Response)			
Outreach Teams	St Mungo's City	LSR Hackney	LSR & Local SORT Newham	St Mungo's Tower Hamlets
ELFT RAMHP Team	Service Manager (Band 8a)			
	0.2 Consultant Psychiatrist			
	Mental Health Practitioner (Band 6)	Mental Health Practitioner (Band 6)	Mental Health Practitioner (Band 6)	0.25 x Mental Health Practitioner (Band 6)

***Figure 2:** Details of local RAMHP teams, © Imperial College Health Partners*

Introduction to RAMHP and context for evaluation

To try and assess whether the programme had been successful in its aims, the GLA commissioned UCLPartners to conduct an evaluation of RAMHP. In conjunction with the GLA, it was agreed that the evaluation should assess the success of the programme as whole, as opposed to the individually assess the four distinct services. This decision was taken as a result of a desire to assess the impact of the programme as a whole, rather than the performance of individual providers.

As such, the report that follows:

- Outlines how the evaluation was conducted, including methodologies, data sources, and approach to analysis
- Shares analysis on three key themes of the evaluation:
    1. RAMHP and the lives of people sleeping rough
    2. RAMHP – service access and shared learning
    3. Factors that contributed to RAMHPs perceived success
- Offers recommendations and reflections on the next steps for RAMHP

Evaluation methodology

Prior to commissioning an evaluation partner, the GLA worked with Imperial College Health Partners (ICHP) to create an evaluation framework that was developed in conjunction with key RAMHP stakeholders. The framework represented an initial overview of the outcomes of interest aiming to inform this evaluation. In December 2021, UCLPartners worked closely with the GLA on producing a revised version of this framework, based on review of data quality, collection processes and overall programme progress. This revised framework was used as the basis for the design of the evaluation approach and can be found in Appendix 1.

The evaluation, which has been carried out between November 2021 and June 2022, used mixed methods to assess the programme progress against its aims.

Quantitative research

Quantitative analysis was carried out using the following two data sources:

- Combined Homelessness and Information Network (CHAIN) data
- RAMHP Key Performance Indicators and Activity data for Trust services, collected by the four mental health trusts, and extracted for evaluation purposes

Throughout the programme, the Trusts collected activity and outcomes data, as well as CHAIN IDs for people seen by RAMHP teams. The CHAIN ID is a unique identifier, enabling the commissioner to interrogate the CHAIN dataset for the cohort of interest. In order to analyse CHAIN dataset, we worked closely with the GLA and the CHAIN team. A summary of data flows can be seen in Figure 3.

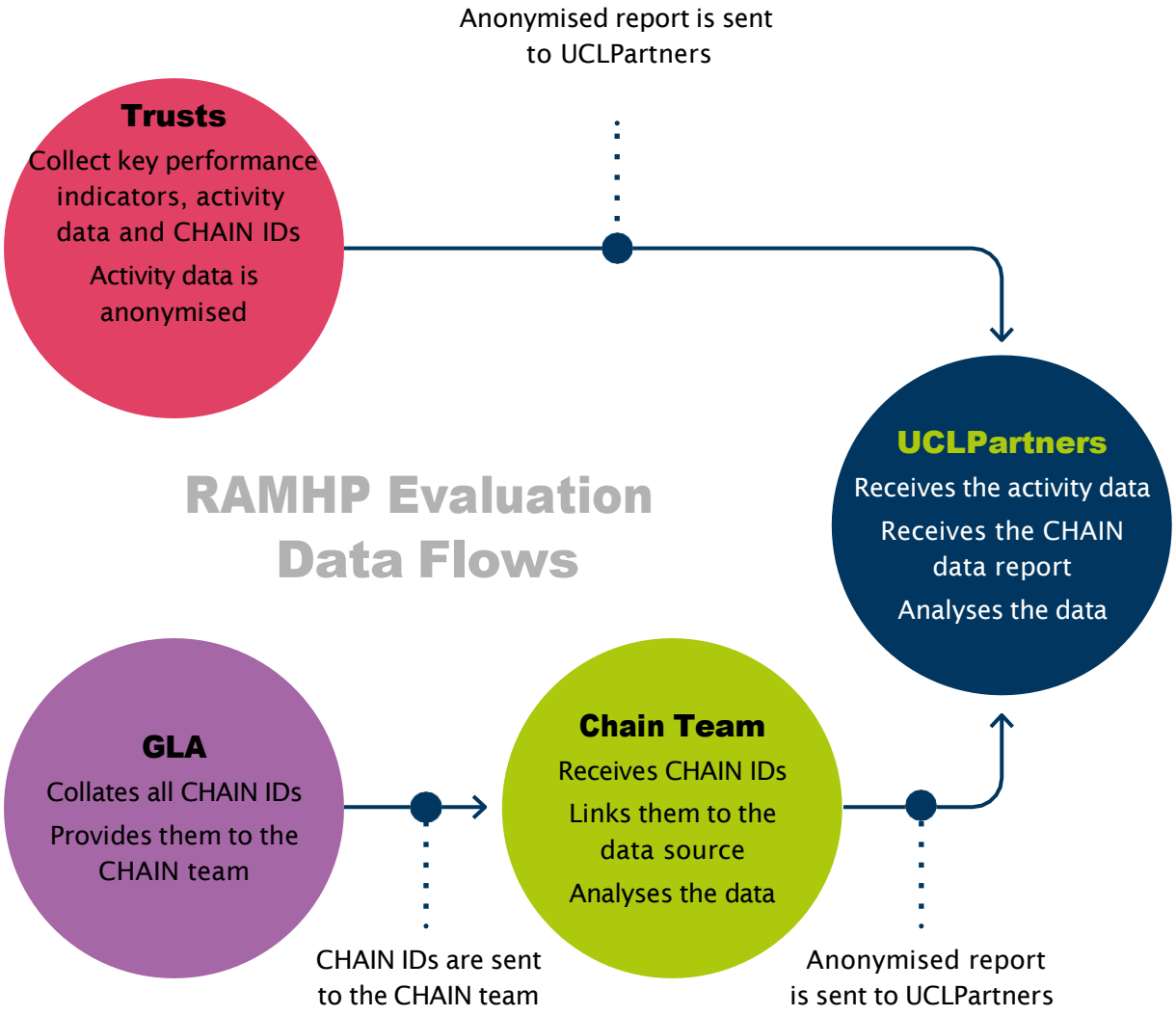


Figure 3: RAMHP Evaluation Data Flows

Anonymised summary outputs from CHAIN dataset were analysed by UCLPartners. Inclusion and exclusion criteria were only applied to CHAIN data analysis. An individual is only included in this analysis if the CHAIN ID provided for them matches a current client ID in the CHAIN system, and if both a service start date and discharge date was provided for them. The data in the report covers the period from April 2020 to March 2022 and was explored in MS Excel 2022.

Qualitative research

In keeping with the commitment to co-design that has been evident throughout the genesis of the RAMHP Programme, and because it is crucial to the quality of an evaluation to hear directly from the people the programme was set up to help, peer researchers with lived experience of rough sleeping and using mental health services were recruited.

As joint research team we designed a comprehensive set of open questions to guide semi-structured interviews. We adapted these questions to three categories of interviewees: a. RAMHP team mental health professionals, b. homelessness outreach professionals, c. strategic partners (including housing commissioners, local authority street population coordinators, members of the co-design advisory group). The interview guide was co-developed with the GLA, peer researchers and academic partners and was designed to understand the impact of RAMHP on people sleeping rough, local services and the wider housing and healthcare system. A series of meetings and interviews were undertaken to understand the context and development of the RAMHP Programme.

A team of three individuals conducted interviews (two with lived experience of rough sleeping or using mental health services), using a semi-structured interview guide across each of three domains: individual outcomes, service and system outcome and what made RAMHP a success. Interviewers were trained and provided with guidance for how to complete the interview (with standard scripts for introduction and question guides) and provided with a template for collating interview outputs. Interviews took on average one hour, were conducted on Microsoft Teams or in person, recorded and transcribed. The interviews were completed between January and May 2022. Table 1 shows the breakdown of who was spoken to and from which organisation they represent.

	Provider					
Team member	**Central and North West London**			**West London**	**Trust or Borough**	

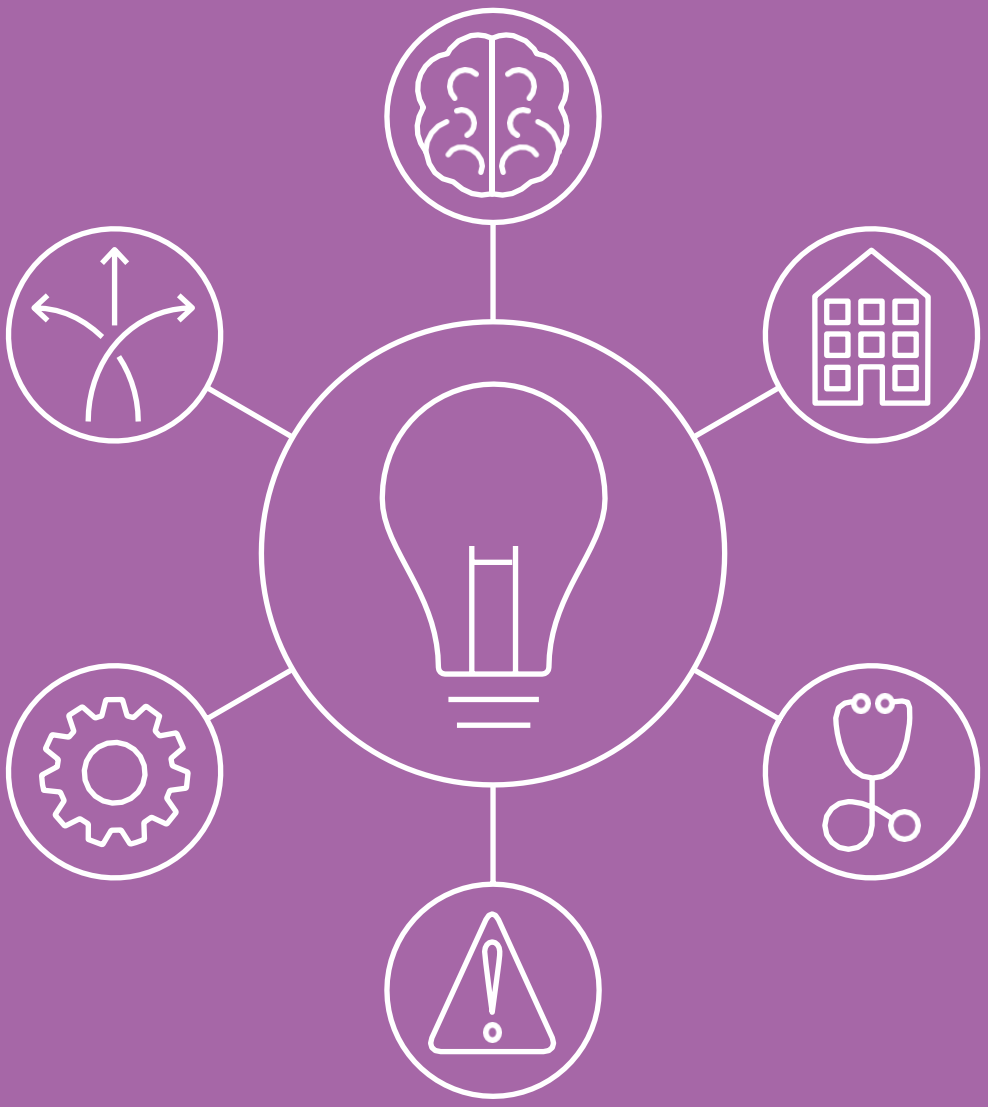
***Table 1:** Interviewees breakdown*

Other sources of information

Further to the qualitative and quantitative research, review of the following sources of information was included as part of the evaluation:

- Trust quarterly reports to the GLA
- Imperial College Health Partners (ICHP) Fidelity Report
- ICHP evaluation framework, including the key performance indicators of the programme
- Collaborative working surveys
- CHAIN Annual Reports

Findings



Findings

The CHAIN Annual Report and CHAIN dataset was analysed to understand the number of people sleeping rough and the level of mental health support need. Support needs data in CHAIN are derived from assessments made by those working with people sleeping rough in the homelessness sector. In 2021/2022, a total of 11,018 people were seen sleeping rough in London. Out of 11,018 people, 8,111 (74%) were assessed for support needs. The most frequently reported support need amongst people seen rough sleeping in 2020/21 was mental health (3,585/8,111 people assessed, 44%). From all people who were discharged from RAMHP, the records were matched to CHAIN dataset for 854 people. This required a matched, current client ID in the CHAIN system, and service start date and discharge date. Out of 854 people discharged from RAMHP, 203 people had a mental health need recorded in CHAIN more than 12 months prior to service start (203/854 people, 23.77%), and 356 people had a mental health need recorded within 12 months prior to service start (356/854 people, 41.69%)

Based on the RAMHP Key Performance Indicators (KPI) and Activity data for Trust services, RAMHP teams have processed a total of 1,712 referrals since the Programme start date (Figure 4). The average number of people worked with was 353 referrals per quarter.

Total number of referrals per quarter for all providers, March 2020 to April 2022

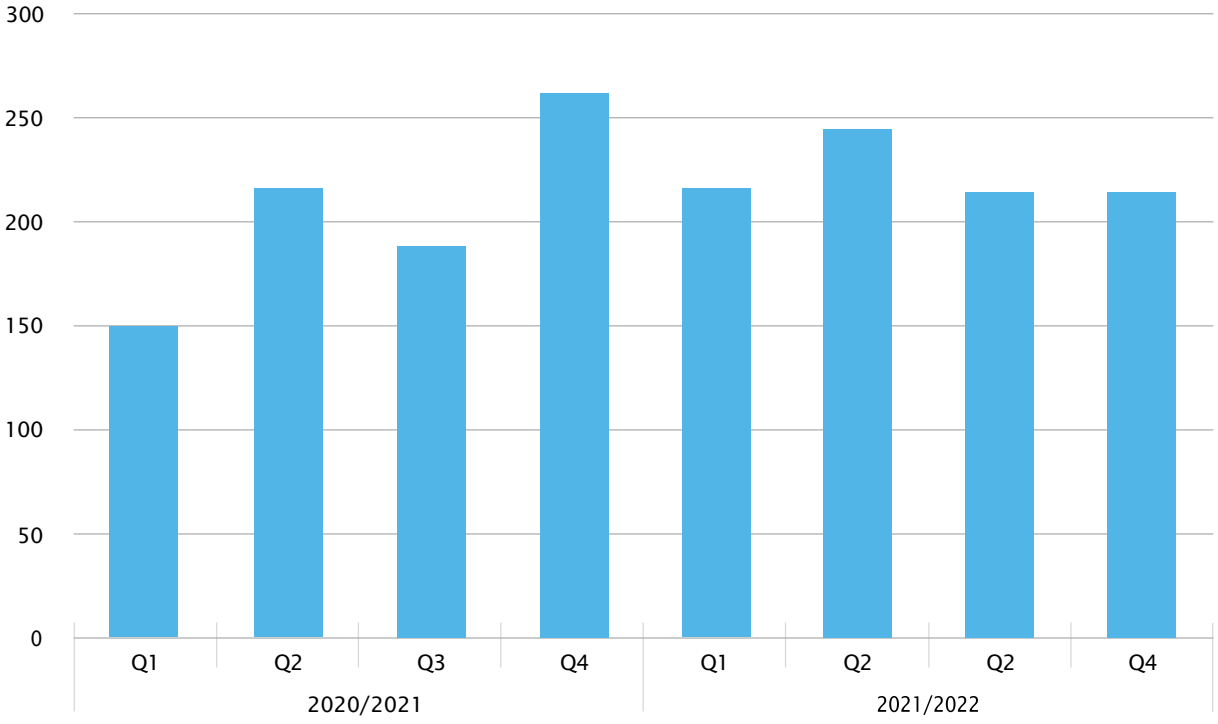


Figure 4: Number of referrals per quarter, all providers, March 2020 – April 2022

Out of all processed referrals, 558 referrals were processed by ELFT team, 462 referrals by NELFT team, 443 referrals by CNWL team and 206 referrals by WL team (Figure 5).

Total number of referrals per quarter per provider, March 2020 to April 2022

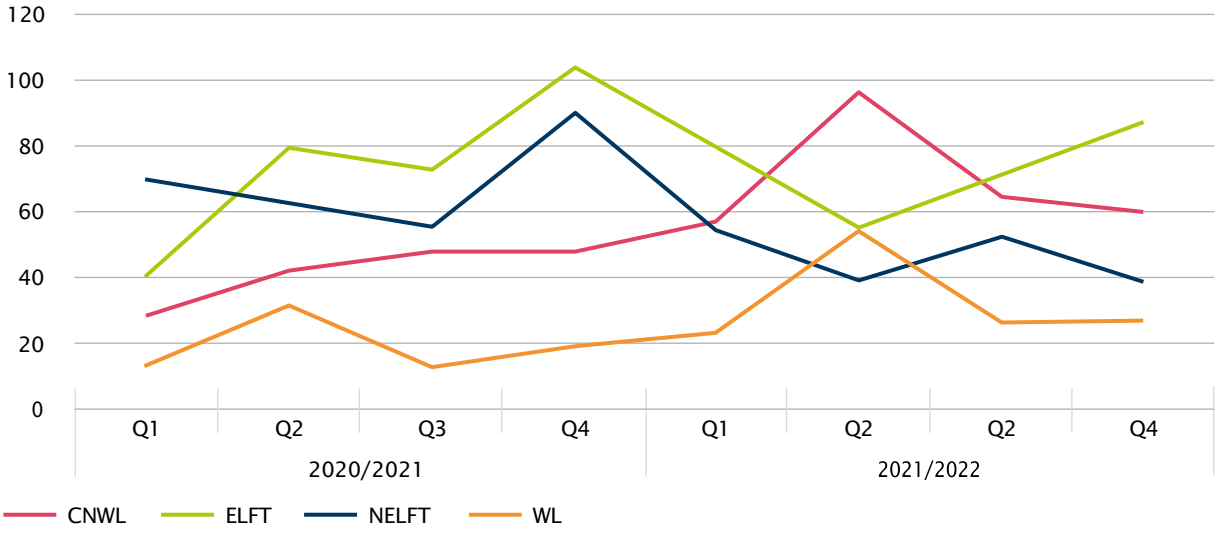


Figure 5: Number of referrals per provider, March 2020 – April 2022

One of the KPIs measured percentage of assessments performed within 28 days of referral. The service should endeavour to carry out a needs assessment for all those referred, with an objective to assess 75% of people and to complete the assessment within 28 days of receiving the referral. Figure 6 illustrates the progress of RAMHP teams in achieving this KPI. Some providers have reported having data quality issues with collecting this metric at the beginning of the programme. It is worth mentioning that some people were difficult to target for an assessment, and they were not seen by the outreach team often, possibly extending the period of time needed to complete the assessment post referral.

Total number of referrals assessed within 28 days per provider, March 2020 to April 2022

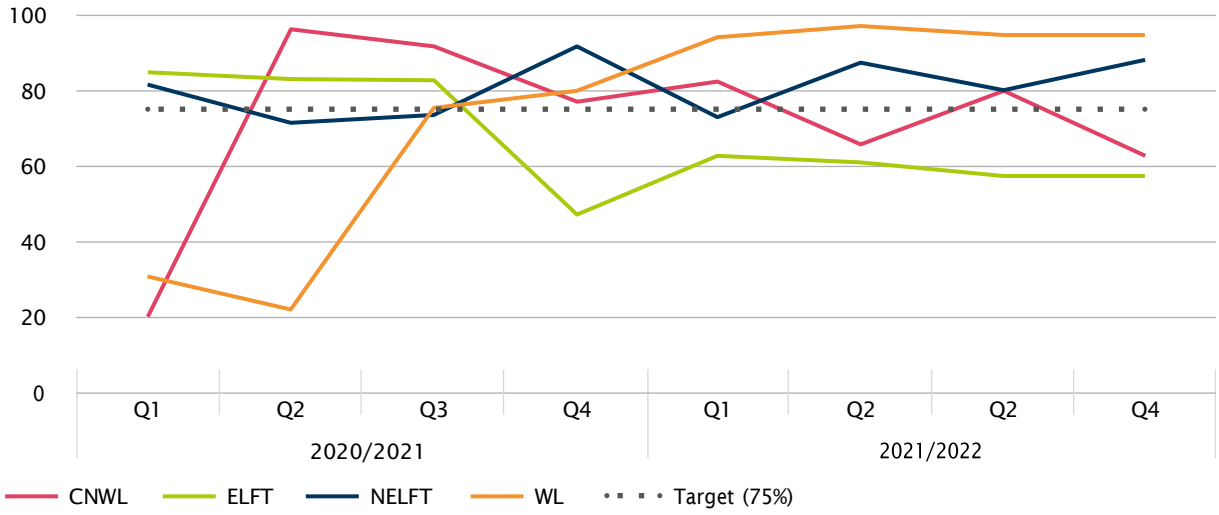


Figure 6: Percentage of referrals assessed within 28 days, March 2020 – April 2022

Interview outputs and quantitative data were analysed using a thematic analysis. The following themes emerged and are described in further detail below:

1. **RAMHP and the lives of people sleeping rough**
    a. The mental health of people sleeping rough
    b. The accommodation outcomes of people sleeping rough
    c. The risk of harm individuals pose to themselves
2. **RAMHP – access to services and shared learning**
    a. Access to GP services
    b. Skills transfer and learning from each other
    c. Mental health services and accessibility to people sleeping rough
3. **Factors that contributed to RAMHPs perceived success**
    a. RAMHP sits within the NHS, not the third sector
    b. Has a flexible delivery model
    c. Has been co-designed by people with lived experience

1. RAMHP and the lives of people sleeping rough

Stakeholders across the system were positive about the RAMHP and the services the providers offered. The benefits described fell into three linked categories:

a. The mental health of people sleeping rough

b. The accommodation outcomes of people sleeping rough

c. The risk of harm individuals pose to themselves

In this section, the report will go into more detail for each of the three above areas.

1a: The mental health of people sleeping rough

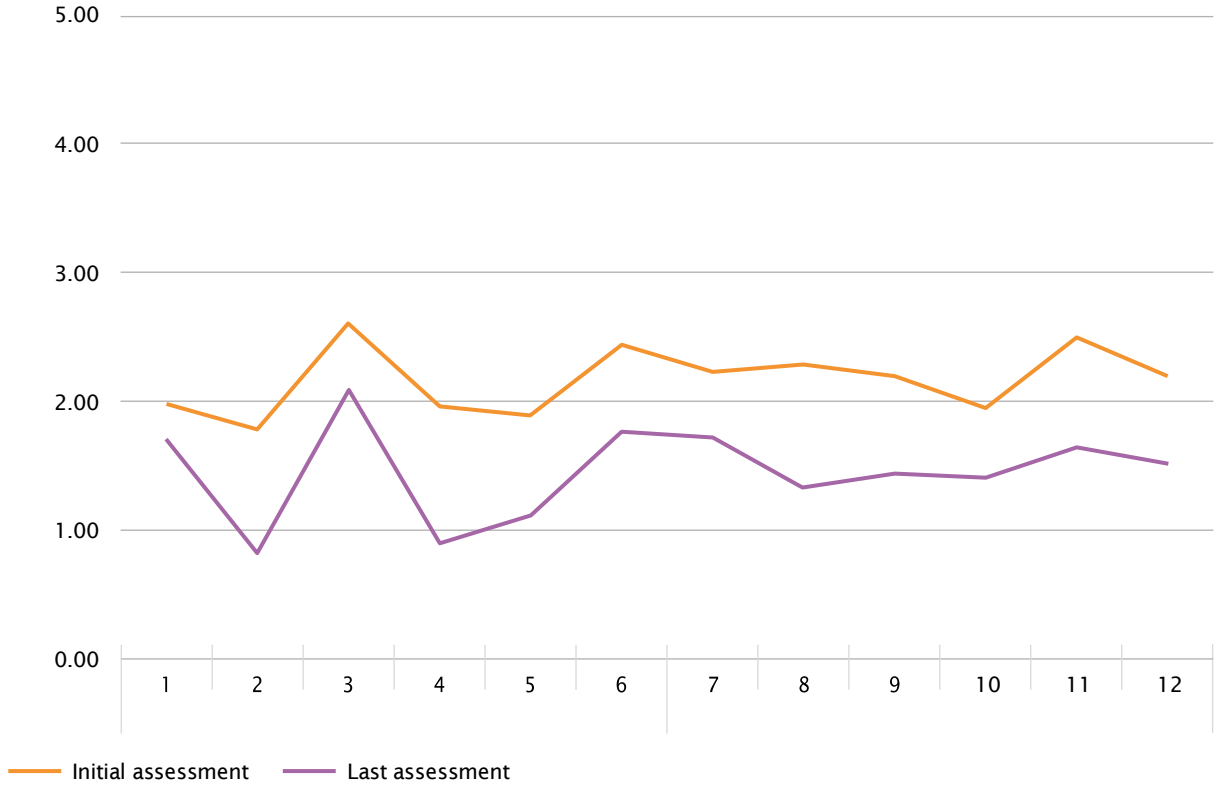
Changes in mental health were measured using the Health of the Nation Outcome Scales (HoNOS) Scale. HoNOS is a clinician reported outcome measure comprising twelve scales measuring behaviour, symptoms and social functioning. The scale is completed at initial assessment and at discharge. Measuring change in the scores, particularly in specific domains, can support understanding of the impact of RAMHP. Perceived changes to mental health was explored further in the interviews. Across the four provider sites, HoNOS scale was not used consistently and as such data collected was incomplete (see limitations section for more detail). However, there were two services that had used the measure consistently as a result provided sufficient data to carry out the analysis. Figure 7 illustrates how to interpret the HoNOS results as they are displayed in the analysis tables.

Effect size (Cohen's *d*)	Interpretation of HoNOS	
-0.8 or lower		**Clinically significant improvement**
-0.5 to -0.8		
-0.2 to -0.5		
-0.2 to 0.2		
0.2 to 0.5		
0.5 to 0.8		**Clinically significant deterioration**
0.8 or higher	Deterioration of critical clinical importance	

Figure 7: Guide to interpretation of HoNOS change score

The data in the figure below was analysed from one provider, covering Q1, Q3 and Q4 2021/2022. The findings represent 134 referrals where initial and last HoNOS scales were completed. We've measured change on each of the 12 HoNOS scales by comparing the mean score at initial assessment, where the score was >= 1, and the score at last assessment. The overview of HoNOS for all referrals in Q1, Q3 and Q4 2022 that had a first and last assessment, demonstrates clinically significant improvement in areas 2-12 (Figure 8).

HoNOS initial and last assessment by scale, Q1, Q3 and Q4 2022, 134 referrals



Scale	1	2	3	4	5	6	7	8	9	10	11	12
Change	-0.28	-0.96	-0.49	-1.09	-0.78	-0.70	-0.50	-0.95	-0.74	-0.52	-0.83	-0.68

Figure 8: Provider 1 – changes in HoNOS score by scale

The categorical change model was explored, where all scores were grouped into two categories:

- Low severity → score of 0-2
- High severity → score of 3-4

Figure 9 below illustrates changes on each scale, through showing proportions of referrals that:

- Improve – from High severity to Low severity (HL)
- Deteriorate – from Low severity to High severity (LH)
- Remain unchanged (from Low severity to Low severity (LL), or from High severity to High severity (HH)

Categorical change model by question, initial assessment to discharge (aggregated scores)

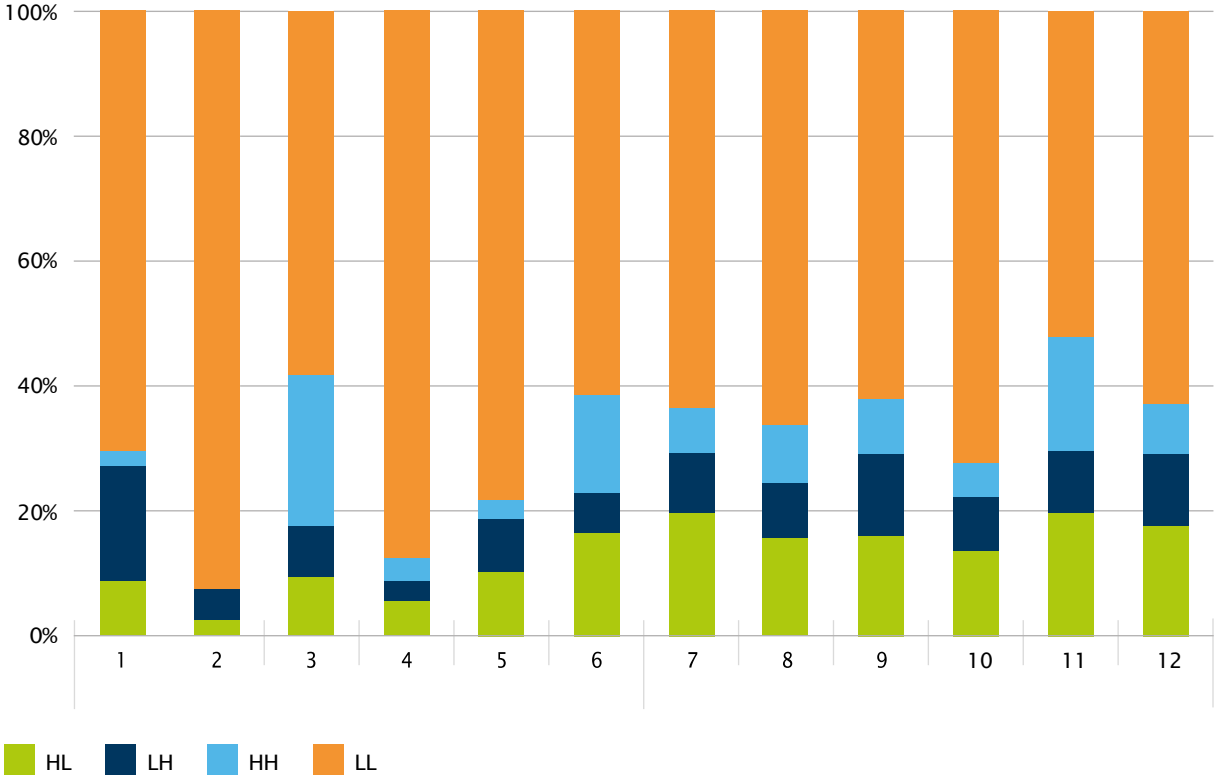
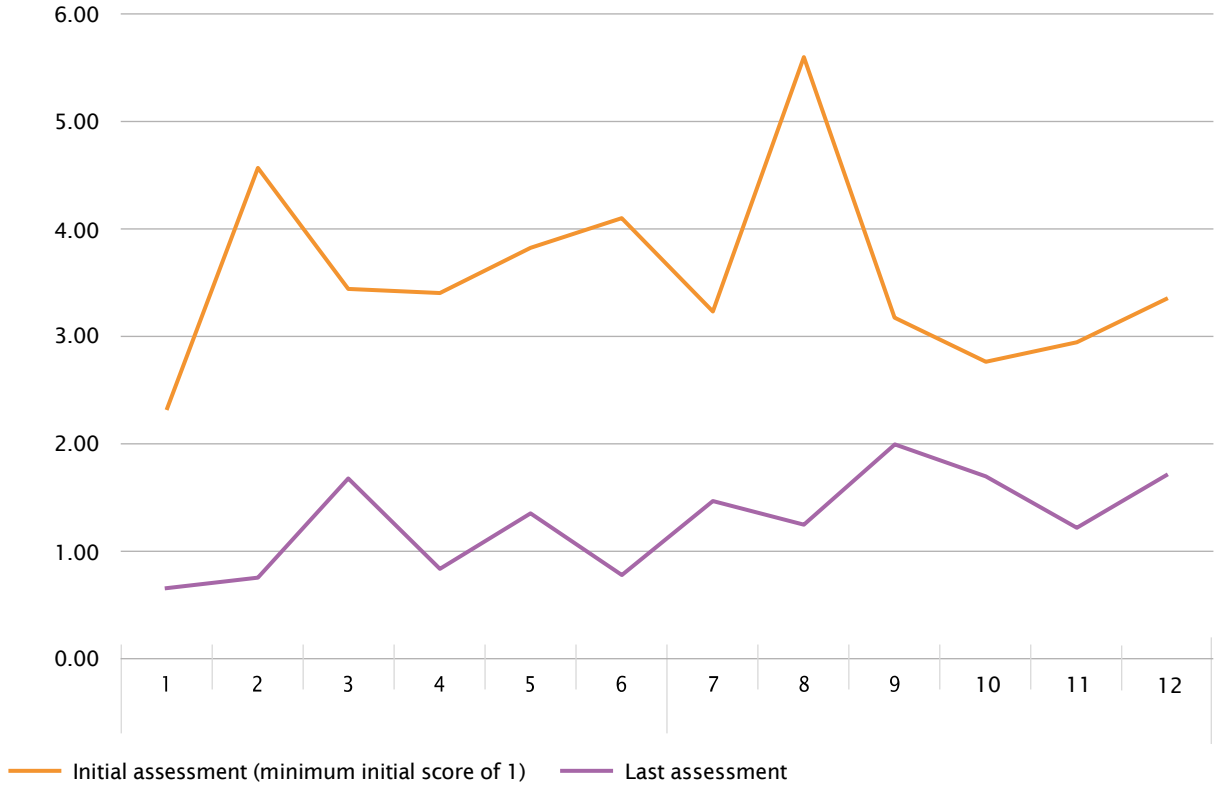


Figure 9: Provider 1 – categorical change model by scale

We also report the data from one provider covering Q4 2021/2022. Figure 10 below is an overview of the HoNOS for all the referrals in Q4 2022 that had a first and last assessment and demonstrates clearly clinically significant improvement in all areas. Change was measured on each of the 12 HoNOS scales by comparing the mean score at initial assessment, where the score was >= 1, and the score at last assessment. The overview of HoNOS for all referrals in Q4 2021/2022 that had a first and last assessment, demonstrates clinically significant improvement in all areas.

HoNOS initial and last assessment by scale, Q4 2022



Scale	1	2	3	4	5	6	7	8	9	10	11	12
Change	-1.09	-0.98	-0.53	-0.70	-0.67	1.07	-0.56	-1.25	-0.92	-1.01	-1.05	-0.87

Figure 10: Provider 2 – changes in HoNOS score by scale

So while data collection was challenging and varied between trusts, there is potential for HoNOS scores to evidence improvements in people's mental health that would be persuasive for future commissioning and service delivery.

Case study 1 on the next page, captured by one of the RAMHP services, reinforce the view that there was some evidence of improvement in the wellbeing of people sleeping rough.

CASE STUDY

E was referred to RAMHP in December 2020 having refused offers of SWEP accommodation and outreach workers reported that his presentation was changeable, at times polite but vague and difficult to engage in conversation, and at other times suspicious and hostile. RAMHP reviewed E at his sleep site with his outreach worker. He was hostile, suspicious and there was evidence of thought disorder. The RAMHP worker was concerned that E was experiencing psychotic symptoms and lacked capacity to make decisions about rough sleeping.

An initial assessment, documenting the concerns about E's mental state, highlighting his previous diagnosis of schizophrenia and the decline in functioning since stopping medication and leaving supported accommodation. The assessment was shared with the hospital and High Intensity User Services, requesting that medication be offered to E. On a subsequent review by RAMHP, including a psychiatrist, E agreed to go with the RAMHP worker to the housing department.

The RAMHP worker and outreach worker supported E to access temporary accommodation. Unfortunately, the following day, E attended the ED and assaulted one of the nurses. He received a prison sentence for this offence. RAMHP liaised with the prison in-reach team, including providing a report summarising E's historical contact with mental health services and his presentation while street homeless. Prison in-reach fed back that the report was extremely helpful and the attitude of the RAMHP team was commended, *"Everyone gave up on this lad except you."*

E spent his sentence in the healthcare wing and voluntarily restarted medication. On release, RAMHP liaised with housing, probation, the outreach GP and the mental health neighbourhood teams to ensure that E was linked in with appropriate services in the community. E has now maintained his tenancy for nearly a year. He has not visited an Emergency Department or required admission to hospital.

It is worth noting that in the example above, and many others that we reviewed. In both these examples the client began to take medication that they had previously not been taking. The chaotic lifestyle of some people sleeping rough may mean it is difficult to access their medication or be prescribed appropriate treatments.

In the words of a consultant psychiatrist:

> *If somebody is really unwell then having medical treatment actually makes a difference to their mental state and the way they see the world, it does make a difference. But it's the relationship that goes with it which really makes a difference – having somebody they can actually rely on. For example, someone we did have [on medication], somebody forgot to give him the injection and he was kind of loss… but he managed to find his way. He knew where to come, because he knows where we are, and he knows it's important [that he take his medication]. So, it's mostly to do with his relationship with the service, that he understands that he needs the treatment or else things will actually go downhill.*
> Consultant Psychiatrist

1b: The accommodation outcomes of people sleeping rough

The providers have been collecting data on accommodation outcomes for people seen by RAMHP teams. This data is captured by service providers at the point of discharge for all people who had three or more contacts with the RAMHP team. Throughout the programme, the providers have been reporting difficulties with the link between accommodation data captured and accommodation outcomes. Therefore, to assess the success or otherwise of this metric, we explored how many people left rough sleeping at discharge from RAMHP, and within 3,6 and 12 months of discharge.

Supporting people to leave rough sleeping was one of the principle aims of the programme. Whilst it was not RAMHP teams' responsibility to find accommodation (the teams worked in partnership with outreach teams and other services to source accommodation), it was hoped that mental health assessments, other additional support and any subsequent improvements in mental wellbeing, might help 'unlock' accommodation options and it was therefore an important measure to capture.

We explored the CHAIN dataset to identify people who were seen sleeping rough during the month prior to their first contact with the RAMHP service. A total of 386 people were seen sleeping rough during this time. To understand how many of these people have left rough sleeping during their contact with RAMHP service, we looked at how many people were seen sleeping rough within 3, 6 and 12 months of discharge from service. The categories are cumulative, someone seen within 12 months will also be included in the figures for 3 and 6 months. People who accessed the service during August 2021-March 2022 will not yet have had a full 12 months within which to be seen rough sleeping.

Out of 386 people who were discharged from RAMHP and have been seen sleeping rough during the month prior to their first contact with RAMHP, 283 were not seen sleeping rough within 3 months of discharge (283/386 people discharged, 73.32%), 266 were not seen sleeping rough within 6 months of discharge (266/386 people discharged, 68.91%), and 243 were not seen sleeping rough within 12 months of discharge (243/386 people discharged, 62.95%). This suggests that, of people who were sleeping rough when they started working with the RAMHP service, a long-lasting solution to that person's homelessness had been found by the time of discharge in almost two-thirds of cases.

This represents a significant number of people leaving rough sleeping and is backed up by feedback from stakeholders in the interviews.

> *I want to reiterate that this dedicated service has been a gamechanger. I've seen lots of teams that have come along, had great ideas, but not really achieved. This service, this concept, this idea has saved lives and joined up long term solutions for people getting them into settled and secure accommodation – it really is achieving.*
> Strategic partner, Local Authority

Some people were not recorded on CHAIN as seen bedded down in the month prior to their first contact with the RAMHP service. This will likely include some people who were sleeping rough during that time without being seen by an outreach team, but in many cases, it will be those with a recent history of rough sleeping who had been placed in emergency/temporary accommodation. There was a dedicated programme during the COVID-19 pandemic that coincided with the start of RAMHP, called 'Everyone In'. This was an initiative that made emergency accommodation available to people sleeping rough in London during the pandemic and meant that towards the start of the programme, the RAMHP teams worked with a higher proportion of people who were in this situation.

We analysed the CHAIN dataset in its entirety to explore how many people had sustained accommodation following discharge from the RAMHP service. This now includes people who were still sleeping rough when they first had contact with the RAMHP and those who were already in some form of emergency/temporary accommodation. As above, the categories are cumulative. Out of 854 people who were discharged from RAMHP, 171 were seen sleeping rough within 3 months of discharge (171/854 people discharged, 20%), 202 were seen sleeping rough within 6 months of discharge (202/854 people discharged, 24%), and 246 were seen sleeping rough within 12 months of discharge (246/854 people discharged, 29%).

> *To have over 70% of people who received support from RAMHP services not seen rough sleeping again within 12 months of discharge from the service is a great outcome. RAMHP's service users are not only experiencing significant mental illness but also often have multiple and complex needs, which means they are more likely to sleep rough for longer or return to the streets following a period in accommodation. This data indicates that this group is being successfully supported to access accommodation and remain off the streets.*
> Commissioner, GLA

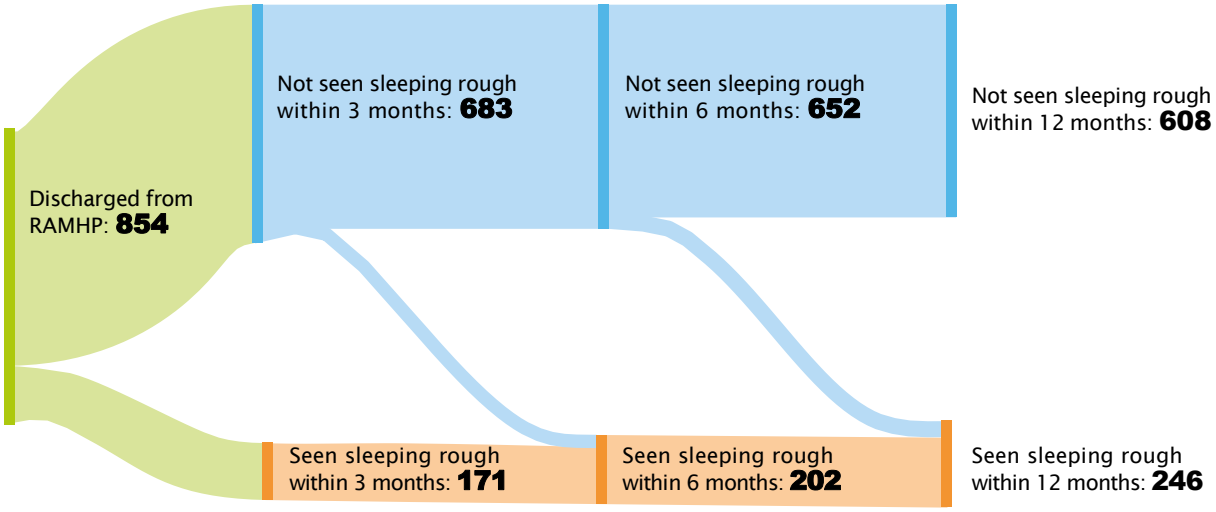


Figure 11: Subsequent rough sleeping for all people discharged from RAMHP (n=854 people)

This positive data is backed up by insight from our semi structured interviews, with one lead commissioner stating:

> *We've been bashing our head against brick walls for a long time trying to get mental health support on board with certain clients and we were just getting nowhere so to have RAMHP come in and been able to do some of that work… we've got people into [psychiatric hospital] and from there they've gone into their own tenancies – long term tenancies - and been stable.*
> Lead Commissioner, CCG

Whilst rough sleeping teams were very good at placing people within traditional services like hostels, the involvement of the NHS meant additional housing could be accessed which might explain the impressive statistics above. For example, one local authority reported that having the involvement of a CPN and Occupational Therapists, who can do Activities of Daily Living Assessments, meant one 70-year-old rough sleeper obtained access to sheltered housing due to clinical need being a component of the access criteria.

1c: The risk of harm individuals pose to themselves

A further benefit of the programme is its ability to reduce risk of harm to individuals. Several stakeholders described the difficulties prior to the RAMHP programme of arranging a psychiatric assessment for people sleeping rough who were "floridly unwell" on the streets. A common issue is a person's refusal to accept accommodation that is offered, particularly during extreme weather. When this happens, outreach teams can become concerned about a person's mental capacity to make informed decisions if staying outside risks their life (e.g. when temperatures are sub-zero). One strategic partner within a local authority stated:

> *In the decade before RAMHP, what I used to have to do [as a commissioner] was go and meet people at serious risk of death on the street because of gaps in services. If you had an entrenched person sleeping rough in acute need and you managed to find them, you were pulling people in to do a role that they were not really commissioned to do and so the service provided to some of the most vulnerable in our community was very hit and miss. You were pulling people in who had an interest and always testing people's good faith and good intentions. Since RAMHP has existed it's been transformative: we have a dedicated team that can pull people together and manage those relationships. It's saved a lot of lives.*
>
> Strategic Partner, Local Authority

2. RAMHP – service access and shared learning

A key aim of the RAMHP was to improve the way services work with each other to support people sleeping rough. Whilst this was principally achieved through the establishment of a dedicated team, it was equally important that the services were delivered within the wider framework of a partnership in order to ensure improved access to services. Traditionally, there have been significant challenges for staff members and services to know how best to work together to support people sleeping rough.

> *When people are rough sleeping they can't always keep appointments because they might not have a phone, and if you DNA [did not attend] a couple of appointments they discharge you. I wouldn't mean to, I'd go to the wrong location – even this morning I got mixed up, I'm seeing so many people that I mix them up in my head.*
> Person sleeping rough

Stakeholders were clear that RAMHP had gone some way to solving the aforementioned challenges by, for example, being more persistent, ensuring people sleeping rough were always met where they felt comfortable, and carrying out walking assessments. More specifically we identified the following themes:

a. Improving access to GP services

b. Skills transfer and learning from each other

c. Making mental health services more accessible to people sleeping rough

2a: Improving access to GP services

Analysis showed that RAMHP had made a lot of progress in supporting people sleeping rough to access GP surgeries, one of the KPIs of the programme. Access to GPs was mostly experienced as straightforward by professionals, with several areas mentioning good relationships with dedicated or specialist GPs serving this population. However, despite these services, we know this isn't always experienced as being the case for people sleeping rough. As one person sleeping rough said:

> *RAMHP team supported me to register with a GP, I hadn't been able to do this before.*
> Person sleeping rough

Quantitative analysis backs up the claim that the services supported people sleeping rough to increase GP registration. The providers have been collecting data on the number of people who were not registered with a GP at the point of referral and had 3 or more contacts with the service, who then have registered with a GP at the point of discharge from the service. Collecting this data presented various challenges, for example, the delays in capturing GP registrations in the system resulted in lower reported values compared to actual number of registrations. However, based on a data quality assessment, a case study focusing on two providers is presented below, covering a period of time from Q1 20/21 to Q4 21/22 which shows consistently high levels of registration for the population. Provider 1 reported no people sleeping rough were discharged without a GP registration at point of discharge. Provider 2 started collecting this data in 2021/2022, and reported no people sleeping rough have been discharged without a GP at points of discharge.

Percentage of people worked with who were registered with a GP at discharge, Q2 2020/2021 to Q4 2021/2022 (target 80%)

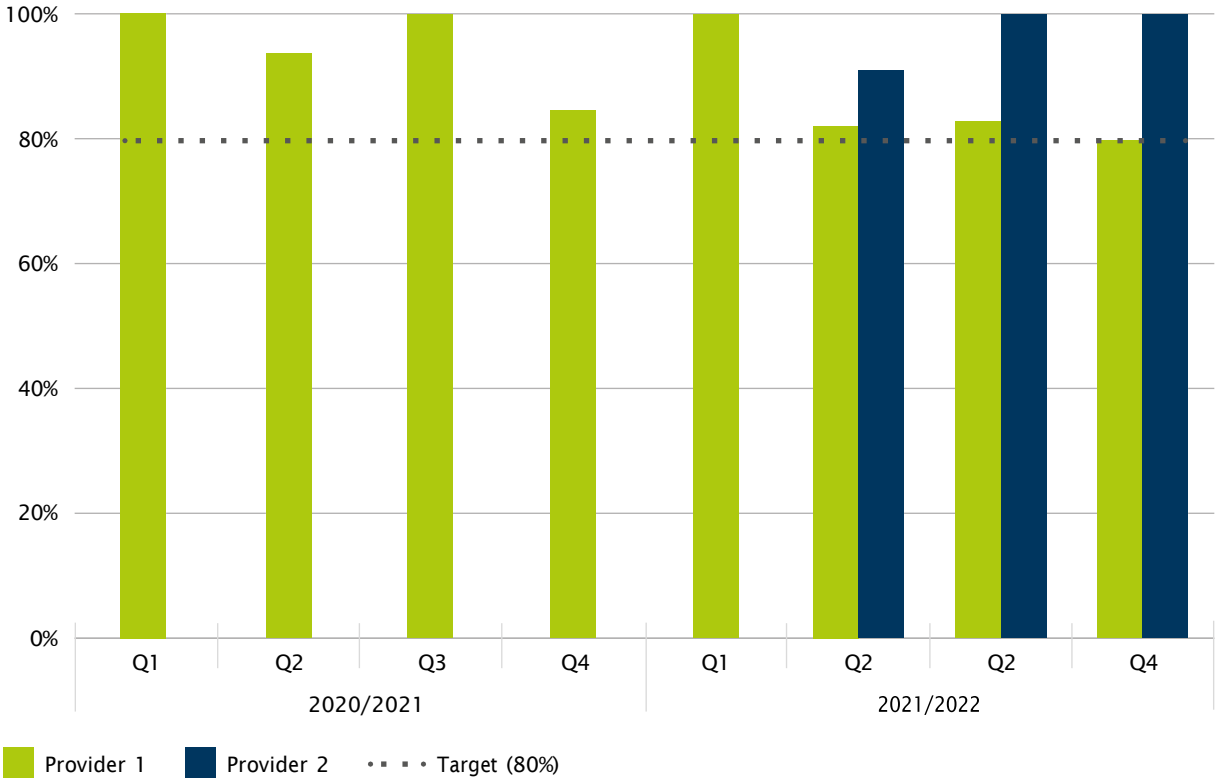


Figure 12: GP registrations for people discharged from RAMHP who were seen 3 or more times, March 2020 – April 2022

2b: Skills transfer and learning from each other

When the GLA established the RAMHP, it sought to increase the level of skills transfer between mental health services and organisations that deliver rough sleeping services, thereby bringing the two sectors closer together. RAMHP services were specifically designed to enable this shared learning by, for example:

- Carrying out joint shifts between RAMHP workers (located within the NHS) and outreach workers
- The establishment of a community of practice that met quarterly across the programme
- Conducting joint training sessions for different members of the partnerships

One outreach worker gave an example of how they supported RAMHP colleagues to better engage with people sleeping rough:

> *It's about the approach – meeting somebody where they're at – if somebody is lying on the ground for example I'm going to come down to their level – so little assertive outreach tips that I think get lost when you've got a certain brief specific to mental health.*
> Outreach Worker

Outreach Workers spoke about the pressure they feel in trying to support someone with mental health problems, who may or may not have 'insight' into the symptoms of their illness and who may pose a risk to themselves or others. While there is great camaraderie between outreach workers, the role itself can be lonely, and they often described finding the responsibility for the vulnerable people they support hard to manage. RAMHP teams, especially given their location within the NHS, were able to provide confidence and support to Outreach Workers when the people they support were in a crisis:

> *If we find someone [with mental health issues] it's not all on the outreach worker to provide an emergency intervention and see things all the way through to conclusion. It gives us solace.*
> Outreach Worker

As stated above, there are multiple examples of successful skills transfer operationally, but also some evidence of the different sectors learning from each other in a potentially more systemic way. Taken together, these two forms of knowledge sharing could lead to longer lasting and sustainable change in how the two sectors work together. Rough sleeping practitioners were clear that working closely with NHS colleagues had enhanced their understanding of mental health and how to navigate the NHS. Specifically, they spoke of better medical knowledge and access to expertise because of interaction with the RAMHP team and, more broadly, increased confidence in navigating healthcare systems.

One strategic partner within the local authority highlighted this improvement, explaining:

> *The RAMHP team upskills the other members of the partnership. They share all their health care knowledge. It's great being in a professional meeting and you can tell the RAMHP team have been there because everyone is using a slightly different language and that shared learning and shared knowledge is cascading.*
> Strategic Partner, RAMHP

This presents a significant opportunity for RAMHP to bring about sustained system change for people sleeping rough, but it should be noted that this has yet to occur. This improvement in relationships and the desire to learn from each other can also be evidenced by the RAMHP staff survey conducted twice by ICHP throughout the programme. ICHP conducted a survey of staff from RAMHP teams and outreach teams in January and February of 2021, (nearly a year into the work) which found that collaborative working as measured along four aspects (mutual respect, deep understanding, collaborative action and shared goals and values) had improved between the two sectors. Prior to the RAMHP Programme, staff reported feeling an imbalance of power: *"like a junior partner"* and said that while they recognised that *"developing a better understanding of the others point of view and way of working would be helpful"* there wasn't time or support to do so.

A small number of respondents admitted that they felt *"that working together was/is really all that important ('you do your bit and we'll do ours')."* By early 2021 the majority of respondents agreed that *"Both members of Mental Health Trusts and Outreach Agencies had/have a high degree of respect for the role, contribution or expertise of the other and this was/is communicated in words or behaviours."* By July of that year, 81% of respondents agreed with the above statement. One comment at the time (Collaborative Working survey 2021) was: *"Amazing relationships between outreach and RAMHP. Not with Community Mental Health Teams. A lot of work needed for RAMHP to refer on to CMHT."*

2c: Making mental health services more accessible to people sleeping rough

Another of the aims of RAMHP was to make accessing mental health support easier for people sleeping rough. This is how a RAMHP manager described it:

> *We've tried to make it easy to access from the street. Somebody [who is sleeping rough] might self-identify as having a mental health need but be finding it difficult to engage in the primary care setup. Or street outreach teams might be working with somebody and thinking "I don't know what's going on here. I think this person might have mental health needs" and rather than going through the hurdles of getting the person to register with a GP and referring to a secondary care service, they [the outreach team] can give us some information and we can, and we will, go out and work with them.*
> RAMHP Manager

There have been some examples over the course of the programme of services seeing people who sleep rough as part of the core business of the NHS, where previously services might look for active reasons to exclude them. In these examples, RAMHP has actively facilitated access to those services.

However, there has not been a full-scale shift towards equitable access of service. People who sleep rough continue to have difficulty in accessing or using NHS services in the same way as other patients. Experiences on inpatient wards were a good example of this challenge.

> *The inpatient side is hard because patients are not staying as inpatients very long and lot of the services do not really understand how difficult it is to stabilize somebody and how long it takes to actually get them back to some settled place. Most often our patients are very quiet on the wards because they are used to being quiet. And sometimes they (inpatient ward staff) just push them out of the ward after a couple of weeks. So we have had some repeated admissions.*
> Consultant Psychiatrist

This was not only a challenge on acute wards but within community mental health teams (CMHTs) as well:

> *Most of the issues we have had have been with our interfaces, with our partners in the community (mental health teams CMHT). Where we have stabilised [the patient] and we want to move them on – they (CMHT) are all over... with their own stuff going on... and there has always been a delay... but we work with them on that.*
> Consultant Psychiatrist

When considering the information above, a distinction needs to be drawn between what RAMHP teams were able to achieve in terms of making their own services more accessible for people that sleep rough and the extent to which this improved accessibility rippled through the system. RAMHP teams' achievements were facilitated by their specialist nature. While limited pockets of flexible provision exist, such as street medics programmes, homeless health teams, or the Everyone In Programme, we heard often about the continued difficulties of access to mainstream services that were not impacted positively by the RAMHP programme.

This section illustrates one of the fundamental tensions that exists within the RAMHP. By commissioning a bespoke service, the GLA has improved the access for people that sleep rough to mental health services. However, there will always be a danger that the commissioning of specialist services delays or prevents greater inclusion of people who sleep rough from mainstream mental health services. As things stand in 2022, this is a commissioner's view on RAMHP:

> *I think they should be a distinct team for quite a while until we really know the broader system change is happening – that rough sleepers are treated equally. That everybody does feel like that they would take rough sleepers on to their case load, if it was just part of generic social work and it worked… but I don't think we're there yet. That kind of culture change hasn't happened.*
> Strategic Partner – Local Authority

The ongoing commissioning of RAMHP or RAMHP-like services must include an element of system and service change that complements the additional provision otherwise the dangerous cycle of exclusion from services may continue for people who sleep rough. A member of the Co-design Advisory Group sets out the challenge:

> *[At the moment it is] down to individuals understanding the need for collaboration and being skilful and passionate, but that isn't good enough, you need to build into the system. You need to build into the system] leadership training and commissioning for collaboration and reflective practice.*
> Strategic Partner – Lived Experience

3. Factors that contributed to RAMHPs perceived success

In this section, the report explores the factors that have supported the delivery of RAMHP in London and beyond. Based on the interviews and other desk-based research, it is the following three components of RAMHP that make it so successful:

a. It sits within the NHS, but is delivered in partnership

b. It is flexible and personalised in how it is delivered

c. It has been co-designed by people with lived experience

This section should be read in conjunction with the Imperial College Health Partners' report The RAMHP Programme: Reflections on core service principles which goes into some the themes below, and others, in more detail.

3a: RAMHP sits within the NHS, but is delivered in partnership

At the start of the pilot, the GLA took the decision to place the funding for the RAMHP services within the NHS and not the third sector. The third sector, which delivers much of the homelessness and rough sleeping provision across London, does not have the clinical expertise of the NHS. Interviews with stakeholders, at all levels of the system, suggest embedding RAMHP within the NHS enabled increased access to mental health services. More specifically, locating services in the NHS meant that:

People sleeping rough get better access to mental health services – previously, obtaining access to mental health services for outreach workers and the third sector advocating on the individuals behalf was challenging and unsuccessful.

> *In the really positive cases, we've been able to access mental health beds that I doubt we would have been able to access ourselves… [if it weren't for RAMHP] we would have been dealing with premature deaths on the streets and the cycle of hospital discharge to the streets and then back in [to hospital] again.*
> Outreach Manager

Staff within NHS RAMHP teams can be more flexible than their non-RAMHP adult mental health NHS colleagues – The value of RAMHP teams' responsiveness and ability to capitalise on opportunities to engage with people sleeping rough was stressed time and again, and highly appreciated by outreach teams who have historically struggled to align traditional NHS mental health interventions with the transient nature of rough sleeping. One Outreach Manager said:

> *[RAMHP nurse] can rearrange her schedule based on priorities and be there in 30-40 mins. If you were to take that away, go back to normal mental health team support where the client will need to engage, to pick up the phone, or to come to an office, I would say 70-80% of the work we have to do would not work.*
> Outreach Manager

However, simply placing the service within the NHS would not have been enough. It was the fact that the services were delivered in partnership with rough sleeping organisations and the local authorities that made the project a success. Stakeholders were clear that a key component of RAMHP teams was their ability to build and maintain comprehensive professional networks.

> *The RAMHP service inherently understand that the solution is through their professional network and they work that network very actively. [They partner with] social care, policing, community police, the community MARAC, with community safety profile, housing solutions, HPU (Homeless Persons Unit).*
> Strategic partner, Local Authority

> *The RAMHP Team has embedded themselves in the professional networks outside of health – beyond CMHT – they understood instinctively that if they stayed within health it would fail.*
> Strategic Partner, Local Authority

It was not only having the right contacts and networks, but building and maintaining a high profile and reputation as a service that has been crucial. Local authority partners spoke of 'health' attending meetings for the first time and doors suddenly being opened that were previously shut. By being rooted in the NHS, but delivered with partners, RAMHP has started to contribute to systemic change. As one strategic partner states:

> *Health has its own lingo – they all talk in acronyms. RAMHP could have sat and stayed in health and talked about admissions to hospital but the success has been that they went for the tougher option: to work the networks and through their passion and determination they have been reordering and changing how people look at things and that takes time.*
> Strategic partner, Local Authority

3b: RAMHP is flexible and personalised in how it is delivered

> *Never have we contacted RAMHP and they've said, no – we're too busy. They're so open and welcoming. Even if they can't give you the answer you're looking for, there will always be a justified reason and that's really appreciated.*
> Outreach Worker

All the RAMHP services worked directly with people sleeping rough on the streets, going to meet them on joint shifts with homelessness outreach teams. This included very early morning shifts and being available out of office hours. It is this greater flexibility of the RAMHP services, which was perceived to be a crucial element of the model. Time and again the importance of the RAMHP team's patient and persistent approach was highlighted.

> *What helps an individual is very much individual. It might take months just for somebody to be able to express some hope.*
> Strategic partner, Lived Experience

The personalised support element was also highlighted as a benefit. In 'meeting people where they are at', and taking the time to build trust, understanding and talking through people's situations and beliefs, people who sleep rough were more likely to engage with service. One RAMHP service manager described how the team ask: *"What happened?"* to understand the events and factors that led to a person sleeping rough. As with any relationship, the quality and depth of the rapport depends on the individual, and is not specific to RAMHP but to the RAMHP worker themselves and their personality:

> *It's very important that someone has a willingness to push themselves ad work hard with these clients – not just fill the role and send couple of emails. We have had other RAMHP workers in neighbouring boroughs, and where we've tried to refer clients back in – their input has been very limited, very official responses, without really thinking through, trying to find solutions. They were trying to divert the issue [away] from them.*
> Outreach worker

RAMHP teams' ability to be flexible and personalised, offering a range of engagement and treatment options was informed by their diverse and combined professional expertise. We do not set out here to describe the ideal staffing mix (some information on a core model is available in the ICHP report – see appendix for more detail) but a few themes stood out from the qualitative work that warrant mention here.

Some teams had medical staff who could prescribe treatment, and some did not. Those that didn't said they wished they did, and the ability to prescribe and presence of a psychiatrist was also deemed important by strategic partners.

RAMHP workers often expressed a wish for more psychological resource in the team or access to flexible or long-term psychological therapies for people sleeping rough. We heard about the limitations of IAPT provision for this client group: of long waiting lists and referrals being closed when clients didn't answer the phone.

Staff who are qualified to conduct Mental Health Act assessments (AMHPs) were highly valued, as were social workers for their knowledge and understanding of structural issues such as benefits systems, experiences of care and adverse childhood events, as well as housing. Occupational therapists' ability to contribute technical information to the reports used to make accommodation decisions was credited particularly by local authority partners to the unlocking of accommodation options.

Administrative staff were highly valued by RAMHP teams themselves for freeing up trained mental health professionals to do their specialist work, and we note elsewhere the importance of quality data capture that administrative staff can support.

What, then, is the 'dream team?':

> *[When] you've got all the professionals who can make the decision at that time – whether it's for their medication, mental health, physical health.*
> Peer Support Worker

When commissioning a RAMHP like service, accounting for some of the reflections on ideal staffing mix will be important.

3c: It has been co-produced by people with lived experience

From the outset and throughout the programme, RAMHP has involved people with lived experience of sleeping rough and having mental health needs. The two key ways in which this occurred in the programme were:

- The programmes Codesign Advisory Group of experts by experience influenced both the design and delivery at a service and programme level throughout the pilot
- Some RAMHP teams employed Peer Support Workers

Where teams had employed Peer Support Workers, they were identified as playing a key role in the success of the programme by both Outreach and NHS staff:

> *We had peer support workers who had lived experience of using mental health services and rough sleeping. That was really very important to us. They brought to us a different perspective of the persons experience of making a decision whether to come in or not. If you've lived out for so long, what does it mean to live inside? Those sorts of challenges were really useful and important for the team.*
> RAMHP Service Manager

> *People with lived experience can really relate to clients. We had a client rough sleeping in the woods and the Peer Support Worker came with me and he had a little gas stove and cooked the client a couple of dishes… showing care is crucial to relationship building and helping that client open up to us and be more willing to engage with mental health services.*
> Outreach Worker

Not only did the Peer Support Workers make a difference in the lives of London's people sleeping rough, they also support themselves to continue their own development:

> *I was really, really thankful that I had the opportunity. It's really kind of changed my life. It was a final driver for me in terms of getting back out there and recovery as well. Plus I'm getting free mental health every day you know because every day I come to work I'm surrounded by all these really gifted and, truly amazing and incredible people. The RAMHP teams save lives. They're an invaluable service.*
> Peer Support Worker

Whilst it is difficult to directly attribute the role of Peer Support Workers, and more generally involving people with lived experience in the design and delivery of the programme, with increased success, the authenticity and increased engagement it brought was clear from those that were interviewed.

Strengths and Limitations

Qualitative

Working with peer researchers undoubtedly improved the quality of our qualitative evaluation, beyond the high quality of their interviewing skills. Colleagues with lived experience were able to sense-check the interview guides and provided genuine challenge and analysis of the findings.

Whilst a breadth of individuals were interviewed, from different roles, organisations and geographic locations, it was not intended as an exhaustive process. There will be individuals that have played substantial roles in the programme whose views may not be reflected in the document. The professionals spoken to were identified by either the GLA, outreach teams or RAMHP teams themselves. As a result, there is potential that they have a bias towards favouring the service.

A specific limitation of our interviews with people sleeping rough was that they were selected by RAMHP teams or outreach teams, and as a result were more likely to be people who had made significant progress with their lives. Those who continued to sleep rough were unlikely to be in a stable enough condition to participate. The peer researchers further noted the challenges of conducting interviews by telephone rather than in person with people sleeping rough. Not all people sleeping rough were clear on who the RAMHP workers were (among the myriad of professionals they interacted with), some had used the service a long time ago and couldn't recall details. All people sleeping rough were appreciative of the help they'd received, although the peer researchers would like to note this is common in interviewing people sleeping rough.

Quantitative

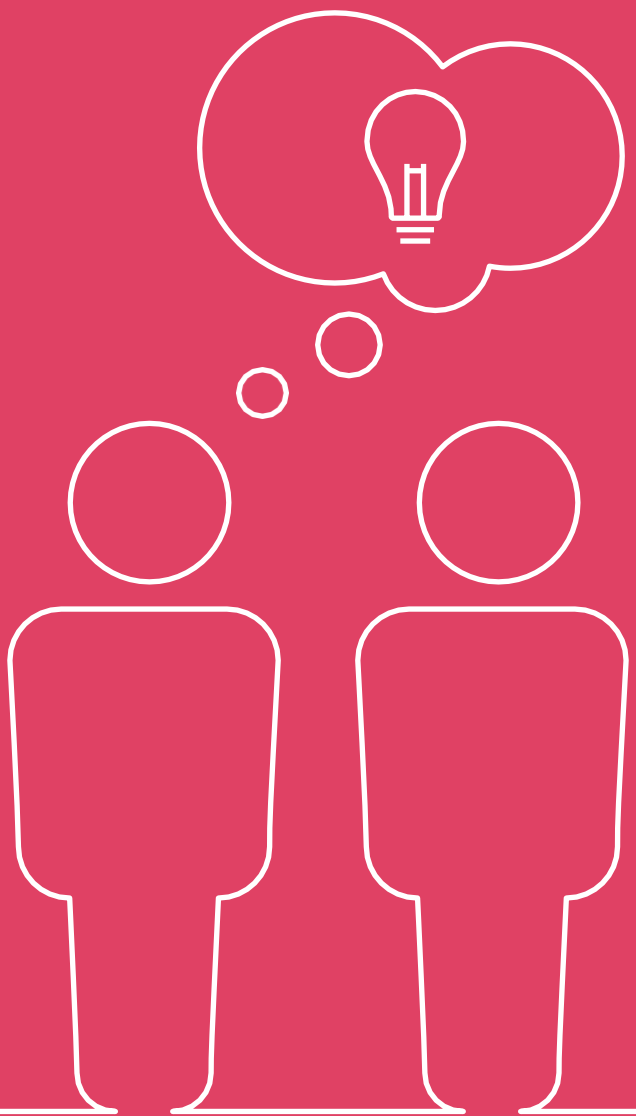
Of particular benefit to the quantitative analysis was the existence of and access to CHAIN data. It is an extremely rich data set and enabled robust analysis of individual outcomes.

Whilst every effort was made to use good quality data, the providers have been flagging issues with data quality and the collection process throughout the programme. UCLPartners worked closely with the GLA and providers to understand the definitions of the data points collected, and the difference between collected and actual data.

The RAMHP Key Performance Indicators and Activity data for Trust services is capturing all referrals to RAMHP. People with mental health needs that are sleeping rough could be referred to RAMHP multiple times. UCLPartners received anonymised, referral level data, and therefore it was not possible to ascertain the total number of people seen by RAMHP teams.

Some providers have recently started collecting data on HoNOS scores, therefore it was not possible to assess the changes in HoNOS scores from all providers. Additionally, it is important to collect detailed data on HoNOS scores by scale. Exploring the summary HoNOS score without exploring changes per scale could be misleading. For example, physical health of a person isn't often known at the first assessment. With time, they might disclose more information about their physical health needs, and it would be expected to see a deterioration in this scale, which should not exclude improvements in other areas. Further definition on when a discharge scale is completed should be agreed, as some providers would be completing the discharge scale depending on the total number of contacts with the service.

Reflections and recommendations



Reflections and recommendations

It has been difficult to draw statistically significant conclusions about the effectiveness of RAMHP due to challenges with data capture within the services. However, our interviews with stakeholders from across the programme confirmed that RAMHP is a valued service and one they would like to see more, not less of. Within each of the three principal areas of analysis outlined below, there are reflections and recommendations that the GLA and other commissioners, NHS trusts, third sector homelessness providers and any other stakeholders might want to consider.

RAMHP and the lives of people sleeping rough

To generate better quality evidence to prove the link between a RAMHP like project and improved outcomes for people sleeping rough, more investment would need to be made in data capture. Based on interviews and some quantitative analysis, RAMHP might improve these outcomes for people sleeping rough, however there is not enough high-quality data to say for sure. More specifically, it is recommended that:

- Investment in team data administrators with responsibility for ensuring good data capture, especially if using the HoNOS metric
- Continued analysis of housing outcomes within areas where RAMHP will operate beyond the two-year pilot period

RAMHP – service access and shared learning

Operational and strategic staff from across the NHS and the third sector spoke of the power of RAMHP in how their teams learned. If/when RAMHP-like projects are commissioned again or their funding is renewed, it is recommended that:

- The partnerships of organizations play a key role in the formation of the services, including the role of communities of practice, joint training sessions and joint shifts that took place in the localities. Whilst it is important that services are located within the NHS to ensure a degree of access to mental health services, for a RAMHP like service to work properly, NHS colleagues will always need to work in partnership with outreach teams
- Consideration is given to the tension between directly commissioning bespoke mental health services for people that sleep rough and attempting to influence mainstream services. Where more RAMHP like services are commissioned, they should include a remit to attempt to influence mainstream services to be more accessible
- Relationships with other NHS services is broadened. Understandably, RAMHP focused on access to mental health services, and did a lot to address some of the immediate barriers, future projects might want to consider wider NHS services and how they can influence them as well

Factors that contributed to the success of RAMHP

There were many factors that contributed to the success of RAMHP but the three highlighted below are particularly crucial and should be noted by any provider or commissioner looking to extend or run a RAMHP like service. It should be read in conjunction with the Imperial College Health Partners' report The RAMHP Programme: Reflections on core service principles

- RAMHP-like services should be located in the NHS but delivered in partnership. One of the key factors in enabling better access to mental health services for people sleeping rough was the location of the staff within NHS services. However, it was because the staff were able to leverage other professional networks and deliver the support in partnership that was a crucial factor in its success
- RAMHP-like services should continue to be flexible in how they are delivered and avoid any staffing structures that are too rigid, such as more traditional 9-5 CMHT services. The service should wrap around the individual, not the other way round
- A mix of professionals who can provide assessment, treatment, therapy, peer support, who are individually persistent and assertive, and effectively supervised and directed
- RAMHP should continue to embed lived experience throughout. The authenticity of this approach was valued by NHS and third sector staff. Specifically, any service specification for a RAMHP like service should include:
  - A co-design advisory group
  - Peer Support Workers as part of the core offer
  - Embedded Peer Researchers to provide ongoing learning and feedback for the programme