IMPERIAL COLLEGE HEALTH PARTNERS

Rough Sleeping and Mental Health Programme

– reflections on core service principles

Mayor of London (GLA)

February 2022

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About Imperial College Health Partners

Imperial College Health Partners (ICHP) innovates and collaborates for a healthier population. We turn the potential of innovation into reality to help solve pressing challenges by collaborating across the health sector. By connecting a unique network of health experts, we can accelerate the adoption and spread of innovation amongst our member organisations.

ICHP is a not-for-profit partnership organisation that brings together NHS providers of healthcare services, clinical commissioning groups and leading universities across North West London. See https://imperialcollegehealthpartners.com/who-we-are/our-members/ for more information about our 20 members. We are also the designated academic health science network (AHSN) for North West London and members of the national AHSN Network.

Acknowledgements

Thank you to all those organisations who have fed into the Rough Sleeping and Mental Health Programme during its initial two-year funding period, especially those who contributed directly into interviews informing this report.

Introduction

The Rough Sleeping and Mental Health Programme (RAMHP) was set up to help people with mental health needs who are sleeping rough take a vital step towards a better quality of life by supporting access to mental health services. RAMHP was launched as a two-year pilot (services operational from March 2020 - March 2022) 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 small teams of mental health professionals, who worked collaboratively with Homeless Street Outreach Teams and Local Authorities to support individuals across 15 boroughs in London. During the two-year pilot, programme management and training support was also provided to support the services.

An evaluation of the RAMHP services and wider programme has been commissioned; this report is separate to that evaluation. It seeks to capture the key principles and components of the RAMHP services as described by the teams involved in the services, with the aim of sharing this knowledge with other stakeholders who may wish to take forward a similar approach. RAMHP was developed and launched in London, however it is hoped the reflections are of use nationally.

This report recognises that there are multiple approaches to providing mental health support for those sleeping rough. The approach taken by the RAMHP services is not the only model; it is, however, a model which has been set up with a relatively constrained funding basis.

The aim of this report is to draw on the experiences of RAMHP services to outline how regions can improve access to specialist mental health services for people sleeping rough, through a pathway and structure which is actively informed by local need.

The report covers:

i. **Why were the RAMHP teams set up?** – the case for change in relation to supporting people who sleep rough to access mental health services
ii. **Who do the RAMHP services support?** – which service users do the RAMHP teams work with?
iii. **Service profile** – what are the core principles present in a RAMHP service?
iv. **Pathway and team structure** – what do the above principles look like in action?
v. **Local application** – what considerations need to be made when looking to implement a similar model in your area, for example, data capture, stakeholder engagement and funding?

All the above are proposals based on local experience in parts of London, and may be subject to variation in scale depending on local population, geography, funding, etc.

The Case for Change

The need to support people sleeping rough to access mental health services

(1) National policy context

The NHS Mental Health Implementation Plan (2019/20 – 2023/24)[1] recognises the need to provide support to people sleeping rough, setting out that:

- All areas should have a mechanism in place to ensure their mental health services can support people sleeping rough
- Five-year plans should include work to complete a mental health needs assessment for people sleeping rough which will identify need and lead directly to action that increases access to mental health services for people sleeping rough
- It is the expectation that services accessed by people sleeping rough will adopt a trauma-informed approach and require the input of several delivery partners to ensure holistic, long-term care and support.

[1] NHS Mental Health Implementation Plan (2019/20 – 2023/24) https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf pg 42

(2) Need in London

There is a clear need to support people sleeping rough to access mental health services in London. The Greater London Authority Rough Sleeping Plan of Action (2018) and subsequent reports have found that:

- Almost half of people seen sleeping rough in London have a mental health support need[2]
- There is correlation between mental health support needs and the length of time someone spends on the streets, with two thirds of long-term people sleeping rough assessed as having mental ill health[3]
- Rough sleeping services reported that mental health services often have high thresholds for access, long waiting times, inflexible working practices, a lack of resources or expertise to support people with complex needs and a reluctance to undertake assessments on the street[4]
- Over three quarters of outreach services in London believed that accessing mental health support for people sleeping rough in their area had become more difficult and almost half of London's outreach teams were unable to secure on-street assessments and support from mental health services[5]
- The result of the inconsistent and often inadequate provision for London's homeless was that people did not receive the help they need, with 54% of people with mental health issues not receiving the treatment and support they wanted[6]

Who do the RAMHP services support?

The RAMHP services were initially designed to support people sleeping rough who had some level of mental health need and were not receiving support from other health services. Current RAMHP services have identified the following inclusion and transfer of care/handover criteria, helping to better understand the profile of the individuals they support.

1. Referral Criteria

The services use the following criteria to determine whether a referral is taken on by the RAMHP services. Referrals usually come directly from the local Street Outreach Team, with whom the team also undertake joint shifts[7].

i. Those who are rough sleeping. The services were initially funded to work with those who were sleeping rough[8], however, the remit could be expanded to include those who are homeless but not rough sleeping[9]
ii. Those likely to have mental health needs, with variations in complexity, with or without concurrent substance misuse
iii. Those who have difficulty maintaining contact with other health services or are resistant to contact owing to the nature of their illness or previous negative experiences
iv. Not receiving mental health support from other health services
v. Those aged 18 years and over. There is no fixed upper age limit, but for service users aged 70 years and above the services would seek to work closely with other specialist services for older people

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[2] CHAIN Annual Report Greater London Full Report (Greater London Authority, 2020/21) https://data.london.gov.uk/dataset/chain-reports pg 35.
[3] Rough Sleeping Plan of Action (Greater London Authority, 2018) https://www.london.gov.uk/sites/default/files/rough_sleeping_plan_of_action_1.pdf pg 64
[4] GLA consultation undertaken for the Rough Sleeping Plan of Action (referenced by GLA in Rough Sleeping Plan of Action, pg 65)
[5] St Mungo's. (2018). National street outreach survey (referenced by GLA in Rough Sleeping Plan of Action, p65)
[6] SPEAR. (2018). Rough Sleeping Plan of Action: SPEAR data analysis. GLA. (Health needs audit of homeless people undertaken in 2017, referenced by GLA in Rough Sleeping Plan of Action, p65)
[7] The RAMHP services launched at the start of Covid-19 pandemic in 2020, so the approach evolved to do 'in-reach', following the 'Everyone In' initiative.
[8] "Rough sleeping" is defined by the Government as: *"People sleeping, about to bed down (sitting on/in or standing next to their bedding) or actually bedded down in the open air (such as, on the streets, in tents, doorways, parks, bus shelters or encampments). People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or 'bashes')."* UK Government (2013) Homelessness data: notes and definitions https://www.gov.uk/guidance/homelessness-data-notes-and-definitions
[9] For example, people in hostels or shelters, sofa surfers, people in campsites or other sites used for recreational purposes or organised protests, squatters or Travellers sites.

Referrals can also be made (at the discretion of each service) where a service user with significant mental health problems is at risk of eviction and consequent homelessness likely to be related to their mental state.

2. Criteria for transfer of care from RAMHP Teams

To be transferred or discharged from the RAMHP service, the service user will need to be:

i. At low risk of harm to self or others; and
ii. Connected to relevant mental health services if required (this may include primary or community health services)

The teams also seek to ensure that the person is in housing/accommodation (if eligible), although the ability to ensure this would usually sit with other services such as the Street Outreach Teams or engaged mental health team. A person may also be discharged if they are no longer locatable by the RAMHP Team or partner organisations.

Service Profile

Each of the four RAMHP teams set up services with slightly different profiles to meet the needs of their local areas. However, there are some core principles and values which have proved fundamental to ensuring a successful RAMHP service.

Principle 1: Trauma Informed Care -
Considering the trauma which someone sleeping rough has likely experienced, to influence more effective onward-care

The care provided by the service needs to be 'trauma informed'. There should be an awareness of, and sensitivity to, the impact of traumatic events on individuals (or indeed the accumulation of microtraumas that people sleeping rough have likely experienced). The complex needs of this population must be understood against the background of trauma, and the responses to trauma that make engaging with services difficult for individuals.

Through a trauma informed approach, the team can determine which care setting (for example, acute care, community care or primary care) and which housing environment will best support the individual based upon their past experiences and current needs.

Principle 2: Assertive Outreach -
Providing a service which is informed by elements of assertive outreach

This involves teams going to meet people outside of a typical buildings-based service, rather than expecting people sleeping rough to actively access and navigate mental health services themselves. This is achieved through joint shifts with Homeless Street Outreach Teams, taking the point of access for the service out onto the streets or to an individual's sleep-site.

It may be that these service users have not asked to see the service teams, which is where aligning with Street Outreach Teams (who typically have built rapport and familiarity with the individual) can support.

Despite not being a buildings-based service, it is important to have a team base. It is valuable to have a place for 'holding' the complexity of this work, where staff can come back to after shifts.

Principle 3: Assessment and Liaison -
Focussing on conducting assessments and liaising with existing services rather than carrying a caseload within the RAMHP service itself

The service usually supports people sleeping rough for relatively short periods, primarily through mental health assessments and navigating service users into existing services and support. By acting as a bridge to other health services, rather than carrying the caseload fully within the RAMHP team, services have been able to work with a larger number of individuals than they would have been able to if the teams also carried the treatment caseload. Ensuring that people are supported to link in with other services makes mental health services more accessible to people sleeping rough as well as supporting those services to understand

how to work with those people. For example, one RAMHP team worked with over 250 people in their first year but estimated they would have only been able to support 50 people in that time if they had adopted a caseload model.

Principle 4: Flexibility and Agility of Service - Adapting to serve the needs of a transient population

RAMHP teams persist when an individual does not initially engage in conversation or misses meetings. Service users are not assigned a set number of sessions and are not discharged after a set number of missed appointments.

Early and late outreach shifts may be crucial to ensure people are reached before they are on the move. These should be built into the funding of the team, since early/late shifts before 7am and after 9pm are considered 'out of hours' and attract enhanced staff payment.

Principle 5: Multi-disciplinary Team - Delivering a service informed by multiple professions to ensure variety of needs can be met

The specialist knowledge base of the team provides mental health and capacity assessments alongside recommendations for appropriate health interventions for a service user, all within the continuity of a single service. This results in better assessment of individuals, informed by a broader set of perspectives. It also increases the likelihood of retaining engagement with service users.

A RAMHP service can be delivered by adopting a core team staffing structure, outlined in a later section of this report (see *'Proposed Generic Staffing Structure'* section). Where possible, an enhanced team should be provided, including roles such as Approved Mental Health Professionals (AMHPs), Occupational Therapists and physical health professionals.

The following roles may contribute to the service's multi-disciplinary team:

- **Mental Health Practitioner –** these can come from a range of backgrounds, but the following have proved helpful to have within the team alongside mental health nurses:
    - **AMHP and Social Worker** - linking in with local authorities, AMHPs are warranted to conduct Mental Health Act Assessments. The extent to which it is helpful to have this in the team will probably depend on how accessible AMHPs are locally. Social Workers work with legislation to provide practical support with social needs, such as housing or finance. They also provide a range of interventions to support the person and their independence and provide advocacy for the person to other agencies
    - **Occupational Therapist** - considers 'functionality' and the impact of physical health on mental health and wellbeing, through looking at the activities of daily living (N.B. Occupational Therapists would need an understanding that people sleeping rough approach daily living in a very different way to the general population). They provide practical support and will assess and monitor mental health, engaging and signposting to other services
    - **Community Mental Health Nurses** - A mental health nurse who works in the community to assess and monitor mental health, provides a range of clinical intervention, consultation, triage advice and liaison functions, monitor effects of medication, and in some cases prescribe medication if they hold a non-medical prescribing qualification. Community Mental Health Nurses will also undertake basic physical health assessments and liaise with other agencies and disciplines
- **Service Manager** - important for colleague supervision, escalating safeguarding issues, training teams, quality improvement and acting as a link to senior Trust colleagues
- **Psychiatrist and/or Psychologist -** access to prescribing clinical support and enabling the complex needs of this population to be understood within a framework of response to trauma
- **Administrator -** supporting the teams with the administration, especially given the number of services the teams work with and their role to support larger numbers of individuals to navigate and access other services rather than carrying a small caseload
- **Peer Support Worker -** often someone with lived experience of sleeping rough, improving approachability/accessibility of the services, and providing the team with a means to ensure communications and outreach approaches are sensitive and informed by lived experience

- **Physical health professional (General Nurse/Doctor) -** where mental health needs of an individual are being exacerbated by physical health (understanding health priorities)

See '*Practical Considerations for Developing a RAMHP service'* for typical staffing structure.

Principle 6: Multi-agency Working - Ensuring continuity of care and stability of service-user journey

Partnership working with Street Outreach Teams (often homeless charities), local authorities and other NHS services (mental and physical) is essential. These partners need to be involved in the early stages including service design. Other agencies may vary depending on locality, but are likely to include drug and alcohol services, police, veteran's associations, safer communities services, day services, etc.

The teams work closely with Street Outreach Teams and Local Authority staff, bringing together knowledge around mental health, physical health, housing, financial, immigration and legal advice.

Multi-agency working allows for learning to be shared across organisations. This supports the development of more comprehensive care plans and a joined-up pathway, reducing the likelihood of the service user 'falling through the cracks'. Close working between agencies also enables better information sharing. This includes known locations for a service user, as well as healthcare/social care information. To facilitate multi-agency working, agreements will need to be put in place in line with local governance and joint-working arrangements, especially regarding, for example, Data Protection Impact Assessments.

Principle 7: Borough/Border Agnostic - Working across Local Authority borders and with services in other regions

The service supports a highly transient population who are not restricted to geographical boundaries. It is important for teams to work across borders within the geography of the Trust, particularly in large urban settings, for effective co-ordination of care.

Working across multiple regions/authorities requires the appropriate information sharing protocols (for example, safeguarding, consent, governance, and infrastructure).

Principle 8: Improving Accessibility - Reframing the problem from 'lack of engagement' to the 'need for more accessible services'

Instead of framing the problem as lack of engagement by service users (i.e. 'people sleeping rough are not engaging with mental health services') RAMHP services consider 'what can we do to make mental health services more accessible to people sleeping rough?'.

Principle 9: Establishing and Supporting a Passionate Team

Service leads (both clinical and operational) have reported that building the right team is essential in the recruitment phase. Managers should be looking for individuals who are not only suitably qualified, but also *passionate* about working with this population, *flexible* to their unique requirements, which may include, for example, late night or early morning shifts, and *willing* to try new ideas. The conditions and cases which a team would typically work with are complex and as such a team should be able and supported to work with uncertainty.

The work can be emotionally taxing. As such, having a team which is aware of these pressures and passionate about providing the service is key to ensuring adequate delivery whilst also safeguarding the wellbeing of the workforce.

Principle 10: Tailored to Individuals -
Considering individual needs, and approaching mental health from a functional rather than diagnostic perspective

The individuals within this target population often have complex needs, be those physical, mental or social. As such, a "one size fits all" approach is not thought to be as effective. Instead, services provided for these individuals must ensure that initial team response and subsequent care plan considers all their individual needs. It is also important to acknowledge that what constitutes a "good outcome" will vary between service users. Approaching the mental health of the individual from a functional perspective, considering activities of daily living and the individual's abilities to function in "typical settings" rather than taking a solely diagnostic position will improve provision to this cohort.

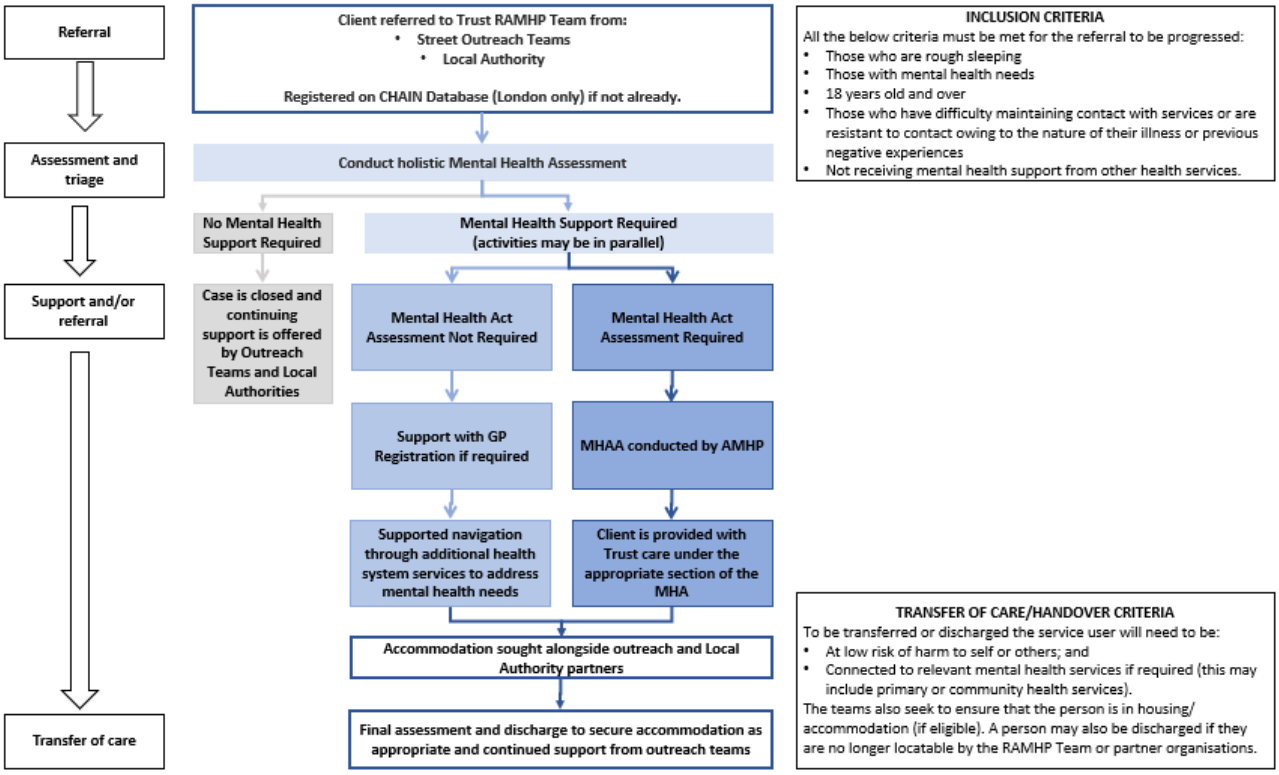
Service User Pathway

Below is a high-level pathway outlining the service user journey through a typical RAMHP service. Depending on locality there may be some variation in the type of support offered and at which stage. However, all services are broadly broken down into:

i. **Initial Contact –** Referral, primarily from Street Outreach Teams with whom the team undertakes joint shifts, possibly from other NHS services or Local Authorities
ii. **Assessment & Triage –** Mental Health Assessment conducted to determine mental health need of the individual. If needed, a subsequent Mental Health Act Assessment may also be undertaken
iii. **Provision of support and/or referral –** The outcome of these assessments, alongside other factors such as the individual's medical and psychological history and access to additional support (accommodation, welfare, and legal advice) will inform what type of additional support is provided
iv. **Transfer of Care –** Services will only transfer care to other clinical services and/or secure accommodation, with the latter usually facilitated through close working with Street Outreach Teams and Local Authority representatives

1. General Pathway

Note: MHAA = Mental Health Act Assessment. CHAIN = Combined Homelessness and Information Network. MHA = Mental Health Act



2. Acknowledging Variation

Position of Service in System (i.e. Standalone vs Integrated)

There are different ways that Trusts might choose to organise their RAMHP service to deliver the pathway. Three of the four pilot areas chose to set up separate RAMHP teams, while one of the Trusts integrated closer with the Community Mental Health Teams, embedding RAMHP 'individual practitioners' into those teams. The service delivered to the service user is much the same, meeting the principles and values outlined in this report. Point of access is also the same as in standalone services, and the Community Mental Health Team model is an alternative way of delivering the multi-disciplinary team required.

Position of Service within Trust

As well as the position of a service within a wider healthcare system, it is also worth considering the position of a service within the Trust itself. Experience from RAMHP shows that teams have most often been placed in directorates with oversight of community provision and outreach, or those services which also host Trust AMHPs, rather than the inpatient services. However, close working between outreach, community and inpatient teams is essential, regardless of the positioning of RAMHP amongst these.

Practical Considerations for Developing a RAMHP service

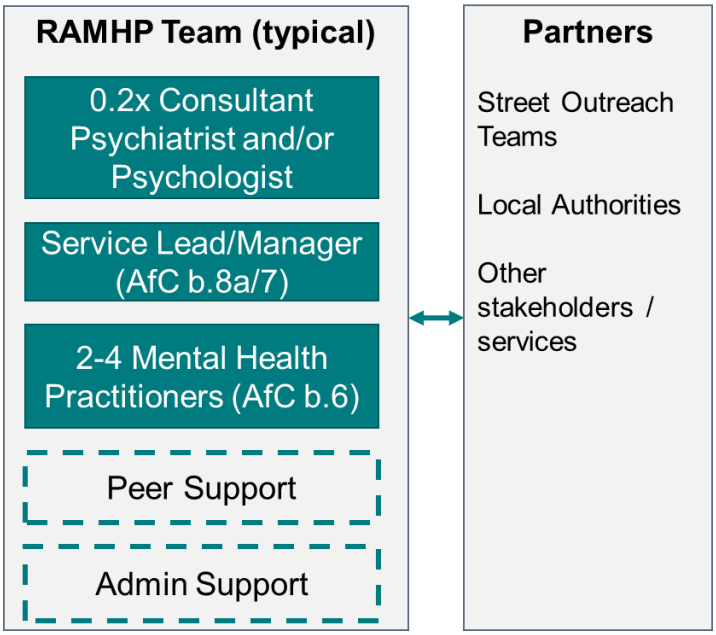
1. Considering Local Need - Data Capture/Validation

When designing a RAMHP service, Trusts should liaise closely with their Local Authority's rough sleeping and Street Outreach Teams (or equivalent) who will be able to provide intelligence on the likely level of need, both in terms of numbers and potential clinical need. In particular, the needs of people who have been sleeping rough for a number of years may differ from those who are new to sleeping rough. It may be that data provided through in datasets only gives a certain level of information (for example if individuals are assessed as having 'a mental health need', rather than specific diagnosis). The insights provided by colleagues across the system working with people directly are, therefore, invaluable to take into consideration when creating a service.

It is difficult to determine a staff ratio when setting up these sorts of teams, due to the very aim of trying not to be a 'one-size fits all'. When explored further with current RAMHP Teams, leads felt comfortable with a 1:25 ratio. This is 1 team member to every 25 service users. This will need to be overlaid by what proportion of those with mental health needs are likely to need support from mental health services (as opposed to, for example, primary care) and those who are not already receiving any such support, since RAMHP teams are designed to plug that gap.

2. Proposed Generic Staffing Structure

Following review of the staffing structures across the four RAMHP pilot services in North London, we were able to identify a typical core structure of a RAMHP service. This is outlined below:



As outlined in Principle 5, the more disciplines which can be included into a RAMHP Team, the better. However, it is acknowledged that there several influencers which will impact on team structure and scale. These influencers are explored later in this report.

Where all services concur is on three core RAMHP roles:

i. Between two and four Mental Health Practitioners who can undertake joint shifts on the street with Street Outreach Teams
ii. a Consultant Psychiatrist (especially for access to prescribing) or Psychologist; and
iii. a Service Manager

Some services have amended their staffing structure to allow for the inclusion of Peer Support Workers and Administrators. Whilst these additional roles were not necessarily planned for in the core team structure during the development of RAMHP, it has since been acknowledged that they are highly beneficial (see Principle 5 for detail).

There are then some additional 'desirable' roles, which not all services have yet implemented but have acknowledged the positive impact these roles would have on the quality of provision. These include Occupational Therapists, Trust AMHPs and Physical Health Nurses.

3. Geography

Consideration must be made for the geography of your service area. An urban setting is likely to have unique benefits and challenges which may not be mirrored in a rural setting, and vice versa.

A sparse population will require a different structure/way of working than a dense population, as this will impact how outreach shifts are delivered. Considerations will need to be made around lone working and accessibility for staff. Some current RAMHP services ensure none of their staff undertake lone working shifts, and instead they deliver joint working shifts with partner agencies.

4. Funding

Whilst perhaps obvious, it is worth noting that the scale at which a RAMHP service can be implemented and the overall number of service users which can be supported is related to team size and therefore funding available.

As discussed under the section *'Practical Considerations for Developing a RAMHP service'*, ideally areas should determine local need to inform the required size and structure of a team, which will in turn indicate the resourcing required. This is to achieve a needs-led implementation, as opposed to one which is informed by the size of a pre-determined budget.

5. Senior Stakeholder Engagement

As mentioned previously, part of the strength of a RAMHP service lies in its multi-agency working, system-wide support, and adequate sustainable funding to maintain provision. These are easier to secure if there is senior stakeholder buy-in from the beginning of the service development. These Senior Responsible Officers (SROs)/Champions should not only be identified in the NHS organisations involved, but also across Local Authorities and the third sectors.

The types of roles which current RAMHP services have found to be supportive, and able to unblock barriers, acknowledge safeguarding and governance risks, and raise service profile across the system, have been:

- Chief Executive Officer/Chief Medical Officer (NHS), for example, unblocking Trust/service barriers such as bed availability
- Director of Transformation/Strategy (NHS), for example, supporting business cases and driving quality improvement
- ICS Head of Mental Health and/or Homelessness Lead (NHS), for example, supporting in the development of strong value propositions for sustainable funding
- Street Outreach Director (Third Sector), for example, championing the benefits of joint shifts between Street Outreach Teams and NHS staff
- Director of Housing/Homelessness (Local Authority), for example, advocate for close working between RAMHP delivery teams and LA teams to secure accommodation