# Service Model Review of UK
# Mental Health and Rough Sleeping Services

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## Introduction

Homelessness and rough sleeping is an issue that is inherently complex, with individual, environmental and structural factors all implicated. Undiagnosed and untreated mental health issues, in the main associated with adverse childhood experiences and complex trauma, are implicated in repeat tenancy breakdown.

These issues are compounded by chronic health problems, drug and alcohol use and difficulties establishing and maintaining trusting relationships. Such complex issues require a multi-disciplinary approach; the evidence indicating that fundamentally, psychologically informed ways of working across disciplines are most effective. Services need to be configured with local needs in mind, but a core set of capabilities are clear in terms of the complex needs of people sleeping on the streets, occasionally transitioning into and out of accommodation.

An important question to be addressed when planning service configuration, is around the capabilities necessary for effective interventions, at the individual, environmental, or systemic or structural levels. The team structure should also be able to leverage the expertise of partner agencies and set up scalable and sustainable structures nationally given that not all capabilities will be available in all areas.

Although an 'ideal' service model can be specified, alternative configurations which allow close approximations to essential capabilities may need to be considered.

Defining a population to serve is difficult given the complexities of presentation and the movement into and out of accommodation.

## Identified unmet needs

Each area will have its own specific needs, but evidence from Manchester, Leicester, London and Southampton indicates the following common unmet needs in terms of current service provision - these deficits will therefore need to be included in any service model that seeks to add value:

1. Access to statutory secondary and tertiary care mental health and drug services, often with current drug and alcohol use cited for exclusion
2. Open access psychological provision for service users and staff working across health, housing, care and voluntary sectors;
3. In areas without specialist homeless GP practices, a responsive support to GPs to provide case management, social and psychological support for service-users who regularly use primary care;
4. Assessment and treatment of those who have autism, learning disability and / or acquired brain injury;
5. Provision of training for all staff across sectors in psychologically informed and trauma-informed approaches, particularly those in hostels and rough sleeping outreach services;
6. A strategic approach that takes into account the costs to different government departments, making use of stronger clinical networks, strong links with in-patient services and emphasis on a multi-disciplinary approach. Such a strategic approach should also build in longer-term planning for people

moving into more secure tenancies. Explicit links with Housing First, to support the wrap-around support is essential;
7. Case management and discharge planning for homeless patients admitted to hospital (Pathway model);
8. Flexible and rapid access to opioid replacement therapy.

## Service model

### Capabilities

Although for a few people homelessness is about a lack of accommodation that can be simply fixed through appropriate housing, for many, the issue of homelessness and rough sleeping is complex, involving an interaction of micro and macro factors at all levels, from the individual, through organisational structures, to economic policy.

The problem is not an individual one, nor is it one of service provision, but should be framed as an interaction between the two. The service model proposed is designed to address the issues faced by those whose needs are not currently met by existing services, due to an interaction between the complexity of needs and inadequacy of those services.

A crude, common and unhelpful simplification of the issue is that it's *either* the individual's fault *or* society's fault. This often leads to service configuration which values either medical models or housing solutions; this bifurcated understanding of the issue can lead to ineffectual service provision as simple solutions (e.g. pharmacotherapy or accommodation without appropriate support) are generated which are not effective with complex problems.

All staff working within the service should be enabled to describe the medical and psychological problems that people sleeping rough face, within appropriate frames of reference, knowing what frame of reference they are using and its limitations.

1. As a result, the service should be fundamentally, psychologically informed to enable the complexities of service user and support staff behaviours to be understood, thereby leading to informed interventions which are led by the experiences of the service user, rather than the service itself.

   These systemic and individual formulation capabilities lie within the scope of clinical and counselling psychologists and some psychological therapists. Clinical and counselling psychologists' core training equips them with a set of skills to work with individuals by making use of evidence-based therapies for trauma and other mental health issues, and at systemic levels, formulating barriers to effective care within and between services.

   Evidence indicates that training in psychological approaches can be useful for hostel staff, housing officers, health professionals and voluntary sector teams, ensuring a consistent approach across varied disciplines. Housing First support staff could benefit from psychological and pastoral support from the team. See the good practice guide around psychologically informed

environments: https://eprints.soton.ac.uk/340022/1/Good%2520practice%2520guide%2520-%2520%2520Psychologically%2520informed%2520services%2520for%2520homeless%2520people%2520.pdf

2. People who sleep rough suffer chronic physical and mental health problems, which often go untreated due to not seeking treatment and / or being excluded from it.

   Nursing capability is therefore essential in being able to assess and treat these issues, in hostels, clinics and on the street (and to support and refer people into other services).

   Both mental health and physical health capabilities are essential. Case management has been found to be an effective way of working with vulnerable populations (Aldridge et al, 2017), so those familiar with these systems is essential.

   Additionally, joint posts with community or hospital mental health teams would enable effective and informed communication between teams. Mental health and physical health nurses, with operational leadership capability are therefore essential.

3. Functioning assessment and interventions are essential to enable people to develop the skills necessary for living in accommodation. Surviving in formal tenancies involves a very different skill set from surviving on the street; it is therefore essential to identify and develop practical skills that support and enable structured living, and to put in place effective interventions that develop these skills. Occupational therapists are therefore a vital part of any specialist team

4. Given that housing is an ultimate aim, the team should have access to expertise in this area in terms of housing law, stock and engagement with social care structures. Case management can be a useful way of framing need and delivery of service. Social workers or other housing experts are therefore essential to advise service users and the team on these issues, as well as working with organisations that provide accommodation. Approved social workers may additionally support compulsory care under the Mental Health Act.

5. Flexible and rapid access to opioid substitution therapy (methadone or buprenorphine) will be vital for patients with opioid addiction.

   This could be managed by primary care prescribing, or by enhanced links to local drug treatment services guaranteeing rapid assessment and access to treatment.

   Also, links, where necessary, into formal psychiatric care, especially under the Mental Health Act may be essential. An understanding of psychotropic and substance medication and its use will augment psychological and functioning

interventions, particularly where diagnosed psychosis and drug use are barriers to sustaining accommodation.

In addition, linking with hospital-based psychiatric liaison teams and community mental health teams through joint appointments may mitigate silo provision, a known barrier in supporting people who are rough sleeping.

The team therefore should have access to a psychiatrist, preferably with a joint role in hospital or community services, as well as access to a general practitioner (see below).

6. In order to augment pharmacotherapy provision and provide a link with services provided in the community, the team should have access to a pharmacist whose specialist knowledge around psychotropic and particularly drug replacement therapy would be invaluable. This would be particularly true should the pharmacist operate in the locale where medicine is dispensed to people who sleep rough, although this cannot be proscribed.

7. Peer mentors and experts by experience will play an essential part in engaging people in the process of change, supporting people in obtaining support from other agencies.

   Theory and evidence points to experiential knowledge as key in establishing relationships with people who are sometimes hard to reach, as a foundation for change and engagement with other services. A network of peers is essential to the team, not only for delivery but also co-design and set up.

   Peer mentor networks are growing in terms of effectiveness and provide a route into employment for people with lived experience. They are also essential in facilitating co-design and delivery of services, at a fundamental level. This kind of career planning and valued activity should be explicit within the model.

   Relatedly, the relatively new role of navigator may be useful in providing practical and psychological support within and between services. Many may have expertise through experience, which may be particularly useful as part of an outreach team.

8. It will be essential for the team to have direct access to primary care, not least due to medical treatments that can be practiced there, but also formal access to other services where primary care is the gatekeeper.

   GPs working on a sessional basis have proved very effective, notably in the Pathway model, which also offers a model for a structured, multi-disciplinary case management-based approach (https://www.pathway.org.uk).

   Ideally such GP's would be employed by a local practice with an interest in Inclusion Health, thus improving links to primary care.

9. Assistant psychologists have been effectively employed not only to augment psychologically informed approaches, but also to coordinate data-gathering.

10. Evaluation and evidence-generating practice are essential in an area in which good quality evidence is sparse, so in order to be an evidence-based team (both outcomes and mechanisms of change), data should be continually generated.

11. It will be essential for such teams to have administrative support to operate effectively and efficiently.

**National initiatives**

12. A national quality support and training network to support team focus, skills and motivation should be established. This will also enable structured national roll-out and development of shared quality standards: Pathway's national network of specialist hospital teams and the Psychiatric Liaison Accreditation Network offer useful models. The Faculty for Homeless and Inclusion Health can support here.

13. Support for progress into more secure accommodation should be an explicit role for the teams, working closely with Housing First initiatives.

14. Health and mental health services are increasingly using digital interventions such as online platforms to enhance delivery of care. These resources are particularly important when working remotely, e.g. on the street. Just such a platform has been developed in a collaboration between the University of Southampton and the University of Houston, Texas, that facilitates online psychologically informed practice, as well as being a repository of outcome data and records information.

Taken together, this mix of interdisciplinary capabilities will break down many of the barriers to effective care, which arguably maintains homelessness and rough sleeping. They address the needs identified around the UK, and should be effective in and of themselves, as well as augmenting other stakeholders' work, e.g. police, local authority housing teams, hospital-based staff, paramedics and the fire service. It will be essential to work with these other agencies to enable every contact to count in the process of recovery, through training and joint working.

**Trainees**

Many of the disciplines will attract trainees to support the team. Specifically, nurses, psychologists, OTs, social workers, and psychiatrists may supervise trainees or students on placements. Although there is significant work associated with the supervision of trainees and students, in order to sustain an expert workforce in the long-term, as well as augment service provision without significant bottom-line cost (other than accommodation, IT), they are an essential component of services to vulnerable people. They often need to conduct research projects, which may be useful in generating outcome and process data for the services. Links with Universities will be essential in this (see below).

**Links with Higher Education**
A number of services have set up fruitful relationships with Universities around the UK, and at least two research centres serving vulnerable people have been set up in Universities. Any opportunities to exploit such relationships should be taken, and the evaluation and research expertise made available through such links employed to improve service effectiveness. Homelessness is a public health issue and making links with Public Health training and resources is developing.

Additionally, links with professional practice programmes may be set up, ensuring that new generations of practitioners are appropriately inspired and trained to continually improve service delivery and development.

**Leadership**
Evidence from existing services indicates that strong leadership is essential in enabling a team to function well when indicators of change are often not clear, and ways of working can be complex and ill-defined. Leadership should come from those with a deep understanding of the front-line clinical issues, both mental and physical, and also a deep understanding of the complex environment in which the service exists and complexities of working effectively with people sleeping rough.

These capabilities are held by a number of disciplines, but existing services in the main ascribe leadership to nurses and psychologists. In addition, if all aspects of the team are to be psychologically informed (e.g. recruitment and retention, risk policies, all professional practice), a psychologist would need to be involved in service configuration.

Anecdotal evidence indicates that nurse-led teams are common and function well in terms of serving a volume of patients, their being trained to address both physical and mental health issues, albeit within a medical model.

Psychologists bring structural, systemic and individual formulation skills, as well as ensuring that services are sustainably and fundamentally psychologically informed.

Services may therefore make use of matrix organisational structures (in which lines of responsibility are set up in a grid according to expertise, rather than a traditional hierarchy; https://hbr.org/1978/05/problems-of-matrix-organizations) to ensure that nursing and psychological expertise is employed to lead.

Other disciplines currently take leads in services in the UK, are occupational therapists, psychotherapists, GPs and in some instances, psychiatrists. GPs in particular have led excellent services, but there is a question about whether this is scalable at a national level. Leadership qualities can of course exist independent of discipline. It will be worth investing in explicit leadership development and support for the new teams.

**Proposed team structure**
The following team structure would be appropriate for a notional population of 40 people in a locale, sleeping rough with occasional brief tenancies:

- Senior Practitioner / team leader - Mental Health Nurse; Band 8; 1.0 wte (0.5 wte clinical, 0.5 wte managerial)
- Mental Health Nurse; Band 6; 1.5wte; plus 0.5 to sit as joint post in mental health service)
- Physical Health nurse band 6; 0.6wte
- Occupational Therapist; 1.0 wte, band 6
- Clinical / counselling psychologists; 0.4 wte band 8c; 1.0 wte band 8b; 1.0 wte 8a (or qualified psychological therapist)
- Assistant psychologist; 1.0 wte band 5
- Peer mentors (experts by experience); 6.0 wte
- Peer mentor co-ordinator, supporter; 0.2 wte band 7 (any discipline with expertise)
- Navigators 2.0 wte; band 5
- Consultant psychiatrist; 0.1 wte
- General practitioner; 0.4 wte
- Administrative support; 0.5 wte; Band 4

**Hours of Operation**
Normal office hours of operation would in the main be appropriate. However, if the service aspires to be flexible and responsive, some out of hours working is warranted. For example, many incidents involving emergency services occur at night. A responsive service would offer a consultation service for police and paramedics to inform the diversion, treatment or other service that may be appropriate.

**Care Programme Approach (CPA)**
A CPA approach is probably not warranted for the service, as the service users being served may not be logged by local NHS mental health services. Those who require managing under would need to be taken on by secondary psychiatric services.

**Hosting of teams**
There are a number of options around where teams may be located. They may be stand-alone teams, which sit for purposes of administration and communication within a local NHS trust, or they may be nested in inclusion health primary care services, a model in which Pathway has significant experience. Hosting organisations should be identified carefully, on the basis of a genuine understanding and stated aim to effectively address the complex issues. Ideally links with the local community should be strong, as rough sleeping can be understood as a community problem.

**Costs**
Table 1 below represents the sessional costs and the total annual costs for each discipline, and the total annual service cost (low, mid and high gradings provided), to

work effectively with a notional group of 40 people who are sleeping rough in any given area of the UK. There will of course be local variation in cost and provision, but the mid-point total annual cost of **£652,536.57** represents a reasonable estimate of a multi-disciplinary team of people who could make a real impact on homelessness and rough sleeping in the UK. This excludes costs of any national initiatives around longer-term change and digital developments.

**Value for money**
It is important to consider the economic advantages of such a multi-disciplinary team. For comparison, US and UK costs associated with someone sleeping on the streets without planned treatment are as follows –

In the US, the costs on average are $35,578 (£26,684) per person per year, according to the National Alliance to End Homelessness (http://endhomelessness.org/wp-content/uploads/2017/06/Cost-Savings-from-PSH.pdf).

A number of organisations have tried to model the same in the UK, and the CRISIS figure of £600,000 for 30 people sleeping rough seems a reasonable starting point (https://www.crisis.org.uk/media/237022/costsofhomelessness_finalweb.pdf).

This represents £800,000 for 40 people, or around £20,000 per person.
These figures make the service costs we have proposed (mid-point £16,313 per person per year) to actively support movement off the streets, seem cost effective in terms of the public purse. These costs will of course replace many of the costs of keeping someone sleeping on the streets.