Mental health and settled accommodation indicator in the SEA PSA: Priority areas for action and delivery.

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Historical note: PSA 16 was a central government priority towards the end of the previous government's term in office. It concerned ensuring access and maintenance of "settled accommodation" for those most at risk of social exclusion; with individuals with significant mental health problems identified as one of 4 key "at risk" social groups. The formal and technical definition of "settled accommodation"(as against "good accommodation") is addressed elsewhere.

This paper focuses on the identification of those with high-level mental health needs, through 4 principal pathways or "routes". Although the PSA itself was abandoned, along with many other national "targets", by the new Coalition government, these issues remain as relevant today.

The issues in Route B, as it is called here, were later adopted by CLG and NMHDU and incorporated into their joint guidance on addressing the psychological and emotional needs of homeless persons.

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Four pathways into the scope of NI 149

Four "routes" or pathways have now been identified by which individuals may come within the scope of PSA 16 National Indicator NI 149, which is concerned with achieving settled accommodation for individuals with significant mental health problems, defined for these purposes as "individuals receiving secondary mental health care services".

These four possible pathways can be used to identify areas for priority action, delivery chains and partnerships, and also risks in and for delivery. This topic-focussed narrative approach can be cross-referenced with the spreadsheets and action plan grids already produced and covering all PSA 16 groups.

Route A

Individuals may initially come to the attention of secondary mental health services through various routes, primarily in referral from other healthcare service areas such as GPs and Accident and Emergency Departments. Once in contact, each individual should have an assessment of their mental health issues and needs, and if assessed as in need of secondary services' care, will be allocated a care co-ordinator to liase with others, as need be, to ensure a comprehensive package of interventions.
NB: The care co-ordinator is not responsible for provision of all service, but for co-ordination of various disciplines' and agencies' efforts.

Where such an individual may subsequently become homeless, the first concern must be for ***early intervention.*** The care co-ordinator will therefore be expected to liase with housing services to assist in assessment of their client's housing needs, including

- their eligibility for social housing on the grounds of vulnerability;
- any particular needs which housing services will need to be aware of, to determine suitable temporary or permanent accommodation; and
- to identify any on-going and future support needs.

Success with the PSA indicators will therefore depend significantly upon

- the ability of housing and resettlement staff to recognise and work with mental health problems
- the knowledge of the care co-ordinator of housing and homelessness procedures, including
- the proper application of any information-sharing protocols; and on
- the availability of suitable resettlement support.

Basic training for all MHT staff, coupled with advice and guidance from more specialist staff on local policies, procedures and services, will be required.
NB: CSIP, CLG and the Housing Corporation have also published good practice guidance which should be available to all staff to consult.

However, the key to ensuring better stability in accommodation, and hence low numbers in the NI 149 indicator, lies in ***prevention*** – in ensuring that all efforts are made to prevent the individual becoming homeless. This would suggest a need – which may be further highlighted by monitoring of this indicator - for

- sufficient specialist or non-specialist housing-related support staff
- dissemination of recent guidance on managing rent arrears and
- guidance on ways to improve communications between mental health staff and general needs housing services
- mental health awareness training for housing staff (identified as a need by several reports)
- Local area "champions" and/or linkworkers between agencies, to oversee better communications between agencies, develop local protocols etc

Apart from the possibility of a need for more housing support staff – which would in future need to be resourced from all available partnership budgets – and for "linkworker" or "local champion" liaison roles (which could require specialist resourcing, perhaps on a spend-to-save basis), these are primarily issues of ensuring that homelessness assessment coupled with care-co-ordination through the Care Programme Approach are more effective in reaching and meeting the needs of this vulnerable group.

New guidance on allocation of the more intensive form of care co-ordination under the Care Programme Approach (CPA) will confirm the need to give greater priority to those homeless or in insecure accommodation. The effectiveness of CPA co-ordination at local level could be monitored by Primary Care commissioners, and assessed by the new regulatory and inspection authority, the Care Quality Commission (CQC). Feedback from other stakeholders, such as homelessness assessment and resettlement staff, could become part of the regular CQC assessment process.

Route B

In Route B, an individual initially comes to the attention of homelessness assessment and/or resettlement services, and there is reason to believe that this individual may have mental health problems that might affect both the homelessness assessment, and any suitable options for temporary placement and/or housing offers, and any on-going support needs, including supported accommodation.

The first concern here is for ***early assessment***. Recent policy guidance recommends joint assessment where possible. Homelessness resettlement service workers also need to be able to make referrals to the secondary mental health service, perhaps via referral first to an outreach

primary care worker (GP or nurse) for "screening", who will then make the secondary services referral.

The speed with which referrals are assessed will depend therefore upon

- the quality of staff training for housing workers in recognising mental health needs.
- the organisation of referrals, and/or
- any out-reach mental health services in each locality

"Fast track referral" mechanisms to secondary care for those in more urgent need should be in place. PCTs in their commissioning role will need to ensure that secondary care referral systems are appropriate, including, where resources allow – and where the indicators suggest a need - secondary care health outreach services, including the option of practice-based commissioning where vulnerable individuals are reluctant to accept MHT referral .

NB: The individual will not become formally "receiving secondary care services" and recorded in the MHMDS until after this referral has been actioned. There is a risk that the impact of NI 149 monitoring could tend to deter mental health services from identifying suitable individuals.

However, for those coming to the attention of SP-funded services, their SP Client Record and Outcomes data should offer an alternative perspective on MHMDS data. Both PCTs and local authorities should exercise ***vigilance*** to ensure that any perverse disincentives to identifying appropriate individuals are addressed.

Route C

Where an individual admitted to a hospital for treatment was homeless on admission, or is unable to return to their former accommodation (for whatever reasons), and is deemed ready, in purely medical terms, for discharge, but will need supported accommodation or residential care, the individual may then be seen as being, in effect, homeless on a hospital ward.

Hospital and community team staff will need to assess the individual's needs and seek suitable accommodation, including intensively supported accommodation for those needing higher levels of support or monitoring. A local directory of suitable services, including specialist "niche" services, and/or specialist advice from a knowledgeable source such as a discharge co-ordinator, should be available, to assist workers with immediate placement options. Information on hard-to-meet needs and on out-of-area placements should then be collected via MHMDS and via SITREPS data on delayed discharge.

PCT commissioners will need to consider the opportunities for pooling of all available resources in health, social care, and support, whether to spot purchase services and/or to develop the commissioned resource base locally. Identifiable supported accommodation needs that could be developed to reduce delayed discharge (and/or provide alternatives to admission) include:-

- Alternatives to admission (crisis houses, respite arrangements, etc)
- "StepDown" (early discharge) accommodation
- "Cluster and core" networks with multiple/integrated/tiered funding
- High-support (or "extracare") mental health supported accommodation
- More specialist "niche" services provided on a regional or sub-regional basis

Local commissioners will need ***good quality information***, from both SITREPS and MHMDS data, on local hard-to-meet needs and shortfalls in existing provision; and will be expected to contribute this information to Joint Strategic Needs Assessments. Improving the quality of both SITREPS and MHMDS data to support commissioning and service re-modelling is therefore an urgent need, currently being addressed.

Some closer sharing of commissioning resources between the PCT and local authority could be encouraged, including, where appropriate, with funds to facilitate the transition process. Examples of particularly effective practice from other parts of the country should be identified, to ensure that ***commissioning*** to meet identified gaps is informed by a wide range of models which can be assessed for "best fit" suitability. Further detailed information on policy, funding and regulatory frameworks concerning the scope for development of new services should be available.

Route D

Route D concerns individuals in touch with secondary services whose accommodation does not provide due security of tenure, to the point where the accommodation must be regarded as not settled. It has therefore been agreed that individuals in residential care will come within the scope of the NI 149 indicator, and receive the same scrutiny.

Local authorities primarily fund the placement costs of residential care, with a contribution from the benefits of the service users, and with or without additional top-up funding from Health according to local continuing care eligibility criteria. The accounts of Social Services finance departments should therefore give a fully accurate measure of the numbers and costs involved, both for local placements and for out-of-area costs.

There has been a marked trend, in both mental health and learning difficulties services, away from residential care and towards supported accommodation and supported living over the past 10 years. Support models and procedures seem more closely akin to modern thinking on social inclusion and recovery than the older residential care model. The pattern of provision and investment currently is largely a ***legacy*** of past funding streams and constraints, and there has yet to be any clear rationale as to when residential care might actually be the housing model of choice in mental health, compared to the new supported accommodation options.

There is however a risk of a perverse outcomes from inclusion of all residential care in NI 149, insofar as many such individuals may be quite settled and stable in residential care, and would not wish to move. Although support services in individuals' own homes may now be quite intensive, the lead time for developing new supported accommodation, for those needing such support, can be quite lengthy. This may deter some LAs and their partners from adopting the NI 149 indicator, unless a more ***needs-led and person-centred*** approach can be introduced to identifying when and where individuals may be ready and willing to move to a less institutional environment.

When considering placement transfers for individuals, and/or de-registration or re-provision of existing residential care, local authorities, PCTs and partners may be expected to seek out current best practice in mechanisms to ensure "in the round" approval of procedures, including inspection reports, local stakeholder feedback, and peer benchmarking (see "triangulation of data"). A stress on local partnerships' ***quality assurance*** of their own procedures and data in moving towards greater autonomy for individuals in supported living would significantly reduce any risks of perverse outcomes from route D in particular.

Overall drivers of improved outcomes

Local authorities, with their social housing partners, are primarily responsible, through local housing needs assessment, and Government Offices and DCLG nationally, for the supply of suitable general needs housing, and of supported accommodation, for the more vulnerable. LAs are also principally responsible, as the brokers of "place shaping", for the development of Local Strategic Partnerships to meet shared outcomes and cross-cutting needs.

Joint Strategic Needs Assessment, however, is now a shared duty of both LAs and PCSts; and DH is jointly responsible, via PCT commissioning under the high-level performance management of SHAs, for the in-put of health care, including care-co-ordination, information sharing policies, data collection, development of outreach and./or capacity building initiatives, and the commissioning or re-modelling of services to meet locally identified needs, in line with national priorities and Vital Signs.

Without the engagement of frontline staff in housing issues, and of local commissioners in re-viewing ***best value and healthcare gain*** from the funds currently committed to high-cost health and social care interventions (in hospitalisation and residential care), only limited progress can be expected towards achieving and maintaining the goal of settled accommodation for the most vulnerable and at risk.

It is clear from the priority action areas above that Primary Care Trusts need to ensure that local services are delivering, through JSNAs and the local commissioning process. The SHAs are now effectively co-terminous with GOs, both geographically and structurally, in terms of their powers and responsibilities in relation to local area services. Their role in ensuring the delivery of the mental health elements of improved outcomes, as identified above, needs to be identified more clearly, to ensure that properly balanced and properly ***resourced*** partnerships are developed.

Delivery Partnership Chains

Partnerships for delivery of the PSA outcomes operate both vertically and horizontally – that is,

- vertically, from national through regional tiers to localities, neighbourhood teams and to the level of micro-communities and individuals, and
- horizontally, at each tier of government or level, with the Delivery Board and Officers Steering Group; the various regional bodies; local strategic partnerships, stakeholder forums and joint strategic needs assessments; and integrated management and pooled funding of frontline services

There are also cross-cutting non-governmental structures, such as membership and/or capacity-building organisations, and quality assurance or regulatory bodies, all of which may have a powerful role to play both in disseminating information, encouraging take-up and best practice, for the membership bodies, and in promoting or constraining shared outcomes and accountability, for the quality assurance bodies.

Finally, there are topic-specific initiatives that have sometimes considerable momentum and impact, but have been developed largely in sector-specific isolation, such as, in mental health, the review of CPA, or the acute wards project, the dignity agenda, or the new policy towards the diagnosis of personality disorder; or, in housing, the Hills review of the role and expectations of social housing, the roll-out of Choice-Based Lettings, or the information sharing protocol over the needs of vulnerable adults.

NB: There is a set of diagrams now in the process of preparation (with on-going revision) to indicate in somewhat simplified form the vertical, horizontal and cross-cutting chains of accountability, information flow and practice monitoring, with some of the key relationships identified. These diagrams are now available as a separate document; as are the action plan grids and spreadsheets; the definition of settled accommodation; and the current proposal for re-definition of the causes of delayed discharge on mental health wards.

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