



Working with Statutory Mental Health Services

A guide for housing and homelessness staff

Let's end homelessness together

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About this guide

This document is for staff working in homelessness and housing services who work with people with mental health problems. The first section discusses your work and responsibilities. The second section describes how different statutory services work and how you can most effectively make referrals to them.



This document has been written by EASL, Enabling Assessment Service London. We are a community interest company formed by mental health professionals with an interest in applying their professional knowledge in the interests of socially excluded people. To find out more visit www.easl.org.uk/



Further advice has been provided by the Mental Health Interventions and Rough Sleepers Steering Group. This project is hosted by Pathway. There is associated guidance on the Pathway website which may also help you to form decisions and make referrals: www.pathway.org.uk/services/mental-health-guidance-advice

Your work and why it matters

When you come across someone in distress, or with a mental health problem, what can you do? Start by thinking about how you can support them in the here and now. People with mental health problems are often marginalised and isolated. Just being there, or helping with a small practical problem, can help them to feel less alone.

It is a myth that only specialist services can make a real difference. This is not the case – don't underestimate your value to a client. What you do will make an impact, even if they are also seeing a specialist service. It is also tempting to think that, once a client is seen by mental health services, a solution will be found. Unfortunately, this is often not the case. Clients can be reluctant or unable to work with services, or they may present with problems that mental health services simply cannot deal with. And, if a client does accept a referral to a mental health service, you may well be needed to support them through the delays and frustrations that often happen during the process.

The best way to get a good outcome for a client with a mental health problem is for every service involved to work closely together. This can create a durable and mutually supportive network for the client. We know that people with mental health problems need more than medication or psychotherapy. Recovery demands attention to a client's social situation, and support within their normal environment. Specialist services can (usually) deal with medication and psychological issues, but social interventions are also powerful and can be done by anyone, in any organisation. The relationship between a worker and a client can often bring about as much change as a specialist intervention, although one often needs both.

What can you do to help?

There are some simple things you can do to help someone with poor mental health. These include:

- Stop and chat, offer a cup of tea or a sandwich.
- Keep an eye on their whereabouts, their health and their moods.
- Ask what help or support they might like.
- Help to register them with a GP.
- Offer to make a GP appointment, or accompany to a clinic.
- Put them in touch with other services.

Get another agency involved when necessary, but try to see them as just one part of an extended support system. This usually involves sharing responsibility rather than passing it on.

How can you better equip yourself to help?

When you work with someone who is distressed or who has a mental health problem, it can affect your own wellbeing. But you need to feel safe and well to be able to support others. Many homelessness organisations are exploring psychological and trauma informed approaches, which pay attention to this issue. You can find out more here:

www.homeless.org.uk/trauma-informed-care-and-psychologically-informed-environments

Some tips:

- Look after yourself and you will be able to help others better
- Don't work on your own. Talk through your concerns and thoughts with your colleagues – this should include regular, structured supervision with a senior colleague
- Discuss your decisions with colleagues
- Support your colleagues in the decisions that they have to make
- Your work will throw up a lot of emotions. Talk these through colleagues. This link includes an introduction to Reflective Practice:

www.homeless.org.uk/trauma-informed-care-and-psychologically-informed-environments

What else can help?

We know that people need physical safety and security (including a stable home) before they can develop, heal, and reach their potential. Homelessness services often meet people when they are at their most vulnerable and disturbed. Those first contacts can be crucial in setting up trust between the client and worker, and in subsequent working relationships. A good first relationship with a worker can give the client a solid base, so they feel safe enough to engage with other workers and agencies.

Alongside yourself and your work, many other agencies and networks should be involved. It's important to work with them, and to encourage the person to engage with:

- GP
- Mental Health Team
- Housing department
- Job Centre / Benefits Advisory Services
- Drug and Alcohol Services
- Voluntary agencies such as Mind
- Religious organisations
- Cultural organisations
- Family and friends

Your responsibilities

When you first start working with a client you need to ask for signed consent to share information, and clearly explain that this might include making referrals to other organisations, including health services.

A client may refuse you permission or they may lack the capacity to consent. This can present significant issues so you need to:

- Be aware of what the law says in terms of what you can and cannot share without consent
- Make sure that you clearly record any decisions to share or not to share information, with the justification for your decision.
- Discuss such decisions with your manager.

This guidance explains the process around using the Mental Capacity Act:

www.homeless.org.uk/our-work/resources/guidance-on-mental-capacity-act

You may also find that guidance about information sharing from the Social Care Institute for Excellence is helpful:

www.scie.org.uk/care-act-2014/safeguarding-adults/sharing-information/what-does-the-law-say.asp

As a general rule, if you have significant concerns for a client's wellbeing or safety, or for the safety of others, you should not automatically take their lack of consent as a reason for not taking action. As stated above, discuss such cases with your manager, keep a record of the decision taken, and the justification for it.

If you do not have significant concerns, but feel a referral would be helpful, you would probably not be justified in breaching confidentiality. The risks of referring without consent (such as loss of trust) are unlikely to outweigh a client's right to make their own decision, even if you think it is an unwise one.

Mental Health: Primary Care

Where to start

Where there does not appear to be an immediate risk, start by contacting the client's GP. The GP will be able to decide whether they can see the person and assess their needs, or whether it is more appropriate to refer directly to a specialist service. GPs often know a lot about their client's mental health needs and are well aware of a person's difficulties. They may be able to manage their needs effectively without additional input from other services.

In most instances, advising someone to discuss their mental health with their GP, or offering to support them in doing this, is a good place to start.

The care available

A person who is homeless is more likely than the general population to have poor physical and mental health, and to be drinking too much alcohol or using street drugs. They have a lot to gain by being registered with a GP and having up to date records.

In recent years, there has been a move towards providing more care for people with mental health problems in settings such as GP practices and primary care psychology services (often referred to as Improving Access to Psychological Therapy or IAPT services).

Many GP practices now have input from mental health workers, often Community Psychiatric Nurses. These services are usually for people with mild to moderate difficulties, who present with risks that can safely be managed without more specialist input.

If your client is not registered with a GP

In some areas, mental health services will only see clients who are registered with a GP in their borough or service area. Try to help someone register with a GP as soon as you start working with them, so there are no delays if you need to access more specialised services later on.

- You can provide someone with a 'care of' address, so that they can register with a local GP.
- In fact, the GP surgery itself can be a 'care of' address for the client, although some GP surgeries seem not to know this.
- A small number of areas have a specialist GP who works with homeless people.

This link includes more information about GP registration for people who are homeless:

www.healthylondon.org/homeless/161214healthcarecards

Sometimes, though, a client won't want to register with a GP. If they are clearly mentally unwell, this should not stop a specialist service from seeing them if you can explain why he or she is not registered.

Clinical Commissioning Groups (CCGs) across the country should have policies to ensure that homeless people can access appropriate health care. If you do have difficulties in getting health care for your client, check with your local CCG what arrangements they have to ensure that homeless people have full access to medical care. This guidance includes some helpful statistics and explanations as to what should be in place locally:

www.londonscn.nhs.uk/wp-content/uploads/2015/03/mh-sclg-homeless-19062015.pdf

Mental Health: Secondary Care

The structure of mental health services provided by the NHS and local authorities varies from place to place. You will need to find out how things work where you are. In most areas there will be an NHS Trust which runs mental health services, with some involvement from the local authority.

Initial referral

Many Mental Health Trusts have moved away from having a single Community Mental Health Team (CMHT) in each geographical area, to having more specialist teams. You will now often find a 'first stage' assessment and referral team. This will often do short term work with a client. They will then, if necessary, refer on to a more specialist team that works with people with longer term needs.

Most Mental Health Trusts and local authorities have websites which explain how referrals can be made to their services – find them by doing an internet search for mental health services in the area where the person lives. Local authority websites can be more helpful than Mental Health Trust websites because they often just give information on the first point of access, rather than information on every service available.

If you are not sure where to refer, talk to the duty worker in the access/assessment/first point of access team. They should know about the services available, and which is likely to be most appropriate for your client.

Examples of referral processes from three London Mental Health NHS Trusts are:

West London Mental Health Trust

There is now an SPA (single point of access), which covers three London Boroughs. You or your client can phone one centralised number, and speak to a member of staff who will screen the referral and decide which team it should be passed to.

South London and Maudsley Mental Health Trust

You will be advised to see the GP in the first instance, who can refer on to other services if appropriate. If a person does not have a GP, referrals can be made directly to Assessment and Liaison teams.

South West London and St George's Mental Health Trust

You will be advised to see the GP or contact the Wellbeing Service, which provides primary care psychology services. People are then screened by the Wellbeing Service and passed on to secondary care services if necessary.

Longer term support

Longer term teams work on recovery, and help people to get to a point where they can be supported in primary care. These teams usually have Psychiatrists, Community Psychiatric Nurses, Social Workers, Occupational Therapists, and Clinical Psychologists.

These teams may also have access to other departments such as Psychotherapy, where more specialist (and long term) therapy might be offered. Clients are usually allocated a named Care Coordinator who is responsible for their care. It will usually be a CPN or Social Worker unless they are only being seen in out-patients, in which case it might be the psychiatrist with the team.

It can be difficult for you to get your client seen quickly by their allocated worker. They may not be available, or may be away. Ask that they be seen by a duty worker, and make sure you speak to the duty worker so they are aware of your concerns and can advise you on what to do.

Crisis teams (Home Treatment Team)

In more urgent situations, where a person needs an immediate response to keep them or others safe, they may need a home treatment team. These can also be called Crisis Teams or Crisis Resolution Teams. These teams see clients intensively, often once or twice a day, to prevent admission to hospital, or enable earlier discharge from hospital. They usually do not accept referrals from non-mental health services, only from the 'first stage' assessment and referral team. Home Treatment Teams are often the gatekeepers for hospital admission. So, any referral where admission may be needed have to go through these services. They then decide if they can prevent admission by providing intensive support to the person, or if the person should be admitted because their illness and consequent risks cannot be managed safely in the community.

Crisis Teams often have high thresholds for taking a client on, as services are stretched. It is unlikely that they will provide a service to someone who does not need hospital admission, and who is only in need of general support.

Why a Home Treatment Team might not take on a client:

- Home Treatment Teams are often very medication-focused in their approach. If there is not a clear need for someone to have their medication supervised every day, home treatment might not be offered.
- Clients are likely to be visited by different members of staff each day. Some individuals find this very difficult, especially if they struggle to build trusting relationships.
- Where risks are not felt to be high and there is no clear need for daily monitoring.
- Where someone has support from other agencies which they are comfortable with, and which could be increased to give them the additional support they need.
- If a client tends to become too dependent on services (such as dependent personality disorder or some long-term anxiety disorders), it may not be helpful for them to have intensive input, as it is likely to reinforce their belief that this is what they need.

Hospital admission

If someone needs to come into hospital, but are not willing to agree to this (or lack capacity to agree), the mental health service will use the Mental Health Act to ensure that the person receives appropriate care.

Mental Health Act

This is used with people who are felt to require hospital admission, but who refuse this, lack capacity to consent to admission, or who consent to admission but are highly likely to change their mind. There are specific criteria for people to be detained under the MHA:

- their mental disorder must be of a nature and/or degree to warrant admission
- the risks (to their own health, safety, or to others) must be of a level to warrant admission

For more information visit: www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

The decision to detain someone under the MHA is often complex, and you may be surprised by the assessing team's decision. MHA assessments are usually carried out by:

- An Approved Mental Health Professional (AMHP)
- A section 12 approved doctor, with special training and experience in psychiatry
- Another doctor, who should be the GP, but rarely is. It is usually an independent psychiatrist.
- The Home Treatment Team

They will weigh up the person's need for treatment and risk management against their right to decide for themselves. The threshold to detain someone is, rightly, high. To detain someone against their wishes is a serious and highly significant act, which is often distressing for the client.

Whilst a MHA assessment is undertaken by the professionals listed above, this tool was developed to enable homelessness staff to provide information to statutory services about why an MHA assessment is thought to be needed: www.pathway.org.uk/wp-content/uploads/2014/06/02-MENTAL-HEALTH-ACT.doc

If your client is not detained, speak with the AMHP, who should be able to explain why this decision was made. The AMHP should also suggest what might be helpful for the client's continuing care and support.

The role of the police

In an emergency, when you cannot wait to speak to mental health services for advice, the police should be called. This would be when a person is presenting with severe symptoms or distress, and present an immediate and severe risk of harm, whether to themselves or to someone else. It is important to remember that, while the police are not mental health professionals, they often play a vital role in keeping someone safe when they are acutely unwell and at serious risk.

It is most likely that the police will contain a dangerous situation and then call in support from mental health services. It is always worth alerting mental health services (for example by ringing ahead to the psychiatric liaison service at the hospital where a person may be taken), so that they can start planning to provide input as required.

The police have a range of powers that they might use when attending a 'disturbance', such as someone behaving aggressively or in a way that might lead to immediate harm to themselves:

- They can intervene to prevent a breach of the peace, which might just be to take a person aside and speak to them about their behaviour.
- If they think that the person has committed a crime, they might arrest them. However this is decreasingly common where the person is presenting with significant symptoms of mental disorder, as there is a move against mentally disordered people being kept in police custody.
- If they feel that the person is in need of urgent mental health care, they might suggest that they take them to a hospital A&E department or to the person's mental health team. They will often do so if the person is willing, but where they lack capacity to make the decision to go to hospital.
- If the person is unwilling to attend hospital, and they are presenting as being mentally disordered and in need of urgent 'care or control', the police can use their powers under section 136 of the Mental Health Act (if the person is in a place 'to which the public have access').

There will be times where you have concerns for a person but the police do not feel that they meet the threshold for use of their legal powers, e.g. because the person has calmed before the police arrived. In such a situation, you should ask the police for their reasons for not removing the person, and then speak with the local mental health team so that they can arrange to see the person.

The fact that you felt a police presence was required, and their response, is important information for the mental health team in terms of deciding how to respond.

Referring to Mental Health services

This depends on the area. Some Trusts now accept referrals via telephone, where you speak with a mental health advisor to make the referral. Other trusts still demand written referrals.

If the person is able, and the local service allows for self-referral, encourage this where you can. This helps a person to feel more involved in their care, and encourages them to take responsibility for their needs. They may need some support, but do try to make them as active a participant as possible. Even small steps can be helpful, such as encouraging them to make their own appointment with their GP.

When talking with your client, think carefully about how you frame a referral to mental health services. It can be tempting to 'sell' them a referral to services. While this is understandable, you may be creating unrealistic expectations about what they will be offered. This can lead to disappointment and worry if these expectations are not met. When discussing a possible referral, it is helpful to explain that a referral may or may not result in them being offered an appointment but that, regardless of the outcome, any feedback is likely to be helpful in developing a plan of how to move forward.

What to include in your referral

Whatever the process for referrals in your local area, the most important thing is to prepare carefully. Mental health services are often over-stretched, and they will rely on you to provide them with the right information. It might well be that they have received ten referrals for acutely unwell people on any given day, and only have capacity to assess five, so they need as much information as possible to help them identify who should be a priority.

When referrals are rejected or delayed, it is sometimes because mental health services did not have access to the relevant information. The referral should be made by the person who knows the client best, so they can answer any questions accurately.

There is a detailed checklist of information that should be included in a referral to mental health services in the Appendix to this guidance. In summary this includes:

- Client's name, date of birth, last known address, current location, how long they have been there
- Client's consent to share information
- Client's GP details and recent appointments
- Client's medical history (as known to you)
 - Medication, and are they taking it
 - Allergies and other medical conditions
 - Risk to self or others
 - Drug / alcohol use
 - Previous treatment if known
- Your concerns
- Your level of support
- Level of urgency

It may also be appropriate to make reference to the Mental Capacity Act Screening Tool if you think the client may lack capacity: www.pathway.org.uk/wp-content/uploads/2013/12/Mental-Capacity-Act-screening-tool-for-out-reach-workers.pdf

This is not so that the person can be admitted using the Mental Capacity Act (which only covers treatment for physical disorders), but as an indication that there is a significant mental health problem that needs to be seriously considered.

There will always be situations where you do not have all the information needed, particularly with a new client or where the client is unwilling to disclose much information. Try to find out as much as you can. If you don't have a piece of information, explain why, as this might be valuable information in itself, e.g. if the person refuses to give details or if they appear too confused to provide any information.

The language to use

It's normal to feel anxious when working with someone who appears very mentally unwell, and this can lead us all into using over-dramatic language. When describing your concerns, do use language that accurately portrays the person. For example, if you describe someone as 'dangerous', you must be able to back this statement up with an example – it is a serious thing to say and has to be justified.

Avoid generic terms and phrases. Mental health services often receive requests for clients to be 'monitored' or 'supported', which do not help them to identify what the client needs. Be specific about what you think would be helpful. For example, if you suspect they are likely to harm themselves and have talked about how isolated and lonely they feel, you could suggest they need more social contact and regular visits to reduce the risk of harm.

Use the language you are comfortable with. You don't need to use medical terminology. It's even more confusing if you use terms without fully understanding what they mean. For example, you might notice that a client isn't making sense when they speak; is connecting unrelated topics; is responding to something you can't hear or see; or talking about feeling excessively frightened or worried about being harmed. You could say that these are all potentially symptoms of psychosis, and each might have a medical word to summarise them (such as hallucination or flight of ideas), but you don't need to do this. You will provide much better information by simply explaining your observations in plain English and avoiding any jargon. By doing this, you are more likely to express your concerns clearly, as well as to provide helpful details of a client's symptoms.

Some example referrals are included at the end of this guide.

Making effective referrals

When services are overstretched, relationships between services can become quite fraught, and this is often the case between homelessness and mental health services. Here are some ways to improve these relationships:

- Build a reputation as being reliable in your own assessments. If you can ensure that you are fair and reasonable in your assessments of urgency, and you identify when you think people can wait a little while to be seen because they don't appear high risk/acutely unwell, you are far more likely to have your urgent and emergency cases responded to quickly.
- Ensure that your referrals are appropriate, and make sure they go to the right place. For example, if someone is going to be moving out of the area in a week, and their situation is non-urgent, there is probably little point in referring them to the services in the area where they are. If you know where they are moving to (even just the rough area or local authority), you should be able to make a referral to services there and advise that you will provide an exact address as soon as you have it.
- Make sure your referrals are made in a timely fashion. If you have had serious concerns for a client for a week, but have only just made the referral, you may well be asked why you didn't make the referral earlier – especially if it is a Friday afternoon! Other than emergencies, most mental health services run a Monday to Friday, 9am-5pm service. It takes time to arrange assessments, particularly if someone is acutely unwell and may need a hospital admission. So if you are concerned for someone, and it is appropriate to refer them, make sure you do it straight away.
- Make sure your referrals are clear, and provide comprehensive information (as outlined in the section above and in greater detail towards the end of the document).
- Identify key issues of concern. When we are worried for someone, we sometimes get caught up in the minutiae of their situation. This may not help others to understand what is going on. If you can group your concerns into a few key areas, and talk to each specifically, you can communicate your concerns clearly.
- A mental health service may respond in a way that you feel does not meet your client's needs. Firstly, speak with the practitioner who has made the decision, and double check that they have understood your concerns. It may be that they didn't fully grasp what you were saying, or that they can provide a clear rationale for not taking a client on or providing less input than expected. This might be quite appropriate. However, if you feel that your concerns about the person have not been given enough weight, speak with your line manager about escalating the issue within mental health services.

Why a referral may be rejected

It is not uncommon for referrals to be rejected, or for clients to be discharged once they have been seen, even where you might still feel that they present with symptoms of mental disorder. Common issues are:

- Drug or alcohol misuse. It is almost impossible to assess someone's mental health needs while they are intoxicated with drugs or alcohol. In some cases, symptoms (including more severe symptoms such as hallucinations) will resolve once alcohol or substance misuse has reduced. If your client can do it, it is better for them to address their alcohol or substance use first, and then see what symptoms still remain. Otherwise, medication may be prescribed unnecessarily. This is ineffective and exposes your client to the risks of side-effects. Medication for a mental health problem will not usually resolve the problems caused by drugs or alcohol.
- People with personality disorders. A diagnosis of personality disorder should certainly not exclude a client from services, but the mainstay of treatment is usually not medication but the process of therapeutic engagement and psychological interventions, which clients often struggle with. It is not unusual for a team to try to help someone on many occasions before the person is ready to engage meaningfully with treatment (usually some form of therapy). You may find that mental health services can help when a crisis arises and risks increase, but they will then discharge the client when they are more settled. It can seem brutal to discharge people who are often distressed, but it is about clients learning to engage therapeutically. This can be a long, and difficult, process for them and those working with them. Homelessness organisations with a psychological, or trauma informed approach, can provide a safe and stable place for the client to be while they start to take steps to engage therapeutically with other services.
- People who already have appropriate treatment or support. It can be unhelpful to have mental health services involved if a person is already well supported. It can be confusing for a client to have too many people involved, and sometimes giving different advice. If there is nothing specific to be gained from a mental health service being involved it can be appropriate for a client to be discharged. But you can expect some advice or recommendations from the mental health team as you are going to continue working with the client.

Building partnerships with Mental Health services

General partnership working between services

When communicating with mental health services, the key is to work together to build a care plan that supports the person. This should incorporate the work that you are doing with that person. Things that you might do without even recognising them as an 'intervention' are often very valuable. Make sure the mental health team is aware of the support you are offering and how it might be helping the person, so that your work can be acknowledged and taken into account in planning further care for your client.

If you feel that your local mental health service doesn't understand what your service does, make it your business to enlighten them! You are doing valuable work, and need to be able to access mental health services for clients in a timely manner, as well as keeping those services involved for as long as the client needs them. If the local service knows who you are, and the work you are doing, they are more likely to have realistic expectations of what you can and cannot provide. For example, if you work in a hostel, some mental health teams might lower the priority of your referral/case because they don't understand that you are not a specialist mental health hostel and cannot provide the interventions they might expect. Staff turnover is often quite high in mental health services so it is important to revisit this regularly to ensure that they know what you do.

There may be specific functions of the mental health service that your team do not fully understand. Ask your mental health service how they might be able to support you and your colleagues to better meet the needs of the people you are all working with. They could provide, for example, training and support around working with specific conditions such as personality disorders, or about the legal aspects of their work. This could take place at, for example, one of your team meetings.

Partnership working when a client is in hospital

If one of your clients is admitted to hospital, keep in touch with the ward staff. Wards can be chaotic, and nursing staff don't always have time to make sure everyone involved is up to speed. Usually, clients will be seen in the ward round every few days, and it is best practice for all involved workers to be invited to attend. This ensures that everyone knows the plan and that they can work. This is especially important when discussing discharge from the ward. Community services need to ensure that there is a clear treatment plan, that can be implemented when the person leaves hospital. With increasing demands on inpatient wards, there is a lot of pressure for clients to be discharged as soon as possible. At times, you may feel that your client is being discharged too soon. This is even more reason to ensure that you attend the ward round to explain your concerns, and discuss them with the Consultant Psychiatrist and their team.

You can provide a great deal of knowledge and information about why you feel a hospital admission might be necessary. Completing a hospital admission plan lets you to tell others about what has already been done, what you can offer to support the person if they are admitted, and when they are discharged. A hospital admission plan can be found at the end of this toolkit:

www.pathway.org.uk/wp-content/uploads/2013/09/RSG-ONLINE-FINAL-lo-res.pdf

Partnership working after referral

It is important to remain in contact with mental health services once they have accepted a client. Your feedback is very useful, and helps them to better tailor the client's treatment plan. Where you might be having difficulty in working with a client, they might be able to provide support and advice (and vice versa), and potentially change aspects of the treatment plan to better meet the client's needs.

For example, you might be working with someone who is engaging poorly because they are suspicious of you and your motives for being involved. It might be that this is one of their symptoms of psychosis, and a small adjustment in their medication might help them to feel less suspicious and more able to work with you. Or you might have a client who is acutely anxious e.g. about going outside. Your natural reaction to their anxiety might be to provide them with reassurance and do things for them that mean they don't have to go out as much. Psychologically however, this can be counter-productive, and could make their anxiety worse in the long term. The mental health team could draw up a plan jointly with you and your client, to enable you to work more therapeutically with them.

You might be working with someone who you find is 'splitting' – saying one thing to one worker, and something else to another. They may be talking negatively about some staff members to other clients, or attempting to form closer bonds with some staff by talking about how much better they are than others. This kind of splitting can be very destructive in a team. It is particularly common in working with people with personality disorders. It isn't always easy to know how to manage it. The mental health team might be able to give you some ways to manage such behaviour, or meet jointly with you and the client to discuss why it is happening and what might be helpful in reducing it.

Appendix 1: What to include for an effective referral

Client details	Full name, date of birth, last known address, where they currently are and how long they have been there for (this is important as mental health services may have been involved in a previous area, and the service is likely to want to talk to previous providers).
GP Information	The client's GP details, and information about whether the GP has been asked to see the client, and if not, why not. Has the GP been asked to provide the client's medical history, and can this be passed to mental health services (the client should be asked whether they consent to this).
Your concerns	<p>The specifics of what your concerns are. You don't need to use technical language, but you should be able to explain in detail why you are worried and how the person is presenting.</p> <p><i>Examples</i></p> <p><i>Rather than just saying you think the person is depressed, it would be better to talk about why you believe this. It might be that they seem low in their mood, are crying a lot, isolating themselves, eating or sleeping little, not caring for themselves well, not communicating much, or talking about harming themselves.</i></p> <p><i>If the person is talking about feeling suicidal, you will need to provide more information about this, as sometimes people say this to express that they are feeling really awful, rather than having any specific intent to end their lives. Have they disclosed any specific plans to harm themselves, and if so, what have they said? Have they got any history of harming themselves that you know of? Is there anything on their medical history to suggest they have attempted to harm themselves in the past? If they have attempted to harm themselves, what did they do? If they took an overdose, what did they take and how much, when did they do this, and did they seek help?</i></p>
Medication, allergies and medical problems	Is the client prescribed any medication for their mental health, and are they taking it? If so, what are or should they be taking?
Allergies and medical problems	Does the client have any known allergies or severe medical problems that you know of?
Risk	Does the person have any known risk history, to themselves or others? If so, what are the specifics of this? Is the person currently presenting in a risky way, such as being aggressive to others?
Drug and alcohol use	Is the person currently using drugs or alcohol, and if so, how much and what are they using? Is this a new problem, or has it been going on a long time? This is important, as it might have an impact on the response or treatment that is needed.

Previous treatment	Are you aware of them having treatment for their mental health in the past? If so, where did they receive treatment and when? A mental health service can then contact a previous provider to request more information.
Your support	<p>How have you been supporting the person? It might be that you are able to provide lots of input that is keeping the person safe for now. Let the person you speak to know what you have been doing. It is helpful for them to know this, and to know how well the person has responded to your support.</p> <p>It is really important to be clear about how long you can continue to provide the care you are giving and, indeed, whether the care you are providing is within your remit at all. If you are providing a very high level of support, but this is not sustainable for more than a few days, you must make this clear, as it may alter the response of the service to your referral.</p>
Urgency	What level of urgency do you put on the referral? If you think it is urgent, be very specific about why you think this is. What are the risks if the person isn't seen quickly? Do you think the person might be able to wait a day or a week, or longer, to be seen, and if so, why?

Appendix 2: Case examples

You will see from the first case study below that you don't need to know everything about a person to make a referral, but that it is best to acknowledge where there are gaps in your knowledge. This is so that it doesn't seem you have simply left out information. In Joe's case, the lack of information may actually be quite informative. It shows he is quite guarded, which may be due to his mental state.

In the second case study, Mary, acknowledging the difficulties around engagement and her changeable responses to accepting help is likely to be useful to the mental health service in thinking about how they could engage with her.

Case study 1: Joe B

Dear Colleague

Re: Joe Bloggins. DoB 01/02/1960. Previously of 1 Abbots Close, NH7 PKY. Thought to have been rough sleeping under Cobbins Bridge since 2014. No contact telephone number or email, but can be contacted through my service as we see him regularly. This is my number ...

I would like to refer Joe to your service. We have been seeing him on and off for the past three years. He has always maintained that he does not want to move to settled accommodation and appeared to be making an informed decision to refuse our help.

Over the past three months, we have become increasingly worried about his behaviour, and more so in the past week or so. He seemed at his worst ever yesterday, hence the reason for the referral now. He seems more erratic, and often doesn't attend appointments, which is very unusual for him. He often appears fearful, and talks about how 'they' want to harm him, but he can't explain who 'they' are, or why they want to hurt him. He has been speaking about how he is a Hollywood movie star, fallen on hard times, but there is no evidence that this is the case – he has insisted we google him, but nothing comes up. We have seen him talking animatedly to himself regularly, but he denies this when we ask who he was talking to. He speaks very loudly and is far more irritable than usual. He usually eats well, but has been refusing meals over the past few weeks, and appears visibly much thinner. His self-care, which has always been somewhat poor, has noticeable declined, and he has pungent body odour and very dirty clothes. He is usually a cheerful person, but he seems really low, and seems despondent about the future now.

We helped Joe to register with a GP when he first came to our attention three years ago, and had hoped to get him seen by them now. However, he has refused, and they have told us that they have never seen him since his registration appointment. He isn't on any prescribed medication and the GP said he didn't disclose any medical problems on registration, though this isn't confirmed as they were never able to obtain his previous medical records. We suspect that Joe has previously been under mental health service care, but he has always refused to discuss this, so we can't be sure.

Joe hasn't talked at all about wanting to hurt himself or other people, and there is nothing in his current or historical (last three years) behaviour that suggests these are risks. However, we are very worried about his rapidly declining mental health and his poor self-care, and feel he is very likely to deteriorate further unless something is done soon.

We have never known Joe to use alcohol or drugs, and he has always said that they are 'poison' to him. It is therefore very out of character that we have seen him obviously intoxicated and smelling of alcohol several times in the last few weeks. He denies it when we ask if he has been drinking.

We are doing our best to keep engaging with Joe, although it is becoming increasingly difficult, as he isn't attending appointments regularly, and often isn't in his usual spot (again, unusual for him) when we try to visit him. We will continue to try to see him, and are trying to encourage him to eat, and use the washing facilities we can offer, but we haven't been very successful in this recently.

We feel very worried for Joe's wellbeing. Although there doesn't seem to be an immediate risk of him coming to harm, he is clearly deteriorating, and is likely to continue to do so, so we do feel he needs to be seen quite quickly as it seems likely he will need some medication and support to stop him getting any worse. It is also getting very cold, and Joe doesn't appear to be recognising the change in the weather. He hasn't changed the way he dresses, despite a massive drop in temperatures, and we see him walking around without a coat. He is leaving his sleeping bag exposed to the elements, although he used to tie it up somewhere dry, and we saw him sleeping in it despite it being wet through.

Because Joe seems quite confused at times, we are worried about his ability to recognise when he might be at risk from others, and to protect himself from harm. Because he is very irritable with people now, we are also worried he might be at risk of retaliation if he is irritable or aggressive to the wrong person.

We have been trying to work with Joe to see if he will agree to being referred, but as he is now largely disengaging, and there seems to have been a very recent and significant decline in his mental health, we have decided to refer at this point.

Joe can be very difficult to track down, so it's probably best to call me on my mobile number (provided above), and I will be able to suggest some times and places where it might be possible to see him. He knows me very well so it might be less stressful for him if I am there when he is assessed. He doesn't know yet that I have made this referral, but I will tell him as soon as I can find him, and will ask him if I can be there at his appointment.

Case study 2: Mary J

Dear Colleague

Re: Mary Jones. DoB 01/02/1980. Room 3, Star Hostel, Barrow Road (a supported project for people who we are helping to access more permanent accommodation). Her mobile number is 07938..., but she often doesn't answer, and said she is happy for you to contact us for more information or to make an appointment.

We would be grateful if you could please offer Mary an appointment.

Mary has a long history of substance misuse problems and traumatic life events. She has been with us for about two months, and we have become worried about her functioning and her self-harm.

Mary tends to become very distressed and angry when she perceives her needs are not being met, or she is being judged in some way, even when we are trying to help her as best we can. Her behaviour has become

increasingly erratic, and when she is upset, she makes very frequent (daily) threats to end her life. We have noticed some cuts to her arm, which she says she did with a razor because we had told her that she would need to find some more documents to help her housing application, and she said she didn't have these. The cuts didn't appear that deep and she declined to go and have them looked at. She has also started banging herself on the head with her fist repeatedly when she gets angry. Mary's threats to end her life are usually along the lines of "I may as well go and walk in front of a bus", rather than anything very specific in terms of when and where. She usually comes back an hour or so later, and denies any intention to harm herself, but it is alarming for staff and other residents at the time.

Mary often talks about feeling very lonely, and not having any friends, but her erratic behaviour means that other residents are wary of her, and tend to keep their distance. She is estranged from her family, and says she hasn't seen any of them for several years. She has very little in terms of meaningful activity in her life, and tends to spend lots of time walking around on her own.

Mary is currently trying to modify her substance use. She has denied any current drug use (she previously used to smoke cannabis daily, and use cocaine when people offered it to her). She is drinking about two cans of strong lager a day, which is a big reduction for her compared to four months ago, when she was drinking about six cans a day. She is keen to reduce it further, but doesn't want any specialist help to do so.

Mary has told us that she was physically and sexually abused by a close family member as a child, and that this was ignored by her wider family despite it being common knowledge. She has been in several abusive relationships in her adult life, both in terms of her being a victim of violence, and being a perpetrator of violence. She isn't currently in a relationship but has spoken a lot about how she is going to find someone to have sex with because she wants a baby. We feel very worried for her, as this doesn't appear to be a good idea for her at her current stage in life. She doesn't recognise that such behaviour could be dangerous to her safety or her health, or that it would be difficult to raise a child alone. She just says she would 'cope', though this seems unlikely as she really seems to struggle with most aspects of her life.

We have spoken with Mary's GP who feels a referral would be helpful. She doesn't really know Mary but said that she thinks it is likely that she has some personality difficulties. The GP doesn't feel any medication should be prescribed in primary care, but said it might be helpful for a psychiatrist to see Mary.

We are currently needing to provide a lot of help to Mary to stop her angry outbursts escalating, but we are finding this very difficult to manage, both in terms of knowing what would really help her, but also in terms of our staffing levels because she is needing so much more support than other residents, and this is taking support time away from other people. Her behaviour is so distressing to others that we are going to have to give her notice to leave if we can't do something to contain her better. The situation is really quite urgent, as we feel she is vulnerable and don't want to see her on the streets, but we may be left with little option if things don't improve in the next week or so.

I am not really sure how receptive Mary is going to be to this referral if I am honest. At times, she is very keen for help and has said she will take anything she is offered. At other times, she says she has no problems, and she doesn't want people interfering with her life. She might be more receptive if I offer to come with her.

I would be very grateful if you could please offer Mary an appointment as soon as you are able. I don't think this is an emergency situation, but as I have outlined above, we are really struggling with her, and she would be very vulnerable if she was out on the streets, so there is some urgency to her situation.



What we do

Homeless Link is the national membership charity for organisations working directly with people who become homeless or who live with multiple and complex support needs. We work to improve services and campaign for policy change that will help end homelessness.

Let's end homelessness together

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