Central and North West London NHS
NHS Foundation Trust

# Joint Homelessness Team

## Overview and Referral Guide

COMPASSION RESPECT EMPOWERMENT PARTNERSHIP

Wellbeing for life
London | Milton Keynes | Kent | Surrey | Hampshire

## Joint Homelessness Team (JHT)

**CONTACT DETAILS:**
*JHT Duty*
*Monday to Friday, 9am to 5pm, excluding bank holidays (Thursday 9am to 1pm)*
*Duty: 020 7854 4206*
*Fax: 0207 931 8087*
*Email: jhtduty@nhs.net*
*190 Vauxhall Bridge Road*
*London*
*SW1V 1DX*

Westminster City Council (WCC), West London Clinical Commissioning Group (WLCCG), Central London Clinical Commissioning Group (CLCCG), North London Housing Partnership and Central and North West London NHS Foundation Trust (CNWL) collectively commission the *Joint Homelessness Team* to deliver four specialist homelessness services:

- JHT Outreach
- Joint Assessment Service (JAS)
- Homelessness Prevention Initiative (HPI)
- Female Entrenched Rough Sleeper Project (FERSP)

## JHT Outreach

JHT Outreach is commissioned by Westminster City Council (WCC), West London Clinical Commissioning Group (WLCCG) and Central London Clinical Commissioning Group (CLCCG)

JHT Outreach forms part of a network of other providers and third sector partners in Westminster and is commissioned to provide an integrated and flexible service for rough sleepers as a route out of homelessness.

JHT Outreach complete street facing mental health, housing and social care needs assessments then provide intensive care co-ordination and case management for those assessed to have eligible needs.

**Our Vision**

- To offer a personalised recovery focused care pathway from the street to stable accommodation.
- To ensure those who are unwilling or unable to access mainstream mental health services, have the same access to health, housing and social care as the housed population.

As an integrated multi-disciplinary team, the team includes:

- Psychiatrists
- Community Mental Health Nurses
- Social Workers
- Approved Mental Health Professionals
- Support Workers
- Administrators

Making a referral

All referrals are processed through a duty system. A referral form must be completed for every new referral, either:

- by the referrer, then e-mailed to jhtduty@nhs.net
- or by the JHT Duty Worker who will take the information over the phone and complete the referral form on behalf of the referrer

All referrals are initially checked on the health and social care databases to see if the person is already known to another service. This check also enables the Duty Worker to establish any known concerns or risks.

Although JHT Outreach is not an emergency service some referrals are clearly more urgent than others and may require priority action. The JHT Duty Senior should be contacted in such cases.

All routine referrals should go to JHT Duty either by phone or email. For an emergency (4hr) or urgent (24hr) response the Single Point of Access service (SPA) should be the point of contact, on 0800 0234 650.

Referral Process:

JHT Outreach will accept a referral for anyone who is a CHAIN verified rough sleeper in Westminster and is unable or unwilling to access mainstream mental health services.

Any non verified rough sleepers need to be discussed on a case by case basis with the JHT Duty Senior. Referrals can be accepted for non-verified rough sleepers if there is significant concern identified and no other service is able to carry out the assessment.

For those placed in hostels (rough sleeping commissioned) or in temporary accommodation who appear to have mental health related health or social care needs, referrals should be made to either Great Chapel Street or Dr Hickey Practice or directly to SPA. JHT Outreach will consider hostel referrals where:

- An individual has a recent, long or intermittent history of rough sleeping in Westminster and has been in the hostel for less than three months

And

- There is real evidence that they are likely to abandon or be evicted in the near future as a result of mental health related behaviour

For hostel residents each referral should be discussed on a case by case basis between the hostel manager and the JHT Duty Senior.

No assessments will be started until a referral has been accepted.

Initial Assessments

All new referrals get discussed at the Thursday afternoon JHT Outreach Clinical Review Meeting (CRM), where a multidisciplinary team (MDT) decision takes place to decide how, when and where the assessment should take place.

It is very rare for a referral not to be taken on for assessment. Sometimes a case conference is held before the assessment takes place or the referral is sign-posted to another service that is better placed to complete the assessment.

Some assessments can take a long time to complete due to the transient nature of some street homeless people and the time of day they can be found.

As the police are no longer able to assist with assessments for those who pose a risk to workers, such referrals will need to be discussed on a case by case basis to determine how the individual can have their needs assessed.

The majority of those referred are either not able or not willing to attend building based appointments, therefore a more flexible and creative way of engagement is needed. The team currently provides:

- Weekly sessions at the Passage Day Centre and Connections at St Martins
- A weekly professionals meeting at West London Day Centre with planned assessments through-out the week
- Late and early street outreach with CAS and COMPASS
- Case Conferences, Safeguarding Meetings and Best Interest Meetings

The team completes an Initial Assessment after the first or second face to face contact to establish:

- Is there evidence of a mental impairment or illness?
- What are the risks to their health, self and others?
- Does the person lack capacity to make decisions about their current situation?

When the Initial Assessment is complete a multi-disciplinary discussion takes place with possible outcomes:

- Mental Health Act Assessment indicated
- Extended Assessment needed
- Allocated for care co-ordination and case management
- Case Conference needed
- Close, no further role for JHT Outreach

Case Management

Once allocated for case management the service user will have:

- Care Co-ordinator or Lead Professional

  A Community Mental Health Nurse (CMHN) or a Social Worker.

  Regular one to one contact, at least monthly but could be more if needed.

- Core Assessment

  Care Programme Approach (CPA) and Care Act 2014 compliant health, housing and social care needs assessment.

  This assessment is co-produced and should include information from all significant others.

  Mental capacity and best Interest forms part of this assessment.

  For those with no recourse to public funds (NRPF) a Human Rights Assessment will be completed to determine if the service user is eligible for support.

  The outcome of this assessment would determine the housing plan which could be a referral into registered care, spot placement, supported placement, general needs housing, sheltered housing or the Single Persons Housing Pathway.

  The outcome of this assessment would determine the identified needs to be addressed in the Care and Support Plan.

- Care and Support Plan

  The Care and Support Plan should clearly detail all the eligible needs identified in the Core Assessment, with evidence of how each need is going to be addressed.

Could include:

- *Evidence-based treatment (NICE)*
- *Psycho-social interventions*
- *Medication management and psycho-education*
- *Talking Therapies*
- *Social Care Provisions - Personal Budget for those who are eligible with unmet needs*
- *Placement or Floating Support*
- *Section 117 Aftercare Needs*
- *Community Treatment Orders*
- *Guardianship*
- *Appointeeship/Deputyship*
- *Subsitance payments (Localism Act)*

If needs are indentifed that can't be met within the resourse of the team, JHT Outreach has referral rights into mental health services provided by CNWL and social care provisions provided by Westminster City Council – examples being; Occupational Therapy, Psychology.

If s117, Human Rights Act and Care Act needs are idenfied for non-UK nationals with no recourse to public funds, funding with be sought via the Westminster Funding Panel.

- <u>CPA Review Meeting</u>

  At least once a year, or more frequently if needed, to review the service user's ongoing needs and their Care and Support Plan.

  For those in a placement this would also be the Placement Review.

<u>Other functions of the team</u>

JHT Outreach has access to crisis beds and a small budget for short term crisis accommodation for those who are at significant risk on the street and need to be somewhere safe for the assessment to take place.

JHT has gate-keeping responsibility for 90 Supporting People Placements for mentally ill verified rough sleepers, ranging from registered care to independent flats with floating support.

JHT Outreach is part of the Integrated Care Network (ICN) for Homeless Health in Westminster. The ICN is a multi-disciplinary network formed from statutory and third sector

organisations to facilitate case management for those identified as a priority by health services and in need of access to intermediate care beds. A key component of the ICN is **Intermediate Care**, for people needing more support than primary care (GP) and less than hospital care. It will be clinically led by the specialist Homeless General Practices in Westminster and the main focus will be on the case management of patients registered with the practices who require intermediate care.

JHT have referral rights into ICN intermediate care beds (sourced from the current stock of mental health and homelessness provisions), where there is a need for further health care, but outside the acute mental health setting.

As a statutory service JHT Outreach carries out Safeguarding Adults Investigations for those service users open to the team. Seniors are trained as Safeguarding Adults Managers and Care Co-ordinators are trained as Investigators.

Closure

JHT Outreach provides a care pathway from the street to stable accommodation. Once someone is in stable accommodation they are transferred to primary care, or to mainstream secondary mental health services if they still have mental health, housing and social care needs.

## Joint Assessment Service (JAS)

The core function of JAS is to carry out Assessments of Vulnerability under Housing legislation for people who present at the Housing Options Service (Westminster's Housing department).

JAS is funded by the Housing department of Westminster. It works in close partnership with the third sector providers of floating support services.

JAS is a uni-disciplinary team of social workers.

The aim of the service is to make a determination about vulnerability and, where appropriate, to ensure that housing applicants are linked in with mental health services.

The servcie provides housing support until the person is settled in permanent accommodation

Referral process

Housing applicants referred to JAS are usually single (but multiple applicants are not excluded so long as they have no dependent children living with them – people with dependent children are dealt with via other services at HOS). The applicant will have presented to HOS as homeless/ threatened with homelessness. They will have informed the caseworker that they have mental health issues or the housing officer will have reason to

believe from the applicant's behaviour or statements that this might be the case. At the point of referral for an AOV, applicants will be temporarily accommodated, pending the outcome of housing's investigations into their application.

The majority of assessments are carried out by a JAS worker at Housing Options, and there is currently a weekly session with allotted time slots.

The Assessment of Vulnerability

The JAS assessment is called an Adult Mental Health Assessment of Vulnerability (AMHAOV) usually abbreviated to "AOV". The legislative framework for the assessment is Part VII of the Housing Act 1996 and the Homelessness Act 2002.

The AOV takes into account the medical and social aspects of the applicant's situation. It is also designed to demonstrate the link between the person's mental health and their lack of ability to fend for themselves if homeless.

Although the JAS AOV will concentrate on addressing the threshold for vulnerability on mental health grounds, the assessment will be holistic and will highlight any other areas of vulnerability or issues which may qualify the person for priority need, to ensure that the caseworker has all the facts for the composite test.

Recommendations made by JAS

JAS workers make recommendations concerning vulnerability. However, JAS does not make the decision about vulnerability. The caseworker makes the decision and uses the information provided in the AOV to inform the decision. The AOV is part of the process of enquiries made by the HOS prior to accepting or rejecting an applicant.

JAS workers may also provide opinions about the intentionality of an applicant's homelessness based on the information gathered during the assessment process. Sometimes mental health issues may account for an act or omission. Intentionality is defined in Section 191 of the Housing Act 1996 and the Code of Practice Chapter 11: *"An applicant is homeless intentionally if they deliberately do or fail to do something in consequence of which they cease to occupy accommodation which is available for their occupation and which is (or would have) been reasonable for them to continue to occupy."*

Work with the Medical Advisor

- A member of the JAS Team meets with the Medical Advisor on a fortnightly basis, or as required, to consider the suitability of an allocation or medical priority for transfer where there is a mental health component to the person's needs.
- The JAS worker will not provide advice where the member of the household with mental health issues is under 18, as Child and Adolescent Mental Health is a separate specialism.

Training

- JAS will provide mental health training to HOS staff on a quarterly basis
- JAS will also be involved in the housing training for mental health staff alongside the commissioners for the various housing pathways.

Housing panel membership

- The Team Leader will be a member of the panels for sheltered and supported housing within the borough of Westminster

Making a referral to JAS

Only Westminster Housing Options can refer to JAS.

## Homelessness Prevention Initiative (HPI)

The HPI is a team of Social Workers, Mental Health Nurses and Peer Support Workers. Although it is managed within community services, the majority of the team's work takes place within the acute mental health inpatient setting.

The service will usually operate between 9am and 5pm Monday to Friday. However, flexible arrangements can be made outside these times.

Aim of the service

This service provides a personalised recovery-focused rapid response for service users admitted to hospital in Kensington Chelsea and Westminster (KCW), who are either homeless or at risk of losing accommodation.

Target Group

All service users admitted to KCW Inpatient Units who are either homeless at the point of admission or have a tenancy-at-risk.

Service users open to the Joint Homelessness Team will not be included in this group as they already receive a similar level of service.

Service users already open to KCW community mental health teams at the point of admission will not be included but Care Co-ordinators can ask for guidance and support with complex community care assessments for tenancy issues.

Core Functions

Identification

- Identification of all service users who are homeless or have a tenancy-at-risk within 24hrs of admission (Monday to Friday excluding Bank Holidays)
- Undertake a face-to-face Initial Assessment within 48 hrs (Monday to Friday excluding Bank Holidays)

Reconnection

- For those service users with no housing, health or social links to KCW - assist wherever possible through mediation and negotiation to re-establish links with family/support networks outside of KCW.
- Work closely with reconnection services.
- Work closely with foreign embassies to facilitate timely repatriation.
- Explore the use of Section 86 of the MHA (removal of alien patients [sic]) reports for foreign nationals, to ensure successful repatriation where appropriate.
- Work closely with the UK Border Agency (UKBA) to assist service users to repatriate where appropriate.

Community Care and Housing Assessments

- Work intensively in partnership with the service user to complete the Core Assessment and housing referral within in 28 days. Peer Support Workers are central to the process of engaging with service users, and ensuring that their own words are central to the assessment.
- Complete Adult Social Care eligibility criteria to determine if social care is needed.
- Formulate a discharge housing plan within 14-28 days.
- Post discharge ongoing assessment for those placed in the Step-Down Bed (Westminster only).

Peer Support Care Navigation

- Assist/accompany service user to get Identification and visit embassies.
- Assist service user to establish benefit entitlement and claims.
- Assist service user to ensure accommodation is ready at the point of discharge.
- Assist service user to register with primary care if links to KCW established.

Preventing Homelessness

- Mediating and negotiating with Housing Options, Housing Benefit, Hostels, Housing Associations and Landlords to preserve tenancies at risk.
- Work closely with Benefit Agencies to re-establish benefit claims and entitlement.

Making a referral to HPI

Only CNWL inpatient services can refer to HPI.

## Female Entrenched Rough Sleeper Project

A Community Mental Health Nurse working with a cohort of 45 female entrenched rough sleepers comprising:

- mostly older females who wander across the boroughs of London, rarely bedding down or engaging with services

and

- a smaller group of more chaotic younger women who are unable to sustain accommodation due to complex trauma and/or anti-social behaviour

The project provides a specific lead practitioner who utilises the knowledge, experience and networks established within the JHT to better understand these women in an attempt to achieve positive outcomes, not just about housing but around quality of life and choice.

The project supports multi-agency case management with good joint working across borough boundaries and with the involvement of statutory and third sector organisations. Multi-agency case conferences enable housing and support plans to be developed in a creative and collaborative way with buy-in from all stakeholders.

This is a cross-boundary initiative and is imbedded in the Pan London Wanderers Group and the Pan London Women's Outreach Network

Referrals to FERSP

All referrals are agreed via the Pan London Women's Outreach Network Group.