

2nd edition

# MENTAL HEALTH SERVICE INTERVENTIONS FOR ROUGH SLEEPERS TOOLS AND GUIDANCE

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Hosted by Pathway, in partnership with Lambeth Council, South London and Maudsley NHS Trust, ThamesReach, the Greater London Authority and EASL

I am a consultant psychiatrist and have worked for 25 years with homeless people with serious mental health problems.

For some people who sleep out, a major mental illness has both been the cause of homelessness and also the thing that is keeping the person homeless. It is even mentioned in the ICD, one of the two major systems for classifying diseases and disorders. This observes of some forms of schizophrenia that “with increasing social impoverishment, vagrancy may ensue”.

Some such people do not report clear symptoms or show clear signs of mental illness. However, the people who know them best can see that there is a real problem. The individual will often neglect their self care, sometimes to appalling extremes. They can't bear the presence of other people, keep themselves very much to themselves and may react angrily when approached. They may say little (or nothing) and show no obvious emotional expression. How can we make sense of this picture?

The problem is that psychiatric diagnosis is usually based on what someone tells me as a psychiatrist. It is much more difficult when I meet someone whose behaviour and history are typical of a psychotic disorder, yet who will not tell me how they are thinking or feeling.

That is why a central feature of this guidance is the use of the Mental Capacity Act to assess the mental state of someone making decisions involving sleeping on the street. Although a conventional “diagnostic interview” may offer no compelling evidence of mental disorder, a mental capacity assessment can clearly demonstrate the result or consequences of such a disorder i.e. the inability to make a particular decision.

My hope is that these tools and guidance will help those working with street homeless people – and those working in mental health services – to better assess and help those who are doubly socially excluded both by homelessness and by serious mental illness.

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These screening tools and guidance were initially developed by a project team comprising of statutory and voluntary sector representatives, and was funded by the GLA and London Borough of Lambeth. The first edition – authored by Jane Williamson & Paul Emerson from SLAM – now requires updating with new requirements such as the Care Act 2014, as well as learning from the application of the screening tools.

The project was set up after a Serious Case Review, published in September 2012, undertaken by the Lambeth Safeguarding Adult Partnership Board. The review concerned a mentally ill person who was sleeping rough and died on the street in the winter of 2010. He had previously been under the care of mental health services and had contact with street outreach teams, ambulance crews and police at his rough sleeping site. He refused all the help that was offered and subsequently died on the street. The Serious Case Review panel decided that it would be helpful to develop a common set of protocols and tools for services working directly with people sleeping rough on the streets.

It is clear that not all homeless people who sleep out are suffering from a mental illness. However across London there is a small but significant group of people who have been sleeping rough for many years and are refusing to accept help to move from the streets. A key theme in the exclusion of such homeless people from mental health services has been an idea that sleeping rough is a lifestyle choice. The experience of the START Team, a community mental health team with over 20 years of working with people sleeping rough, is very different.

**Initial engagement with people sleeping rough should be informal and collaborative, and where possible focussed on the needs identified by the person. This guidance is intended for use when all other forms of engagement have failed, been rejected or the situation is very urgent due to significant risk. The aim is to help workers assess mentally ill people sleeping rough and elicit appropriate responses from statutory agencies.**

The tools and guidance may also be of use when trying to support hostel residents and other vulnerable adults in any setting who are at risk, not engaging constructively and there is evidence of possible impairment of, or disturbance in the functioning of the mind or brain.

This document therefore includes:

- Guidance on assessing the risks associated with rough sleeping
- Guidance on the use of the Mental Capacity Act – is this individual really making an informed decision to sleep on the streets?
- Guidance on the use of the Mental Health Act and developing a hospital admission plan
- Guidance on raising safeguarding adults alerts

The tools and guidance can be found on the Pathway, ThamesReach and Homeless Link websites here:

<http://www.pathway.org.uk/services/services/mental-health-guidance-advice/>

<http://www.thamesreach.org.uk/publications/research-reports/mental-health-service-interventions-for-rough-sleepers-toolkit/?locale=en>

There is also a helpline contact available at **mentalhealthenquiries@pathway.org.uk**; tel: **020 3291 4184 (answering service)** provided by **EASL (Enabling Assessment Service London)**. Enquiries will be responded to within 5 working days.

**Risk assessment**

Assists practitioners in assessing some of the particular risks associated with rough sleeping.

**Mental Capacity Act screening tool**

Enables a formal assessment of a person's capacity to make decisions and in particular their decision to stay on the street.

Person sleeping rough is refusing offers of help e.g. accommodation, health care, practical support.

**Mental Health Act screening tool**

Enables outreach workers to assess whether a referral for a Mental Health Act assessment is appropriate.

**Hospital admission plan**

Aims to help ensure that the hospital admission provides effective assessment, interventions and discharge plans for the person sleeping rough.

**Safeguarding adults guidance**

Assists practitioners to raise safeguarding alerts in respect of people sleeping rough.

# RISK ASSESSMENT

This guidance is designed to assist practitioners in assessing some of the particular risks associated with sleeping rough.

## Key pointers for all practitioners for good practice in assessing risk

- These pointers should be used to identify some of the particular risks associated with sleeping rough. They should be used to supplement and not replace agencies' own risk assessment tools.

**Key factors for all practitioners (outreach workers, approved mental health professionals, doctors, police, ambulance staff) to consider when assessing risks associated with sleeping rough.**

### Demographic factors

- Is the person's age, gender, sexual orientation etc. likely to lead to an increase in concern about their vulnerability?

### Current physical health

Is the person:

- in poor physical health?
- refusing to attend to their physical health needs?
- having difficulty accessing physical health care?
- using drugs or alcohol?
- maintaining adequate personal hygiene?
- accessing adequate food and drink?

Are physical health problems being exacerbated by sleeping rough?

### Current mental health

Is the person:

- actively isolating themselves?
- looking anxious or scared
- confused and/or disorientated?
- talking aloud to themselves or others who are not there?
- withdrawn, slow in response or uncommunicative?
- angry, threatening and aggressive?
- refusing to attend to their mental health needs?
- having difficulty accessing mental health care?

### Current or expected weather conditions

Does the person:

- have appropriate clothing for the weather conditions?
- have warm bedding?
- use day centres or other facilities to shelter from the weather?

Is the sleep site sheltered and dry?

### Level of isolation

Is the person:

- isolating themselves from others?
- receiving support from other people sleeping rough or family and friends?
- avoiding services and support provided by homelessness services?
- likely to develop a trusting relationship that may lead to them accepting accommodation?

Is the sleep site safe?

### Monitoring arrangements

- Is it possible to monitor the person effectively?
- Is it possible to implement a plan to reduce risk?
- Is joint working needed with other agencies such as day centres and street outreach teams?

### Access to welfare benefits or other statutory support

Is the person:

- entitled to support from statutory services?

(Consider duties towards them under Housing Legislation [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/7841/152056.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/7841/152056.pdf)

or if they "No Recourse to Public Funds" other legislation <http://www.nrpfnetwork.org.uk/guidance/Pages/default.aspx>)

- able to organise themselves to claim benefits?
- experiencing paranoid ideas that prevent them engaging in official processes?

### Pattern of homelessness

- How long has the person been sleeping rough?
- Are they constantly moving from place to place?

These factors may provide a framework to refer the person sleeping rough on to appropriate services.

Adapted from Lipscombe, S (1997)

### Particular risks to consider when carrying out a Mental Health Act assessment (or a mental capacity assessment/ best interests decision)

Be mindful of any potential risks associated with the sleep site. Try to arrange a meeting point for the assessing team that is well lit and not too isolated as the assessment may need to take place early in the morning or late in the evening.

- Is the sleep site safe?
- Are there others with the person sleeping rough who may pose a risk?
- Are members of the public likely to get involved?
- Does the person have a history of violence?
- Does the person have a dog?
- Does the person have a weapon?

### The ABC model of risk

When contacting the police it may be useful to collate risk information under the headings below using this model. It is being adopted by the Metropolitan Police as a way of assessing risks to vulnerable people. It identifies five key areas to be assessed

- **Appearance and atmosphere:** What the assessor first sees in a person in distress, including physical problems such as bleeding.
- **Behaviour:** What the person in distress is doing, and whether this is in keeping with the situation and their usual self.
- **Communication:** What the person in distress is saying and how they are saying it.
- **Danger:** Is the person in distress in danger and are their actions putting other people in danger?
- **Environment:** Where is the person in distress situated, and is anyone else there?

McGlen I, Wright K, Croll D (2008)

# THE MENTAL CAPACITY ACT 2005

This includes key pointers for good practice for all practitioners using the Mental Capacity Act to assess a person's capacity to make a decision.

## Key pointers for good practice in use of the Mental Capacity Act 2005 (MCA)

### Key factors for all practitioners (outreach workers, approved mental health professionals, ambulance staff, doctors, police) to consider

#### • Be clear what the decision is about e.g. consent to:

- assessment for treatment or care
- provision of treatment or care
- being conveyed to hospital or a care home
- going to a hostel or other accommodation

#### • Be clear why the decision needs to be made at that point in time e.g. risk to self because of:

- indication of a severe mental health problem(s)
- indication of a severe physical health problem(s)
- intoxication
- severe weather
- severe self neglect
- possible threat from others (but this may also require a police/safeguarding response)
- Is there evidence that the person may lack mental capacity to make the decision because of a known/suspected mental health problem, learning disability, brain injury, dementia, or intoxication, even after as much help as possible has been given to them to understand the decision? If so, an assessment of capacity should be carried out.
- If there is an indication of a mental disorder and the person is posing a risk to themselves or others then an assessment under the Mental Health Act should be considered.

### Key factors for practitioners carrying out an assessment of capacity and best interests decision under the MCA

- Start off by assuming the person has capacity to make the decision (**first principle of the MCA**) – but if you are unsure then an assessment of capacity should be carried out (see below).
- Make sure that as much help as possible is given to the person to understand and make the decision themselves (**second principle of the MCA**) – but if you are still unsure if they can make the decision then an assessment of capacity should be carried out (see below).
- If the person's decision appears unwise, eccentric or odd this is not necessarily proof they lack capacity (**third principle of the MCA**) but if you are unsure then an assessment of capacity should be carried out (see below).

- Their capacity to make the decision should also not be judged solely on the basis of their appearance, behaviour, age or condition. Make sure they are free from external pressures when making the decision and if possible, consult with others who know the person when carrying out the assessment.
- If there is evidence that the person has an “impairment of, or disturbance in the functioning of the mind or brain” (as indicated by a known or suspected mental health problem, learning disability, brain injury, dementia, or intoxication) then this may indicate a lack of capacity and the MCA four stage assessment of capacity should be carried out (more information about this is in the MCA Code of Practice). This involves finding out if the person can:
  - understand the information involved in making the decision;
  - retain the information long enough to make the decision;
  - use or weigh up the information to make the decision;
  - communicate their decision.

## Key pointers for good practice in use of the Mental Capacity Act 2005 (MCA)

- If on the **'balance of probabilities'** the person is able to do all four of the above then they have capacity to make the decision – even if this is an unwise one.
- If on the **'balance of probabilities'** the person is unable to do one or more of the four stages above then they lack capacity to make the decision and a **'best interests'** decision needs to be made (**fourth principle of the MCA**) on behalf of the person regarding the decision in question (e.g. does the person need treatment, conveying to hospital, etc.?).
- The best interests 'checklist' contained in the **MCA** and the **MCA Code of Practice** should always be followed. This includes:
  - involving the person as much as possible in the decision;
  - considering whether the person might have capacity to make the decision at some point and what their decision would be;
  - the person's known wishes and feelings, beliefs and values that relate to the decision;
  - not making a best interests decision based solely on the person's age, appearance, behaviour or condition;
  - if possible and appropriate, getting the views of others who have been named by the person to consult with, or who are providing care or support to the person;
- if there is no-one to consult with other than paid staff and the decision involves going into hospital, a care home, or serious medical treatment then an **independent mental capacity advocate (IMCA)** should be involved.
- A best interests decision should be made on the **'balance of probabilities'**. It should always take into account alternatives that are **'less restrictive of the person's rights and freedoms'** (**fifth principle of the MCA**), providing it is still in the person's best interests.
- If a best interests decision is made involving **"acts in connection with care or treatment"** these can be carried out under the authority of the MCA. If necessary, the MCA allows you to use restraint to carry this out, but the restraint must be proportionate to the likelihood of the person suffering harm and the seriousness of that harm if the care or treatment is not provided. For example, if someone has severe, life-threatening hypothermia and lacks capacity to consent to going into hospital but is physically resisting being taken in an ambulance then physical restraint could be used. However, if their physical health problems were non-life threatening and they were resisting, using physical restraint to take them to hospital would not be permissible, even if hospital had been deemed to be in their best interests.
- When doing a mental capacity assessment or best interests decision it may be useful to consider the risk factors in the risk guidance for carrying out a Mental Health Act assessment.
- Make sure you record:
  - the assessment of capacity;
  - the outcome of the assessment;
  - the best interests decision;
  - any actions in connection with the person's care or treatment that were based on the best interests decision, including any use of restraint.

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### Other helpful resources

- The MCA Screening Tool is designed to help guide you through this process.
- The MCA Code of Practice gives important guidance on how to follow the principles of the MCA, carry out an assessment of capacity and best interests decision, and provide care and treatment to people who lack capacity. If you are doing an assessment of capacity or best interests decision you should refer to this.

# THE MENTAL CAPACITY ACT SCREENING TOOL

This tool is designed to enable a formal assessment of a person's capacity to make decisions, and in particular their decision to stay on the street.



# Mental Capacity Act (MCA) screening tool for street outreach teams

Name of person:

DOB:

Rough sleeping location:

Date of assessment:

**1**

What is the decision the person you are concerned about needs to make, and why do they need to make this decision now?

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**2**

Yes

No

Is there reason to believe that the person may lack mental capacity to make the decision due to a known/suspected mental health problem, learning disability, brain injury, dementia or intoxication?

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**3**

Yes

No

Has sufficient information been given to the person to help them understand the decision?

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**4**

Yes

No

Have all practicable steps been taken to support the person to make the decision?

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**5**

Yes

No

Is it felt that the person is free from external pressures to make their decision?

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# Mental Capacity Act (MCA) screening tool for street outreach teams

## Assessment of capacity

If the person is unable to demonstrate their ability in one or more of the four areas below, then they lack capacity to make the decision and it needs to be made in their best interests.

**6** Yes  No

Can the person understand in simple language the information involved in making the decision?

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**7** Yes  No

Can they retain the information long enough to make the decision?

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**8** Yes  No

Can they use or weigh up the information to make the decision?

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**9** Yes  No

Can they communicate their decision (whether by talking, using sign language or any other means)?

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**10** Yes  No

The decision: does the person on the balance of probabilities have the capacity to make the specific decision at this particular time?

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**11**

How did you decide what was in the person's best interests?

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**12**

What action should be taken in the person's best interests?

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Name of person completing form:

Date:

# Guidance regarding the Mental Capacity Act screening tool

- Please outline reasons under each section. Do not simply answer yes/no

## 1 What is the decision the person you are concerned about needs to make, and why do they need to make this decision now?

Examples may include a decision to go to hospital regarding physical health problems or to accept an offer of accommodation.

Can the decision making process be delayed?

## 2 Is there reason to believe that the person may lack mental capacity due to a known/suspected mental health problem, learning disability, brain injury, dementia or intoxication?

The person must be assumed to have capacity unless proved otherwise. If you answered 'no' then they are assumed to have capacity and no further assessment is required.

If you answered 'yes' then the assessment moves to the next stage.

You will need to outline any behaviour that leads you to suspect that this is the case, although a clear diagnosis is not required.

## 3 Has sufficient information been given to the person to help them understand the decision?

This should include the nature of the decision, the reason why it is needed and the likely effect of deciding one way or another or making no decision at all.

If the decision is about moving to hostel accommodation you should provide relevant details which may include photos, written information or an informal visit.

## 4 Have all practicable steps been taken to support the person to make the decision?

A person should not be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

Record details of discussions with the person about the decision.

## 5 Is it felt that the person is free from external pressures to make their decision?

For example, are they being pressurised by friends or acquaintances?

## 6 Can the person understand in simple language the information involved in making the decision?

Ensure that the options have been explained clearly and use interpreters or other forms of communication as required.

## 7 Can they retain the information long enough to make the decision?

The person must be able to hold the information in their mind long enough to make an effective decision. They only need to show that they are able to retain the information specific to that decision.

## 8 Can they use or weigh up the information to make the decision?

Is it felt that the person is able to understand the principle risks and benefits of what is proposed?

The person may understand the information, but an impairment or disturbance stops them using or weighing this up. For example a person sleeping rough may be able to demonstrate that they understand the consequences of refusing accommodation but paranoia or delusional beliefs prevent them from using this knowledge to make their decision.

The person may agree that refusing health care puts them at serious risk but still decline help. This could be seen as demonstrating an inability to use and weigh the information.

## 9 Can they communicate their decision (whether by talking, using sign language or any other means)?

If a person is sleeping rough and not speaking despite being at significant risk you may decide that they lack capacity.

Failure to communicate may also be due to inebriation or unconsciousness.

## 10 The decision: does the person on the balance of probabilities have the capacity to make the specific decision at this particular time?

Indicate here under which of the four criteria the service user demonstrates that they lack capacity. There is no need to repeat the details of why this is the case.

## 11 How did you decide what was in the person's best interests?

Indicate here how you followed the best interests 'checklist'.

## 12 What action should be taken in the person's best interests?

This space allows suggestions to be made as to what that action might be.

It may be advisable to consider the options of 'taking action' or 'not taking action', looking at the advantages and disadvantages of each.

Any action taken should be the least restrictive of the person's rights and freedom in line with the fifth principle of the MCA, providing it is still in the person's best interests.

# THE MENTAL HEALTH ACT 1983

This includes key pointers for good practice for all practitioners in use of the Mental Health Act.



## Key pointers for good practice in use of the Mental Health Act 1983

### Key factors for all practitioners to consider when working with a person sleeping rough who may have a mental disorder.

#### Be clear about any signs of mental disorder that you are aware of:

- You are not expected to make a diagnosis or use jargon, simply describe the appearance or behaviour of the person.
- Describe if/how the person's health has deteriorated.
- Are the problems severe or acute?
- Are you aware of any previous psychiatric history or diagnosis?

#### Be clear about any concerns that you have about the person's health or safety or the risk that they present to others

In order to meet the criteria for detention under the Mental Health Act (MHA) the person needs to present a risk to either their own health OR their own safety OR to the safety of others. A risk in any one of these categories is sufficient to consider assessment under the MHA.

Concerns about health could include:

- Physical health
- Mental health

Concerns about safety could include:

- Self neglect
- Self harm
- Suicide
- Environment
- Threat from others
- Threat to others
- The latter two may also require a police or safeguarding response.

#### Be clear about what other support or interventions have already been offered

- Accommodation
- Practical support- food, clothing, finances
- Day care
- Medication or treatment
- Informal hospital admission

#### Be clear about any other people involved

- Day centre staff
- Outreach workers
- Friends
- Carers
- Relatives

#### Other helpful resources:

The *MHA Code of Practice* gives important guidance on how to follow the principles of the MHA.

The *MHA screening tool* is designed to help guide you through this process.

# THE MENTAL HEALTH ACT SCREENING TOOL

This tool enables outreach workers to assess whether a referral for a Mental Health Act assessment is appropriate.



# Mental Health Act 1983 screening tool

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**Name of person:**

**DOB:**

**Rough sleeping location:**

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**1**

**Yes**

**No**

Is the person showing signs of mental disorder to the extent that they need admission to hospital for assessment and or treatment?

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**2**

**Yes**

**No**

Is the person presenting a risk to their own health or safety or to other people?

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**3**

What other support or interventions have already been offered?

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**4**

**Yes**

**No**

Are there any relatives, carers or other services involved?

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**Name of person completing form:**

**Date:**

# Guidance regarding the Mental Health Act 1983 screening tool

- Please outline reasons under each section. Do not simply answer yes/no

## 1 Is the person showing signs of mental disorder to the extent that they need admission to hospital for assessment and or treatment?

- For many people sleeping rough you may not be able to provide details about the person's psychiatric history or diagnosis as this information may be unknown or unclear.
- Describe how the mental disorder is being exhibited e.g. actively isolating themselves, talking aloud to others who are not there.
- Drug or alcohol dependence alone is not considered to be a mental disorder under the Mental Health Act (MHA). However it may be accompanied by a mental disorder which does fall within the Act.
- If possible state why you believe that the person's refusal to accept accommodation or support is linked to a mental disorder in order to challenge the assumption that the person is making a lifestyle choice.

## 2 Is the person presenting a risk to their own health or safety or to other people?

- Health and safety risks may also include the person's level of self neglect compared with other people sleeping rough, e.g. lack of shelter at sleep site, very poor self care and nutritional intake, refusal to attend day centres or accept offers of clothing, food and drink.
- Untreated mental illness, especially where it is leading to a person becoming homeless may constitute a risk to health.

## 3 What other support or interventions have already been offered?

The approved mental health professional (AMHP) should consider the least restrictive alternative so it is important to provide details of the following

- Are there any alternatives to detention in hospital?
- Can the person receive the assessment or treatment in any other way?
- Are they willing to go to hospital voluntarily?
- Are there any other ways that risk can be reduced?
- Is there any accommodation available for the person?

## 4 Are there any relatives, carers or other services involved?

The AMHP should contact other relevant people and for some sections of the MHA will need to consult with the person's nearest relative. Many people sleeping rough have lost contact with relatives; however it will be helpful to provide any details that you have.

## Principles for AMHPs and doctors carrying out a MHA assessment

- You should ensure that any decisions taken maximise the safety and mental and physical wellbeing of the person being assessed.
- You should work to promote the person's recovery.
- You should protect other people from harm.
- You should attempt to use the least restrictive option.
- You should recognise and respect the diversity of the person being assessed and take factors such as ethnicity, age, gender into account.
- You should consider the views, wishes and feelings of the person.
- You should give the person the opportunity to plan, deliver and review their own treatment as far as possible to ensure that it is appropriate and effective.
- You should encourage involvement of carers or other interested people.

(MHA Principles - MHA Code of Practice)

# Guidance regarding the Mental Health Act 1983

## Key factors for AMHPs to consider in setting up a Mental Health Act assessment for a person sleeping rough.

### Relevant sections of the MHA

- People sleeping rough will usually be assessed under Section 2 MHA.
- Section 3 may be more appropriate for people who are well known to services, where there is a clear diagnosis and treatment plan.
- Section 4 for emergency assessment, or police powers under Section 136 may need to be considered in urgent situations.
- Section 135 warrants for police to search for and remove persons are not usually needed. (see below)
- Section 7 and 8 use of Guardianship may be considered to require a person to live in a specified place.

### Doctors

Involve a doctor who knows the person or who has knowledge and expertise in assessing people sleeping rough, wherever possible.

### Location of the assessment

The law does not prevent a Mental Health Act assessment taking place on the street; however it can be difficult to interview the person in a public place. If the person attends a local day centre it may be preferable to arrange the assessment there.

If the assessment has to take place on the street it is important to gather information about the person's patterns of activity and sleep site prior to the assessment. Street outreach teams, community wardens, police safer neighbourhood teams, and park department staff are often good sources of information.

You will need to check the following:

- What times does the person sleeping rough bed down or get up in the morning?
- Where else can the person sleeping rough be seen other than their sleep site?
- If the assessment needs to take place at the sleep site at what time might it be least busy to minimise disruption and maximise confidentiality? (E.g. avoiding rush hour or lunchtimes)
- Is there a place nearby which is more private? (E.g. a quieter side street or park).
- Is the sleep site on private land and if so is a Section 135 (1) warrant required?
- Does the person attend a day centre?
- What times and days of the week do they attend?
- Do day centre staff agree that the assessment can take place on the premises?

### Warrants

- A Section 135 warrant is not necessary if the assessment is taking place on the street. However an AMHP may need to consider applying for a warrant if the assessment is taking place in the public area of a day centre.
- Other locations which may require a warrant are abandoned cars and buildings.

### Applying to the magistrate for a warrant

Below are some points you may want to consider when providing the information to the Magistrate.

- Have you made reasonable attempts to access the sleep site and interview the person without a warrant?
- Does the person have a history of not engaging with services?
- Are there risks associated with accessing the sleep site without police?
- Is there a risk that the person will change sleep site and be lost to services?

### Personal safety – see Risk Section

- Has consideration been given to a suitable rendezvous point?

Try to arrange a meeting point for the assessing team that is well lit and not too isolated as the assessment may need to be set up early in the morning or later in the evening.

### Alternatives to hospital admission or detention under the MHA

- Is there suitable temporary accommodation available including hostels, night shelters or bed and breakfast hotels?
- Does the local mental health crisis intervention team work with people sleeping rough? Are they willing to assess?
- Will the person sleeping rough attend a day centre or engage with other services to reduce risk?

- Is the person willing to go to hospital voluntarily?
- Could Guardianship be used as a less restrictive alternative?
- Have you considered use of the Mental Capacity Act?

### Police powers under Section 136 of the Mental Health Act 1983

Police are often called out to attend to people sleeping rough and have powers under Section 136 to take a person to a place of safety for assessment. Police officers will need to be satisfied that the person appears to suffer from a mental disorder and that they are in immediate need of care or control.

If you need to call the police it is useful to use the ABC model referred to under the Risk Section.

Police will usually expect mental health services to intervene if the situation is not urgent rather than use Section 136. However if there is an urgent situation that requires immediate action use of Section 136 may be appropriate. Various factors such as severe weather may influence this decision.

It may be useful for the outreach worker to attend the 136 suite with the police to assist with providing information for any subsequent assessment, and help with alternatives to admission if the outcome is not to admit.

If the police agree to consider use of Section 136 the Mental Health Trust should identify the place of safety. If the person sleeping rough is detained under S136 conveyance to the place of safety should be by ambulance unless there is good reason to convey in a police vehicle.

If the person is admitted to hospital it is also useful to provide a hospital admission plan wherever possible.

# THE HOSPITAL ADMISSION PLAN

This plan aims to help ensure that the hospital admission provides effective assessment, interventions and discharge plans for the person sleeping rough.

# Hospital admission plan

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**Name of person:**

**DOB:**

**Rough sleeping location:**

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**1**

Reasons why hospital admission is needed, (attach MHA Screening Tool)

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**2**

Evidence of mental disorder

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**3**

Risks to self and others

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**4**

Details of previous psychiatric history (if known)

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# Hospital admission plan

## 5

What other support and interventions have already been offered?

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## 6

Does the person lack capacity? If so, attach the MCA Screening Tool

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## 7

What factors will indicate that the person is ready for discharge?

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## 8

What actions need to be taken by ward staff and/or others to facilitate appropriate discharge?

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Name of person completing form:

Date:

# GUIDANCE ON RAISING SAFEGUARDING ADULTS ALERTS

This guidance aims to assist street outreach workers and other practitioners to raise safeguarding alerts regarding people sleeping rough.

## Key pointers for good practice in raising safeguarding concerns

### Key factors for all practitioners (outreach workers, approved mental health professionals, ambulance staff, police) to consider

- A Safeguarding Adults Enquiry is a multi-agency response, coordinated by a local authority, with the aim of producing a shared understanding and shared decision making in situations where people with care and support needs are at risk of experiencing harm or abuse. This may be an alternative approach to manage the risks faced by a person sleeping rough.
- Safeguarding adults situations are where there is a risk of, or actual, abuse or neglect of a person with care and support needs. The abuse might be by someone else, whether an organisation or an institution, or be self-neglect. Safeguarding does not refer to situations when someone is at risk or becoming distressed because of mental illness or other health problems and disabilities.
- It isn't relevant whether the abuse or neglect may be intentional or not, or whether the person has the mental capacity to make decisions about managing risk and protecting themselves.
- The Care Act 2014 and the Care and Support statutory guidance create a legal framework for organisations and individuals with responsibilities for safeguarding adults to work together to prevent abuse and neglect and to respond to concerns when they arise.
- There is a duty on the local authority to have a safeguarding enquiry where an adult:
  - has needs for care and support (whether or not the local authority is meeting any of those needs) and;
  - is experiencing, or at risk of, abuse or neglect; and
  - as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

### Types of abuse

The Care and Support statutory guidance gives the following categories:

**Physical abuse** – including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.

**Domestic violence** – including psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence.

**Sexual abuse** – including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

**Psychological abuse** – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.

**Financial or material abuse** – including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

**Modern slavery** – encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.

**Discriminatory abuse** – including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion.

**Organisational abuse** – including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

## Key pointers for good practice in raising safeguarding alerts

**Neglect and acts of omission** – including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.

**Self-neglect** – this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

- Self-neglect was a relatively late addition to safeguarding categories and presents challenges to commonly held beliefs regarding lifestyle choices or failure to engage; The Care Act guidance recognises the issues raised by safeguarding and self-neglect, and proposes that each local authority's Safeguarding Adults Board provides leadership and guidance regarding approaches to self-neglect.

### Referring safeguarding adults concerns

Organisations working with people who may have care and support needs must make the local authority for the area where the abuse or neglect took place or is at risk of happening aware of situations where a safeguarding enquiry may be needed. The Care and Support statutory guidance says it is not for front line staff to second-guess the outcome of an enquiry in deciding whether or not to share their concerns. Each organisation should have policies and processes about how they do this.

When reporting a safeguarding adults concerns issues, be clear about what leads you to believe

- The person has experienced, or is at risk of, abuse or neglect
- The person has care and support needs, and how this prevents them from protecting themselves

If you are able, you should also find out from the person who has experienced or is at risk of abuse what they want to happen. The Care and Support statutory guidance promotes the Making Safeguarding Personal approach, which involves all those involved finding out what outcomes the person wants, and working together to meet them as best as we are able.

### What happens next?

The local authority will decide if the duty to have an enquiry has been met. If it has, it will decide what form the enquiry will take. The objectives of the enquiry are

- to establish facts
- to ascertain the adult's views and wishes
- to assess the needs of the adult for protection, support and redress and how they might be met;
- to protect from the abuse and neglect, in accordance with the wishes of the adult;
- to make decisions as to what follow-up action should be taken with regard to the person or organisation responsible for the abuse or neglect; and
- enable the adult to achieve resolution and recovery.

Meeting these objectives need involve actions by the local authority, but the local authority is responsible for ensuring the enquiry takes place. An enquiry might involve several strands, and could include things like an assessment of need for care and support, police enquiry, a complaints process, or actions by an employer or provider of services. What makes it a safeguarding enquiry is the coordination, and the shared focus on the abuse or neglect issue.

Once the enquiry is completed, the local authority must decide on what actions, if any, are needed and who by. This can be in the form of a safeguarding plan.

### Other helpful resources

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/366104/43380\\_23902777\\_Care\\_Act\\_Book.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf)

See in particular section 14, Safeguarding

[https://s3-eu-west-1.amazonaws.com/media.dh.gov.uk/network/497/files/2014/05/14\\_Guidance\\_safeguarding.pdf](https://s3-eu-west-1.amazonaws.com/media.dh.gov.uk/network/497/files/2014/05/14_Guidance_safeguarding.pdf)

<http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted>

**ABC assessment tool**

A tool being implemented by the Metropolitan Police Service to assess risk.

**Approved Mental Health Professional (AMHP)**

A social worker or other professional approved by a local authority to carry out a variety of functions under the Mental Health Act.

**Best interests**

Any decisions made, or anything done for a person who lacks capacity to make specific decisions must be in the person's best interests.

**Capacity**

The ability to make a decision about a particular matter at the time the decision needs to be made.

**Care Act 2014**

The Care Act 2014 creates a legal framework so key organisations and individuals with responsibilities for adult safeguarding can agree on how they must work together and what roles they must play to keep adults at risk safe.

**Decision-maker**

A person required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves. The decision maker has a responsibility to work out what would be in someone's best interests.

**Independent Mental Capacity Advocate (IMCA)**

Someone who provides support and representation for a person who lacks capacity to make specific decisions when the person has no-one else to support them.

**Mental Capacity Act 2005**

A law that governs decision making on behalf of people who lack capacity.

**Mental Health Act 1983 (amended 2007)**

A law mainly about the compulsory care and treatment of people with mental health problems.

- **Section 2** - Admission for assessment (or for assessment followed by treatment)
- **Section 3** - Admission for treatment
- **Section 4** - Admission for assessment in case of emergency
- **Sections 7 and 8** - 'Guardianship' Arrangements made to appoint a guardian for a person with a mental disorder to ensure that the person gets the care they need in the community.
- **Section 135 (1)** -Warrant to search for and remove patients.
- **Section 136** - Mentally disordered persons found in public places.
- **Mental Health Act assessment** - The process of examining or interviewing a person to decide whether an application for detention or guardianship should be made.

**Section 12 doctor**

A doctor who has been approved by the Secretary of State under the Mental Health Act as having experience in the diagnosis or treatment of mental disorder.

**Street outreach teams**

Teams that engage with people sleeping rough on the streets during early morning and late-night shifts. They often have access to hostel or other temporary accommodation and provide a range of practical support including welfare benefits advice and making referrals on to appropriate agencies such as mental health teams and GPs.

Ballintyne, S (1999) Unsafe Streets: The Street Homeless as Victims of Crime, *New Economy*, June 1999, (6) (2) pp. 94-97.

Department of Constitutional Affairs (2007) *Mental Capacity Act 2005 Code of Practice*, London: TSO.

Department of Health (2000) *No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*, London: DOH.

Department of Health (2008) *Reference Guide to the Mental Health Act 1983*, London: TSO.

Jones, R (2012) *The Mental Health Act Manual (15th Ed.)*, London: Sweet & Maxwell.

Jones, R (2012) *The Mental Capacity Act Manual (5th Ed.)*, London: Sweet & Maxwell.

Lipscombe, S (1997) *Homelessness and Mental Health Risk Assessment*, In Kemshall, H and Pritchard, J (Eds) (1997); *Good Practice in Risk assessment and Risk Management 2 Protection, Rights and Responsibilities*, London: Jessica Kingsley.

McGlen, I Wright K, Croll D (2008) *The ABC of Mental Health, Emergency Nurse*. Nov 2008, Vol. 16 Issue 7, p25-27.

Reeve, K (2011) *The hidden truth about homelessness: experiences of single homelessness in England*, Crisis UK

SCIE (2011) *Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse*, London: SCIE

SCIE (2011) *Safeguarding adults at risk of harm: A legal guide for practitioners*, London: SCIE

Teixeira, L (2010) *Still left out? The person sleeping roughs '205' initiative one year on*, London: Crisis.

WHO (1992) *The ICD-10 Classification of Mental and Behavioural Disorders*, Geneva: WHO

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## With thanks to:

The London Street Outreach Teams, with special thanks to: Ealing Outreach (St Mungo's), Tower Hamlets Outreach (Thames Reach), London Street Rescue (Thames Reach),

Homeless Link, Thames Reach and Pathway for hosting the tools online.

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Who offered assistance and advice with the development of the initial project



