Annex 1

How the current system is falling short for individuals with complex needs in terms of both individual outcomes and system-wide efficiencies

An overview of the key issues

1. Most people experiencing mental ill-health have a suitable home to live in or return to but for those who do not the current approach is falling short in terms of individual outcomes and system-wide efficiencies in the following ways:

2. **The 'revolving door' is institutionalisation for the post- care in the community age**. People moving between hospital, prison and unstable or hostel based accommodation are likely to lose the skills associated with living in a stable and independent home, to become increasingly reliant on support, and to have greater reliance on high cost interventions such as hospitalisation and prison.

3. **The links between homelessness and mental health are complex and non-linear**. However, without a stable home people are more likely to miss appointments, lose skills, self-medicate with alcohol or illicit substances, have poorer physical health outcomes, have poorer mental health outcomes, and use acute, rather than prevention based, health services.

4. **Inappropriate placements in accommodation with lower levels of support or in homeless accommodation**. There is a high rate of exclusion or eviction associated with this, as well as local case studies demonstrating specific harm to individuals through self harm or harm to others.

5. **Homeless hostels, and lower level Mental Health supported accommodation, do not have staff with specialist mental health training**. People with complex needs are more likely to have unstructured lifestyles which mean that they engage badly with appointment based services. However, the reactive support they can access in hostels is unable to meet their need due to the lack of specialism in the accommodation and staffing.

6. **Some people with mental ill-health may find it difficult living in the shared environment of a hostel**, which may cause them to be

particularly vulnerable, or in some cases (especially if they have complex/multiple needs) may have a particular impact on others. A homeless hostel can be a very stimulating environment due to the variety of individuals and needs it has to accommodate, and if the balance is disrupted by attempting to accommodate someone who is not able to engage in the resettlement program this can impact on the recovery and progress of a number of individuals.

7. **Some people with mental ill-health may be very vulnerable to abuse (financial, verbal etc) from others, and there may be some geographic areas where this is a higher risk due to demographics etc.** There is currently not a co-ordinated approach to managing and reducing this across partner agencies, (e.g. through telecare solutions, concierge type blocks etc).
8. **There are currently a small number of people in CYC general needs housing with disproportionate needs, causing significant neighbour issues and anti-social behaviour.** Paranoid thoughts, disordered thoughts, and delusions have a particular impact on neighbour relations and ASB. Current services are appointment based, focussed on one aspect of the person (health/housing/crime). This leads to heavy staff input across partners, with current gaps in the joint working process between the ASB hub and mental health/social work teams. This leads to poor outcomes for the individuals as well as affected neighbours, to dissatisfaction and increased stigma in communities, and, in the worst cases, to eviction.

9. **The formal support provided to people who have moved into a general needs tenancy but who are struggling is likely to come from a range of providers** (mental health community team, floating support, housing provider, community addiction services). It is likely to be largely or exclusively appointment based, focused on one area or some areas of the individual's life, and be provided via different teams. Communication between teams is not consistent.

10. **Individuals who do not engage (or do not attend appointments) are likely to be signed off services.** There are no shared non-engagement protocols across partners to ensure that those who have stopped engaging due to worsening health are able to re-engage with support easily/in other ways, or to prevent admissions and other negative outcomes.

11. **Inappropriate placements in homeless accommodation lead to 'blocking' the resettlement route, as individuals are unable to**

progress through the resettlement program. This also prevents or slows vital access to the resettlement route for newly homeless people - it is well documented that every night of rough sleeping significantly increases the challenges in helping someone to get out of homelessness.

12. **Delayed discharge from hospital while accommodation is sought, with associated negative outcomes and high cost.** Whilst attempts have been made to put a discharge protocol/procedure in place this is not currently followed consistently, exacerbating the delays.

13. **Higher use of out of area placements for specialist accommodation**. With associated high costs, and difficulty in maintaining support networks.

Three individual case studies

Please see below, three case studies of individuals with complex needs that help illustrate (a) the ‘whole system’ financial cost of not being able to provide the right type of accommodation and support (Case studies P1 and P2), and (b) the benefits to the individual, and in turn the ‘whole system’, of closer joint working and extensive outreach support (P3).

Case Study - P1

P1 - diagnosis / background:

- Diagnosis: ‘Schizophrenia/schizo-affective disorder, with numerous inpatient admissions over 4 decades, P1 experiences delusions, paranoid thoughts, suicidal ideation, can present as disinhibited and grandiose.
- When unwell P1 is often verbally or physically aggressive and violent towards others.
- Long history of illicit drug use including a range of drugs.
- Tenancy at recent community based property ended due to threats and aggressive behaviour towards neighbours
- Remains in forensic placement.

P1 – whole system costs: total = £183,026

Health - inpatient admissions: £150,320
- 4 acute inpatient admissions totalling 86 days
- 3 psychiatric intensive care unit (PICU) admissions totalling 78 days (approx £700 per day)

Housing: £25,842
- This includes time living out of area, ‘sofa surfing’ at a range of addresses in York, living in resettlement hostels and in temporary accommodation.

Other health costs: £5,664
- This includes 5 emergency department admissions, 2 planned hospital contacts, and known contacts with community mental health services (please note that contacts with community mental health services are incomplete in this case study).

Police: £1,200

- This is made up of reports from neighbours, staff and contact direct from P1.

Social services: costs not known/provided.

Case Study – P2

P2 - diagnosis/background

- Schizophrenia. P2 experiences auditory, visual and tactile hallucinations of a very disturbing nature, and P2's reaction to these causes significant noise nuisance to neighbours which has resulted in numerous complaints, tenancy action, and moving other neighbours whose health has suffered as a result of noise nuisance.
- At the time P2 moved in to the property there were concerns from health and social care services that the property was not appropriate.
- P2 has spent a significant amount of the time they have held the tenancy in hospital and unable to return to it due to ill-health.
- At the time of writing this individual is in a locked rehabilitation ward.

P2 – whole system costs: total = £191,562

Health - inpatient costs: £156,225
- 8 months in an acute ward - £12,000 per month
- 5½ months in 'locked rehabilitation ward' £10,950 per month

Other health costs: £18,732
- Made up of 1 emergency department visit, 1 planned hospital appointment, and known community mental health contact (as above these are incomplete)

Legal costs: £12,022
- These are approximate costs, based on the hours spent on the case and barrister costs, however they do not reflect housing officer time spent on this case, which is not recorded but has been significant.

Housing: £2,633
- Detached general needs bungalow being held by social services: £73.14 pw.

Police contacts: £1,950
- This included 11 contacts for assault, theft and a number of calls from neighbours regarding disturbing behaviour and/or noise nuisance.

Social services: costs not known/provided.

Case Study – P3

P3 – diagnosis/background

- Diagnosis of psychotic illness, underlying personality issues and significant history of substance misuse. Involved with mental health services for many years and risk history dates from 1990.

Challenges

- 13 years in hospital (including forensic inpatient care and Psychiatric Intensive Care), B&B's, prison and homeless hostels.
- 2009 – 2017: 16 hospital admissions, 12 homeless hostels, 2 prison stays, 1 incident of rough sleeping.
- Risk incidents include physical and verbal aggression to family, staff and police, public order and ASB offences. Disinhibited behaviour.
- Physically frail, with conditions requiring long term management.
- History of difficulties in maintaining a tenancy
- Shared living exacerbated ill health.

Costs

- P3's loss of hope and optimism for a settled future
- Loss of skills to manage daily needs
- Negative effect on physical health
- Lack of sense of belonging and control
- Extended length of stays in hospitals & hostels at a significant financial cost
- Lack of opportunity to maintain and establish family and social networks.

Plan

- P3's aim was to live independently
- Joint approach from Community Health & Housing to facilitate this.
- Social care assessment completed in out of area hospital to identify discharge requirements
- Clear plan constructed with P3 by homeless & health staff
- Health met with housing staff before and after each visit with client for any updates / feedback.

- P3 seen daily for 4 weeks, gradual reduction to 3x's per week
- Joint harm minimisation mitigation plan. Inc. service user and all staff involved
- Health intervention around benefits, planning for future tenancy, medication management
- Frequent communication with all involved
- Honest and open relationships with key people including the hostel manager
- If P3 in crisis - no one panicked, the plan was revisited
- Health responded immediately on a number of occasions to concerns.

<u>Independent flat identified Feb 2017</u>

- Supported with tenancy skills
- Beesom project helped with furniture
- Settling into flat, describing feeling "proud of it"
- 3 visits a week from health
- Joint visits with homeless hostel workers.

<u>Outcome</u>

- Permanent tenancy offered
- Skills increased in managing tenancy, no bills outstanding
- Independently managing both mental & physical health
- Reduced alcohol intake
- P3 proud of themself and this has made a significant impact on their recovery
- No inpatient stays for 1 year
- P3 participated in decision about their housing - which was successful
- P3 has now has choices in their everyday life.