Appendix 4

Focus Group Interview Transcripts Coded & Un-Interpreted

This document should be read or used as a reference to appendix 2 and chapters 2, 8 and 9 of Plymouth's Mental Health Accommodation Strategy.

Appendix 4 contains copies of all the original transcripts taken from the 14 focus group interviews, implemented as part of a research plan designed to inform the development of the Mental Health Accommodation Strategy.

The focus group interviews were undertaken over a 6 week period, which included services from the inpatient, community psychiatric services and supporting people funded services from the community voluntary sector.

This appendix is arranged in two parts. Part one provides copies of the transcripts after they have been coded and part two before they had been coded. For an explanation of how the coding process was applied see appendix 2.

As part of the focus group interview process participants were advised that their views and opinions would be recorded as anonymous. For this reason each transcript has been issued an identity number as opposed the name or names of the participating organizations, which are then broken down into service sectors. The numbers placed against each transcript in part one and two, which are aligned in the same way for easy of reference.

Part One

Inpatient and Rehabilitation services

Focus Group One

One: Training

Need to better understand client's needs especially around their mental health diagnosis, presentation and appropriate ways of working (i.e. offering appropriate opportunities and not overwhelming with choice). Providers also need to develop

a better understanding of risk, especially the difference between historic and current risk. (1A)

Staff need to have a better understanding of mental health and the impact it has on individual's abilities to respond in appropriate ways (i.e. deadlines, completing forms). They need to develop more flexibility or have a different approach for clients with mental health needs. (1A)

Support needs to include vocational opportunities and other specialist skills like welfare rights and benefits. (1A)

Having access to psychological therapies at stages 2-4 would help people move on more quickly and continue therapeutic work started in stage one. Community based treatment would increase confidence of staff and clients. (1B)

The service will need to be targeted at the right people and access strictly controlled. The service will need to retain its focus (1B)

They seem to promise a lot but don't deliver and clients don't get positive outcomes. Front line staff need to have a better understanding of mental health. There is an over reliance on AOS or HTT for things that do not need mental health staff support. Often, services are acting as an 'alarm' system. Providers need to offer appropriate support informed by their knowledge of mental health (1D)

Training will be required for crisis house staff to ensure they have the right skills to enable clients to move on quickly (1D)

Supervision of medication is important. This could be achieved through co locating staff and would facilitate clients moving on. (1D)

Support plans in supported housing should reflect what has already been achieved during clients in patient stay. They should consolidate this work and move forward. (1D)

Patients / clients would benefit from opportunities to learn about independent living skills, benefits and have education / vocational opportunities (1E)

Patients should have a say in where they move on to and should be aware of the options open to them. They should have copies of the pathway (diagram) (1E)

Two: Crisis House

Crisis house provision would be very beneficial for clients moving on from Lee Mill (2B)

The time limit on stay is too long. Patients should either be assessed as needing acute admission or linked in with additional support within 48 hours (2C)

Practical support will be a very important focus especially around benefits and welfare rights issues. The support must not be mental health focused. It may be better run as a day service rather than over night stay (2D)

Three: Barriers

It is really important to be able to move in both directions of the accommodation pathway and step back to receive more support when necessary (3C)

Over subscription for supported housing placements means that providers are able to 'pick and choose' clients. This means that clients with high needs or risk history are not chosen. This constant refusal is very demoralising for staff and clients (3D)

Historic risk is a significant barrier to clients being able to move on especially if the risk relates to:
Forensic history
Drug and alcohol issues
Arson
Assault
Poor compliance or insight (3D)

There are not sufficient resources to meet placement needs (3D)

There is too much pressure to move on (3E)

Four: Support

There is a need for all services to understand the role drugs and alcohol play in mental health. All services should expect clients to have a dual diagnosis (4B)

Drug and alcohol issues are prevalent too and access to services focused on this primary need, but able to understand and work with mental health are also needed. (4B)

The staff team felt that drug and alcohol issues cannot be separated out from mental health and are a significant problem for 90-95% of clients. All services need to reflect this dual need. (4B)

Access to waiting lists and treatment is extremely important (4B)

Co located staff or access to specialist support (either mental health or housing support depending on the service) would be extremely beneficial. STR type staff would be beneficial. (4D)
Residential services are dispersed across a large area. Staff feel isolated and not in touch with what is going on. Either a directory of services or co located staff would reduce this isolation. This would increase / improve access to services, knowledge and options available to patients (4D)

The mental health client group is becoming increasingly younger. These patients will need appropriate services to move on to. There also needs to be better links with child and adolescent services

Staff do not have the confidence or knowledge to give advice / support to patients about their housing options, benefits, availability of services and processes (applications, homeless approaches etc) (4D)

The Spring project seems to work more effectively with clients. They are more active with clients and have a better understanding of mental health. This may be because they have a CPN working at the project. (4D)

Implications Arising from Research

- **Other themes**
- **Positive**
- **Negative**

- Staff explored their experience of crisis provision in Hull (Humber PCT and MIND) and Portsmouth these services experienced problems and one had closed and one changed into a drop in / day centre where multi disciplinary support was available. Both services had problems with inappropriate referrals and became 'clogged up' very quickly with people whose principle support needs were either personality disorder or drug and alcohol issues.

- The STR training program is good because it provides a consistent and comprehensive approach to training.

- When a patient has the sanctions associated with section removed they often experience deterioration in their mental health. There is a definite need for stage 2 services. These should be staffed 24 hours a day with staff from health. They should provide a structured environment with firm or rigorous regimens. This would help clients continue to develop within a safe environment. There is too big a gap between being on section / secure unit and living in supported housing.

- There is a lack of long term secure facilities. Staff felt placements are often made based on cost rather than need. There is a need for long term placements which are more homely and less like a hospital environment

- Perhaps there should be some kind of trouble shooter who can problem solve issues to do with mental health or housing support.

- Staff felt that the stage one services need to be seen as part of the accommodation pathway. They need to be included in information sharing and the links between stages need improving.

Focus Group Two

One: Training

Currently there is a poor transfer of information about the progress, knowledge and skills the service user has developed during their stay in inpatients and residential rehabilitation services, which can sometimes result in patients not being able to move on. (1A)

Staff teams working in the voluntary and community sector need training around mental health generally. (1A)

Training should take the form of mental health awareness and presenting needs which should likewise include attaining an understanding of triggers and the early signs and symptoms of a person's health deteriorating. (1A)

Training should also include breaking the fear barriers associated with working with some clients who present or have the mental health label. (1A)

Training should be provided to all staff on communication as communication provides the opportunity to catch the early signs and symptoms associated with mental health crisis. (1A)

If services had access to psychological therapies this could help service users to move on or sustain their independence in the community. (1B)

Service providers in the community would benefit from having access to psychological therapies as long as training was provided. (1B)

Inpatient services and rehabilitation services would benefit from having access to psychological therapies, which could help service users in their recovery and maintain their recovery. This might likewise help to increase patients to move on. (1B)

Inpatient and residential rehabilitation services start the training process that enables service users to prepare for move on. This takes the form of budgeting, personal care, cooking and other practices that help prepare people for a more impendent lifestyle. (1D)

Labelling is a barrier to move on as service users with this background are seen as to a high risk, which is often based on perception rather than real need. (1D)

The training the service user receives when they are in inpatients should be continued and built upon when they leave by other support services. Currently this does not happen. (1D)

Community and voluntary sector services need to continue the work started by the inpatient and residential rehabilitation services, as this helps to keep people from returning to inpatients. (1E)

Service users would greatly benefit from financial advice and support. (1E)

Two: Crisis House

Additional help needed in the crisis house to help service users reduce their crisis should include 'counselling'. (2A)

Budgeting, money management (paying bills), personal hygiene, cooking and personal care should be part of the support offered by the crisis house. (2A)

Home Treatment Team as gatekeepers of acute care (inpatient) services would be well positioned to manage access to the crisis house. However, Assertive Outreach Service should likewise have direct access due to the type and nature of the client group. (2B)

Crisis accommodation would help throughput from inpatient and rehabilitation services. (2B)

Crisis accommodation as an option if things go wrong would increase a service user's confidence. (2B)

Counselling promotes confidence. (2B)

Service should be short term stay. (2C)

If the crisis service did not have a maximum time limit it would leave it open to abuse. Some service users would misuse crisis accommodation and treat it as respite or a long term housing option if no limit on stay were made. (2C)

Having a time limit will help avoid blockages, enabling more people to get access to the crisis service. (2C)

24/48 hours should be enough time for most service users to reduce the crisis and move back to their normal place of residence. (2C)

Crisis (Mental Health) is short term; length of stay should reflect this. (2C)

If the crisis lasts longer than 5 days then the service user is likely to need acute inpatient services or rehabilitation services. (2C)

Additional support should include domiciliary care as service users accessing the crisis house will have different backgrounds' and levels of support needs. (2D)

Carer and community involvement alongside CPN input in the crisis house would help promote move on. (2D)

Having access to a crisis house would reduce admissions to inpatient services. (2E)

Supported housing providers should have access to the crisis house. (2E)

Access to the crisis house should be determined on the basis of need. (2E)

Three: Barriers

Confidence to move on is a big factor for service users; however it is generally felt that with the right kind of support networks service users accessing residential rehabilitation can move on. (3C)

Service users presenting with enduring mental health problems currently do not fit with the available accommodation services outside inpatients and rehabilitation (Health) care services. (3D)

Some service users have the ability to move on but do not want to move on because many of the services offered to them are unsuitable for their need. (3D)

Service users sometimes feel vulnerable because the move on options available to them do not offer the right kind of support. (3D)

Housing services in the community have to a high expectation of service user for many to qualify for access to their services. (3D)

Quality of support is a contributing factor in staying well. (3D)

For timely move on to take place in a controlled way good quality accommodation with one to one support needs to be made available. This helps prevent a decline in health. (3D)

One of the biggest barriers to move on is the support service users receive after they leave inpatients and rehabilitation services. Often to low and staff outside the inpatient and rehabilitation services often do not understand the needs of the service user. (3D)

Service users need slow processes to operate if they are to progress to a position which will enable move on. It likewise has to be planned. (3E)

Housing services in the community are driven by the need to fill accommodation vacancies. This is not compatible with the need and time it takes to prepare a service user for move on. (3E)

Referrals to services in the community are often returned because the service users need and risk is considered to high. (3E)

Knowledge of mental health specific services in the supported housing sector is limited. (3E)

Awareness of housing and accommodation services and move on should be provided by a Social Worker but this has never happened. (3E)

Four: Support

Help with medication once service users have moved on will continue to mean service users are dependent and in need of care. However, living independently with support around medication could help service users move on from residential rehabilitation. (4A)

Inpatient and rehabilitation services would benefit from housing support workers being co-located. (4D)

Confidence could be improved if Domiciliary Care, Supporting People funded housing related support services, A.O.S, PCLT and Home Treatment supported the move on process. (4D)

Service users with enduring mental health problems could move on if residential services in the community provide more one to one support. (4D)

Some service users do not have the ability to move on, but would be able to manage independent living if the right level of support and package of care were available. (4D)

Access to a housing support worker or housing advice worker would benefit the residential rehabilitation services and increase the opportunity for the right kind of move on to take place. (4D)

Residential rehabilitation would benefit from a link to a service that provided housing advice. (4D)

Service users with a high level of need could live in the community if services were better tailored to meet their specific needs. (4E)

Implications Arising from Research

- **Other themes**
- **Positive**
- **Negative**

- Crisis can mean respite for the family supporting the service user in the same way crisis can be respite from the family for a service user.

- Supported housing and residential services are at their most effective if they are small in physical size. This promotes good mental health, stability and reduces inpatient re-admission.

- Size of residential service is important, big is not better. The bigger the service the more likely service users are to get into crisis with their mental health.

- Most services in the community have a large number of units with staff who find it difficult to communicate with service users or build good relationships. This often results in isolation and a deterioration in their mental health and well being.

- If the right support were made available staff would feel more confident about moving service users on.

Focus Group Three

One: Training

There is a lack of understanding / knowledge of benefits and grants within health services (1A)

Staff felt that they need to understand what services are out there and what they offer. This would help them when considering future accommodation options for clients. (1A)

Clients are sometimes a barrier to moving on. Some have become institutionalised, feel safe and don't want to move. Many see the unit as their home (1C)

A.O.S expertise is used to help find placements (1D)

Increasing awareness of the model / services that are available may inform clients and their families and help promote independence (1E)

Two: Crisis House

Staff felt that a crisis house was a positive development and would stop clients being re admitted to acute services. They felt that the service should have the following characteristics:
24 hour staff (2A)
24 hour access to medical staff (2A)
Maximum stay of 5 days (2C)
Staff familiar to clients – staff who are already supporting the client should be able to 'follow' them into the crisis house (either from the community teams or from supported housing) (2E)
Practical support (daily living skills such as personal hygiene, cooking, money management, maintaining accommodation, communication) (2D)

Access should include clients who are living in supported accommodation. (2E)

Three: Barriers

There are currently no stage 2 services (3A)

Clients experience many periods of relapse and where possible are re admitted to the Gables rather than Glenbourne. To help the unit is developing a respite bed. (3C)
Staff felt that the development of stage 2 services would, increase the number of clients who are able to move on and decrease the length of stay in the residential unit (3C)

Past experiences often act as a barrier. Clients have had bad experiences of supported housing and of being supported by community services. (3C)

There is a lack of knowledge about what accommodation services are available. The staff at the Gables rely on social workers to find and secure placements for clients. Options are therefore limited by the knowledge of the social worker (3D)

Supported housing criteria are too restrictive. People with a history of arson, forensic background, historic risk, high suicide risk, violence (3D)

Lack of staff knowledge of supported housing options. Only aware of those that have been used before, or that social workers are aware of. (3D)

Staff also have no confidence in current services and very inadequate knowledge of what is available. (3D)

Increasingly, supported housing providers are expecting residential services to get client's benefits and grants in place before they move on from their services (3E)

Four: Support

Any step down service must have adequate mental health support. This should include medication, links to community services, support with physical needs, domiciliary care and daily living skills / housing related support. (4A)

Practical support is really important particularly with attending appointments and communication (4B)

Services need to provide help with benefits including making applications and appeals (4D)

Co location of staff would be really positive. Mental health staff co located in supported housing would mean clients could receive support with medication, have understanding of the clients mental health needs and prevent re admission during relapse (4D)

Co located housing staff in residential units would increase the skills and knowledge available to clients who are ready to move on. These staff could attend planning reviews so move on planning starts earlier (4D)

Need to make sure that there is a high level of mental health support in stage two services (4D)

A mental health version of extra care provision would be a really suitable option for clients using the Gables. This service would need to be able to work with a younger age range. (4D)

Implications Arising from Research

- **Other themes**
- **Positive**
- **Negative**

- Currently, most clients are moving on to long term residential services.

- GP's will not take on clients on certain medications as they are expensive and require considerable monitoring through blood tests.

Focus Group Four

1. Training

Need easier access to people for benefits information. (1A)
Some information about what's available regarding accommodation would be helpful. (1A)
Not allowed to fill in forms for service users have to refer them (1C)
Already receive training on budgeting, looking after themselves and environment, access to jobs. (1C)
Training in benefits for staff and service users (1E)

2. Crisis House

Invaluable to people who have different types of personality disorder. (2B)
This would not be good for people in residential care. (2B)
Stay should be maximum of 1 week as 5 days may not be long enough. (2C)
Supported Housing providers – they should have access to crisis house and it should be based on individual need. (2E)

3. Barriers

Also have outreach clients who could benefit from these services (3A)
When discharge do so with certain amount of confidence. (3C)
Should not be expectation that everyone can move through. No everyone can live independently. (3C)
Not enough residential placements for people that need them. Don't always need to move people out of residential. (3C)
Barrier is person's ability to move on. (3C)
Not knowing what accommodation is available (3D)
Lot of clients whose movements are governed by the Home Office due to offences committed. No forensic housing in city. (3D)
Barrier – to move to independent living could be waiting a long time for housing – better support to look at planned movement and including all providers. (3D)
18-30 not suitable due to level of functioning. These are mainly females who are vulnerable. (3D)
Time spent at each stage could play a big part in moving people on, some time is too short for some. (3E)

4. Support

Consistent approach – some people trust those people. It is not necessarily about people needing to be told when to take medication. (4A)
If the service where they are assisted with their medication was taken away then their health would deteriorate. (A4)
If chaotic with medication should have A.O.S worker (4A)
Practical support – access to benefits, social housing, advice about health promotion, drug/alcohol treatments. (4B)
Co-located housing advice – would help to have mixture of qualified support at stage 2. (4B)
Stage 2 – Housing that moved on to would need specialist support from this type of service but not to the largest side. (4D)
SP funded services stage 3 (4E) – is this beneficial – yes.

Implications Arising from Research

- **Other themes**
- **Positive**
- **Negative**

- Like to see residential services have access to this service and also home treatment.
- Drug/Alcohol – struggled to get support for people with these problems
- Some people will always be at Stage 2 due to their illness. They are not barriers they have reached their limit they need to know that they are not going to be pushed through.

Focus Group Five

One: Training

Staff knowledge of what is available. This is mitigated by the Support, time and recovery manager's role. Having a member of staff with knowledge and skills around securing placements is very positive. (1A)

Psychological therapies should follow the patient and it would be very positive if they were delivered where ever they are living. This is especially relevant for therapies such as brief solution focused therapy. These could be delivered by housing staff if they received appropriate training. (1B)

There is no budget at stage one services to start this work. This kind of support should be offered at stage one as staff have often built up good working relationships with clients. There needs to be an STR type role at stage one. (1D)

Stage 2, 3 and 4 services should build on the work undertaken at the preceding stage and not start over again. There should be an integration period when a

service user transfers from one stage to the next to allow for better hand over and for links with the new service to be developed (1D)

Service users need to have training around:
Basic life skills
Self esteem and confidence
Ability to deal with anxiety
Strategies to deal with loneliness and develop links with their local community
Help to participate in ‘ordinary’ services
Independent living skills (budgeting, shopping, etc), supported housing providers need to understand that this is what service users need (1E)

Two: Crisis House

There should be a female only space where vulnerable females can feel safe. (2A)

The project needs to be staffed with people experienced in working with mental health clients in crisis. The team should include a mix of males and females, qualified (medication) and unqualified, OT’s (2A)

HTT or AOS should gate keep access to the service (2B)

Maximum stay should be 5 days. 5 days should allow sufficient time to establish if the client needs a higher level of intervention. The length of stay may need to be reviewed following evaluation. (2C)

Consideration should be given to allow Devon Partnership clients access to the service (2E)

Three: Barriers

Clients are often seen as too high functioning or too risky to go to supported housing. Historic risk is often a barrier particularly around violence, arson or forensic history. (3D)

There is a lack of suitable placements including:
Residential placements
24 hour supported placements (but at a lower level than acute services)
Placements for high functioning clients who still need support
People with a history of risk or previous experiences of supported housing
Specialist placements (3D)

Client’s previous experiences in supported housing can be a problem either because they did not have a positive experience or because the services are not prepared to take them in again. (3D)

The application forms and interview processes to access housing services are a barrier (3E)

The step from 24 hour supported or secure services to supported housing services with staff 9-5 Monday to Friday is too great. (3E)

Four: Support

Co located staff so that clients can receive support to take their medication. Not having someone to supervise or dispense medication can mean clients remaining in inpatient services. Clients have had to remain linked to inpatient services to receive their medication as GP's surgeries have refused to take on clients on some anti psychotic medication because of the expense and the ongoing testing required. (4D)

Linking into ordinary services rather than mental health specific services, Community integration, normalisation (4D)

Clients often need support around diet and exercise, motivating, time management, work and education (4E)

Implications Arising from Research

- **Other themes**
- **Positive**
- **Negative**

- Stage two services are definitely needed, however these may need to be single sex provision
- There should be a downstairs room for disabled access
- Funding for residential placements

Focus Group Six

One: Training

Awareness on issues relating to learning disabilities is regarded as essential. 1A
Training in organizing and maintaining benefits is also of high priority. 1A

Promote independent supported living - a continuous process maintaining skills on a continuous basis. 1A

Good counselors or advocates are always useful in promoting better mental health. 1B

It is desirable to train people to deliver therapies. 1B

Knowing how to access specific services is very useful. 1C

This needs a multi-agency approach and a co-location of staff to create a holistic understanding of a wide paradigm of needs. 1C

These should be holistic and based at a strategic rather than managerial level. 1D

Two: Crisis House

It was felt that there should be a "gatekeeper" and it would be desirable if Home Treatment/AOS regulate access to providers. 2A

The group felt that a week was the absolute maximum – indeed the best idea for the facility would be a couple of days "to get clients sorted out." 2C

With only four beds available prioritisation of need is essential. 2E

Patients should "be carefully placed" in this environment to avoid possible conflict. 2E

Three: Barriers

This is a "mixed bag." Some people cannot move on due to lack of accommodation then they "slip-back" and are no longer ready for the transition. 3C

Some clients may not want to move on. They may have both the potential and, over time, the ability to live independently but they still demand the security and nursing care available in "the Willows." 3C

Some clients have everything done for them and become institutionalised thus making their options very restricted. 3C

The ability to be flexible concerning individual's needs is essential and in this scenario staff look to build structured transitions tailored to each person. However, this is a process that cannot be rushed. 3C

From the perspective of the group some of their clients could manage residential accommodation but they would need some support. Furthermore, residential is limited. So, the underlying barrier is the lack of suitable housing. 3D

This is determined by the lack of available housing stock. 3D

Service teams generally have very limited knowledge as they rely on care management/social workers for advice. 3D

With the lack of resources, the group estimates that 80% to 90% of their client group will not move past stage one in the process of transition to more independent living. 3D

Once again the group emphasised the importance of structured transition for clients but time becomes an issue as there is few opportunities to place individuals as they become more confident. 3D

Frontline workers should be part of the decision making process concerning the placement of clients however with the limited resources available they need to negotiate for the best deal they can get. 3E

Four: Support

The group felt that a multi-agency approach was the best strategy and this would embrace the co-location of staff. They also noted that in most residential placements untrained staff do "give" medication. 4A
Regarded as a useful initiative. 4D

- **Implications Arising from Research**

- **Other themes**
- **Positive**
- **Negative**

- In some respects the most problematic cases do best. Finance is available for extreme cases but this takes up the majority of the available resources.

- This will need an element of assessment to evaluate a particular situation and could be a short cut to in-patient admission.

- If someone accesses the facility two to three times over a two month period then there is an issue over effective analysis of the underlying problem.

Community Voluntary Sector

Focus Group Seven

One: Training

Supported Housing Providers – need more training around mental health, particularly understanding of mental health conditions, how these impact on a client's behaviour and then how to modify behaviour or support to maximize contact with a service. (1A)

Some supported housing providers are really good at providing training for employees. This training could be shared with other professionals e.g. support planning, risk assessment etc. (1A)

Supported housing providers should not be trained to deliver therapies. Supported housing is a client's home. Clients do not want to deal with issues in their home. This should be done elsewhere so that home can remain a safe space. (1B)

Service users need some training / education about what supported housing is, and what will be expected of them when they go there. They also need educating about the longer term options that are open to them. There is a general misunderstanding that going to supported housing means you will end up with a council house. Clients often have unrealistic expectations about their future permanent accommodation. (1C)

There needs to be an improvement of the links between CPA and Support Plans. This could be a training issue as SH providers and MH professionals may not have a shared understanding of the processes. (1D)

Some supported housing providers use a training package with service users to help prepare them for living independently. These 'practical housing units' are of benefit to providers and service users. (1E)

Acute services at stage one should focus on the client's mental health. Rehab / longer stay services at stage one should be helping to prepare clients to return to the community through the use of OT's etc. They should focus on practical skills such as cooking, cleaning and personal care. Currently the training clients receive depends on the unit they are in. Some clients do not have the foundations there for supported housing to work on. (1E)

Two: Crisis House

The service should continue to link with the client when they return home – linking in support services where necessary. (2A)

There should be one point of referral with access gate kept by statutory mental health services. (2B)

Mental health services should be responsible for managing the service and retain the duty of care / responsibility for managing the crisis and for managing the clients within the crisis house. (2B)

The stay at the Crisis House should be no more than 5 days. However there should be a small degree of flexibility for a few days over the 5. It may well be that people will only need to stay one or two days. (2C)

A mixture of staff will be needed to run the service. There needs to be medically qualified staff to ensure that medication can be administered and the house managed as above. There also needs to be practical support offered such as domiciliary care, cooking, managing money, preventing neglect, making sure clients are eating and drinking, personal care. A combination of health and housing. (2D)

It will be really positive to have a crisis house so that people are able to step out and then back to their own accommodation rather than going backwards. However, there does need to be a good link with Glenbourne to ensure that those clients who enter the crisis house and are assessed as needing inpatient services, or those people who deteriorate and need inpatient services are fast tracked. (2E)

Three: Barriers

Service user's unrealistic expectations of move on options. (3B)

Some clients do not want to move on. Some will require additional support for a long time. Currently there are no services for longer on going support in the community. Does not need to be mental health support but the kind that develops confidence and integration in the community, develops a structured day and provides practical support. There is not currently enough support in the community to encourage people to move on. (3C)

Knowledge service users have at stage one is a barrier. They don't understand what services are available or what these services offer. (3D)

Staff knowledge at stage one. (3D)

Lack of move on from supported housing in terms of quality, affordability, location and cost. (3D)

Barriers with the private rented sector. This includes private landlord's unwillingness to take on tenants with mental health needs or who are on benefits. (3D)

Mental Health Staff – need training around supported housing, particularly around knowledge and understanding of supported housing. (3D)

The key to successfully working with a client is to; understand the issues and know where to sign post. All people involved with supporting clients should have these skills and if not need training to obtain them. (3D)

Client debt (3E)

Four: Support

Services need to provide clients with support to take medication (holding, dispensing, getting prescriptions, taking, monitoring). This is a key element to enable clients to move on. The aim should be to encourage clients to become increasingly independent so that they become self medicating ASAP. (4A)

Mental health services should only work with clients with a dual diagnosis where the client has demonstrated commitment to stability. Otherwise the impact on the other residents in a project is too great. (4B)

We should replicate the CPN support offered at the SPRING across all supported housing projects including homelessness. SH staff benefit from the increased knowledge of mental health. CPN's benefit because their knowledge of supported housing is increased and SH staff are able to provide the practical support. Service users benefit because they receive a holistic service. (4D)

There should be co located staff at stage 2. This would be a 100% advantage in helping people move on from stage one services. (4D)

Service users would find it difficult to identify with professional identity. There is benefit having clear role definition, but do need to work in a multi disciplinary way. (4D)

There should be linking of support and multi agency working at each stage (4D)

Crisis support will be really positive so that clients are able to step sideways and prevent a re admission. (4E)

- **Implications Arising from Research**

- **Other themes**
- **Positive**
- **Negative**

- The proposed model with stage 2 services in would encourage service users to move on. Realistic steps rather than giant leaps to the unknown. Model at the Spring with CPN support and stage move on (house, flats, FS) has produced successful outcomes. It gives clients time to develop.

- Concern was raised that there was no blurring of the roles between mental health practitioners and supported housing practitioners, could be a conflict if staff assume a dual role.

- Access to the crisis house

- Lack of stage 2 services.

- Support should always be needs led.

- Not sure where this fits in, but didn't want to lose it. MIND stepping out were able to use some money from the reimbursement grant to pilot a project where housing related support services linked with the service users before they were discharged from Glenbourne to try and prevent early relapse or readmission. The service produced a report on the work. (attached) Representatives at the group noted that there is a shift in client group. There is an increase in the number of clients released to their homes on section. This means there is a need to work much more closely with the HTT who have primary responsibility for these clients care. MIND identified the need for supported housing services to in reach into Glenbourne / acute services to ensure support is linked to clients before they are discharged.

Focus Group Eight

One: Training

Training so far has been good and important. (1A)

Clients have to accept the first place offered by P.C.C. this may not always be appropriate. (1A)

There will be more high risk resident and staff need training in that area. (1A)

Therapy training would be good as a support worker role covers lots of areas and boundaries need to be separated. It is important to know enough to identify the boundaries and signpost. (1B)

People are feeling stretched in their roles due to recent changes. People do need to know what roles you cover as they are not aware of our criteria. (1B)

Referral process is clear that we do not do therapeutic duties. (1B)

Referred service users do not come prepared for independent living. Referrals and preparation made but service users should have more training before reaching the service. (1C)

There is an expectation of the service user; they should have more training for independent living before reaching the service. (1C)

We ask residents what they expect from us. (1E)

Two: CRISIS HOUSE

It should be 24 hour support backed up by the home treatment team and nursing staff. (2A)

If a client is going into crisis who gate keeps the case? A clear and agreed process should exist with a clear criteria and making service users clear of the service. (2B)
Clients want a middle care service, they do not want to be referred to Glenbourne, and we know this from the client questionnaire. (2B)

Should there be a time limit on a crisis. Service users should have a time limit, as a crisis could turn into a chronic situation. Others thought there should be no time limit. (2C)

Crisis House is an alternative prevention service. If in house required then refer. (2E)

Crisis House can only be used from Social Services, but supportive living does need access to the service. (2E)

Three: Barriers

There is a disadvantage to get people through vulnerable panels. Service users do not want to live independently. (3C)

Conscious service users do not want to move on; these are mostly the older clients. Younger people do understand it is a 2 year placements. It is an anxious time for people as they want to feel secure. (3C)

Supporting People is a 2 year placement. (3D)

Make a referral to vulnerable people panel that can make an impact on the 2 year limit. (3E)

The services do not meet the need. (3E)

Referrals received pose a higher risk than they can manage, services are stretched. (3E)

There is a big gap in support from possibly two people per day to a maximum of 6 hours per week. (3E)

When clients are referred to the service the referrer takes a back seat. (3E)

The majority of people want council houses as it is more affordable living. They go before the mental health panel and cannot get housing if they are well, they can if they are ill, but then they cannot live independently and could end up in unsuitable accommodation. (3E)

Four: Support

If forensic support is available additional support would be required as it would be a higher risk clientele. (4C)

If a person has a forensic team that would be easier to handle. (4D)

More support hours per person in the community is required, have the option to increase if required. (4E)

Implications Arising from Research

- **Other themes**
- **Positive**
- **Negative**

- Crisis House is funded by health – clients can still keep their house. There is no cost to the service user at present.
- Hopefully the scheme will be up and running by December. It will be one property with 4 units – 3 units communal with one unit possibly for vulnerable females.

- How is this prioritised - home treatment will gate keep.
- Priority will go to any service with 24/7 access.
- Half of the team have been in position for approx 6 months, the others longer.
- It relates to what services are available and not necessary training.

Focus Group Nine

One: Training

Psychiatric therapy might be helpful, but are we entering an area of work we are not sure of. This might blur the boundaries we have worked hard to create, housing related support and independent living should be one service, psychiatric help should be separate. (1B)

Is this a cheap way of getting rid of CPN's and psychologists, if so this could be dangerous and messy. It would be more beneficial to have separate services. Service user relationship could be impacted by worker knowing too much information about client. How does this affect confidentiality? (1B)

Service users need more training/time to develop their skills prior to reaching this service. (1C)

Glenbourne has a shortage of staff and there is no where for clients to go from Glenbourne prior to arriving with us to receive the training required. (1C)

Right information is not always supplied; reference support plans. Providers make referrals with a lack of knowledge. Not a lot of information re. The person involved, plenty of information on care person has received. (1D)

Service user needs to have some input as they are not always aware of what information is on the referral. Sometimes no history of the client is provided. (1D)

Inpatient's to supported housing is a big step. Training needs to be completed when they are an inpatient. (1E)

Preparation for the right type of training from inpatient to community living needs to be identified. (1E)

Two: Crisis House

24/7 with therapeutic input and support at crisis house. Clients can feel isolated. (2A)

Home treatment will gate keep; it may be in danger of becoming an assessment centre. (2B)

Proposing a 2/3 day max stay depending on depth of vulnerability. (2C)
How long is a crisis? Max. 5/7 day stay was suggested and should be flexible as each clients needs are individual. Access can be made at any time within a 24 hour period. (2C)

Timescales should be fixed around client's needs and not max stay period. (2C)

People need time out sometimes. Beneficial if clients know this is an alternative to admission to Glenbourne. (2E)

Three: Barriers

Private landlords will not accept service users on housing benefits or mental health clients within the sector. Stigma with mental health issues. (3A)

Not enough housing stocks available within Plymouth City Council and a great lack of choice. (3A)

Clients feel nervous going to certain areas of Plymouth to live. (3C)

No guarantor available for most clients (private landlords). Landlords need to be trained to understand the needs of clients. (3D)

Local authority needs to allocate appropriately and take clients wishes and needs into account. (3E)

Four: Support

If we had the option of a CPN working in this service it would be good to help with medication etc. (4D)

Multi agency working is the way ahead. (4D)

A skill exchange would be good. (4D)

Implications Arising from Research

- **Other themes**
- **Positive**
- **Negative**

- Training flat would be a good opportunity within an inpatient or supported living unit prior to them coming into the community. A bridge needs to be identified to close this gap.

- Case by case knowledge, more needs people have the harder it is to engage them.

- Media also has an impact.

Focus Group Ten

One: Training

If staff where trained to deliver psychological therapies it would be difficult along with their existing roles as they are currently bursting at the seams. (1B)

Support/care plan should be started as a impatient with this group continuing the plan not starting it. (1D)

Independent workshops should be given to prepare for independence and this service would follow after that. (1E)

Two: Crisis House

24 hour support, counseling, manage medication, personal responsibilities should all be provided in the crisis house. (2A)

Could learn additional skills and follow on with personal responsibilities when they have left crisis house. (2A)

Could be a conflict of interest as the home treatment team might prioritise their own clients. Home treatment as a service might service themselves only. (2B)

It is not a need's lead service if there is a cut off point after 5 days. Issues of flexibility should be tailored into the need and not a fixed time scale of 5 days. (2C)

Does need time frame but 5 days is to short with a mixture of support with follow up work to prevent the crisis happening again. (2C)

Access should be at discretion of need and what the crisis is for example, environmental and this could impact on length of stay. There should still be a maximum stay, however long that may be. Crisis House could have opposite effect on some clients in that they would not want to live independently. (2C)

Follow up work needs to be completed after leaving crisis house.
Need to record and evaluate follow ups to reduce number of people who use crisis house. (2D)

Domiciliary Care in crisis house – not necessarily needed as taking independence away from client. (2D)

It should be an independent service to give access to crisis centre with quick access. (2E)

Can Colebrook refer to crisis house, if so training will be required (2E)

Three: Barriers

Money is a barrier, private rented property, council property in poor areas. £360 is the housing benefit this is not enough as the average rent is £500 per month for private rented accommodation. (3A)

Private landlords will not accept housing benefits. (3A)

Allocation of Plymouth City Council properties is not suitable and this could affect their mental health needs. (3A)

Conflict reference aims of services and make process more confusing for clients. (3C)

Limited supported housing, shortage of residential units. (3D)

Staff generally need further positive attitude. Change of attitude and culture. This culture is across all services. (3E)

Divide between community psychiatric services and independent sector supporting people. (3E)

Four: Support

Medication – clients could self medicate and self manage. Training should be given to them. Insight is needed; this should be preparation work before referral to the community. (4A)

One specialist post would be a good idea. (4D)

A member of this staff group working in Glenbourne and Glenbourne staff working in community would help clients to move on. It would be beneficial to client but isolating to staff members. (4D)

Implications Arising from Research

- **Other themes**
- **Positive**

- **Negative**

- Higher need people block a crisis house; others should not need it if they received the right service in the community in the first place.

- Definition for access as to what a crisis is.

- What happens when crisis house is full?

- Home treatment teams assessment, and in patient interpretation of process, when home treatment assessments needs is different to this groups interpretation.

- Look at services available, would the finances going into crisis house be more useful to go to services/resources available in the community and then the crisis may not occur.

- Crisis house is reactive rather than preventative.

- It feels as if people get abandoned.

Community Psychiatric Services

Focus Group Eleven

One: Training

Need to make staff much more aware of mental health issues and needs and need to break down the prejudices. (1A)

Psychological Therapies – this is a huge issue. It is needed and a lot of people cannot access therapies unless they have some kind of care co-ordinator / are a patient. 'Low level' individuals cannot access therapies and thus may become 'high risk'. This could be avoided. (1B)

There does seem to be a post code lottery as to whether some people can access psychological therapy. (1B)

Two: Crisis House

Carer support – in situations where a care package has broken down the carer may need support from staff. Input from staff may help to support the carer. (2A)

3 – 5 days stay would be about right. Would not want longer as we may then be reinforcing that being in a crisis situation 'is ok' and people may settle. (2C)

7 days could also be ok because of the varying nature of situations. The length of time needed depends of the individual and the nature of the crisis.
Need to be very tight on referrals. A.S.W's need to have access to the crisis house to make referrals. (2C)

Three: Barriers

Contracts need to be clear. Providing clients with info about the expectations e.g.: clear leaving dates etc. This can also have a negative effect though as some clients become stressed around the time that the leaving date is approaching at the prospect of moving on. (3C)

Need movement forwards and backwards. Clients need to know that they can move back a step if necessary. (3C)

Joint working needed with other agencies. Appear to be fighting against each other at times. (3D)

Staff skills – we see staff at some of the Colebrook schemes as not being trained well enough, seen as 'non skilled'. They appear to be focused on their particular service and do not see the bigger picture. (a lot of them appear to use Colebrook as a springboard). We definitely need more training at the Stage 3 services to manage clients. (3D)

Stage 4 – need specifically trained staff at this level. Staff appear to find it hard to manage. Dom care doesn't have the training to deal with complex mental health issues – 'find it daunting and scary'. (3D)

Workers should continue to work with patients after they move on for a period of time before handing over completely to someone else. This will promote better continuity which in turn helps the patients. (3E)

Correct info needed regarding processes for referring clients to different schemes and for housing etc. At the moment we tend to make a lot of referrals to different places to for the same client – is there just 1 that we could do for multiple schemes. (3E)

Training can be 'patchy' in some supported housing services – definitely needs to be improved upon. (3E)

Four: Support

There is a definite issue regarding particular medications. There are cases where patients require support from their GP, such as for blood tests and monitoring – and this is not always happening / not managed very well. (4A)

A lot of crisis situations that happen are related to drugs or alcohol. Knowledge is needed to deal with this. Training for staff regarding these issues and other issues such as debt, housing advice etc would be very useful. (4B)

Patients with multiple issues e.g. drugs problems that may then bring on mental health issues need to have a multi – agency approach in supported housing. Outreach also needed with this approach. (4B)

Better links to Primary Care needed in the community. (4D)

Definite need for a co-location worker who has links to other teams such as housing, benefits etc. Need routes in to other peoples 'worlds'. (4D)

Westcountry Housing and MIND already have outreach and floating support services to keep in contact and maintain continuity with their clients. This seems to be working very well for them. (4D)

Possibly a co-location worker would be useful. (4D)

Implications Arising from Research

- **Other themes**
- **Positive**
- **Negative**

A single assessment is best in terms of the referral. Would not be good if we had to pass on to another agency to do the referral.

Focus Group Twelve

One: Training

Providers need to focus on activities, social inclusion and needs assessment
They need to focus on increasing independent living / enabling skills including:
Daily needs
Cooking

Budgeting / bill paying
Sleeping patterns
Hygiene
Supportive social networks
Problems solving, confidence and assertiveness (1A)

Staff will need to be competent and confident to deal with mental health crisis (1A)

Clients to be compliant with their medication and therefore prevent relapse (1A)

Some supported housing provides do provide this type of recovery focused support with a more positive focus on move on. The example given was a younger person's service. (1A)

Supported housing providers need training to train service users. (1A)

There are psychological therapies available through PCLT's and other health services. Service users can access them through PCLT's, GP or voluntary sector. (1B)

Will need to establish links with these and help clients attend appointments, but do not need to provide additional therapies (1B)

Support plans and service delivery needs to be recovery focused, positive and around reducing social exclusion. (1D)
Support plans should include medication needs (1D)

Service users need training around life skills and independent living skills (1E)

Two: Crisis House

It may prevent a client moving to residential or acute inpatient care (2B)

Access should be from anywhere in the community as long as clients are working with A.O.S or the home treatment team. (2B)

The maximum length of stay should be 5 days. (2C)

Practical support on top of mental health support will be needed. (2D)

Access to the crisis house from supported housing could be used as a respite and might reduce the likelihood of eviction. (2E)

Three: Barriers

There is a need for stage 2 (inpatient, assessment and move on service, short term residential facility) accommodation (3A)

The inability to go back to a more supportive environment (culture) (3A)

Chaotic behavior excludes people from all stages (3D)

These individuals are forced to go straight to independent living, even though it is not the most suitable solution as none of the other service are able to cope with them. (3D)

Availability of back up services (3D)

Lack of access to health support (3D)

Lack of creative solutions (3E)

Four: Support

The ability to support, monitor and store medication – extremely useful. Staff need to encourage, prompt clients (4A)

Staff need to ensure clients pick up their prescriptions (4A)

Relapse is often caused by clients not taking their medication. Someone monitoring this would greatly increase recovery (4A)

Risk History – a client's risk history is a significant barrier to move on especially if there is a forensic, drug or alcohol history. (4C)

Historic risk is used as a predictor of current risk. (4C)

Current risk can be a barrier (4C)

Supported housing should have enhanced support to prevent clients having to use the crisis house. This could be achieved through co location. Having skilled people with knowledge and links would be very positive and really useful in reducing barriers and cultures. (4D)

Co locating CPN staff to single homeless and mental health sector would support (4D)

Implications Arising from Research

- **Other themes**
- **Positive**
- **Negative**

- Training flats – It would be really helpful to have training flats (like LD) where clients can try out living a more independent lifestyle.

- Stage 2 services might present a solution

- Communication issues around need and risk.

- The use of B and B and temporary accommodation (Clearsprings). Clients are not able to sustain these kinds of placements. They are too vulnerable (from other people in the properties) and give up, then being found intentionally homeless. Staff at the homeless unit are unhelpful and don't understand the needs of mental health clients. Attitudes are very poor and clients with mental health needs are stigmatized. Processes are too slow and not flexible working to the needs of the service and not the client.

Focus Group Thirteen

One: Training

Those dealing professionally with young people should have the necessary knowledge to adopt appropriate attitudes. Thus anti – discriminatory training is essential as well as the capacity to reflect over praxis informed by the relevant theoretical models. 1A

The needs of each client must be fully assessed and this would include information about problem families. 1A

The skills need to be developed. 1A

Any information to assist the smooth delivery of the process must be beneficial. 1A

Specialised intensive therapeutic support is needed, based on models of counselling theories. 1B

This should be based on a holistic approach where all users are aware of the challenges of youth transition and mental health issues. 1C

More trust is needed from housing staff in dealing with applications from young people. Furthermore, they should engage with professional youth workers so that they can benefit from a holistic picture when allocating tenancies. 1D

…the service… think they have experience that could be profitably shared on an inter-agency basis. 1E

Two: Crisis House

A variety of time horizons were envisaged ranging from two weeks to two days - undoubtedly there is a need to be flexible. 2C

This time-span has some use as an average for budgeting purposes but again the group emphasized flexibility. 2C

Clients may need a couple of nights to calm down and during this period one to one assistance might be preferable. 2C

A multi-agency approach is essential - the structure in the crisis house needs to be determined on a multi-disciplinary basis. 2E

Three: Barriers

There is a lack of understanding "about where clients are" – "what their issues are." Thus, young people want to live independently but lack the confidence. 3B

There are practical issues – the difficulties of raising deposits/rent in advance. Often there is a lack of confidence in a young person to successfully manage a tenancy. 3D

This is desirable but the group was somewhat cynical about the availability of the necessary housing stock. 3D

Throughout the private rented sector there are deposit issues and, anyway, accommodation is very limited and often restricted, for instance "No DSS." 3D

It is apparent that some supported housing providers are not taking clients who would get most from the service. 3D

Four: Support

If the crisis house staff could dispense medication this would be of considerable help. 4A

This issue, rooted in dual diagnosis, needs to be dealt with on a positive basis that offers an individualistic analysis of need. The client then decides whether to embark on a supplementary course of treatment. 4B

One again discussion with individuals should determine their requirements. Obviously if the choices available are widened this can be beneficial for clients with diverse learning needs. 4C

Young people have a perception of what their own accommodation should be like but the reality is often very different from these pre-dispositions. Therefore, there needs to be more honesty in the process. 4D

Implications Arising from Research

- Other themes
- Positive
- Negative

Extra time should be provided pre-eviction.

Focus Group Fourteen

One: Training

Individual care co-ordinators need to learn how to write reports and what skills are needed to understand the parameters of independent living, what it constitutes. 1A

It would be a benefit to know the content of the assessment forms used by housing workers and to have an understanding about the theoretical models that guide their work. 1A

If a detailed series of therapies are offered ……… cannot anticipate when these programmes will be regularly used as the Crisis House needs to stipulate how it will be managed, how it will be manned. 1B

Right now we are addressing the issue on an “ad hoc” basis – what is being done is unstructured. 1B

Two: Crisis House

In a hospital environment everything is done for you so the Crisis House could be the antithesis of this – therapies could be complied through the ethos of the institution. 2A

There is no middle ground for …our service… but Social Work Staff see a Crisis House as “another option.” 2A

Social Workers can embrace the middle ground as an option to avoid the costs of B & B. 2A

A care-planning analysis needs to be put in place before entry into the crisis house. 2A

It is recognised that the Crisis House should not be used as a lengthy option – instead it should be limited to 5 days a week. 2C

The group thought that 5 days to a week was an adequate time-span. 2C

They all felt that discharge planning should take place on entry on the basis that crisis is short-lived. 2C
It was re-iterated that one five-day stay should usually be adequate to address a “crisis period.” 2C

Clients experience an environment in hospital where everything is done for them – so the crisis house could not be contrary to this ethos. 2D
In this context, the construction of good support plans are essential with the patient informed about what is in their plan and how they are being helped. 2D

There was agreement that the crisis house would not be used regularly by AOS clients. 2E

The group saw the house as a valuable opportunity to “give time out” so it would become a valuable tool in their armoury. 2E

Care must be taken to ensure that the crisis house is not perceived as another hostel. 2E

Three: Barriers

The participants perceived a change of remit between housing providers which causes a “push and pull” between services, appropriate rate in an appropriate place etc. 3D

The group also noted that some people do not go into in-appropriate accommodation. 3D

There are people who target mental health patients and this has lead to a strategy where they all live in one area. The question is “where is the dignity for the individual in this approach?” 3D

Furthermore, inappropriate areas may be selected where everyone is "in one space out of the way." This can have a detrimental affect resulting in people becoming frightened and afraid. 3D

Definition of what constitutes supported housing needs to be re-thought. 3D

Training and knowledge is an important issue for all personnel involved particularly getting the balance right between housing needs and mental health. 3D

More details of the choices that are available are essential – at present agencies tens to "cherry pick" leaving some service users with few options. 3D

There is no pathway, no clear links, no resource directory – the only way for staff to discover the parameters of choices is through experience. 3D

Concern was expressed as to "how much an individual has to know and how much they can know" about complex issues. 3E

Four Support:

Difficult for those workers involved – it is the client's personal choice to take of refuse this extra support. 4B

Concern was expressed that housing providers would not know these clients well enough to offer an effective level of support. 4C

A.O.S proscribe and deliver but a trained nurse would be a useful addition to the staff of the crisis house. 4D

The question was raised over the level of achievement possible for satellite workers. Evidence suggests that some improved outcomes could be possible but this might not be the product of co-location as "anyone could plant the seed." 4D

There needs to be a transparency about the notion of supporting people so that indictments about individuals being discharged "worse than they came in" can be legitimately avoided. 4D

The management of risk is very complicated in that it is difficult to understand the necessary paperwork. 4D

This was perceived as a necessity in view of the specific demands of individual clients. 4E

- **Implications Arising from Research**

- **Other themes**
- **Positive**
- **Negative**

- Service users should be "put at the heart of the matter."

- Staff need to be aware about how to distinguish between "severe cases and those that are not."

- This service…would like to send their staff into the crisis house but had concern over an extension to their existing workload.

- It was noted that the primary issues were how the house will be managed, how it will be staffed and the procedures that it will adopt.

- There was general agreement that the structure of the house (both physically and as regards process) is very important.

- The participants saw no middle ground for …their service… and contrasted their position with a social worker that might perceive the facility as "just another option" as an alternative to a bed and breakfast.

- The crisis house should not receive the negative label of "you can do with…"

- "Ghetto-isation" of mental health patients is an issue.

- Some concern was expressed that the crisis house may become an attractive destination with clients returning regularly.

Part two

Inpatients and Rehabilitation services

Focus Group One

Section One – Training

A – Staff have the skills and knowledge

- **Stage one services** – staff do not have the confidence or knowledge to give advice / support to patients about their housing options, benefits, availability of services and processes (applications, homeless approaches etc)
- **Supported Housing Providers** need to better understand clients needs especially around their mental health diagnosis, presentation and appropriate ways of working (i.e. offering appropriate opportunities and not overwhelming with choice). Providers also need to develop a better understanding of risk, especially the difference between historic and current risk.
- **Dual Diagnosis** - There is a need for all services to understand the role drugs and alcohol play in mental health. All services should expect clients to have a dual diagnosis
- **Benefits / homeless team** staff need to have a better understanding or mental health and the impact it has on individuals abilities to respond in appropriate ways (i.e. deadlines, completing forms). They need to develop more flexibility or have a different approach for clients with mental health needs.
- **Positive practice** – The Spring project seems to work more effectively with clients. They are more active with clients and have a better understanding of mental health. This may be because they have a CPN working at the project. The STR training program is good because it provides a consistent and comprehensive approach to training.

B – Psychological therapies

- Having access to psychological therapies at stages 2-4 would help people move on more quickly and continue therapeutic work started in stage one. Community based treatment would increase confidence of staff and clients.

D – Support plans

- They seem to promise a lot but don't deliver and clients don't get positive outcomes. **Front line staff need to have a better understanding of mental health.** There is an over reliance on AOS or HTT for things that do not need mental health staff support. Often, services are acting as an 'alarm' system. Providers need to offer appropriate support informed by their knowledge of mental health

E – Service user access to training

- Patients / clients would benefit from opportunities to learn about independent living skills, benefits and have education / vocational opportunities

Section Two – Crisis House

Staff explored their experience of crisis provision in Hull (Humber PCT and MIND) and Portsmouth These services experienced problems and one had closed and one changed into a drop in / day centre where multi disciplinary support was available. Both services had problems with inappropriate referrals and became 'clogged up' very quickly with people whose principle support needs were either personality disorder or drug and alcohol issues.

A – Extra Help

- Crisis house provision would be very beneficial for clients moving on from Lee Mill

B – Access

- The service will need to be targeted at the right people and access strictly controlled. The service will need to retain its focus.
- Training will be required for crisis house staff to ensure they have the right skills to enable clients to move on quickly

C – 5 Day stay

- The time limit on stay is too long. Patients should either be assessed as needing acute admission or linked in with additional support within 48 hours.

D – Practical support

- Practical support will be a very important focus especially around benefits and welfare rights issues. The support must not be mental health focused. It may be better run as a day service rather than over night stay.

Section Three – Barriers

A - Accommodation Options

- **Over subscription** for supported housing placements means that providers are able to 'pick and choose' clients. This means that clients with high needs or risk history are not chosen. This constant refusal is very demoralising for staff and clients.

- **Stage 2** - When a patient has the sanctions associated with section removed they often experience deterioration in their mental health. There is a definite need for stage 2 services. These should be staffed 24 hours a day with staff from health. They should provide a structured environment with firm or rigorous regimens. This would help clients continue to develop within a safe environment. There is too big a gap between being on section / secure unit and living in supported housing.

- **Flexibility** - It is really important to be able to move in both directions of the accommodation pathway and step back to receive more support when necessary

- There is a lack of **long term secure facilities**. Staff felt placements are often made based on cost rather than need. There is a need for long term placements which are more homely and less like a hospital environment

B – Wish to live independently

- Patients should have a say in where they move on to and should be aware of the options open to them. They should have copies of the pathway (diagram).

E – Time
- There is too much pressure to move on

Other Barriers
- **Historic risk** is a significant barrier to clients being able to move on especially if the risk relates to:
    - Forensic history
    - Drug and alcohol issues
    - Arson
    - Assault
    - Poor compliance or insight

- **Resources –** there are not sufficient resources to meet placement needs

- **Support plans in supported housing** should reflect what has already been achieved during clients in patient stay. They should consolidate this work and move forward.

Section Four – Support

A – Medication
- **Supervision of medication** is an important. This could be achieved through co locating staff and would facilitate clients moving on.

B – Drug and Alcohol treatment
- The staff team felt that drug and alcohol issues cannot be separated out from mental health and are a significant problem for 90-95% of clients. All services need to reflect this dual need.
- Access to waiting lists and treatment is extremely important

D – Co location
- Co located staff or access to specialist support (either mental health or housing support depending on the service) would be extremely beneficial. STR type staff would be beneficial.

- Perhaps there should be some kind of trouble shooter who can problem solve issues to do with mental health or housing support

- Residential services are dispersed across a large area. Staff feel isolated and not in touch with what is going on. Either a directory of services or co located staff would reduce this isolation. This would increase / improve access to services, knowledge and options available to patients

E – Access to all types of supported housing

- The mental health client group is becoming increasingly younger. These patients will need appropriate services to move on to. There also needs to be better links with child and adolescent services

- Drug and alcohol issues are prevalent too and access to services focused on this primary need, but able to understand and work with mental health are also needed.

Other issues

- Support needs to include vocational opportunities and other specialist skills like welfare rights and benefits.

- Staff felt that the stage one services need to be seen as part of the accommodation pathway. They need to be included in information sharing and the links between stages need improving.

Focus group Two

Focus group was provided with service map:

Crisis House

- Service should be short term stay.
- If the crisis service did not have a maximum time limit it would leave it open to abuse. Some service users would misuse crisis accommodation and treat it as respite or a long term housing option if no limit on stay were made.
- Having a time limit will help avoid blockages, enabling more people to get access to the crisis service.
- Crisis accommodation would help throughput from inpatient and rehabilitation services.
- 24/48 hours should be enough time for most service users to reduce the crisis and move back to their normal place of residence.
- Crisis (Mental Health) is short term; length of stay should reflect this.
- Crisis can mean respite for the family supporting the service user in the same way crisis can be respite from the family for a service user.

- Consensus that five days should be the maximum length of stay for anyone needing the crisis house. If the crisis lasts longer than 5 days then the service user is likely to need acute inpatient services or rehabilitation services.
- Having access to a crisis house would reduce admissions to inpatient services.

- Additional help need in the crisis house to help service users reduce their crisis should include 'counselling'.
- Additional support should include domiciliary care as service users accessing the crisis house will have different backgrounds' and levels of support needs.
- Budgeting, money management (paying bills), personal hygiene, cooking and personal care should be part of the support offered by the crisis house.

- Supported housing providers should have access to the crisis house.
- Access to the crisis house should be determined on the basis of need.
- Home Treatment Team as gatekeepers of acute care (inpatient) services would be well positioned to manage access to the crisis house. However, Assertive Outreach Service should likewise have direct access due to the type and nature of the client group.

Barriers

- Service users presenting with enduring mental health problems currently do not fit with the available accommodation services outside inpatients and rehabilitation (Health) care services.
- Service users with a high level of need could live in the community if services were better tailored to meet their specific needs.
- Service users with enduring mental health problems could move on if residential services in the community provide more one to one support.
- Supported housing and residential services are at their most effective if they are small in physical size. This promotes good mental health, stability and reduces inpatient re-admission.
- Size of residential service is important, big is not better. The bigger the service the more likely service users are to get into crisis with their mental health.
- Most services in the community have a large number of units with staff who find it difficult to communicate with service users or build good relationships. This often results in isolation and a deterioration in their mental health and well being.

- Some service users have the ability to move on but do not want to move on because many of the services offered to them are unsuitable for their need.
- Service users feel sometimes feel vulnerable because the move on options available to them do not offer the right kind of support.
- Some service users do not have the ability to move on, but would be able to manage independent living if the right level of support and package of care were available.

- Confidence to move on is a big factor for service users, however it was felt that with the right kind of support networks service users accessing residential rehabilitation.
- Confidence could be improved if Domiciliary Care, Supporting People funded housing related support services, A.O.S, PCLT and Home Treatment supported the move on process.
- Crisis accommodation as an option if things go wrong would increase a service user's confidence.
- If the right support were made available staff would feel more confident about moving service users on.
- Counselling promotes confidence.

- Knowledge of mental health specific services in the supported housing sector is limited.
- Awareness of housing and accommodation services and move should be provided by a Social Worker but this has never happened.
- Access to a housing support worker or housing advice worker would benefit the residential rehabilitation services and increase the opportunity for the right kind of move on to take place.
- Residential rehabilitation would benefit from a link to a service that provided housing advice.

- One of the biggest barriers to move on is the support service users receive after they leave inpatients and rehabilitation services. Often to low and staff outside the inpatient and rehabilitation services often do not understand the needs of the service user.

- Service users need slow processes to operate if they are to progress to a position which will enable move on. It likewise has to be planned.
- Housing services in the community are driven by the need to fill accommodation vacancies. This is not compatible with the need and time it takes to prepare a service user for move on.

- Referrals to services in the community are often returned because the service users need and risk is considered to high.
- Housing services in the community have to a high expectation of service user for many to qualify for access to their services.

- Quality of support is a contributing factor in staying well.
- For timely move on to take place in a controlled way good quality accommodation with one to one support needs to be made available. This helps prevent a decline in health.

Support

- Help with medication once service users have moved on will continue to mean service users are dependent and in need of care. However, living independently with support around medication could help service users move on from residential rehabilitation.
- Service users would greatly benefit from financial advice and support.
- Carer and community involvement alongside CPN input in the crisis house would help promote move on.

Training

- Staff teams working in the voluntary and community sector need training around mental health generally. Training should take the form of mental health awareness and presenting needs which should likewise include attaining an understanding of triggers and the early signs and symptoms of a person's health deteriorating.
- Training should also include breaking the fear barriers associated with working with some clients who present or have the mental health label.
- Labelling is a barrier to move on as service users with this background are seen as to a high risk, which is often based on perception rather than real need.
- Training should be provided to all staff on communication as communication provides the opportunity to catch the early signs and symptoms associated with mental health crisis.

- If services had access to psychological therapies this could help service users to move on or sustain their independence in the community.
- Service providers in the community would benefit from having access to psychological therapies as long as training was provided.

- Inpatient services and rehabilitation services would benefit from having access to psychological therapies, which could help service users in their recovery and maintain their recovery. This might likewise help to increase patients to move on.

- Inpatient and residential rehabilitation services start the training process that enables service users to prepare for move on. This takes the form of budgeting, personal care, cooking and other practices that help prepare people for a more impendent lifestyle.
- Community and voluntary sector services need to continue the work started by the inpatient and residential rehabilitation services, as this helps to keep people from returning to inpatients.
- Inpatient and rehabilitation services would benefit from housing support workers being co-located.
- Currently there is a poor transfer of information about the progress, knowledge and skills the service user has developed during their stay in inpatients and residential rehabilitation services, which can sometimes result in patients not being able to move on.
- The training the service user receives when they are in inpatients should be continued and built upon when they leave by other support services. Currently this does not happen.

Focus Group Three

Training

- There is a lack of understanding / knowledge of benefits and grants within health services

- Increasingly, supported housing providers are expecting residential services to get client's benefits and grants in place before they move on from their services

- There is a lack of knowledge about what accommodation services are available. The staff at the Gables rely on social workers to find and secure placements for clients. Options are therefore limited by the knowledge of the social worker

- Staff felt that they need to understand what services are out there and what they offer. This would help them when considering future accommodation options for clients.

Move On

- Currently, most clients are moving on to long term residential services.

- Clients experience many periods of relapse and where possible are re admitted to the Gables rather than Glenbourne. To help this the unit is developing a respite bed.

- Staff felt that the development of stage 2 services would:
  - Increase the number of clients who are able to move on
  - Decrease the length of stay in the residential unit

- Need to make sure that there is a high level of mental health support in stage two services

- A mental health version of extra care provision would be a really suitable option for clients using the Gables. This service would need to be able to work with a younger age range.

Crisis House

- Staff felt that a crisis house was a positive development and would stop clients being re admitted to acute services. They felt that the service should have the following characteristics:
  - 24 hour staff
  - 24 hour access to medical staff
  - Maximum stay of 5 days
  - Staff familiar to clients – staff who are already supporting the client should be able to 'follow' them into the crisis house (either from the community teams or from supported housing)
  - Practical support (daily living skills such as personal hygiene, cooking, money management, maintaining accommodation, communication)
- Access should include clients who are living in supported accommodation.

Barriers

- There are currently no stage 2 services

- Supported housing criteria are too restrictive. People with a history of arson, forensic background, historic risk, high suicide risk, violence,

- Lack of staff knowledge of supported housing options. Only aware of ones that have been used before or that social workers are aware of.

- AOS expertise is used to help find placements

- Clients are sometimes a barrier to moving on. Some have become institutionalised, feel safe and don't want to move. Many see the unit as their home

- Increasing awareness of the model / services that are available may inform clients and their families and help promote independence

- Past experiences often act as a barrier. Clients have had bad experiences of supported housing and of being supported by community services.

- Staff also have no confidence in current services and very inadequate knowledge of what is available.

- GP's will not take on clients on certain medications as they are expensive and require considerable monitoring through blood tests.

Support

- Any step down service must have adequate mental health support. This should include medication, links to community services, support with physical needs, dom care and daily living skills / housing related support.

- Services need to provide help with benefits including making applications and appeals

- Practical support is really important particularly with attending appointments and communication

- Co location of staff would be really positive. Mental health staff co located in supported housing would mean clients could receive support with medication, have understanding of the clients mental health needs and prevent re admission during relapse

- Co located housing staff in residential units would increase the skills and knowledge available to clients who are ready to move on. These staff could attend planning reviews so move on planning starts earlier

Focus Group Four

1. Training

Training in benefits for staff and service users
Need easier access to people for benefits information.
Not allowed to fill in forms for service users have to refer them
Already receive training on budgeting, looking after themselves and environment, access to jobs.
Some information about what's available regarding accommodation would be helpful.

2. Crisis House

Invaluable to people who have different types of personality disorder.
When discharge do so with certain amount of confidence.
This would not be good for people in residential care.
Like to see residential services have access to this service and also home treatment.
Also have outreach clients who could benefit from these services
Stay should be maximum of 1 week as 5 days may not be long enough.
Practical support – access to benefits, social housing, advice about health promotion, drug/alcohol treatments.
Supported Housing providers – they should have access to crisis house and it should be based on individual need.

3. Barriers

Some people will always be at Stage 2 due to their illness. They are not barriers they have reached their limit they need to know that they are not going to be pushed through.
Barrier is person's ability to move on.
Not knowing what accommodation is available
Lot of clients whose movements are governed by the Home Office due to offences committed. No forensic housing in city.
18-30 not suitable due to level of functioning. These are mainly females who are vulnerable.
Time spent at each stage could play a big part in moving people on, some time is too short for some.

4. Support

Consistent approach – some people trust those people. It is not necessarily about people needing to be told when to take medication. If the service by where they are assisted with their medication was taken away then their health would deteriorate.
If chaotic with medication should have AOS worker
Drug/Alcohol – struggled to get support for people with these problems
Co-located housing advice – would help to have mixture of qualified support at stage 2.
Stage 2 – Housing that moved on to would need specialist support from this type of service but not to the largest side.
Barrier – to move to independent living could be waiting a long time for housing – better support to look at planned movement and including all providers.

SP funded services stage 3 – is this beneficial – yes.

Should not be expectation that everyone can move through. No everyone can live independently. Not enough residential placements for people that need them. Don't always need to move people out of residential.

Focus Group Five

Training

- Service users need to have training around:
    - Basic life skills
    - Self esteem and confidence
    - Ability to deal with anxiety
    - Strategies to deal with loneliness and develop links with their local community
    - Help to participate in 'ordinary' services
    - Independent living skills (budgeting, shopping, etc)

- Supported housing providers need to understand that this is what service users need

- There is no budget at stage one services to start this work. This kind of support should be offered at stage one as staff have often built up good working relationships with clients. There needs to be an STR type role at stage one.

- Stage 2, 3 and 4 services should build on the work undertaken at the preceding stage and not start over again. There should be an integration period when a service user transfers from one stage to the next to allow for better hand over and for links with the new service to be developed

- Psychological therapies should follow the patient and it would be very positive if they were delivered where ever they are living. This is especially relevant for therapies such as brief solution focused therapy. These could be delivered by housing staff if they received appropriate training.

Crisis House

- HTT or AOS should gate keep access to the service

- Maximum stay should be 5 days. 5 days should allow sufficient time to establish if the client needs a higher level of intervention. The length of stay may need to be reviewed following evaluation.

- Consideration should be given to allowing Devon Partnership clients access to the service

- There should be a downstairs room for disabled access

- There should be a female only space where vulnerable females can feel safe.

- The project needs to be staffed with people experienced in working with mental health clients in crisis. The team should include a mix of males and females, qualified (medication) and unqualified, OT's

Barriers

- The step from 24 hour supported or secure services to supported housing services with staff 9-5 Monday to Friday is too great.

- Clients are often seen as too high functioning or too risky to go to supported housing. Historic risk is often a barrier particularly around violence, arson or forensic history.

- There is a lack of suitable placements including:
  - residential placements
  - 24 hour supported placements (but at a lower level than acute services)
  - Placements for high functioning clients who still need support
  - Specialist placements
  - People with a history of risk or previous experiences of supported housing

- Stage two services are definitely needed, however these may need to be single sex provision

- Clients previous experiences in supported housing can be a problem either because they did not have a positive experience or because the services are not prepared to take them in again.

- The application forms and interview processes to access housing services are a barrier

- Funding for residential placements

- Staff knowledge of what is available. This is mitigated by the Support, time and recovery manager's role. Having a member of staff with knowledge and skills around securing placements is very positive.

Support

- Co located staff so that clients can receive support to take their medication. Not having someone to supervise or dispense medication can mean clients remaining in inpatient services. Clients have had to remain linked to inpatient services to receive their medication as GP's surgeries have refused to take on clients on some anti psychotic medication because of the expense and the ongoing testing required.

- Clients often needs support around diet and exercise
- Motivation
- Time management, work and education
- Linking in to ordinary services rather than mental health specific services. Community integration, normalisation

Focus Group Six

Training

Staff Skills/Knowledge:

- Awareness on issues relating to learning disabilities is regarded as essential.
- Training in organising and maintaining benefits is also of high priority.

Psychological Therapies:

- Good counsellors or advocates are always useful in promoting better mental health.
- It is desirable to train people to deliver therapies.

Service User Skills:

- Knowing how to access specific services is very useful.
- Promote independent supported living - a continuous process maintaining skills on a continuous basis.

Support Plans:

- These should be holistic and based at a strategic rather than managerial level.

Service User Access to Training:

- This needs a multi-agency approach and a co-location of staff to create a holistic understanding of a wide paradigm of needs.

Crisis House

Extra Help:

- This will need an element of assessment to evaluate a particular situation and could be a short cut to in-patient admission.

Crisis House Access:
- If someone accesses the facility two to three times over a two month period then there is an issue over effective analysis of the underlying problem.
- With only four beds available prioritisation of need is essential.

5 Day Stay:
- The group felt that a week was the absolute maximum – indeed the best idea for the facility would be a couple of days "to get clients sorted out."

Practical Support:
- Patients should "be carefully placed" in this environment to avoid possible conflict.

Supported Housing Providers have Access:
- It was felt that there should be a "gatekeeper" and it would be desirable if Home Treatment/AOS regulate access to providers.

Barriers

Accommodation options:
- In some respects the most problematic cases do best. Finance is available for extreme cases but this takes up the majority of the available resources.
- From the perspective of the group some of their clients could manage residential accommodation but they would need some support. Furthermore, residential is limited. So, the underlying barrier is the lack of suitable housing.

Wish to Live Independently:
- This is a "mixed bag." Some people cannot move on due to lack of accommodation then they "slip-back" and are no longer ready for the transition.
- Some clients may not want to move on. They may have both the potential and, over time, the ability to live independently but they still demand the security and nursing care available in "the Willows."
- Some clients have everything done for them and become institutionalised thus making their options very restricted.

Confidence to Reduce Support:
- The ability to be flexible concerning individual's needs is essential and in this scenario staff look to build structured transitions tailored to each person. However, this is a process that cannot be rushed.

Knowing what is out there:
- Service teams generally have very limited knowledge as they rely on care management/social workers for advice.

- Frontline workers should be part of the decision making process concerning the placement of clients however with the limited resources available they need to negotiate for the best deal they can get.
- With the lack of resources, the group estimates that 80% to 90% of their client group will not move past stage one in the process of transition to more independent living.

Time:

- Once again the group emphasised the importance of structured transition for clients but time becomes an issue as there is few opportunities to place individuals as they become more confident.

Support:

Medication:

- The group felt that a multi-agency approach was the best strategy and this would embrace the co-location of staff. They also noted that in most residential placements untrained staff do "give" medication.

Access to Drug or Alcohol Treatment:

- No comment from the group on this issue.

Ex-Offenders:

- As above.

Co-located Housing Advice Resource:

- Regarded as a useful initiative.

Access to all types of Supported Housing:

- This is determined by the lack of available housing stock.

Voluntary & Community Sector

Focus Group Seven

Training

- Supported Housing Providers – need more training around mental health. Particularly understanding of mental health conditions, how these impact on a client's behaviour and then how to modify behaviour or support to maximise contact with a service.

- Concern was raised that there was no blurring of the roles between mental health practitioners and supported housing practitioners. Their could be a conflict if staff assume a dual role.
- Service users would find it difficult to identify with professional identity. There is benefit having clear role definition, but do need to work in a multi disciplinary way.

- Mental Health Staff – need training around supported housing, particularly around knowledge and understanding of supported housing.
- The key to successfully working with a client is to:
    - Understand the issues
    - Know where to sign post

- All people involved with supporting clients should have these skills and if not need training to obtain them.
- Some supported housing providers are really good at providing training for employees. This training could be shared with other professionals e.g. support planning, risk assessment etc.

- There needs to be an improvement of the links between CPA and Support Plans. This could be a training issue as SH providers and MH professionals may not have a shared understanding of the processes.

- Supported housing providers should not be trained to deliver therapies. Supported housing is a clients home. Clients do not want to deal with issues in their home. This should be done elsewhere so that home can remain a safe space.

- Some supported housing providers use a training package with service users to help prepare them for living independently. These 'practical housing units' are of benefit to providers and service users.

- Acute services at stage one should focus on the clients mental health. Rehab / longer stay services at stage one should be helping to prepare clients to return to the community through the use of OT's etc. They should focus on practical skills such as cooking, cleaning and personal care. Currently the training clients receive depends on the unit they are in. Some clients do not have the foundations there for supported housing to work on.

- Service users need some training / education about what supported housing is, and what will be expected of them when they go there. They also need educating about the longer term options that are open to them. There is a general misunderstanding that going to supported housing means you will end up with a council house. Clients often have unrealistic expectations about their future permanent accommodation.

Crisis House

- The stay at the should be no more than 5 days. However there should be a small degree of flexibility for a few days over the 5. It may well be that people will only need to stay one or two days.

- There should be one point of referral with access gate kept by statutory mental health services.

- Mental health services should be responsible for managing the service and retain the duty of care / responsibility for managing the crisis and for managing the clients within the crisis house.

- A mixture of staff will be needed to run the service. There needs to be medically qualified staff to ensure that medication can be administered and the house managed as above. There also needs to be practical support offered such as dom care, cooking, managing money, preventing neglect, making sure clients are eating and drinking., personal care. A combination of health and housing.

- The service should continue to link with the client when they return home – linking in support services where necessary.

- It will be really positive to have a crisis house so that people are able to step out and then back to their own accommodation rather than going backwards. However, there does need to be a good link with Glenbourne to ensure that those clients who enter the crisis house and are assessed as needing inpatient services, or those people who deteriorate and need inpatient services are fast tracked.

Barriers

- Access to the crisis house

- Lack of move on from supported housing in terms of quality, affordability, location and cost.

- Barriers with the private rented sector. This includes private landlords unwillingness to take on tenants with mental health needs or who are on benefits.

- Client debt

- Lack of stage 2 services. The proposed model with stage 2 services in would encourage service users to move on. Realistic steps rather than giant leaps

to the unknown. Model at the Spring with CPN support and stage move on (house, flats, FS) has produced successful outcomes. It gives clients time to develop.

- Knowledge service users have at stage one is a barrier. They don't understand what services are available or what these services offer.

- Staff knowledge at stage one.

- Service users unrealistic expectations of move on options.

- Some clients do not want to move on. Some will require additional support for a long time. Currently there are no services for longer on going support in the community. Does not need to be mental health support but the kind that develops confidence and integration in the community, develops a structured day and provides practical support. There is not currently enough support in the community to encourage people to move on.

Support

- Services need to provide clients with support to take medication (holding, dispensing, getting prescriptions, taking, monitoring). **This is a key element to enable clients to move on.** The aim should be to encourage clients to become increasingly independent so that they become self medicating asap.

- We should replicate the CPN support offered at the SPRING across all supported housing projects including homelessness. SH staff benefit from the increased knowledge of mental health. CPN's benefit because their knowledge of supported housing is increased and SH staff are able to provide the practical support. Service users benefit because they receive an holistic service.

- There should be co located staff at stage 2. This would be a 100% advantage in helping people move on from stage one services.

- Mental health services should only work with clients with a dual diagnosis where the client has demonstrated commitment to stability. Otherwise the impact on the other residents in a project is too great.

- There should be linking of support and multi agency working at each stage

- Crisis support will be really positive so that clients are able to step sideways and prevent a re admission.

- Support should always be needs led.

NOTE: Not sure where this fits in, but didn't want to lose it. MIND stepping out were able to use some money from the reimbursement grant to pilot a project where housing related support services linked with the service users before they were discharged from Glenbourne to try and prevent early relapse or readmission. The service produced a report on the work. (attached) Representatives at the group noted that there is a shift in client group. There is an increase in the number of clients released to their homes on section. This means there is a need to work much more closely with the HTT who have primary responsibility for these clients care. MIND identified the need for supported housing services to in reach into Glenbourne / acute services to ensure support is linked to clients before they are discharged.

Focus Group Eight

Group maps distributed to meeting.

TRAINING

- What additional training is required?
  Half of the team have been in position for approx 6 months, the others longer. It relates to what services are available and not necessary training.
- Training so far has been good and important.
- Therapy training would be good as a support worker role covers lots of areas and boundaries need to be separated. It is important to know enough to identify the boundaries and signpost.
- People are feeling stretch in their roles due to recent changes.
- People do need to know what roles you cover as they are not aware of our criteria.
- When clients are referred to the service the referee takes a back seat.
- Referral process is clear that we do not do therapeutic duties.
- Referred service users do not come prepared for independent living. Referrals and preparation made but service users should have more training before reaching the service.
- There is an expectation of the service user, they should have more training for independent living before reaching the service.
- There will be a more high risk resident and staff need training in that area.
- Referrals received pose a higher risk than they can manage, services are stretched.
- We ask residents what they expect from us.

CRISIS HOUSE

- Crisis House is an alternative prevention service. If in house required then refer.
- Crisis House can only be used from Social Services, but supportive living does need access to the service. It should be 24 hour support backed up by the home treatment team and nursing staff.
- If a client is going into crisis who gate keeps the case? A clear and agreed process should exist with a clear criteria and making service users clear of the service. Clients want a middle care service, they do not want to be referred to Glenbourne, we know this from the client questionnaire.
- Should there be a time limit on a crisis. Service users should have a time limit, as a crisis could turn into a chronic situation. Others thought there should be no time limit.

BARRIERS

- The majority of people want council houses as it is more affordable living. They go before the mental health panel and cannot get housing if they are well, they can if they are ill, but then they cannot live independently and could end up in unsuitable accommodation.
- There is a disadvantage to get people through vulnerable panels. Service users do not want to live independently.
- Supporting People is a 2 year placement.
- Conscious service users do not want to move on, these are mostly the older clients. Younger people do understand it is a 2 year placements. It is an anxious time for people as they want to feel secure.
- Make a referral to vulnerable people panel that can make an impact on the 2 year limit.
- Clients have to accept the first place offered by P.C.C. this may not always be appropriate.
- The services does not meet the need.

SUPPORT

- What type and level of support do service users need to move on to access supportive housing?
- If forensic support is available additional support would be required as it would be a higher risk clientele.
- If a person has a forensic team that would be easier to handle.
- There is a big gap in support from possibly two people per day to a maximum of 6 hours per week.
- More support hours per person in the community is required, have the option to increase if required.

QUESTIONS

- Crisis House is funded by health – clients can still keep their house. There is no cost to the service user at present.
- Hopefully the scheme will be up and running by December. It will be one property with 4 units – 3 units communal with one unit possibly for vulnerable females.
- How is this prioritised - home treatment will gate keep.
- Priority will go to any service with 24/7 access.

Focus Group Nine

Group maps distributed to meeting.

TRAINING

- Case by case knowledge, more needs people have the harder it is to engage them.
- Service users need more training/time to develop their skills prior to reaching this service.
- Glenbourne has a shortage of staff and there is no where for clients to go from Glenbourne prior to arriving with us to receive the training required.
- Inpatient to group is a big step. Training needs to be completed when they are an inpatient.
- A training flat would be a good opportunity within an inpatient or supported living unit prior to them coming into the community. A bridge needs to be identified to close this gap.
- Preparation for the right type of training from inpatient to community living needs to be identified.
- Psychiatric therapy might be helpful, but are we entering an area of work we are not sure of.
- This might blur the boundaries we have worked hard to create, housing related support and independent living should be one service, psychiatric help should be separate.
- Is this a cheap way of getting rid of CPN's and psychologists, if so this could be dangerous and messy. It would be more beneficial to have separate services.
- Service user relationship could be impacted by worker knowing too much information about client. How does this affect confidentiality?

- Right information is not always supplied re. support plans. Providers make referrals with a lack of knowledge. Not a lot of information re. the person involved, plenty of information on care person has received.
- Service user needs to have some input as they are not always aware of what information is on the referral. Sometimes no history of the client is provided.

CRISIS HOUSE

- People need time out sometimes. Beneficial if clients know this is an alternative to admission to Glenbourne.
- 24/7 with therapeutic input and support at crisis house.
- Clients can feel isolated
- Proposing a 2/3 day max. stay depending on depth of vulnerability.
- How long is a crisis? Max. 5/7 day stay was suggested and should be flexible as each clients needs are individual. Access can be made at any time within a 24 hour period.
- Timescales should be fixed around clients needs and not max. stay period.
- It may be in danger of becoming an assessment centre.
- Home treatment will gate keep.

BARRIERS

- No housing benefits, no DHS clients with private rented accommodation. Stigma with mental health issues.
- No guarantor available for most clients. Landlords need to be trained to understand the needs of clients.
- Media also has an impact.
- Not enough housing stocks available within P.C.C. and a great lack of choice.
- Clients feel nervous going to certain areas of Plymouth to live.
- Local authority needs to allocate appropriately and take clients wishes and needs into account.

SUPPORT

- If we had the option of a CPN working in this service it would be good to help with medication etc.
- Multi agency working is the way ahead.
- A skill exchange would be good.

Focus Group Ten

Group maps distributed to meeting

CRISIS HOUSE

- Higher need people block a crisis house. Other should not need it if they received the right service in the community.
- Definition for access as to what a crisis is.
- It is not a needs lead service, if there is a cut off point after 5 days.
- Issues of flexibility should be tailored to need and not a fixed time scale of 5 days.
- Should be at discretion of needs and what the crisis is for example environmental and this could impact on length of stay. There should still be a maximum stay however long that may be.
- Could have opposite effect to some clients in that they would not want to live independently.
- 24 hour support, counselling, manage medication, personal responsibilities should all be provided in the crisis house.
- Could learn additional skills and follow on with personal responsibilities when they have left crisis house.
- Follow up work needs to be completed after leaving crisis house.
- Need to record and evaluate follow ups to reduce number of people who use crisis house.
- What happens when crisis house is full?
- Dom. Care in crisis house – not necessarily needed as taking independence away from client.
- Home treatment teams assessment, and in patient interpretation of process, when home treatment assessments needs is different to this groups interpretation.
- Could be a conflict of interest as the home treatment team might prioritise their own clients. Home treatment as a service might service themselves only.
- It should be an independent service to give access to crisis centre with quick access.
- Does need time frame but 5 days is to short with a mixture of support with follow up work to prevent the crisis happening again.
- Look at services available, would the finances going into crisis house be more useful to go to services/resources available in the community and then the crisis may not occur.
- Crisis house is reactive rather than preventative.

BARRIERS

- Money is a barrier, private rented property, council property in poor areas. £360 is the housing benefit, this is not enough as the average rent is £500 per month for private rented accommodation.
- Private landlords will not accept housing benefits.
- Allocation of P.C.C. properties is not suitable and this could affect their mental health needs.
- Staff generally need further positive attitude. Change of attitude and culture. This culture is across all services.
- Divide between community psychiatric services and independent sector supporting people.
- Conflict re. aims of services and makes process more confusing for clients.
- Limited supported housing, shortage of residential units.

SUPPORT

- Medication – clients could self medicate and self manage. Training should be given to them. Insight is needed, this should be preparation work before referral to the community.
- Independent workshops should be given to prepare for independence and this service would follow after that.
- Support/care plan should be started as a impatient with this group continuing the plan not starting it.
- A member of this staff group working in Glenbourne and Glenbourne staff working in community would help clients to move on. It would be beneficial to client but isolating to staff members.
- It feels as if people get abandoned.

TRAINING

- Can Colebrook refer to crisis house, if so training will be required.
- If staff where trained to deliver psychological therapies it would be difficult along with their existing roles as they are currently bursting at the seams.
- One specialist post would be a good idea.

Community Psychiatric Services

Focus Group Eleven

Training:

- Pschological Therapies – this is a huge issue. It is needed and a lot of people cannot access therapies unless they have some kind of care co-ordinator / are a patient. ‘Low level’ idividuals cannot access therapies and thus may become ‘high risk’. This could be avoided.
- There does seem to be a post code lottery as to whether some people can access psychological therapy.
- Staff skills – we see staff at some of the Colebrook schemes as not being trained well enough, seen as ‘non skilled’. They appear to be focused on their particular service and do not see the bigger picture. (a lot of them appear to use Colebrook as a springboard). We definitely need more training at the Stage 3 services to manage clients.
- Possibly a co-location worker would be useful.
- Stage 4 – need specifically trained staff at this level. Staff appear to find it hard to manage. Dom care don’t have the training to deal with complex mental health issues – ‘find it daunting and scary’.
- Need to make staff much more aware of mental health issues and needs and need to break down the predjudicies.

<u>Crisis House:</u>

- A lot of crisis situations that happen are related to drugs or alcohol. Knowledge is needed to deal with this. Training for staff regarding these issues and other issues such as debt, housing advice etc would be very useful.
- Carer support – in situation where a care package has broken down the carer may need support from staff. Input from staff may help to support the carer.
- 3 – 5 days stay would be about right. Would not want longer as we may then be reinforcing that being in a crisis situation ‘is ok’ and people may settle.
- 7 days could also be ok because of the varying nature of situations. The length of time needed depends of the individual and the nature of the crisis.
- Need to be very tight on referrals. ASW’s need to have access to the crisis house to make referrals.
- A single assessment is best in terms of the referral. Would not be good if we had to pass on to another agency to do the referral.

<u>Barriers:</u>

- Contracts need to be clear. Providing clients with info about the expectations e.g; clear leaving dates etc. This can also have a negative effect though as some clients become stressed around the time that the leaving date is approaching at the prospect of moving on.
- Need movement forwards and backwards. Clients need to know that they can move back a step if necessary.

- Joint working needed with other agencies. Appear to be fighting against each other at times.
- Correct info needed regarding processes for referring clients to different schemes and for housing etc. At the moment we tend to make a lot of referrals to different places to for the same client – is there just 1 that we could do for multiple schemes.
- Training can be 'patchy' in some supported housing services – definitely needs to be improved upon.

Support:

- Better links to Primary Care needed in the community.
- There is a definite issue regarding particular medications. There are cases where patients require support from their GP, such as for blood tests and monitoring – and this is not always happening / not managed very well.
- Definite need for a co-location worker who has links to other teams such as housing, benefits etc. Need routes in to other peoples 'worlds'.
- Patients with multiple issues e.g. drugs problems that may then bring on mental health issues need to have a multi – agency approach in supported housing. Outreach also needed with this approach.
- Workers should continue to work with patients after they move on for a period of time before handing over completely to someone else. This will promote better continuity which in turn helps the patients.
- Westcountry Housing and MIND already have outreach and floating support services to keep in contact and maintain continuity with their clients. This seems to be working very well for them.

Focus Group Twelve

One - Training

Skills and knowledge

- Providers need to focus on activities, social inclusion and needs assessment
- They need to focus on increasing independent living / enabling skills including:
    - Daily needs
    - Cooking
    - Budgeting / bill paying
    - Sleeping patterns
    - Hygiene
    - Supportive social networks
    - Problems solving, confidence and assertiveness

- Some supported housing provides do provide this type of recovery focused support with a more positive focus on move on. The example given was a younger persons service.
- Training around support planning – see notes below

Psychological Therapies

- There are psychological therapies available through PCLT's and other health services. Service users can access them through PCLT's, GP or voluntary sector. Will need to establish links with these and help clients attend appointments, but do not need to provide additional therapies

Support Plans

- Support plans and service delivery needs to be recovery focused, positive and around reducing social exclusion.

Training

- Supported housing providers need training to train service users.
- Service users need training around life skills and independent living skills

Two – Crisis House

- The maximum length of stay should be 5 days.
- Practical support on top of mental health support will be needed. Staff will need to be competent and confident to deal with mental health crisis
- Should people in supported housing be able to access the service or should additional mental health support be increased in the supported housing service?
- Access to the crisis house from supported housing could be used as a respite and might reduce the likelihood of eviction. It may prevent a client moving to residential or acute inpatient care
- Access should be from anywhere in the community as long as clients are working with AOS or the home treatment team.

Three – Barriers

- There is a need for stage 2 (inpatient, assessment and move on service, short term residential facility) accommodation
- Training flats – It would be really helpful to have training flats (like LD) where clients can try out living a more independent lifestyle
- Risk History – a client's risk history is a significant barrier to move on especially if there is a forensic, drug or alcohol history. Historic risk is used as a predictor of current risk.
- Current risk can be a barrier
- Lack of creative solutions
- The inability to go back to a more supportive environment (culture)

- Chaotic behaviour excludes people from all stages (1-4). These individuals are forced to go straight to independent living, even though it is not the most suitable solution as none of the other service are able to cope with them. Stage 2 services might present a solution
- Communication issues around need and risk.
- Availability of back up services
- Lack of access to health support
- The use of B and B and temporary accommodation (Clearsprings). Clients are not able to sustain these kinds of placements. They are too vulnerable (from other people in the properties) and give up, then being found intentionally homeless. Staff at the homeless unit are unhelpful and don't understand the needs of mental health clients. Attitudes are very poor and clients with mental health needs are stigmatised. Processes are too slow and not flexible working to the needs of the service and not the client.

Four – Support

- Supported housing should have enhanced support to prevent clients having to use the crisis house. This could be achieved through co location. Having skilled people with knowledge and links would be very positive and really useful in reducing barriers and cultures
- The ability to support, monitor and store medication – extremely useful. Staff need to encourage, prompt clients
- Co locating CPN staff to single homeless and mental health sector would support clients to be compliant with their medication and therefore prevent relapse
- Support plans should include medication needs
- Staff need to ensure clients pick up their prescriptions
- Relapse is often caused by clients not taking their medication. Someone monitoring this would greatly increase recovery

Focus Group Thirteen

Training

Staff Skills/Knowledge:

- Those dealing professionally with young people should have the necessary knowledge to adopt appropriate attitudes. Thus anti – discriminatory training is essential as well as the capacity to reflect over praxis informed by the relevant theoretical models.

Psychological Therapies:

- Insight think they have experience that could be profitably shared on an inter-agency basis.

Service User Skills:

- This should be based on a holistic approach where all users are aware of the challenges of youth transition and mental health issues.

Support Plans:

- The needs of each client must be fully assessed and this would include information about problem families.

Service User Access to Training:

- Any information to assist the smooth delivery of the process must be beneficial.

Crisis House

Extra Help:

- Specialised intensive therapeutic support is needed, based on models of counselling theories.

Crisis House Access:

- A variety of time horizons were envisaged ranging from two weeks to two days - undoubtedly there is a need to be flexible.

5 Day Stay:

- This time-span has some use as an average for budgeting purposes but again the group emphasised flexibility.

Practical Support:

- Clients may need a couple of nights to calm down and during this period one to one assistance might be preferable.

Supported Housing Providers have Access:

- A multi-agency approach is essential - the structure in the crisis house needs to be determined on a multi-disciplinary basis.

Barriers

Accommodation options:

- There are practical issues – the difficulties of raising deposits/rent in advance.
- Often there is a lack of confidence in a young person to successfully manage a tenancy.

- Throughout the private rented sector there are deposit issues and, anyway, accommodation is very limited and often restricted, for instance “No DSS.”

Wish to Live Independently:
- There is a lack of understanding “about where clients are” – “what their issues are.” Thus, young people want to live independently but lack the confidence.

Confidence to Reduce Support:
- More trust is needed from housing staff in dealing with applications from young people. Furthermore, they should engage with professional youth workers so that they can benefit from a holistic picture when allocating tenancies.

Knowing what is out there:
- Young people have a perception of what their own accommodation should be like but the reality is often very different from these pre-dispositions. Therefore, there needs to be more honesty in the process.

Time:
- Extra time should be provided pre-eviction.
- It is apparent that some supported housing providers are not taking clients who would get most from the service.

Support:

Medication:
- If the crisis house staff could dispense medication this would be of considerable help.

Access to Drug or Alcohol Treatment:
- This issue, rooted in dual diagnosis, needs to be dealt with on a positive basis that offers an individualistic analysis of need. The client then decides whether to embark on a supplementary course of treatment.

Ex-Offenders:
- One again discussion with individuals should determine their requirements. Obviously if the choices available are widened this can be beneficial for clients with diverse learning needs.

Co-located Housing Advice Resource:
- The skills need to be developed.

Access to all types of Supported Housing:
- This is desirable but the group was somewhat cynical about the availability of the necessary housing stock.

Focus Group Fourteen

Training

Staff Skills/Knowledge:

- Individual care co-ordinators need to learn how to write reports and what skills are needed to understand the parameters of independent living, what it constitutes.
- It would be a benefit to know the content of the assessment forms used by housing workers and to have an understanding about the theoretical models that guide their work.

Psychological Therapies:

- Right now we are addressing the issue on an “ad hoc” basis – what is being done is unstructured.
- There is no pathway, no clear links, no resource directory – the only way for staff to discover the parameters of choices is through experience.

Service User Skills:

- The management of risk is very complicated in that it is difficult to understand the necessary paperwork.
- More details of the choices that are available are essential – at present agencies tens to “cherry pick” leaving some service users with few options.

Support Plans:

- Service users should be “put at the heart of the matter.”
- There needs to be a transparency about the notion of supporting people so that indictments about individuals being discharged “ worse than they came in” can be legitimately avoided.

Service User Access to Training:

- Staff need to be aware about how to distinguish between “severe cases and those that are not.”
- If a detailed series of therapies are offered …this service.. cannot anticipate when these programmes will be regularly used as the Crisis House needs to stipulate how it will be managed, how it will be manned.
- In a hospital environment everything is done for you so the Crisis House could be the antithesis of this – therapies could be complied through the ethos of the institution.
- There is no middle ground for the …this service… but Social Work Staff see a Crisis House as “another option.”
- Social Workers can embrace the middle ground as an option to avoid the costs of B & B.

- It is recognised that the Crisis House should not be used as a lengthy option – instead it should be limited to 5 days a week.

Crisis House

Extra Help:

- There was agreement that the crisis house would not be used regularly by AOS clients.
- It was noted that the primary issues were how the house will be managed, how it will be staffed and the procedures that it will adopt.
- There was general agreement that the structure of the house (both physically and as regards process) is very important.
- Clients experience an environment in hospital where everything is done for them – so the crisis house could not be contrary to this ethos.

Crisis House Access:

- The participants saw no middle ground for AOS and contrasted their position with a social worker that might perceive the facility as "just another option" as an alternative to a bed and breakfast.
- The group saw the house as a valuable opportunity to "give time out" so it would become a valuable tool in their armoury.

5 Day Stay:

- The group thought that 5 days to a week was an adequate time-span.
- They all felt that discharge planning should take place on entry on the basis that crisis is short-lived.

Practical Support:

- A care-planning analysis needs to be put in place before entry into the crisis house.
- The crisis house should not receive the negative label of "you can do with…"
- Care must be taken to ensure that the crisis house is not perceived as another hostel.

Supported Housing Providers have Access:

- In this context, the construction of good support plans are essential with the patient informed about what is in their plan and how they are being helped.

Barriers

Accommodation options:

- The participants perceived a change of remit between housing providers which causes a “push and pull” between services, appropriate rate in an appropriate place etc.
- The group also noted that some people do not go into in-appropriate accommodation.

Wish to Live Independently:
- “Ghetto-isation” of mental health patients is an issue.
- There are people who target mental health patients and this has lead to a strategy where they all live in one area. The question is “where is the dignity for the individual in this approach?”
- Furthermore, inappropriate areas may be selected where everyone is “in one space out of the way.” This can have a detrimental affect resulting in people becoming frightened and afraid.

Confidence to Reduce Support:
- Definition of what constitutes supported housing needs to be re-thought.

Knowing what is out there:
- Training and knowledge is an important issue for all personnel involved particularly getting the balance right between housing needs and mental health.
- Concern was expressed as to “how much an individual has to know and how much they can know” about complex issues.

Time:
- Some concern was expressed that the crisis house may become an attractive destination with clients returning regularly.
- It was re-iterated that one five-day stay should usually be adequate to address a “crisis period.”

Support:

Medication:
- AOS proscribe and deliver but a trained nurse would be a useful addition to the staff of the crisis house.
- AOS would like to send their staff into the crisis house but had concern over an extension to their existing workload.

Access to Drug or Alcohol Treatment:
- Difficult for those workers involved – it is the client’s personal choice to take of refuse this extra support.

Ex-Offenders:
- Concern was expressed that housing providers would not know these clients well enough to offer an effective level of support.

Co-located Housing Advice Resource:

- The question was raised over the level of achievement possible for satellite workers. Evidence suggests that some improved outcomes could be possible but this might not be the product of co-location as "anyone could plant the seed."

Access to all types of Supported Housing:

- This was perceived as a necessity in view of the specific demands of individual clients.