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**BROKERING REALITY – A review of service provision in Leeds for homeless people with personality disorder/complex needs**

Please find attached a review document which was produced by Ray Middleton of Community Links on behalf of the Leeds Personality Disorder Clinical Network.

This work arose due to concerns regarding equity of access to services for the homeless population who have significant mental health problems, and in particular was prompted by individual cases where progress was often hampered by issues of complexity of need and philosophically differing approaches to the provision of care and support.

The report has involved many of the key stakeholders coming together at various points to share views and frustrations and to offer valuable suggestions to be considered when endeavouring to improve the current situation. This has also led at times to better working arrangements being explored to the real benefit of individual clients.

The report highlights the difficulties faced for those using and providing dedicated NFA Services and some of the barriers which exist and prevent a co-ordinated and cohesive response across tiers of services.

We make no recommendations from this report, as we are not authorised to do so; instead we offer points for future consideration.

We would encourage those who read the report, when looking at the points for future consideration, to think about how they could get involved in helping to work toward making services and life better for the population of people we have focused upon.

We would welcome all comments upon the report being forwarded to the Clinical Network at the address above and we look forward to continuing our work with colleagues and collaborators in the coming years.

Yours sincerely

**TOM MULLEN  
CLINICAL SERVICE MANAGER  
LEEDS PERSONALITY DISORDER CLINICAL NETWORK**



community links

linking community support  
to health and housing

# Brokering Reality

A review of service provision in Leeds for homeless people with  
personality disorder/complex needs

Ray Middleton

Community Links

September 2008

Commissioned by the Leeds Personality Disorder Clinical Network

## **SUMMARY OF FINDINGS**

### **A review of Services for Homeless People with Personality Disorder/Complex Needs**

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\*Due to the range of views around the term Personality Disorder, with regards to stigma and labelling and because most homeless clients who meet the criteria for Personality Disorder do not have a formal diagnosis, the phrase “Complex Needs” is being used interchangeably with Personality Disorder in this document to help the discussion move on to how services can improve pathways towards better outcomes.

September 2007 – September 2008

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## **Rationale for the Review**

This review was commissioned by the Leeds Personality Disorder Clinical Network.

An initial rationale for this review was that the homeless population with personality disorder issues intersects a number of different Government policy agendas and agencies, namely the Department of Justice's agenda around reducing offending<sup>1</sup>, the Department of Health's agenda around improving services for the personality disordered population<sup>2</sup> and the Government's Supporting People agenda around preventing homelessness<sup>3</sup>. Most Government departments in health, social care or criminal justice emphasise the increasing complexity of citizen's needs and consequently the need for better integrated health and social care in order to improve outcomes such as reducing homelessness<sup>4</sup>, reducing offending or improving physical or mental health outcomes or occupational outcomes.

Included in the rationale for this review is the fact that although there has been very little research into the link between personality disorder and homelessness, academic research<sup>5</sup> into the characteristics of homeless people finds evidence of above average rates of issues that are also common amongst people with personality disorder, namely:

- A disturbed childhood
- Previously having been in local authority care
- Mental health problems
- Drug and alcohol misuse
- History of contact with the criminal justice system, crime and imprisonment
- Poor social skills – poor relationship skills
- Lack of social support network
- Poor living skills (cooking, cleaning, shopping, dealing with bills)
- Poor budgeting skills - debts, poverty, low income, rent arrears.
- Transient, temporary and sporadic occupational history

Research also evidences common trigger events preceding a pathway into homelessness as:

- Family or relationship breakdown
- Eviction from accommodation (e.g. for debts or anti-social behaviour)
- The death of a partner or spouse whose skills kept a tenancy going

Other common triggers for homelessness are leaving an **institutional setting** such as:

- Discharged from prison
- Discharged from a psychiatric or general hospital without appropriate accommodation
- Discharged from local authority care
- Discharge from the armed forces

These are all life events that people with personality disorder characteristics would find particularly difficult to manage successfully enough to secure alternative accommodation.

More locally, in Leeds, this review follows on from the excellent research undertaken by Kesia Reeve and Ian Leedham, published in 2004:

“Bleak Reality: Exclusion, Disempowerment and Fragmented Responses to Need: The Pathways of Rough Sleepers with Personality Disorder”<sup>6</sup>.

Their research looked at the journeys and pathways through services for a small group of homeless service users who met the criteria for personality disorder. Their research highlighted the fact that this client group tended to be stuck in “a revolving door” – in touch with some services (eg. NFA services or Prison Services) but generally having poor pathways through existing services and this client group generally still did not achieve good outcomes from existing mainstream services.

Four years on there were concerns raised by NFA services about this client group still being stuck in a revolving door and that access to appropriate effective services had not generally improved since the Bleak Reality Report was published. Thus it seemed timely to undertake this review. One experienced homeless worker described the current experience of supporting this client group, four years on from this report, as “like playing ping pong inside a revolving door”.

## Review Aims:

The review aimed to answer the following questions and further clarify the complex issues involved:

1. How prevalent is the population? - What percentage of NFA services' clients have characteristics consistent with personality disorder?
2. What are the barriers to better outcomes and conversely what would help this client group get better pathways through services and get better outcomes?
3. What would help staff to work more effectively in relation to this client group?
4. How could effective multi-agency working be further developed?

The review looked to canvass the views of staff in contact with this client group. For both ethical and practical resource reasons it was decided not to interview clients for the purpose of this review. It would be good to consider how to involve service users in any future work on this issue and canvas the views of clients with regard to the complex issues involved.

## Methodology

### Semi Structured Questionnaires

Semi structured interviews were conducted with 41 staff from services that are likely to come into contact with this client group in Leeds (mainly NFA services). The initial questionnaire is in Appendix 1.

The first 20 questionnaires were analysed to identify emerging themes and common trends.

The next 20 staff received an amended version of the questionnaire which drew upon the emerging themes from the first 21 replies. This version allowed staff to tick boxes around what issues they thought were important, as well as providing them with the opportunity to add any additional issues they felt important (Appendix 2).

### The Questionnaire: Staff were asked:

1. What percentage of their clients did they estimate met the criteria for personality disorder?
2. What percentage had a formal diagnosis of personality disorder?
3. a) What would be an ideal **pathway** through your service (if there were no **blocks or barriers**) and b) what would be a **good outcome** from your service?
4. They were then asked what **barriers and blocks** made it hard for clients to move through services and get good outcomes?

In addition, the same questions were asked to approximately 40 staff in workshops at two Shelter conferences in Manchester and London. Their answers are marked separately in the findings (Appendices 6,8,10).

### **Information and Training Sessions**

In Leeds, Manchester and London we found that knowledge and understanding of “Personality Disorder” varied widely from no knowledge whatsoever to a very good understanding of the issues involved.

In order to increase the validity of the answers to the questionnaire training sessions were offered for staff who requested it on “What is Personality Disorder?” before they answered the questionnaire, so they could make an informed estimation about how many of their clients were likely to demonstrate characteristics consistent with Personality Disorder.

### **Other forms of feedback**

We also encouraged staff to contact by phone or email if they wished to express any other relevant views.

### **Who we spoke with:**

Comments were invited from a wide variety of sources, those who actively participated included representatives from the NFA Medical Centre Team, Leeds Street Outreach Team, St. George’s Rolling Night Shelter, Faith Lodge, Regent’s Terrace, St. Anne’s Day Centre and Leeds Prison Mental Health In-reach Service.

Additional thanks to representatives from a number of services who contributed less formally, such as attending the forum or phoning/emailing me their views, such as representatives from the Police, Archway, Bewerley Croft, Bracken Court, Barnardo's Night Stop UK, Caring for Life, The Hollies Hostel, Housing Advice Centre, Holdsworth Court, Pennington Place, Sinclair Project, St. Anne’s, Leeds Federated Housing and Stonham.

## What we found

### Summary of the findings from the questionnaire:

Areas where there appeared to be a consistent picture emerging included the following:

#### 1.0 Not everyone who is homeless has Personality Disorder issues

It is important to note that in this questionnaire a significant number of homeless clients were considered as having issues other than personality disorder.

Examples given by staff included: Learning Disability, Asperger's, autism, dementia, head injury, foreign nationals without recourse to public funds, young people with a breakdown in family relations who will function adequately once housed, domestic violence, schizophrenia.

#### 2.0 A significant proportion of the homeless client group have complex needs consistent with Personality Disorder.

Specifically this review found staff estimated:

- **66.9 %** of their clients present with characteristics consistent with Personality Disorder.

Additionally, staff from different services consistently estimated that these clients were mainly undiagnosed:

- Only around **ten percent** of these clients actually had a formal diagnosis of "Personality Disorder".

These general findings appeared to be consistent across workers and across different services and service providers.

#### 3.0 Staff described multiple/complex needs for this client group as:

Staff described clients as demonstrating a number of significant needs in differing areas of their life. Staff said this usually included a combination of the following support needs:

- (i) **Mental Health Support Needs** (specifically meaning problems managing emotion and distorted or 'psychotic' thinking. Problems with their identity and fitting in, difficulties solving problems, relating to others and lack of motivation to change)
- (ii) **Alcohol and Drugs**
- (iii) **Accommodation**
- (iv) **Occupational**

**(v) Social**

**(vi) Criminal Justice related needs**

Services and clients were often unsure about which of these six areas of need should be addressed first, by which service and in what order?

This combination of complex need was the source of much frustration, discussion and debate amongst staff. The homeless clients with personality disorder often present with needs from five or six of the above areas (i-vi).

**4.0 There are major difficulties in establishing effective pathways for this client group:**

There were genuine differences of opinion as to which needs should be addressed first, as well as frustration with a lack of services that are willing to work collaboratively and flexibly one stage up from homeless services.

This created a tension or dilemma in that in the absence of enough easily accessible services that meet complex needs, clients tended to identify with the services that engaged with them and the other clients they attract, but then find it difficult to move on in their “recovery” to new services that seemed “safe enough”. Clients feel safe with what they know and often lots of work had been put in by workers in engaging and building trust with this client group. However, there are major difficulties in establishing effective pathways for this client group and clients moving on - clients get stuck in a revolving door. Given the current situation, staff’s experience has been described as “like playing ping pong” without getting clients out of the revolving door.

In this context, tensions exist between services in relation to “letting go” of clients and getting different needs met by different services. Tensions exist between those services that are currently more actively engaging with this client group and services that are resistant to, or do not currently engage with, these clients. Progress in terms of pathways would involve a shift on both sides: services not currently engaging with this client group would need to explore how they might start to engage, and services more actively engaging would need to reflect on how they might develop their practice in relation to other services in order to have wider needs met.

Staff generally expressed the view that the idea of collaboratively assessing a client’s range of needs and signposting them through a range of appropriate services sounded like a good idea in theory, but currently in practice this does not happen and there are a number of reasons and issues given for why this was. There was a general consensus amongst staff that currently clients usually would be ‘stuck’ in a cycle, moving between the same set of services that were willing to engage with them. These short engagements with predominantly NFA services are often interspersed with periods in:

- Prison
- The general hospital as their physical health declined
- Geographical moves around the country
- Short, unsuccessful, stays in supported accommodation or homeless hostels
- Premature death

There was general agreement that in terms of services being effective with this client group currently there exists a lot of room for improvements and developments.

The staff questioned then went into more detail around the barriers to pathways to successful outcomes. These issues divided into three broad areas: client characteristics, problems within someone's own service and problems with other services.

5.0 The following **client characteristics** were identified as significant barriers for clients accessing services:

- **Offending behaviour**
- **Receiving long prison sentences**
- **Actively seeking prison as a containing environment**
- **Having a criminal record**, particularly some kinds of criminal activity such as:
  1. Arson
  2. Violence
  3. Sexual offences
- **Alcohol and drug dependence**
- **High risk taking behaviour by clients causing harm to others**
- **High levels of personal vulnerability to harm from others**
- **Lack of skills to co-operate with others**
- **Lack of skills to deal with conflicts**
- **Difficulty managing emotions**
- **Lack of motivation to change**
- **Lack of basic problem solving skills**
- **Lacking hope for a better future**
- **Self loathing/lack of self worth**
- **Developing over dependency on one particular service**
- **Lack of any meaningful occupational activity**
- **Deliberate self harm**
- **Suspiciousness of others**
- **Lack of trust in staff/services/other people**

(Please see appendix 5 for a detailed breakdown of what staff said regarding these issues and appendix 6 for answers given at Shelter conferences in Manchester and London):

6.0 Staff identified the following difficulties **from within NFA services** as blocks to effective working with this client group.

Although there was a general consensus around these issues, staff and services did differ as to which of the following they thought a priority to address in their service and some held opposing views over whether some issues were actually a block to effective work.

- **Lack of training around personality disorder**
- **Lack of knowledge of best practice with complex needs**
- **Lack of knowledge and formal links with other “complex needs/personality disorder friendly” agencies.**
- **Lack of knowledge of other services that might engage around other areas of need**
- **Lack of support for staff**
- **Emotional drain on staff/burnout risk**
- **Too high workload**
- **The wrong working environment**
- **Our referral and working criteria are too tight.**
- **Our referral and working criteria are too lax**
- **No problems with our service**
- **Lack of commitment to and belief in recovery**
- **The limitations of our service**
- **Style of working – we do not reach out assertively**
- **We create a peer group of very troubled people for clients which hold them back**
- **A miss-match between what we offer, what clients want and what they need.**

(Please see appendix 7 for a detailed breakdown of what staff said regarding these issues and appendix 8 for answers given at Shelter conferences in Manchester and London):

7.0 Staff identified the following difficulties with **other services** as blocks to pathways with better outcomes.

- **Unwillingness to work with “Dual Diagnosis” issues:** e.g. “The client is currently misusing substances and alcohol”
- **Unwillingness to work with “mental health” problems or more specifically an unwillingness around “personality disordered” clients.**
- **Unwillingness to work with a “homeless” client with no fixed address/postcode.**
- **Lack of flexibility around engagement from other services**
- **Services do not engage with clients whilst they are in prison prior to release**
- **Unwillingness to engage with clients involved with the criminal justice system**
- **Unwillingness to take clients who appear to be a high a risk**
- **Services not sharing all the risk history to allow us to make informed choices leading to poor relationships**
- **The Council’s homeless assessment system is not “personality disorder friendly”**
- **Other services are not “personality disorder friendly” in approach or expectations of clients**
- **Supporting People do not have a personality disorder specific service**
- **There is a lack of trust between services and damaged relationships**
- **Other service’s criteria is too tight**
- **Staff Attitudes: Other services have negative and judgemental attitudes to both homeless clients and those with personality disorder**
- **Staff Attitudes: Other services have negative and judgemental attitudes to NFA Services and staff**
- **Other services do not know enough about our service - what we can and can not do** so their expectations of us are either too high or too low, leading to poor relationships.
- **Other services need training – they do not understand personality disorder/complex needs or homelessness**

(Please see appendix 9 for a detailed breakdown of what staff said regarding these issues and appendix 10 for answers given at Shelter conferences in Manchester and London):

## 9.0 **Bleak Reality: Four Years on**

With reference to the “**Bleak Reality**” (2004) research, we did some further follow up work and asked where the clients are now, four years on, who were interviewed for that research.

Thank you to John Rossington, Manager, Street Outreach Team, for researching this question for me.

To the best of the knowledge of services they contacted, the understanding is:

- Jake died about three years ago of a drugs overdose whilst sleeping rough.
- Mandy had been working with the Prostitution Intervention Team, but now has been on a Mental Health Secure Unit for about the last year
- Damian has disappeared off the radar of the Street Outreach Service. However he appears to still be presenting at Housing Advice in a cycle of homelessness.
- Colin is living in Supported Housing in Southampton at the last report and “doing pretty well”.
- Jayne we believe is now doing well in her own tenancy.
- Sean is living in a Social Services Mental Health hostel in Leeds and doing OK.

## 10.0 **Diversity: Ethnicity, Culture Class:**

Very few staff had any comments or views to express around this client group’s ethnicity, culture or class or other diversity issues. There was a view expressed that if a client was “...white and working class” then they were felt to be more likely (than any one else with similar mental health problems) to be given a diagnosis of “anti-social Personality Disorder” and be directed into “the Criminal Justice System” rather than mental health services. Black clients with the same presentation it was felt were likely to be diagnosed with schizophrenia.

### **Discussion**

What does this review tell us?

It is clear from this review that frontline homeless service staff identify clients with these issues as a significant proportion of their client group – around two out of every three of their clients having these kinds of complex and co-existing problems.

This client group tend to not get into traditionally structured services and have very chaotic and disordered pathways into and around care. Many of them do not come in contact with mental health services at all.

This review gives a clear indication of the complexities involved regarding both the client group and NFA services. It also indicates a complex relationship of both clients and NFA

services with other services (accommodation, addiction, mental health services, criminal justice services).

Clearly homeless services are coming into contact with this client group. However there is a general consensus that the client group tend to revolve around such homeless services. Some pathways to some other services do exist, but this tends to rely on individual worker relationships rather than an agreed ideal pathway for this client group. Reflecting on the findings, we think there are a number of different issues which are worth teasing out as they each represent areas in which services to this client group could improve.

The evidence for effective work with this client group is that a consistent, collaborative approach with validation of the clients experience helps to build motivation to change which can lead toward recovery. At the moment there appears to be inconsistency in approach, a lack of collaborative working and a lack of trust and validation between services. In short, there is no agreed care pathway for the client group or for an appropriate range of services to work seamlessly together.

It is worth explaining briefly what is meant by an agreed care pathway as it is a collaborative and agreed undertaking, by all involved, with a commitment to joint reflection on improving it – it is not just a mapping exercise of possible services available to clients.

Care pathways are agreements between services, with the aim of having:

- **the right service**
- **in the right place**
- **at the right time.**

Care pathways are structured and agreed plans which map out some of the ideal routes into, through and between services for a particular client group. This can be seen as their 'ideal' recovery journey. This can involve more than one service working with a client at one time.

Care pathways also describe the type, quality and timescales of the care services expect to deliver to clients and the anticipated outcomes from each service.

Once agreed, care pathways can help multi-agency working and help to clarify the different categories of care or interventions being tried, in what order and at which point in time.

They also allow timescales to be placed on interventions and the stating of hoped for outcomes (both long term and short term).

Care pathways are not just about agreeing at what point one service ends it's interventions and hands over a client to another service, they are intended to be more about agreeing multi agency working at the same time and in so doing co-ordinating multiple interventions. Two or three services could be involved with a client at the same time. This would help stakeholders to be clear about boundaries and roles and discuss both acceptance into and discharge from services.

A care pathway approach could be very beneficial to this client group because clients with complex needs require multiple interventions. As people recover it can also be an agreed staged process for some agencies to discharge clients whilst other agencies may come in new at an appropriate time to the agreed treatment package.

This approach does not assume all will go well, but instead once the ideal care pathway is agreed, variance from this pathway can be recorded, reflected on and discussed. Why have some clients not had the hoped for outcome? This can help services reflect together on the factors influencing clients not going through a pathway to a good outcome and in so doing help services to continually improve the service they offer and to work out conflicts between services in their working relationships. It can also help to manage expectations of clients and services of what to realistically expect from each other.

Advantages of care pathways are that they can help manage and reduce risk in the community, by facilitating better multi-agency working, and so offer better public protection. There is evidence from other areas within health that once pathways are agreed they can improve communication, resource management, reduce general costs and reduce unfair and unnecessary variation in treatment approaches for a particular client group.

To work they need services, staff and service users to be involved in the process. If services feel a care pathway is imposed without their involvement, the care pathway tends to fail. Care pathways need a system for services to act on the feedback about variations from the plan and not just collect the data. Care pathways need to be communicated clearly with the client or service user. Done well this can then empower the service user to be fully involved in a collaborative narrative approach to their planned recovery route. Care pathways can then help communicate realistic and reasonable expectations of “care” and “progress”/“recovery”.

Service user journeys into recovery can then be mapped and this can create evidence of service effectiveness or improvements.

Services with high rates of personality disordered clients would particularly benefit from the development of agreed care pathways because:

1. It is a common enough condition to be worth working out care pathways for
2. It is an area of high risks (so the risks could be better managed and reduced) and
3. It is an area where most services willingly acknowledge there is a lot of room for improvement (in individual practice, in service delivery, in multi-agency working and new service development).

The fourth factor that leads to care pathways working and being effective, according to the research, is a strong expressed commitment of staff in services for the care pathways. This is a risk, challenge and an opportunity in this area as the commitment and engagement of a number of services to this would need further exploration.

This review has explored the groundwork around current pathways generating evidence from staff questionnaires that it is a common problem, involving managing high risks and that there is a willingness to acknowledge that there is a lot of room for improvement and an expressed desire by staff for pathways and outcomes for this client group to improve. However, there remains real difficulty in taking this forward.

Clearly there is a need and a desire for training around personality disorder for homeless service staff, particularly as a large percentage of their clients appear to demonstrate these characteristics. As well as staff and managers looking at what is available it is worth noting that a range of training is being developed around personality disorder by the NHS under the “Knowledge and Understanding Framework” (KUF). This will roll out a variety of levels of training including online training.

There was also a desire for services who could potentially be involved with a clients’ care pathway to receive training around personality disorder to help increase their confidence and reduce their anxieties about accepting a homeless client with personality disorder.

There is a separate issue that the review highlighted about clients and services needing to know more about what other services are in the community, what they do and do not offer and what outcomes they are aiming for. For example some staff had wanted to know about what choice there was around addiction services, psychological services, specialist personality disorder services, mainstream mental health services, occupational services, accommodation choices, etc. Clients and staff need a system for getting the basic information together about what is available – particularly as some services end and new services emerge.

Some, but not all, of the tensions between services could be around unrealistic expectations of what services offer and the limitations of what they can do. Information sharing around this could help improve relationships between services. This issue is particularly important as staff working with clients act a “brokers of reality” to clients about what choices and services are available to clients and so the more frontline staff know about potential choices and “routes into recovery” the better they can broker this reality to clients as choices.

One way to address this issue could be to set up a regular forum looking at this client group’s pathways through services. Although not an original aim of this review, my steering committee asked me to set up a forum to discuss the issue of homelessness and personality disorder, which I did on 19<sup>th</sup> June 2008. The agenda (Appendix 3) and minutes (Appendix 4) are attached.

To improve multi-agency working, it needs to be acknowledged that there is a variety of different service philosophies and cultures within the homeless services themselves as well as between homeless services and other agencies. These services may have different commissioners with different priorities and outcome measures, for example in terms of the homeless services working together there is commissioning from Supporting People, the Ministry of Justice (NOMS) and the NHS. This does not mean multi-agency working cannot work, just that acknowledging different philosophies and aims brings added complexity when building collaborative relationships.

There exists variation in philosophy and culture across services in relation to this client group, particularly around issues of personal responsibility, capacity and motivation to change. Whilst the review identified services and individuals who wanted to have little to do with this client group, there were clearly other services and individuals who appeared to be overly involved with this client group. This produces a “split” in services and creates difficulties in establishing good working relationships across services.

This review does not seek to deny the complexity of problems involved in delivering services to this client group and the challenges of successful multi-agency working or the

challenges of recovery itself to the individual service user. However it is hopeful in believing that better care pathways, better services and better individual practice is always possible.

### **Points for Future Consideration**

The following is a summary of points for the reader to reflect on and answer in relation to this review:

1. **Strategic Partnership Approach?** Commissioning bodies could consider collaborating across the PCT, NOMS, Supporting People and other relevant agencies.
2. **Improving relationships between services?** What is the range of actions that could be taken to improve relationships between services? This could be in a number of different ways. For example, staff from different services could shadow each other to see the other services' point of view, there could be secondments into other services, visiting staff meetings or client review meetings to appreciate other services practice? Communication could improve, such as **information sharing**, what would be an effective system for sharing information between potential services about what services offer and the limits of what they can do? A Forum, email distribution lists or making use of existing systems?
3. **Increasing the psychological thinking of homeless staff?**

As it is homeless staff who are currently engaging with his client group it is worth considering ways of increasing their reflection on the psychology of the clients. Some staff do this anyway but many do not. Things that could help with this are "frameworks for understanding", case studies presented which explain some of the dynamics which may be going on internally for the clients or staff. Discussions led around common issues such as "splitting" of teams, transference of emotions or the motivations of staff, such as the desire to rescue someone or why someone might "push our buttons"?

**More structured support for staff?** Services could improve their structured support for staff as there is a lot of emotional 'wear and tear' working with this client group. There may be scope for services to engage appropriate external staff to facilitate group or one to one supervision for the reflection and processing of thoughts and feelings around working with this client group.

**Training needs?** There are clearly training needs of homeless service staff specifically around personality disorder and ways of working. This could link in with the emerging NHS Knowledge and Understanding Framework (KUF) and to the local Personality Disorder Clinical Network.

4. **The identification of Personality Disorder clients or not?** It is important to remember that homeless services are generic and by their own estimation one in three of their clients have issues other than personality disorder or complex needs. There is an issue to consider here for the future about how staff might identify clients who appear to have these issues and differentiate them from

clients who may have a different set of underlying problems at the route of their homelessness.

5. **Service user involvement?** All staff and services could think about how to improve service user involvement in any of the possible initiatives for improving pathways, services and outcomes. This would be a challenge, but creative ways to improve this and facilitate views and feedback on services and what service users think they need would be very beneficial.
6. **Pathway development?** To develop an effective care pathway (described in the discussion section) for this client group could involve the setting up of a further multi agency group to explore and describe what such a pathway would look like. A commitment to regularly reflect on the variations from the ideal and the working out of improving the pathways for this clients group. There already exists in Leeds a multi-agency group looking at improving care pathways for women with personality disorder. This review has shown the necessary ingredients are present for a care pathway approach working to improve outcomes for these clients. Someone would need to lead this piece of work and it would need the commitment of most of the likely stakeholders. Who would like to try this?
7. **Future service provision?** To develop an effective new service for this client group could involve the setting up of a further multi agency group to explore what services might look like if they were more connected together and then these new services were more integrated and connected to the wider systems. For example, what would a service look like with workers from housing, addiction, mental health, occupation and probation all work in the same team? If such a service worked effectively with this client group could they also have a remit of working with mainstream services to improve outcomes? Other future commissioning could be considered, such as the suggestion of a “Core and Cluster” model of accommodation specifically for personality disordered clients who are homeless. Creative thinking about future service provision is by no means limited to these ideas, other ideas could be explored, such as making the HAP homeless assessment process more accessible to this client group (e.g. a process for people who have high levels of suspiciousness, impulsiveness, emotional distress and impaired thinking).

This work was around personality disorder and the homeless population but arguably a lot of the issues raised could relate to mental health and homelessness as well.

**We would particularly like to thank the following for participating in this review:**

John Rossington (Manager) and all the staff at the Leeds Street Outreach Team  
Debbie Roe (Primary Care Mental Health Nurse for the Homeless) and Nigel Dawson (Nurse Therapist) from the NFA Medical Health Centre for the homeless  
Jo Smith (Social Worker) from Social Service's Mental Health Housing Support Team/Leeds Street Outreach Team  
Hilary Brooks, Liz Dismuir and Claire Dodge (Team Leaders) and all the staff at St. George's Crypt rolling night shelter  
Paul Cloke and all the staff at St. George's Crypt Faith Lodge and Regent's Terrace  
Ian Cowell (Manager) and staff from the Prison Mental Health In-reach Service at Leeds Prison  
Sgt Paul McKenna from the West Yorkshire Police  
Mia Cameron (Manager) from the Hollies Hostel (for homeless women)  
Isobel Worswick (Manager) and staff at St. Anne's Day Centre for the homeless  
Sam Bryne (Development Officer) Shelter Good Practice Unit  
Sharon Prince (Consultant Clinical Psychologist) Personality Disorder Network  
Debbie Forward (Supporting People Manager) Housing Strategy and Commissioning, Leeds City Council  
Glynn Ramsden (Manager) Spen Croft Social Service Mental Health Hostel  
Dominic Murray (Manager) Bewerly Croft Social Service Mental Health Hostel

**Appendix 1**

**Personality Disorder and Homelessness Questionnaire**

Having listened to an explanation of what “Personality Disorder” means\*, what percentage of your clients would you estimate have sets of problems consistent with personality disorder?

0%	10	20	30	40	50	60	70	80	90
100%									

What percentage of your client group do you think currently have a formal diagnosis of “personality disorder” from a mental health service?

0%	10	20	30	40	50	60	70	80	90
100%									

Thinking about this client group, how would you describe their “ideal journey” (or pathway) through your service, if they engaged well and there were no real blocks or setbacks?

List the **barriers and blocks** to them moving through your service in a positive way and starting to get into recovery. List these in the three areas below:

1. Problems with some of the characteristics of the clients, - **‘barriers and blocks’** to pathways

\* If you would like a training session on Personality Disorder first - contact [ray.middleton@commlinks.co.uk](mailto:ray.middleton@commlinks.co.uk)

2. List the **Barriers and Blocks** that are to do with difficulties with your service or practice:

--

3. . List the **Barriers and Blocks** that are to do with problems with other services:

--

Thinking about this client group, what things do you think would help to get better outcomes for them and help them move on and start their recovery?

--

What service do you work for?

--

How many clients do you have / or your service have?

--

What is the aim or goal of your service?

--

Thank you for taking part in this questionnaire.



**Barriers and Blocks 2. Difficulties with your service or practice:**

for example,

I have not received training around personality disorder and would benefit from some [Y/N]

My workload or client load is too high to give these clients sufficient time [Y/N]

Any other problems with your service or practice which may block progress:

**3. Problems with other services:**

For example,

We are the only service involved with the client so it is difficult to share a plan/risks [Y/N]

Any comment:

We need to know more about other services available and what they can and can not offer [Y/N]

Comment:

Any other blocks to clients progress from other services:

Thinking about this client group, what things do you think would help to get better outcomes for them and help them move on and start their recovery?

What service do you work for?

How many clients do you have/or your service have?

What is the aim or goal of your service?

Thank you for taking part in this questionnaire.

## **Appendix 3**

### **Forum:**

#### **Improving outcomes for homeless people with personality disorder/complex needs**

### **Agenda**

**Date:** Thursday 19<sup>th</sup> June  
**Venue:** 68 Brussels Street – (Behind N.F.A. Building)  
**Time:** 1.30 – 3.00 p.m.

**After the meeting:** Networking hour 3pm until 4pm. Services to bring any information about their service to share (leaflets etc.)

The aim of this Forum is improve outcomes for homeless people with personality disorder/complex needs. It hopes to do this by bringing together services that come into contact with this client group to discuss what changes and actions could improve outcomes. The forum builds on the review of services for this client group undertaken by Ray Middleton (copies available).

### **Meeting Agenda:**

- Introductions from those present, including briefly what their service does.
- Apologies

#### **Discussion point 1:**

**1. What do your services need to be more effective with this client group?**

a) **For your staff:** e.g. training/information on other services

b) What do your services need, to be more effective, **from other services?**

#### **Discussion point 2:**

**2. How could working relationships between services get better**, in relation to supporting the client?

#### **Discussion point 3:**

**3. Consider and discuss a case study** to tease out some of the issues

#### **Discussion point 4:**

**4. Discuss what work participants are willing to do between now and the next Forum to improve things?**

- Would participants like to hold a regular meeting?  
Discuss frequency (Quarterly?) and What Content/Agenda would people find most helpful?

Close the meeting and **have an hour of informal networking and conversation** between staff from different services.

#### **Appendix 4:** Minutes of the first meeting of the Leeds Personality Disorder Forum

68 Brussels Street, Leeds - Thursday 19<sup>th</sup> June

Chair: Ray Middleton (Manager) Community Links Personality Disorder Services

Minutes: Samantha Byrne (Development Officer) Shelter's Good Practice Unit

Attended by: Eleanor Mundie, Marcie Firth, Tom Mullen, Sue Doyle, Isabel, Mia Cameron, Sabina Ibrahim, Ian Brewer, Fiona Cunningham, John Rossington, Debbie Roe, Nigel Dawson, Sgt Paul McKenna, Dawn Flinch, Peter Howarth, Rod Picking, Heather, Karen Wilcock, Sam Byrne

The meeting was opened by Ray Middleton who outlined the aim of the forum:

To improve outcomes for homeless people with personality disorder/complex needs in Leeds by bringing together relevant local agencies to discuss positive ways forward in service development and delivery.

Ray gave a brief overview of the review of services that he is currently undertaking and summarised some of the key findings. It was proposed that the discussion should build upon these by focusing on four clear discussion points:

1. What do your services need to be more effective in working with this client group:
  - a) For your staff (e.g. training/information on other services)
  - b) From other services
2. How could working relationships between services improve in relation to supporting clients?
3. Consider and discuss a case a study to tease out some of the issues
4. Discuss what participating agencies are willing to do between now and the next forum meeting to improve outcomes locally, and consider the frequency and content of future forum meetings.

It was then proposed that the meeting would close with an hour for informal discussion and networking.

Discussion point 3 - It was agreed that discussion point 3 would present an ideal opportunity to illustrate key issues and generate discussion. Participants were asked to consider a case study – Jake's Accommodation Pathway, taken from the 2004 report 'Bleak Realities' by Kesia Reeve and Ian Leedham – and, using the Pathway Reflection sheet, discuss what the situation is like now and what changes have occurred.

The following key points were raised:

- The situation is, in some respects, more difficult for this client group now, particularly in terms of the removal of the bed and breakfast option and in the reduction of psychiatric bed spaces.
- All local hostels provide emergency and short-stay accommodation, offering little stability. This emphasis on short-term provision, determined in many cases by funding criteria, doesn't allow or encourage staff to form relationships with clients, assess their needs holistically or develop long term plans etc.
- Mental illness is on the increase and so is the number of people presenting to services with complex needs, yet access criteria to statutory mental health services are getting tighter. The discharge process is problematic as very often the services that people need

aren't available for them to be discharged to. There is little continuity of care and limited availability of 24-hour crisis services.

- Mental health pathways have become more problematic. People are now required to engage with more agencies in order to get the same service. This makes it harder for practitioners to build trust and engage with this client group in any meaningful way.
- The case study illustrated that a wide range of services were engaged with Jake but to little effect. Jake's 'reputation' preceded him and bore little relation to the person that he actually was. The view that services had of Jake, whether substantiated or not, impacted upon his view of himself which led to a self-fulfilling prophecy, deterioration in behaviour and client/ practitioner relationships. Jake would regularly inform new services that "I'm not as bad as people say I am."
- People can look very 'risky' on paper, yet when risk is taken people are very often easier to work with and engage than their service histories suggest. However, not all agencies are prepared to take a risk and difficulties arise when trying to move people on. This is compounded when people have a history of committing particular criminal offences e.g. arson, sex offences etc.
- Stigma is a significant issue for people with formal and informal diagnoses of personality disorder. Agencies are often reluctant to trust other agencies' assessments, resulting in multiple and conflicting assessments. Some agencies are better than others at information sharing. Some practitioners play down the level of risk that some people present in order to 'sell' their clients to other services. This serves to increase levels of mistrust between services and it is the service user who loses out. There is an assumption among some practitioners that service users don't change and will continue to present a challenge to services, and yet a person's behaviour can change significantly over a period of time. Issues such as past rent arrears, damage to property etc. are some of the hardest for people to shake off.
- Different services have different funding sources, philosophies and outcome criteria. Agencies operate with different referral and assessment processes, making multi-agency working much more of a challenge.

Discussion point 1a – Key points raised included:

- Training was discussed as one possible way forward. Many homelessness and housing services are generic providers of 'bricks and mortar' and are not specialists in personality disorder or complex needs. Services accommodate a large number of people with a broad range of support needs. Practitioners would benefit from training and information on complex needs and the range of services that exist locally, their referral and assessment criteria, and what they can realistically be expected to achieve. Joint training of multiple agencies could provide a forum in which greater knowledge and understanding of different sectors, agencies and personal roles is gained.
- The formal development of a mental health and homelessness strategy would identify gaps in services and commissioning, and would map potential pathways through services.
- The potential benefits of the development of a Care Co-ordinator to take responsibility for engaging service users with agencies and allocating and accessing services was discussed.
- Re-structuring of existing services to take into consideration the needs of service users outlined in 'Bleak Realities' and the review of services. Services need to be flexible and offer long-term support, 'fitting' the person, rather than the other way around.
- Statutory mental health services need to work more effectively to prevent people from coming into contact with criminal justice agencies. They need to be accessible and responsive to the needs of clients.

Discussion point 1b – Key points raised included:

- Better access to out-of-hours mental health support is needed, both for frontline workers and service users. People presenting at homelessness services under the influence of drugs/ alcohol and exhibiting mental distress are more likely to be excluded from the

service if mental health support is not available for staff to assist them in assessing the client.

- Trying to access other services for clients is time consuming and difficult. Practitioners would benefit from knowing what services exist, how to access them and who to contact to raise concerns about lack of service involvement. Different pathways are needed for different people.
- Services can be judgemental about people with personality disorder and this needs to be addressed. Most of the time, people with personality disorder are not engaged with mental health services. This lack of engagement is made worse if people have co-existing drug and alcohol use. Where this is the case the door to mental health services is closed from the outset.
- Is the lack of development of flexible, appropriate services more a 'hearts and minds' problem, rather than a structural response?

Discussion points 2 – Key points raised included:

- There is an urgent need to improve communication and information sharing among agencies, and the quality of the information being shared. The development of shared database or common assessment framework would assist with this.
- The development of a long-term supported housing scheme, based on the core and cluster model, would improve the housing situation of those people for whom hostels provide too much stimulation and independent tenancies create high levels of anxiety.

Discussion point 4 – Key points raised included:

- Services need to start by assessing and addressing the professional attitudes towards personality disorder and complex needs that exist within our own services.
- Members of the forum may look towards developing a mental health and homelessness strategy for the region. Invite the strategic lead officers for the PCT and Supporting People to the next forum meeting to take this issue forward.
- Members of the forum could organise a wider forum or 'market stall' type event for all local homelessness, housing, health and support agencies to attend. This would improve practitioners' knowledge of services, access and referral criteria, and better manage expectations about what services can achieve.
- People expressed that there was not much more that services can do to change. Agencies are constrained by the wider social, policy and commissioning agenda. It was suggested that members could use the forum as a vehicle for developing local policy.

## **Appendix 5**

Please see Appendix 5 for a detailed breakdown of what staff said regarding these issues:

### **What are some of the characteristics of this client group that create barriers to them having better pathways through services to better outcomes?**

The following issues were reported by staff, but not all issues by all staff or services. Services varied as to how much of a **barrier or block** these were thought to be to their clients moving through their service to a successful outcome:

- **Offending** and then getting caught interfered with their recovery pathway. This was reported as less of a problem where the type of accommodation was alcohol free, such as St. Georges Faith Lodge. Other services reported law breaking as a significant break in services, with clients sometimes going into prison on remand, sometimes getting bail, sometimes losing their accommodation due to prison sentence and losing continuity of service from community based staff whilst in prison. **Long sentences** tended to necessitate

services discharging clients. For some services, it was felt clients needed to break the law in order to access them, as they were funded by CJS, for example, some alcohol and drug services. Some staff said their clients lacked the basic skills not to get caught. More 'highly functioning clients with better social skills could break the law and not get caught'.

- **Desiring prison:** Some clients report breaking the law with the intention of being caught as a strategy to get into prison in order to "escape from the community".
- **A Criminal Record:** Having a criminal record can then hold clients back in their recovery if they do change their way of life, as many employers do not want to employ someone with a criminal record. A lack of occupational opportunities for ex offenders/ex drinkers was mentioned.
- **Particular kinds of criminal activity** (eg Arson, Violence, Sexual offences): Although it was noted that many people with Personality Disorder characteristics never break the law, a small minority commit particular kinds of crime which significantly affect their choices, when they choose to work at changing their life and getting into recovery. For example, clients with convictions for
  1. **Arson** staff find particularly hard to accommodate, also clients with convictions for
  2. **Violence** or hostage taking can be hard to get into shared accommodation and it was also noted that clients with past
  3. **Sexual offences** are also difficult to refer into mainstream services.

It was felt that these difficulties remain even if some years have passed since the original offence. At other times there were genuine current concerns around these issues.

- **Alcohol and Drug dependence:** For most clients currently using alcohol or drugs was felt to hold them back from progressing their recovery and getting good outcomes. Opinions were divided on this issue. Some staff viewed that clients were unlikely to make much realistic progress until they stopped or reduced their alcohol and drug use. Other staff thought that clients were unlikely to stop drinking and taking drugs - and so services should be more open to accepting clients who are actively drinking and taking drugs and hold lower expectations of clients prospects for recovery. Some staff thought you might be able to help someone with a few limited issues, such as their housing, if they were actively addicted to substances but realistically they needed help to stop their addiction before progressing any distance along any recovery journey. Other staff said we should not expect this client group to stop drinking and taking drugs as this was an "unrealistic expectation". Some staff felt current alcohol and drug services were not set up in a way that was accessible to this client group and so filtered them out. Finally some staff expressed their concern that making some services too easily accessible by people still drinking and taking drugs could be enabling them to stay in denial about having to address their addiction, for example providing social company, food and occupational activity to someone who needed to primarily address an alcohol dependence problem could then take away their motivation to address this issue. Others disagreed and saw such low threshold services as ways to engage the client as a "starting point" to build motivation.

- **High Risk behaviour by clients and high levels of vulnerability.** Barriers were either around clients being too vulnerable or too high a risk to others. Sometimes there was a combination of their vulnerability increasing their dangerousness to others. Some clients were vulnerable to exploitation by others due to their desire to be liked and belong to a group (this could be a group of street drinkers or a group engaged in criminal activity). Some clients lack the relationship skills that allow them to protect themselves from others. Some clients were described as appearing not to have the general grasp on “what is ok and what is not ok”. A sub group of clients trust anyone and keep being abused and exploited by other more predatory members of the homeless community. Others trust no-one, including service providers. These very vulnerable clients tend to be repeatedly traumatised by bad experiences in and around the homeless community.
- **Lack of skills to co-operate or deal with conflicts.** Over 95% of staff said that clients’ difficulties accepting and co-operating with the help offered and lack of interpersonal skill in dealing with the conflicts that arise in someone’s recovery journey created barriers. This makes forming a genuinely collaborative working relationship a challenge.
- **Difficulty managing their emotional life.** Most staff felt that clients’ difficulty managing their emotional life, such as feeling angry, fearful, anxious, fed up, guilty etc, blocked their recovery. Staff expected clients to have difficulties in this area but gave specific examples of how difficulties managing emotions interfered with their engagement with services. For example, excessive anxiety might mean they avoid their service and do not engage. For someone else excessive anger might lead to a client being asked to leave a service (if they expressed that anger in damage to property or person). The client group appeared to lack an emotional vocabulary to be able to identify and express if they were feeling angry, sad, fearful or fed up. Often they just ended up acting angry.
- **Lack of motivation to change.** Some staff described the client group as lacking motivation to change their way of life. Sometimes it was hard to discern who is motivated to change if there are lots of clients accessing a generic service.
- **Ethnicity, Culture Class.** Very few staff had any comments or views to express around this client groups’ ethnicity, culture or class or other diversity issues. There was a view expressed that if a client was “...white and working class” then they were felt to be more likely (than any one else with similar mental health problems) to be given a diagnosis of “Anti-Social Personality Disorder” and be directed into “the Criminal Justice System” rather than mental health services. Black clients with the same presentation it was felt were likely to be diagnosed with schizophrenia.
- **Lack of basic problem solving skills.** Staff reported clients appear to lack basic problem solving skills, examples given included: tending not to take responsibility for their own problems, reacting impulsively to problems, feeling overwhelmed by problems, denying or avoiding obvious problems they had, blaming others for their problems.

- **Lack of hope for a better future.** Staff reported these clients significantly lack any **hope** for their future and appear to have very **little motivation** to change their way of life or lifestyle.
- **Clients do not care about themselves or hate themselves.** Some clients' view of themselves affected engagement with services, for example, 'feeling unworthy' of someone else's help preventing the acceptance of help offered. Some clients "appear to hate themselves" and "act in a self destructive" and "self defeating" manner which "does not seem rational". "Sometimes a client acts so out of character it makes me wonder if they are under the influence of something else, something very destructive". Clients are "self sabotaging in all areas of their lives".
- **Over dependency on a service.** A minority of staff felt some clients became over dependant on their service as a 'safe' place to have relationships with familiar staff and that this dependency on a service then contributed to clients not moving on in their recovery. They appear to have engaged and then got 'stuck', sometimes for 'years and years'. Some clients had used services for years in a dependant way without getting better or moving on in any way.
- **Self harming** (eg. cutting, burning, overdosing, and getting into fights they know they will lose) tends to set back clients' recovery journey. Impact of self harming on staff was reported by staff as very high and hard to deal with emotionally.
- **Suspiciousness of other's/lack of trust** interfered with their recovery pathway. Staff tended to think there may be lots of reasons for this suspiciousness. However, this mistrust or suspiciousness characteristic tended to make engagement initially difficult and then if this was achieved, referral to another agency could be doubly difficult as the client would find it hard to trust the other agency.
- **In addition to the above, the following comments were made by some staff:**

Clients have "complex cynicisms about statutory services and high levels of frustration about the voluntary sector". "Clients' have frustrations at same old same old". "Certain clients become obsessed and target other clients". "I wonder sometimes if there are dark forces at work?"

## **Appendix 6**

**These questions were also asked at Shelter Conference workshops in London and Manchester:**

**Shelter Conference  
- New Directions In Street Homelessness: Volume 2  
Between sectors: Filling the gaps in services for people with personality disorders**

**Answers to this Question in Manchester Workshop – 11th March 2008**

- Clients with personality disorders constantly 'test' relationships with workers. People can be very demanding of attention and push boundaries to the limits. Difficulties within services can then become a self-fulfilling prophecy.
- Trust and mistrust are big issues/obstacles.
- People with personality disorders can find it difficult to take ownership of and responsibility for their actions, often resulting in the transference of responsibility.
- Risk and aggressive behaviour are areas of concern when working with people with personality disorders.
- Service users may not want help. They may not agree that they have problems and may not feel ready to move on. People can experience real difficulties in understanding their own needs.
- High or low expectations of what services can do.

**Answers to this Question in London - 25th March 2008**

- Once made, clients can become attached to their diagnosis.
- 66% is too low a figure. Practitioners working with homeless people in a counselling/therapeutic environment argue that the real percentage among this group is far higher.
- It is often the service users themselves who create obstructions to accessing services.
- It is difficult to engage with people who constantly move through the system.

## Appendix 7

### Blocks to Better Care Pathways to better Outcomes:

#### Question Two:

#### What is it about your own service or practice that creates a block or barrier to these clients moving on in their recovery?

- **Lack of Training around Personality Disorder** (55% of respondents identified this). Staff said if they received more training around working with Personality Disorder this would help clients move through their service to get better outcomes.
- **Lack of knowledge of best practice with Complex Needs.** “Our service does not know what interventions can be offered, what is current best practice for homeless clients with Personality Disorder characteristics?”

However, not all staff or services wanted the same training, some wanted training around personality disorder and complex needs, others wanted training around what mainstream services were available and accessible for this client group in different areas of need, for example, what occupational, psychological or alcohol and drug services, crisis services, mental health services are available, realistically, for this Homeless people with Complex Needs? How can clients access them?” “What do these services really do / what can and can’t they do?” “What are their thresholds?”

- **Lack of knowledge and formal links with other “Complex Needs/Personality Disorder friendly” agencies.** “We lack knowledge about other (PD friendly) Agencies and we lack good relationships and links with such agencies. “Who else helps?” We lack knowledge of what other agencies there are and what they do. We lack access for our clients to occupational activity that is relevant to them

In addition, areas identified where services could improve included:

- **Lack of support for staff.** Some staff asked: “What help is available for staff struggling with supporting this client group? “Could we have supervision or group supervision from an experienced Personality Disorder case-worker?”
- **Emotional drain on staff/burnout risk:** “PD clients are a drain on our personal resources so therefore there is a limit to how many PD clients we can accept into our service”.
- **Too high workload.** Concerns about workload being too high varied a lot depending on the service – some staff felt overwhelmed with their workload and business, others did not find workload too high at all whilst for some staff in some services it depended on the time of day, sometimes there was lots of time to spend with this client group (if they were in a hostel which allowed more one to one time, then the question was “what would be productive to work on together?”) “We lack undisturbed time to go into in-depth work with our client. I work night and day for these clients, what is the answer?”
- **The wrong working environment.** Some staff felt the environment they worked in prevented effective skills building work, for example, working inside prison was a “different world with its own rules and regulations quite different from living in the

community". Prison takes responsibility away from clients and de-skills them, prison becomes an attractive option.

- **Our referral and working criteria are too tight/too lax.** "Our service cannot be flexible and work with clients if some aspects of their status changes", for example, if they get discharged from prison or hospital, if they get remanded into prison, if they are evicted from our accommodation, "if they get too needy/challenging, they need to leave". "If they get too well for our service they will need to leave, they may not be ready or willing to do this". "We are not clear about when people are too well or too unwell for our service – we are not sure how to move people on". In addition to some staff feeling their thresholds and criteria for accepting clients was too high or too low, staff also voiced some frustration at the thresholds of other services thinking other services thresholds were too high.
- **No problems with our service.** Some staff voiced the view that the problems lay with other services and not their own: "There are no problems with our service", "We are open and flexible, working with all PD clients as the need arises". "our practice is solely blocked by the responses and judgements of other agencies when we try to access services and use the term "personality disorder"
- **Lack of commitment to and belief in recovery.** "Our service lacks a commitment to recovery", " We do not have a concept or idea about what recovery for this client group could mean", "I've never seen anyone recover from Personality Disorder"
- **Limits of our service:** We cannot do everything. "There is a need for other services involved, More Multi-agency Working. "Our service is limited in capacity and what we can do", "we are concentrating on promoting an abstinence recovery program and structured day care.....we cannot do everything". "Complex needs? We need help!" We want "Help from Statutory Services", but alternatively, "We are service user led so some people will reject 'professional help offered/"
- **Style of working:** "We do not work in an "assertive outreach style". "We do not do outreach work – this is our normal practice"
- **We create a peer group of very troubled people for clients;** this then creates peer pressure not to recover, to stay with the group because they "belong". "Problem with our service is that all our clients have the same kinds of problems with drink and drugs so as soon as one person starts to get better and into recovery the temptation is right there for them from other service users to go backsliding into drink and drugs". "We need positive role models of recovery, not same old same old."
- **A miss-match between what we offer and what clients want/what they need:** "Do PD clients want what we offer? What should we offer? "The problem is we are trying to bring a structure to an unstructured life, a life lacking boundaries, structure or routine, I'm not sure if this works? Will the clients disengage from the structure we offer their lack of structure?" "We can give advice but the clients already lack the skills to accept and act on advice." "We lack in-house counselling service for PD homeless clients". "We do not offer what these clients want."
- **Ethnicity, Culture Class:** Very few staff had any comments or views to express around this client group's ethnicity, culture or class or other diversity issues. There was a view expressed that if a client was "...white and working class" then they

were felt to be more likely (than any one else with similar mental health problems) to be given a diagnosis of “Anti-social Personality Disorder” and be directed into “the Criminal Justice System” rather than mental health services. Black clients with the same presentation it was felt were likely to be diagnosed with schizophrenia.

## **Appendix 8**

**These questions were also asked at Shelter Conference workshops in London and Manchester:**

### **Shelter Conference**

#### **- New Directions In Street Homelessness: Volume 2**

**Between sectors: Filling the gaps in services for people with personality disorders**

#### **Answers to this Question in Manchester Workshop – 11th March 2008**

- It is really important for service users to have consistent relationships, build trust and receive 'brokerage' services. It is helpful for people to have a constant, single caseworker with them throughout the support process.
- People with personality disorders need manageable goals and support to help them build their confidence and improve their problem solving skills.
- Appropriate staff training must be provided for practitioners working with people with personality disorders.
- Tailored training could be purchased.
- Frontline staff must be given the right support through regular one to one and group supervisions.
- Services can become chaotic with a high turnover of staff.
- Service development must be creative.
- Longer term befriending services could be beneficial.
- The expectations of both staff and service users must be managed from the outset.

#### **Answers to this Question in London - 25th March 2008**

- Services often dictate to people what their recovery should be rather than the recovery process being client centred.
- It is harder to do recovery work than it is to do maintenance work and this can put practitioners off from adopting the recovery approach.
- As a practitioner, being honest, straightforward and hopeful with people with personality disorders can be very difficult.
- People with personality disorders can be very 'needy' and require at least two practitioners to work with them at any one time. This is resource intensive.
- Can people recover from personality disorder? Or does it just become more manageable?

## Appendix 9

### **Blocks to Better Pathways to better Outcomes:**

#### **Question Three:**

#### **What is it about other services that creates a barrier to clients moving on through care pathways into their own recovery?**

Staff reported lack of flexibility or willingness to multi-agency work or willingness to work with these clients from some other services for a number of different reasons:

The difficulties with other services are listed below:

- **Unwillingness to work with “Dual Diagnosis” issues:** eg. The client is currently misusing substances and alcohol.

There was some general frustration aired at mental health services being unwilling to engage with clients with substance misuse issues or who are homeless. Some staff voiced the view in discussion that they felt the “alcohol and drug” reason for not accepting clients with personality disorder/complex needs was sometimes an excuse for rejecting genuinely needy clients. A service may judge that they dislike them or see them as ‘bad’ and not ‘mad’ (a view sometimes voiced to staff by mental health service staff). Clearly there are a range of views on this alcohol/substance misuse issue, but there is a general consensus it is a significant issue.

Some staff felt that some other services had an unrealistic expectation of what alcohol and drug services in Leeds could do when they said that a client “should address their alcohol and drug problems with these agencies first, before referring to them”. It was felt by some staff that this was unrealistic as most alcohol and drug services would not engage well with clients with Complex Needs/Personality Disorder who were homeless, and most would not be promoting abstinence, so this approach created one part of the “revolving door” problem with this client group. Some felt alcohol and drug services were delivered in a way that clients with personality disorder would not easily engage with. It was also felt that alcohol and drugs services did not understand Personality Disorder characteristics and presentation.

- **Unwillingness to work with “personality disorder” or clients with mental health problems.**

A number of staff have found that referrals to other services are blocked by services’ unwillingness to work with clients with mental health or personality disorder/complex needs characteristics and services will express this openly. This is frustrating when staff hear from Mental Health Services a range of other reasons for not working with this client group, hence the more complex clients fall “through the gap”. Mentioned by more than one service was a frustration with Crisis Resolution and Home Treatment team responding to homeless clients. Staff expressed they were not sure if this was because the client had personality disorder presentation or because they were “homeless”, or if their poor response was for some other reason.

- **Unwillingness to work with homeless clients.**

Staff report that sometimes the fact that the client has not got settled and stable accommodation is given as a reason for other services not accepting a client yet. This can be frustrating as the view was generally held that by definition the homeless population with personality disorder characteristics would inevitably have multiple needs and need help with managing their emotions and thinking, relationships, housing, effective help with alcohol or drug addiction, help finding occupational activity and help accessing crisis services to get through a crisis’.

Some of the comments from staff included: “Other services need to be trained about personality disorder/complex needs”. “They often dismiss referrals by saying “this client is bad not mad” or “this is clearly behavioural”- but then fail to explain exactly what this stock phrase means! Does it mean –‘we do not want this client in our service’?” “Personality Disorder is always viewed negatively and using the phrase is always a barrier and block to referrals in our experience”. “The worst cases are where the label PD is used informally for years without a formal diagnosis as a way to warn services off.”

- **Services can not be flexible and engage with clients whilst they are in prison.**

Comments from within prison, such as from Prison In-reach, were that they needed more willingness from community based services to come into prison to build relationships with prisoners who are homeless with PD characteristics prior to release in order to increase the likelihood of positive outcomes on release (such as housing providers, CMHTs, occupational services). Other staff reported and discussed that a number of this client group deliberately break the law as a strategic move with the intention of getting into prison as they feel safer in prison as opposed to the challenges of living in the community and solving problems such as getting somewhere to live, cleaning it up, cooking a meal, getting a job or something useful to do with their time and getting a social life. For some clients all these problems appear more easily solved by getting deliberately caught committing a crime and going to prison.

- **Some services are unwilling to engage with clients involved with the criminal justice system.**

Some comments by staff included: [Referring a client to another service they might say].. “They have convictions – this sounds like Forensic Psychiatric Services Remit”. Some frustration was voiced by a small number of staff at Community Forensic Services. Some staff felt when mainstream services did not want to work with their client because they appeared to have mental health problems and convictions, they would be signposted to forensic services, but this was found to be a dead end. A view was shared by some staff that forensic services appeared a little unwilling to work with personality disorder and appeared more comfortable working with Schizophrenics. However most homeless staff were unaware of forensic services and their role and remit.

- **Other Services are unwilling to take clients who appear too be a higher risk**

Some clients dangerousness to others are viewed as being too high by other services, particularly if they are delivering their service in a social or group environment with other service users.

In discussion, a distinction could be made by some staff between clients who were genuinely too risky for a particular service to take on as a client and what was felt to be a

reluctance by some services to take on more risky clients and that it was felt that in some cases 'too high risk' was used as an excuse to unfairly reject clients. Generally there was some puzzlement expressed by homeless services staff that clients they worked with all the time were deemed to be too risky by better funded and staffed teams. Some homeless service staff were encouraged to consider if their own risk assessment and management systems were sufficient for this client group.

Comments included: "Other services use "Risk" as an excuse for not working with certain of these clients. They appear to be anxious but instead of saying that they say the client is "too high risk". We work with risky people, why will some other services not?"

- **The council's homeless assessment system is not "personality disorder friendly"**

"Council Housing lack a "personality disorder/complex needs friendly" assessment route – one that is flexible and quick and understands PD as mental health/addiction needs criteria." "Passporting personality disorder/complex needs clients quickly might save the council a lot of work/hassle." "Clients with this level of a disordered thinking do not make 'wise' choices when bidding for properties"

- **Supporting People do not have a personality disorder specific service**

A view was voiced that for this client group generic homeless hostels do not work well as the clients find there is too much stimulation around relationships with other very troubled clients. These pathways often break down with damage to both service, staff and clients. On the other hand just putting someone with this level of needs into a flat away from support often fails quickly for a variety of reasons such as the client wanting company or lacking skills to manage. A core and cluster model was suggested as a possible model for supporting this client group where more flexible support could be offered by staff not far away to clients who are in self contained flats in the community. This, it was thought, had the potential to break some of the cycles of breakdowns and relieve stress on generic homeless hostels.

- **Some services do not share all the risk history to allow us to make an informed choice.**

Some residential accommodation services voiced their concern that they thought sometimes some homeless services were so keen to get their client housed anywhere that they did not always share all the risk information with them and that risks have come to light after they have accepted a client that have meant they have had to move them on from their service as inappropriate and this has interfered with the clients recovery pathway. Some staff wondered if their own risk management systems were adequate.

- **There is a lack of trust between services.**

Comments included: "Exclusionary practice by statutory services is constant frustrating block." "The NFA service can be confrontational with us" [the police] "Some services put us down, then the police drop someone off and think we can work miracles!" "Other services are unforgiving and hold grudges against certain clients". "Other services watch these clients fall through the gap again and again." "Other services ban our clients for their behaviour."

“Sometimes for some clients, for some reason, too many services get stuck in and the client overdoses on services, duplication, conflict, splitting, lack of communication, etc.”

“If agencies whose focus of work is Personality Disorder actually got up and did some work with people who are suffering rather than just ignoring things, if PD specific services would support us and other agencies, then we could help the client move forward. People with PD are looked down on from other services”

“Most other services express Personality Disorder behavioural problems themselves and therefore are not helpable, and this is used to deny services which in my experience has included the PD Network itself.”

“Other services lack a structured remit requiring them to multi agency work with PD clients if an agency refers them, only this structural change will move some service in into the 21<sup>st</sup> Century.”

- **Other services criteria is too tight/inflexible or too lax:**

Some comments by staff included: “Other services criteria are too strict and inflexible.” “Other services are too lax and lack good boundaries and do not want to let their clients go.”

- **Attitudes: Other services have negative and judgemental attitudes to homeless clients with personality disorder.**

Staff expressed the view that other services have a very negative, entrenched and judgemental attitude to this client group (homeless people with personality disorder/complex needs). “The hearts and minds of other staff in other services blocks progress.” Some staff said they had become quite ‘hardened’ to the client group themselves as a way to survive and protect themselves from the constant difficult news about them. Some staff in other services freely express the view that NFA PD clients are “bad not mad” and that makes the clients mad, not bad. “Repeated rejection by services for whatever reason wears down the client’s sense of themselves”.

- **Other services do not know what we can and cannot do as a service.**

Comments included: “Other services need training in personality disorder/complex needs – they also need training in what accommodation support and homeless services can and cannot do so they stop thinking we work miracles or that we are not effective. They have split /confused view of what we do”

- **Other services do not understand personality disorder/complex needs**

Comments included: “PD is not understood by other services so they think it means something else, like “stress” or “risk”, or “do not touch”. “Other services that engage a generic mainstream – not PD specialists. This clientele need a special kind of approach.”

## **Appendix 10**

**These questions were also asked at Shelter Conference workshops in London and Manchester:**

**Shelter Conference  
- New Directions In Street Homelessness: Volume 2  
Between sectors: Filling the gaps in services for people with personality disorders**

**Answers to this Question in Manchester Workshop – 11th March 2008**

- Funding criteria may restrict service users from accessing other services.
- Mental health services are reluctant to continue to work with people diagnosed with personality disorder. Doors are closed without signposting to other services. Little or no explanation is given as to what the diagnosis really means.
- Lack of access to mental health services for homeless people.
- Diagnoses of personality disorder can be both helpful and unhelpful. Diagnoses can sometimes assist with obtaining priority need status for housing, or they can exclude people from accessing accommodation services.
- Better information sharing between services is needed, particularly around risk. The people who are considered to be the most 'risky' often end up in homeless and faith based services.
- Mainstream services are designed for most people but exclude particular groups.
- There is a lack of flexibility in service provision.
- There is often reliance upon key individuals rather than upon systems as a whole.
- Many people with personality disorders are passed from pillar to post.

**Answers to this Question in London - 25th March 2008**

- Practitioners and agencies need to be much better at signposting services for people with personality disorders.
- 'Informal diagnosis'. Personality disorder is a common diagnosis and one that is sometimes made with little clinical input.
- Personality disorder is seen as a medical issue and therefore untreatable.
- The label of personality disorder conjures images of someone who either cannot or will not be helped.
- There is a general lack of understanding among practitioners and service users of what personality disorder is and what it means.
- Supporting People criteria is the biggest barrier to working effectively with people with personality disorders.
- Flexibility is needed to work effectively with people with deeply engrained behaviour.
- Diagnoses cost money and this is one possible reason for the under-diagnosing of personality disorders.
- Frequent inappropriate labelling of service users.

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The **Leeds Clinical Personality Disorder Network** is a multi agency service, established to improve services to people with personality disorder in Leeds.