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MENTAL HEALTH
Transformation
NOTTINGHAMSHIRE

Making a Difference
Trust Honesty Respect Compassion Teamwork

Developing an Assertive Mental Health response for people experiencing Mental health and Homelessness .

Severe Mental Illness Transformation

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A lack of Mental Health support for people experiencing homelessness .. How did we identify this need?

- **Health inequalities** - 80% of homeless people reported some form of mental health issue, and 45% had been diagnosed with a mental health issue.
- Integrated health and social care for people experiencing homelessness- NICE guidelines
- Stigma..‘ I am too complex’ ‘not ill enough’ ‘stop substances first
- Barriers to access e.g. ID / GP
- Complicated system of services
- Identified service gaps with services not focused on prevention
- Long waiting times for mental health services
- Lack of assertive approach
- Leading to an excess use of acute pathways , A&E, Crisis teams , Street Triage

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A City Homeless Mental Health Service .

How did we develop the offer?

- Three Mental Health Practitioners deployed within the City Place-Based-Partnership Integrated Severe Multiple Disadvantage service provision.
- Mental health offer brought to the streets to work directly with people who are experiencing homelessness with street outreach and hostels etc
- Referrals accepted from all services, not from GP and including self referral
- 'Service works around me' a personalized care that flexes to meet access need
- Flexible trauma informed assessment and treatment
- Enabling people to tell their story , feel valued and listened to
- No wrong door – we navigate the system for service users
- Advice / consultation to improve system response to MH needs
- Management of caseload to enable no waiting lists
- Partnership working – WAMDT / SMD partnership

The Outcomes

‘The MH response has changed so much it’s like night and day ‘

- Over 600 assessment completed , 909 referrals received with 784 onward referrals to the system (as of march 2025)
- Improved Mental health outcomes
- Reduced use of acute pathways eg A&E, police, hospital admissions
- Reduction in gaps between primary and secondary MH care
- Reduction of health Inequalities
- Less falling ‘between the gaps’
- System learning / system held risks

- **‘ If it hadn’t been for your support, I would have been lost.’**

- **‘You give me a lot of support you make me believe I can change for better.’**
- **‘you gave me confidence and made me see my potential’**
- **‘I feel understood ‘**

Why did we meet the person?

A lady referred for MH support who had limited engagement with professionals. She would excessively use substances leading to frequent Emergency Department attendances, at times unconscious but she would not always stay to be treated. She would rough sleep and at times she was found naked. She was working as a prostitute and reported frequent sexual assaults. She was at high risk of exploitation and had a low level of awareness of her own safety.

What did we offer?

The support offered was trauma informed, underpinned by safety, collaboration, and empowerment. There was a need for a gentle approach and active engagement. We offered support for this lady to attend her appointments, make sure she has eaten and celebrate small victories such reducing alcohol. Offering a non-judgemental space to explore her mental health. We closely worked with the health shop and womens services and substance teams to provide wrap around care. This enabled us work to move her into accommodation with a robust care plan to support her.

Where are they now?

This lady is now housed at an accommodation suited to her complex needs. She still drinks but her intake has markedly reduced. She is thinking of going to Rehab which is a positive. She engages with professionals and tries to attend her appointments. She has mental health medication and has ongoing psychological offer from the team. She can still be vulnerable to exploitation, but the incidents are fewer and has not attended the Emergency Department for a lengthy period. Progress is not linear, but she is the right path.

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What did we learn ? Can others learn ?

This approach has genuine partnership working at the heart of delivery with a combination of statutory & voluntary sector providers

- Partnership brings opportunities and enables flexibility
- Open front door , non GP referrals have improved access
- Assertive engagement is key to improving health outcomes
- Approaches must be trauma informed
- Staff require support and training / shared system learning
- All services need to be supported to manage MH needs therefore advice and consultation to manage complex needs
- You cannot work in silo , wrap around care is needed – WAMDT
- In line with national learning from Fulfilling Lives programme & the Dame Carol Black review / drug strategy/ NICE guidelines

The Evidence Base / Recommendations

- **http://www.nice.org.uk/guidance/ng214**
- **https://www.nice.org.uk/guidance/ng58**
- **https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives**
- **https://healthandcarenotts.co.uk/care-in-my-area/nottingham-city-pbp/severe-multiple-disadvantage-smd/**
- **Dame carol black enquiry**
  https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwj_7-CGgtWCAxUFR0EAHUc8A4kQFnoECBYQAQ&url=https%3A%2F%2Fwww.gov.uk%2Fgovernment%2Fpublications%2Findependent-review-of-drugs-by-dame-carol-black-government-response&usg=AOvVaw2hoLAJEw0Ah0YRqzZTk95X&opi=89978449

Why did we meet the person?

A 40 years old male referred for Mental health support, very chaotic and using heroin IV and mamba. He was rough sleeping and agencies were concerned about his risks and behaviour. He has a diagnosis of Psychosis with several inpatient stays however he had a 'lack of engagement' with missed appointments leading to discharge from services. No active treatment for his mental health

What did we offer?

Assertive outreach, worked with services to locate him and assess his mental health over time. It required seeing him most days to build trust and assess his needs. We worked closely with drug services enabling a harm reduction approach to managing substance and mental health together. Working with him around making sense of hearing voices giving him insight into some of his difficulties and how his poor mental health impacts upon substance misuse.

We worked with the GP and later LMHT to reestablish medication for his mental health.

Where are they now ?

He is receiving mental health treatment from the local mental health as he is able to attend appointments. He has reduced substance use and is working with drug services and has accommodation. The main success is sustaining tenancy this isn't always easy for him as old habits remain (begging) but this is far less frequent. This has been a case that demonstrates collaborative working and highlights the benefit of assertive outreach

Why we did meet the person ?

Gentleman referred to the team with Anxiety, PTSD and deterioration of mental health due to being street homeless. Suicidal ideation with frequent overdoses. Experiencing verbal abuse from his deceased father in the context of psychosis. Feeling targeted due to sexuality. This man was often seen as ‘angry’ ‘difficult 'and ‘hard to engage’

What did we offer?

Active engagement on the streets with street outreach. We carried out a trauma informed , longitudinal assessments that identified aspects of neurodiversity where this person was experiencing overwhelm and dysregulation . We worked on formulation of sensory and emotional triggers, overwhelm, and coping mechanisms. Worked on strategies to aid in self-regulation, including grounding techniques and sensory-friendly adjustments. Care planning with other services to provide wrap around care.

Where are they now ?

Reduced use of acute services, no overdoses. He is able to manage his distress and is able to use his strengths to advocate for himself improving his overall well being and social circumstances. There has been a reduction in substance use as he no longer needs to manage his MH through use of substances. His Mental health has improved and he is maintaining his tenancy and is moving forward in his recovery looking for voluntary work

Why did we meet the person ?

We has a referral for a 35 year old pregnant lady who was rough sleeping in a tent and using substances. Reported diagnoses of anti-social personality disorder, bipolar and anxiety and depression. Long history of mental health with ‘poor engagement’.

What did we offer?

Active engagement, trauma informed assessment of MH needs and risks. Services worked together to offer warp around support and had regular communication to enable management of her needs and to help in engagement. MDTs held with social care, substance teams and housing to support this lady. The outcomes of which was aiding her moving into temporary accommodation, support with the pregnancy, mental health and social needs. We worked on access to GP for medication and stabilisation skills and management of mental health symptoms.

Where are they now ?

This lady continues to remain stable, is managing her tenancy well and avoiding contact with previous people who would have had a ‘negative influence’. She has had her baby who has been placed for adoption however support has been given for this lady to be as involved as much as possible. She has reduced substance use and improved quality of life. She has ongoing goals for her recovery and she has been referred through to the local mental health team for ongoing care as she no longer requires assertive MH support.