Submission to Sinn Féin's consultation on mental health services

Q. 1. What are the 'Principles' of a good mental health service? Examples if possible

Rights Based

The Principles of a good mental health service would incorporate a rights based provision which is consistent with UN/CoE/EU standards. The service should be easily accessible and be located within a community and adopt a person-centred approach rather than a medical model approach which is evident in the case of CAMHS for example.

Person-Centred

A person-centred approach means that patients are treated on an individual basis with tailored intervention and support and not a one-treatment-fits-all approach. Person-centred means that there is a focus on the relationship between the care professional and the individual (which differs to being 'needs-centred'). This also requires services to meet individuals at their point of need and not the service point of convenience. Service users should also be at the centre of creating, developing, governance, and service delivery (principles of peer support).

There should be a service user driven forum at the centre of mental health services in order to oversee the implementation, running, and the delivery of services. A simple and timely reporting system should be in place for services users to report complaints and poor practice with clear policy guidelines on how issues are resolved. The forum should be consulted when service delivery issues arise.

Responsive and flexible service

The traditional model of offering 2 initial mental health appointments by post, is inflexible and an unrealistic expectation is placed on the most vulnerable and marginalised service users, including people:

who are homeless;
who have serious mental illness;
with life limiting physical health challenges;
within the criminal justice system;
with learning disabilities, and;
people who are dual diagnosed.

Currently if a service user does not attend either of the initial appointments they are discharged and referred back to the GP. A greater understanding of the needs, issues, and challenges faced by these service users needs to be incorporated into the service delivery

framework. Statutory workers should be flexible in their approach to these client groups, in fact, preferential treatment, including a fast-track system, should be provided to prevent vulnerable service users from slipping through the net of mainstream services where they are 'exiting' even before entering. Consideration should be given to the creation of dedicated teams within mental health services for vulnerable groups.

In addition, consideration needs to be given to where services can be accessed. Many of the most vulnerable people in our society have difficulty accessing traditional mental health services. For some, including people with a criminal record, there may be restrictions preventing them from entering premises where they could come into contact with other vulnerable groups. Imaginative approaches are required, including collocated mental health services within voluntary and community sector projects which have developed good, and trusting, relations with vulnerable people.

Providing greater flexibility to service users should result in higher attendance rates, better engagement and ultimately more positive outcomes.

Continuum, interconnected with a clear and concise support plan

There should be a continuum in the provision of services, with entry points clearly 'signposted' from early intervention – prevention – intervention – post intervention – recovery stage, where people can access the right service at the right time.

The transition from child to adult mental health services can present huge challenges for service users and their families. The latest research in brain development highlights that young adults, men in particular, do not fully mature until the age of 25; which highlights that the split between young people and adult mental health should be a cause of concern and, in many respects, is arbitrary. Often a young person will have invested in the professional relationship in children's service to then move to different adult practitioners and services which can result in the young person experiencing crisis. There should be flexibility within the services to allow practitioners to continue working with young adults up until the age of 25 to avoid adversely impact the person's mental health.

Service users need to be kept well informed as to the nature of their treatment/care or support plans. Care plans should clearly document the task/actions that each professional will be taking and the timescales involved. Alternative crisis management plans should be explored with the service user if there will be delays to their treatments. Service users, their families and/or carers, should have the opportunity to be consulted prior to the implementation of any care/support plans. All options and/or care pathways should be discussed with services users and a final plan agreed by relevant stakeholders. If disagreement arises regarding the services users preferred care plan, an independent adjudicator should then decide in consultation with the mental health service user forum and relevant stakeholders.

Commitment to be fully inclusive and comprehensive with joined up practice between statutory and voluntary sector services

Clinical professionals working within the voluntary sector, when engaged in interagency work with the statutory sector, should be able to make direct referrals to state services. This 'best practice' would allow qualified persons within the voluntary sector, for example social workers or mental health nurses, to refer directly into statutory service in order to obtain specialised support for their service users. The current practice means professionals within the voluntary sector, primarily, have to access statutory services through General Practitioners or emergency services. This can result in significant delays in treatment for the service users, due to the pressures on GP practices for appointments and subsequently increased costs to the Trust. When someone accesses mental health services through emergency services there has been a missed opportunity, a failure of the system, to avert the crisis with community mental health services. It is in the community, where early intervention is possible and is known to have the best outcomes for recovery. Presenting at emergency services for mental health support also puts unnecessary pressures on already stretched Emergency Departments.

In essence, services need to be multi-disciplinary including medical and social care professionals which focuses on prevention, health promotion and wellness. With greater flexibility when responding to people with multiple diagnoses and complexity of need.

Q. 2. Can you provide an example of an effective, preventative intervention, for mental ill health?

In answering this question a very literal interpretation has been taken. Extern does provide effective intervention services to people who have mental health needs which prevent further deterioration and relapse. Explanation and evidence of these services are referred to throughout this submission.

Funding and support for Tier 1 and 2 services are critical for youth engagement prevention and early intervention.

The recent campaign 'Take Five Steps to Wellbeing' (connect, give, be active, take notice, and keep learning) was a simple campaign from the PHA which could be built upon.

Q. 3. What and where are the current pressures/demands on services? What could help to address these?

Funding and challenging poverty and marginalisation:

Poverty, service accessibility, atomisation and lack of community connectedness, medical model approach to service delivery, social media, funding structures and commissioning approach.

More funding, more security around commissioning, joint commissioning of services, wider understanding of how mental health and well-being are connected, more community events.

The emerging trends relating to the impact of social media and poor mental health for young people, the increasing numbers of suicides, particularly in deprived neighbourhoods and amongst young men, are serious concerns which require an investment in research to better understand the issues and how to provide targeted interventions. Without intervention there is a risk that the instances of suicide will continue to increase. In addition to programmes like CCIS, there are very good examples of where communities have rallied to provide responses to "suicide clusters", such as PIPS Charity who engage the community in responding to suicide as well as Belfast City Council's (albeit dated) suicide prevention strategy. Active Communities in west Belfast and many of the local youth providers will reach out to local young people in instances where there has been a suicide and will offer additional support and engagement to prevent others taking similar action. We need to learn from these experience and roll-out similar types of community/voluntary responses.

Lack of funding to voluntary sector services

Poor funding is leading to insecure service provision and skeleton staff to meet the needs of a growing population. A large portion of mental health support is provided by the voluntary sector whose services tend to be more flexible and responsive than statutory services. However, they are massively underfunded and the trend is for further funding reductions which is impacting on service delivery. Mental health services provided by voluntary sector organisations need increased funding urgently.

Prevent and reduce delays

For young people, services are currently struggling at two key points:
i) Referral to CAMHS at the initial point of early intervention and prevention – waiting lists are too long and because of the wait for services, the initial issues have spiralled by the time the appointment comes;

ii) There are currently not enough secure beds to meet the needs of young people presenting with multiple and complex issues. While meeting the "threshold" for secure treatment they are having to wait which results in community services, like ourselves, being asked to provide "holding" support until a bed becomes available. This is putting acute strain on the young people, their families, and our own staff.

Delays in accessing CAMHS and secure beds is compounded by the increasing number of young people presenting and being diagnosed with ADHD, ASD, and anxiety. For older children 15+ there is anecdotal evidence that the impact is more severe, perhaps due to lack of earlier intervention, resulting in family breakdown and teenagers being brought into the care system.

Waiting times for community based services

Before reaching crisis point many people are referred for community based mental health support. However, from the point of referral the initial appointment can take 6-8 weeks by which stage people have experienced further decline in their mental state – often reach crisis point – resulting in more aspects of life being adversely affected.

People with multiple complex needs should have rapid access to services. Possibly due to austerity, admission into statutory services are being managed by excluding clients who have more than one diagnosis.

There needs to be investment in additional voluntary services, such as mentoring and family support, for young people who are in crisis, and waiting to access services.

Inpatient bed shortages

More mental health beds are needed as a matter of urgency to ensure people have access to the treatment they require and to prevent a revolving door to inpatient wards.

The shortage of beds has resulted in an increase in-patients being placed outside their Trust area which places additional strain on family support networks due to difficulties in travel. It would not be uncommon for people to be managed in the community for prolonged periods because there are no beds. Bed shortage leads to delays in admissions and people being discharged before they are stable enough to leave.

Individuals who are excluded from essential services (for example, Day services and supported accommodation)

Due to a lack of services available, funding cuts, and strict access criteria for statutory services, people with complex needs, who are extremely vulnerable, are excluded from treatment and supported accommodation schemes. Without appropriate professional assertive outreach teams these individuals, in many cases, would not have their basic, let alone complex, needs assessed or met.

Support Community responses to mental health needs

Reach Out and Belfast Crisis Services

Extern's Reach out and Crisis are community based, response driven, services that provide a pathway of tiered support and prevention depending on the level of intervention required for individuals, families and groups. The services provide a range of supports from practical help in accessing benefits, to more intensive, one to one support for those who need it.

Like many community and voluntary projects there are funding concerns, however, with a growing number dying by suicide there is clear evidenced of need for these services, to support families and individuals who are still struggling with the trauma of the Troubles, particularly for those who are also living in poverty. In addition, more and more people with complex and multiple issues are accessing community services, including: debt information advice, addiction, family problems, sexuality/identity, homelessness, unemployment, and isolation.

Crisis Intervention Service Derry City & Strabane District Council

Community Crisis Intervention Service (CCIS), which is currently in operation as a pilot programme in Derry City & Strabane District Council area, provides a responsive and flexible 24 hour support service to people experiencing emotional distress or situational crisis over the weekend period. The pilot, which started in January 2019 has quickly established itself as an integral element of the support available in this area. CCIS is a non-clinical service which offers individuals a safe space to talk to trained staff, who help them de-escalate their immediate crisis, and co-develop a safety plan. CCIS are able to respond to an individual in crisis, and offer them the opportunity to come into the service and be seen within 30 minutes of receiving the enquiry compared to lengthy waits in A&E.

CCIS pilot has shown the potential for positive collaboration between clinical and non-clinical service provision to the benefit of the service user. There are the beginnings of strong professional relationships being established, which, should the pilot be extended and funding provided, can allow for necessary governance and guidance to be developed.

Moving Forward Moving On

Keep & Stay Series which addresses both presenting behaviours and underlying causal reasons at the same time whilst drawing together a "circle of support" for the individual.

Not enough access to talking therapies

A lot of people who have complex needs are reluctant to take medication for a number of reasons, including, previous negative experiences, adverse side effects, paranoia, or a belief that the medication does not work or is harmful. After engaging with services many will change their mind and start taking their medication, however, for others they will not, but will engage with 'talking therapies'. Talking therapies assist the individual and aid recovery and also allow for better monitoring and assessment of those who are acutely unwell in the community. Waiting times for talking therapies are long, which delays recovery.

For many who have accessed Extern Services, listed throughout this submission, the opportunity to speak with someone, about their current crisis, or sometimes a wider range of issues, in a non-judgemental environment where they feel listened to and valued as human beings has been a welcomed change. This also has undoubtedly reduced the need for many of these people to present to A&E when in crisis, with the associated lengthy waiting times.

Accessing medication if people move areas

Some people cannot access a GP without ID. Many, especially those experiencing mental health issues, find it difficult to complete simple tasks such as GP registration or other form filling exercises. This can lead to a break in medication that can have a devastating impact on the individual. The time delay and processes behind medication transfer needs to be simplified. A person's prescription should follow them in the same way their benefits do, a simple phone call should allow for medication to be transferred to an alternative chemist for collection.

The Belfast Healthcare Hub, which provides support for the most vulnerable who are, or feel, excluded from mainstream services is a welcomed development. The addition of mental health practitioners to the Hub will be of considerable benefit to service user. This model of service delivery should be reviewed and if successful should be a template for similar services elsewhere.

Legislative change

Legislation needs to be changed to allow the medical certification of doctors from other countries, living in Northern Ireland, to be recognised and allowed to work.

Emergency Department (ED) presentations

Individuals are having to wait 8-16 hours at ED before their mental health crisis is assessed and treatment options decided. In some instances vulnerable, mentally unwell, people are having to wait on their own. Waiting times need to be reduced massively to decrease the amount of people presenting and leaving without treatment. Delays in accessing services only increases the risks and the potential likelihood of people refusing to consider seeking help in the future.

Lack of specialised staff in the community

Many of the current statutory mental health services available will not work with those who are using substances (dual diagnosis) or who have additional complex needs; this is leaving a vulnerable cohort with no services. Flexible and responsive low threshold services are required to support these individuals to reduce the barriers to accessing mental health treatment.

Q. 4. What specific Interventions would help, especially to reduce the inequalities of outcomes? (Include costings if possible)

Answers to questions 3 and 4 are not mutually exclusive and should, in many incidents, be read together. Many of the points made in question 3 would address inequalities of outcomes.

CAMHS

For statutory services, there is a need to increase capacity at CAMHS's referral stage and at the crisis stage where secure accommodation is required to keep both the young person and others safe.

For the voluntary sector, which is providing an increasing number of services to adults and young people with a complexity of need there is a need for greater state support to invest in staff in terms of specialist training and remuneration to be able to meet the level of need. For organisations providing services, funding needs to be long-term and not year-on-year to allow for service and staff development.

Young people and Families in Crisis

Early intervention and prevention is the best and the most cost efficient option, however, currently the demand at crisis points is at a level that immediate intervention is required. An

enhanced and intensive Janus and Time Out service could be provided by Extern as a 6 month pilot intervention for 12 young people at an estimated cost of £80,000 which would include intensive individual and family support and planned and emergency respite.

Services/support at transition points

Target programmes for young people particularly around transition points, for example school, gender, moving from children to adult services, accommodation, training and employment. Support for young people exploring their sexuality and identify including support for LGBTQ+.

Emergency service (a more adaptable service needed as an alternatives to A&E)

An alternative to traditional A&E is needed for people with a mental health issue and in crisis. The service would need to be multi-disciplinary and nurse/Social worker led with a focus on talking therapy (CBT and EMDR). It may also be helpful to explore partnership working with the PSNI as they are often the first point of contact for people in crisis. A triage arrangement with PSNI where people are re-directed to a mental health crisis service rather than subject to a criminal justice response. This recommendation is developed further under Question 5 'Re-imagined emergency service'.

Addressing language barriers and promoting cultural awareness

Mental health services should proactively recruit staff that can communicate with service users in their native language (in particular, Arabic). There is a lack of mental health and addiction services that are delivered in languages other than English. Information leaflets regarding mental health service are not printed in enough ethnic minority languages resulting in a lack of awareness regarding services available to minorities. There is a lack of cultural awareness in mental health services, particularly for asylum seekers and refugees.

Counselling services and helplines do not have access to interpreters. Refugees and asylum seekers have often experienced high levels of trauma and anxiety and they suffer disproportionately from mental health difficulties. It is imperative that they are able to access the same range of support services that are available to other people living in NI. Therefore, investment is needed in interpreter services in the area of mental health.

Waiting times for mental health statutory support when transferred between Trusts

At present, when a service user moves out of one Trust area they are put on a transfer list and some have to wait considerable periods of time before being allocated a new worker – this often delays their treatment and recovery. Some people are forced to leave one Trust area due to lack of: housing, supported living placements, or emergency accommodation. It is not uncommon for service users, who have moved repeatedly between Trust areas to now not be receiving any support services.

Variations between the different Trusts results in services not being standardised across regions, for example, some Trusts offer inpatient beds for those with serious issues related to personality disorder while others do not. This subsequently results in an inequality of outcomes for service users based solely on their location.

Waiting times for Substitute Prescribing Team (SPT)

At present, waiting times for SPT varies widely across Trusts. There is no standardisation across regions resulting in a post code lottery and inequality of outcomes based solely on geographical location. Clear standardised protocols need to be implemented across all Trusts so patients can access SPT in a fair and timely manner regardless of location. People with severe mental illness and opiate addiction should be allocated specialised dual diagnosis staff in order to assist them with their recovery. More specialised supported accommodation is needed for those with opiate addiction and mental health issues.

Q. 5. What are the priority areas that we need to act on?

A number of these points have been noted earlier but prioritised here. Many of the concerns resonate with the findings of 'Making Parity a Reality: A Review of Mental Health Policies in Northern Ireland' by By Professor Siobhan O' Neill, Professor Deirdre Heenan and Dr Jennifer Betts (See here), in particular, waiting times, access to services, and the need to be more creative/innovative in service provision.

Re-imagined emergency service

A specific *Emergency Department (ED)* alternative for those in mental health crisis is urgently required, with purpose built individual waiting spaces for service users, carers and/or their families. The current practice of service users in acute mental health crisis presenting at traditional EDs is not suitable for all and can often result in people leaving hospital without having been assessed. Current EDs can actually be a barrier to accessing emergency services because waiting times are too long. At present, the current practice creates risks specifically in relation to those in crisis leaving the hospital without treatment and the potential for those mentally unwell to physically harm themselves/others either within the hospital waiting areas or within the wider community.

At present traditional EDs are focused mainly on addressing physical injuries. The environment can often be busy, crammed, some people can be in physical pain and distress and children can also be present. This external stimuli is not good for those experiencing distress, hallucinations or paranoia. Having a specialised mental health ED would offer service users in mental health distress dignity, privacy and a quicker response to their mental health needs. There should be a qualified staff member on hand 24/7 in the ED in order to provide rapid assistance to service users.

Transition points

Transition periods for young people and particularly the transition for those who have been involved with CAMHS and are moving to adult mental health services, there should be a lead in or stepped approach to this.

Talk Therapies

Talking therapies particularly for people who have experienced trauma.

Language and cultural awareness

Services provided in additional languages and cultural awareness programmes for health professionals.

When people are in the asylum system their mental health needs are ignored. Individuals with no recourse to public funds, who have been admitted following a mental health crisis, are being discharged to the street following a hospital admission. There is no continuity of care into the community for asylum seekers, which is provided to the general public.

Best practice tells us that patients should be able to access professionals who can converse with patients directly. Individuals engaging via interpreting services are often reluctant to engage fully or be open about their illness due to concerns about the interpreter knowing people within their community and the stigma attached to mental illness. While this might be difficult to achieve, it is something that needs to be explored further.

More specialised mental health/dual diagnosis supported accommodation

Homeless accommodation is not a suitable discharge option, it is often a distressing environment for individuals including those with mental health issues. Homeless hostels accommodate people who all have their own presenting issues, this is not a stable environment for anyone in mental health recovery. Equally current supported mental health schemes cannot accommodate for those with Severe Mental Illness and substance/alcohol use which leads to many vulnerable individuals falling through the gaps in services.

Improved Partnerships

There needs to be better joined up partnership working between the NIHE and Trusts. In particular, the practice of having, as part of someone's discharge plan, "present to NIHE for housing," is inappropriate and needs to stop. Someone coming out of a mental health facility is very unlikely to be provided with suitable accommodation from on the spot presentations. Therefore, everyone discharged without an address to go to needs a planning meeting involving the relevant service providers, including the relevant Trust and NIHE, to ensure the best accommodation, and support package available, is provided.

Standardisation of treatment and diagnosis across NI

At present the chances of being admitted to hospital and of receiving community supports depends on the Trust area in which you live. This needs to change so mental health services are based on presenting need and not geographical location.

Ease of access to wellbeing services

There is a need for more services that support wellbeing and not the focus on crisis driven services. Too many wellbeing services require a diagnosis, without such, people cannot access them, this often leads to, what would have been, a preventable crisis. Allowing those with difficulties that are undiagnosed would also allow for monitoring and sign-posting to more suitable services if/when required.

Attitudes of medical professionals need to change

Extensive awareness training in regards to substance use is needed across mental health services and Emergency Departments. Presenting at an ED can be extremely stressful for people in mental health crisis. Rather than being encouraged by their engagement with mental professionals, they are often told that their problem is substance related and therefore treatment cannot be provided.

There is also a need to increase awareness of the challenges faced by individuals who are transient or homeless as they are often unable to access appointment letters or attend set appointments as they are prioritising having their basic needs met.

Greater flexibility is required if people miss community mental health appointments – non-attendance is not a reflection of the person no-longer requiring service. Sometimes people struggle to engage and there needs to be improved flexibility to provide services to that person during times when they feel able to engage.

Complaints procedure needs to be simplified

It needs to be easier for patients to complain if they feel they have experienced negative treatment.

Q.6. What one idea or topic doesn't get enough attention in relation to mental health and wellbeing?

Challenging behaviour among adolescents

The correlation and rise in challenge and complexity when conditions such as ASD, ADHD and Foetal Alcohol Syndrome combine with adolescence. We need more research on this, both in terms of data collection and on what actually happens in the brain that causes this "explosion" of behaviours and then how can we best manage this in families, communities and services.

Using mentors

The benefit of a mentor particularly for young people who are suffering mental health issues.

Transgenerational Trauma

The effects of transgenerational trauma and the importance of talking therapy.

Dual Diagnosis

People who have a mental health issue and a comorbid addiction to substances often do not have their primary mental health needs addressed by statutory services. This is because traditional mental health services require service users to be abstinent for up to six weeks before they have their mental health needs assessed. This contradicts the current mental health strategic framework for Northern Ireland on mental health and wellbeing.

Substantial change is needed across Northern Ireland if Trusts are to adhere to the strategic framework. At present service provision across regions is patchy and inconsistent for those with dual diagnosis, with primary mental health and addictions services currently working separately from each other. This results in service users being passed back and forward from addiction to mental health services resulting in many people receiving neither service.

Traditional mental health and addiction services should establish dual diagnosis teams and have specialised staff to work intensively with this group. Specialised, high tolerance, low threshold access supported living placements are required for those with dual diagnosis in order to have their needs fully met.

Stigma around Suicide

The stigma around the word suicide still exists, we need to have a society where people feel able to have the conversation with someone they are worried about. The question "Are you thinking about suicide? " needs to be one that we feel comfortable asking, we have to move away from the thinking that by asking the question we will plant the seed of suicidal thoughts, where there hadn't been before.

Programmes such as SafeTalk and Applied Suicide Intervention Skills Training (ASIST) need to be more widely available to more people. At present, it is mainly professionals who avail of such training. The CCIS team have developed a new model that could be delivered to community groups, given the appropriate level of funding and support.

Appendix

Two case studies highlighting the important role of intensive support for people with mental health and addiction needs.

The *Dual Diagnosis Street Team* (DDST) brings a professional led intervention service to people at their point of need. DDST uses an assertive outreach model to provide services to vulnerable and marginalised people experiencing homelessness who also have drug and/or alcohol dependence with co-existing mental health issues. DDST aims to engage with service users to ensure their needs are assessed and met holistically. A number of case examples are outlined below which will demonstrate the nature of the interventions provided by DDST whilst highlighting the complexities and challenges of accessing statutory services at present.

Case Example 1

Prevention of loss of life in a male who was experiencing significant mental health crisis. The Belfast Trust Drug Outreach Service signposted John [not his real name] to DDST following a severe mental health crisis. John had a history of depression, anxiety, adverse childhood experiences, self-harm and was experiencing auditory hallucinations for the past 3 years. Voices were telling him to kill and harm family members and himself. John had made the decision, again, to try and seek help from professionals one last time – he had previously experienced great difficulty accessing statutory supports for his mental illness. He had a clear and specific plan to end his life on the day he presented to DDST, if his attempts to access help or services were unsuccessful. John was severely emotionally distressed and there was clear evidence that he was responding to inter-stimuli. While he had a history of prolonged poly-drug use, which included IV heroin use, this was in his past, until, two weeks prior to his referral to DDST, he intentionally overdosed, which resulted in hospital admission and PSNI involvement.

John was originally referred to the Belfast Trust Drug Outreach Team following the intentional overdose, however they concluded he was not suitable for their service because he was not opiate dependent at the time of his referral. He was subsequently seen by *Extern's Crisis Team*, however he did not engage with their service, due to the severity of his mental illness. John was also self-medicating with low doses of prescription medications (Pregabalin). Contact was made with his GP practice who were unable to offer an emergency appointment until the following day despite the imminent risk to life and physical safety.

Two DDST social workers went with John to the Emergency Department and supported him throughout the medical and psychiatric assessment process. He was subsequently admitted to a psychiatric ward, for a voluntary crisis admission, however the process took a full 10 hours in the Emergency Department. There is no doubt that without the support provided to John by DDST he would have left the Emergency Department. The DDST team subsequently attended a discharge formulation meeting and an agreed plan was set in place. Statutory services agreed they would be taking the lead as mental health was his primary issue and when he was to return to his family home the Home Treatment Team would initially work with him intensively and then he would be referred onto Primary Mental Health Services when ready, with onward referral for Dialectical Behaviour Therapy (an evidence based psychotherapy intervention) in the future. Extern's Crisis Team would also provide follow up support services.

At the formulation meeting it was agreed that the DDST service would cease engagement as appropriate supports were now in place and he was returning home to family post discharge. John remained on the psychiatric ward following the formulation meeting in order for the Home Treatment Team to undertake their initial assessment and he was advised that he could return home later in the day once they had seen him.

Within days John had made contact with DDST, stating the Home Treatment Team had refused to take on his case, furthermore he did not have the ongoing daily mental health support as agreed at the formulation plan. He had also missed an appointment with the crisis team due to still experiencing paranoia, anxiety, auditory hallucinations, poor sleep patterns and low motivation. Inter-agency working with the Crisis Team was required to secure another appointment. John subsequently telephoned DDST to advise that he could no longer cope with life and stated he had cut his arm and was losing consciousness because he had lost so much blood. DDST contacted emergency services, who, when found, was unconscious from blood loss. John was taken to hospital, treated for his physical injuries and discharged the same day, without mental health support services.

John's next-of-kin contacted DDST to explain that John had left the family home and was homeless again; they were longer able to provide the supports he needed. The family were concerned both for his safety and the safety of others within the home due to the state of his mental illness. DDST worked with the PSNI to complete a missing persons report, highlighting the serious risks to himself and others because of his mental state. Working with the PSNI John was found and brought to a place of safety to have his mental health addressed.

DDST supported John to attend an appointment with a Community Psychiatric Nurse (CPN), within the primary mental health service, who, following a brief conversation with John, stated he would refer him to the Drug Outreach Team because he should address his addiction issues first before they would consider his mental health challenges. The decision taking by the CPN is in stark contrast to the Mental Health Care Pathway framework that the Trust should be working under, and is common when working with dual diagnosed service users. The Primary Mental health team's refusal to provide ongoing support further compounded John's sense of isolation and hopelessness and further deterioration in his mental health. DDST had to continue supporting him due to the absence of agreed statutory services. John remains unable to navigate the statutory mental health and addiction support systems without significant assistance from DDST.

Case Study 2

Prevention of significant physical harm to self and/or members of the public - In the initial stages of the intervention DDST professionals spent a considerable period of time building a positive professional relationship with Frank [not his real name] following his prison release and subsequent rough sleeping. DDST conducted a comprehensive assessment with Frank and a number of statutory and voluntary stakeholders in order to build a holistic understanding of his needs.

Frank suffered a serious adverse childhood experience (ACE) and was removed from his mother's care as an infant. There was childhood sexual abuse and trauma, complicated further by his mother's addiction issues. He had a number of problematic foster placements and when Frank turned 18 he became homeless and subsequently began using alcohol and illicit substances as a coping mechanism. He has no peer or family support network and is socially isolated which impacts negatively upon his mental health. Frank has been homeless on numerous occasions and has spent prolonged periods rough sleeping. He has been diagnosed with a number of mental health issues, however a number of years previous, he was seriously assaulted and sustained a significant brain injury, whereupon his mental health deteriorated and the risks he posed to others increased substantially. Frank experiences auditory and visual hallucinations, disordered thoughts, can be verbally and sexually inappropriate towards women, aggressive towards men and is unable to regulate his behaviour around others. He is unable to manage his finances or take medications as prescribed. Frank's behaviours while intoxicated can be unpredictable requiring him to be supported by two professionals at all times.

While Frank has been offered a number of tenancies, these have broken down very quickly, often with weeks, due to him being unable to maintain a property because of his cognitive impairments, significant mental health challenges and substance misuse. He was convicted of a serious assault while mentally unwell and was sent to prison. When released he was unable to obtain homeless hostel accommodation due to his mental health and the significant risks he poses to others. Frank cannot avail of any mental health supported living because he is not receiving any statutory support services (as he is, for all intents and purposes, excluded from the system).

Frank requires intensive multi agency support from DDST, his GP, PBNI and the PSNI. Due to his offending history and complex issues he is excluded from many homeless day services resulting in DDST having to provide daily support to meet his basic needs. Due to the unmet needs of his complex mental health issues and polysubstance misuse, Frank is repeatedly arrested and imprisoned for breaking the law; a cycle that continuously repeats itself. By repeatedly being imprisoned, Frank is not in the community long enough to receive statutory mental health support.

Following Frank's most recent release, DDST, working with the Northern Ireland Housing Executive and Prison health care and housing rights, managed to find him emergency accommodation. However, Frank's mental health had deteriorated even further and he was now an even greater threat to himself and others as he had started carrying a knife because of his paranoia. Working with his GP, and PSNI, DDST were able to secure an emergency mental health assessment with Belfast Trust's unscheduled care team. Due to the risks posed to the public by Frank, DDST had to accompany him to the mental health assessment. In fact Frank only attended the assessment because of DDST's support and the positive relationship he has with the DDST team.

DDST staff discussed Frank's case with the unscheduled care team and it was agreed that he needed to be hospitalised in order to keep him, and the public, safe given the state of his mental health.

DDST attended a number of multi-agency meetings with the Belfast Trust Acute Mental Health team and PBNI to determine the level of risk he presented to himself and members of the public. DDST were instrumental in advocating to the statutory agencies of Frank's needs and how his mental state remains a significant barrier to accessing accommodation and statutory mental health services. Without DDST support he would still be rough sleeping in Belfast city centre where he would be a risk to himself and others given his poor mental health. Frank was formally detained for treatment and will now receive the statutory support he requires, DDST remains involved at the request of Frank and Statutory Mental Health services. When he is released from hospital, he will require the input from a range of services in order to live within the community and prevent future rough sleeping episodes.

These two case studies highlight the importance of services within the community for vulnerable people experiencing poor mental health and the challenges they have with accessing statutory mental health services. The DDST operate a low threshold, high tolerance, assertive outreach approach and are flexible in their working hours in order to adapt to service user needs and facilitate organisational demands. DDST is a flexible service to people who are 'hard-to-reach' and marginalised, it does not walk away from even the most challenging case. As the two examples highlight, DDST deal with complex cases which result in positive outcomes for those involved.