Mental Health Social Care Summit II

5th and 6th March 2024

MHSCI Mental Health Social Care Incubator

SUPPORTED BY NIHR | National Institute for Health and Care Research

LSE The London School of Economics and Political Science

Manchester 1824 The University of Manchester

Association of Mental Health Providers

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Introduction

The Mental Health Social Care Incubator (MHSCI) is working to build a community to grow research capacity in mental health social care (MHSC). It has been funded by the National Institute of Health and Care Research (NIHR) over an initial 3 years, starting from January 2024. An engagement event with representatives from the sector was held in December 2023, and report of that Summit can be viewed here.

To continue establishing the community, shaping our shared agenda, and building momentum, we held a second Summit in Manchester on the 5th and 6th March 2024. We brought together 40 people with an interest in raising the profile of MHSC. Some were at the previous event, demonstrating their continuing commitment to helping consolidate the growing community. For others, it was their first meeting with the MHSC research community.

Over the course of two days, we discussed progress towards growing the community and building research capacity, the perspective from frontline organisations, and an example of a MHSC project in development between academic, community and lived-experience colleagues. The goals were to build more connections between people, strengthen understanding and trust, and lay foundations for further collaborations. We are pleased to report that the event was a success, achieving these goals. We now have collaborations delivering concrete actions to build research capacity in MHSC, and we look forward to building on this and reporting updates at future events and in reports.

For now, we want to acknowledge the continuing support of members of the MHSC research community. We thank everyone for their endeavour to deliver our shared vision of more people and organisations connected with MHSC, all engaged in building a robust evidence base for the sector.

The MHSC Research Summit

The morning began with Incubator co-lead, Michael Clark, updating attendees on the development of the Incubator and the MHSC community. Michael noted that there is a growing identity and profile for MHSC and related research, building on more solid understanding of what the sector is. The report from the Mental Health Social Care Policy and Oversight Group (2023) *'Mental Health Social Care: What it is, why and how it matters for integrated care'* has been a crucial foundation for building a sector coalition and raising its profile, nationally and internationally. This has articulated key principles for the sector including being about helping people to live fulfilling lives grounded in a social understanding of mental illness and distress; working with communities to do this; being alongside people by recognising our mutual interdependence; and not treating individuals as isolated entities.

Ongoing work by Shoshana Lauter at the London School of Economics & Political Science has further added to this by identify four overlapping frames of reference across which MHSC sits. These four are:

Values and Models of Care:
a biopsychosocial model where the social is afforded equal stature and prominence, underpinning an understanding of personal recovery towards living a fulfilling life.

Organisational Relationships:
understanding the roles of the Department of Health and Social Care, Local Government, and the NHS, working alongside community and voluntary Sector organisations to deliver a vibrant and evidence driven MHSC community.

Legislation and Statutory Guidance:
how the Care Act, Mental Health Act and other legislation establish roles, responsibilities, and boundaries within which NHS mental health and MHSC organisations can work together to best support people.

Practice Identities and Roles:
understanding the respective roles of social workers and others, including Peer Workers, and how they can operate together with individuals needing support and their communities.

On these principles we are now building the MHSCI to support each other to grow research capacity. To our knowledge, there are six research projects, proposals in development, and personal research fellowship applications connected with the Incubator. People are being encouraged and supported to take the first steps in contemplating developing their own research interests and proposals. We are also in the early stages in the Incubator of establishing a formal programme of support for such people. All of this has been guided by the Incubator Steering Group, who have warmly welcomed these positive steps forward.

Lastly, Michael noted that we have challenges ahead to maintain momentum to deepen and widen the reach of the community's roots. We are committed to be inclusive and helping to play our part in addressing inequalities. The Steering Group and a growing network of important contacts in this field have acted as crucial critical friends in this regard. However, overall, we have a positive foundation of a network based on mutual interests and understanding and trust from which to meet these challenges.

Perspectives from MHSC

The day continued with perspectives from different parts of the MHSC community to consider the future of MHSC and MHSC research. First **Liam Gilfellon, Director of Relationships at Everyturn Mental Health**, a national non-profit organisation delivering a range of mental health support, described the work of his organisation, who operate to ensure '*no one struggles alone'*. This helped those less familiar with the frontline work of MHSC to better consider what priority issues might be for future research. It also reinforced the message of MHSC as about *being alongside each other.*

Next, **Grace Collins provided a lived-experience perspective** on mental health social care and research. Grace commented that currently the research system and processes feel too insular non-inclusive. Those excluded at present feel weary, worry they'll be seen as making '*too much fuss'*, and cope by *'making do with what they've got*'. Grace presented a vision, in wonderful graphical style, of how the system could work better. In this vision, ideas for research can come from a more diverse set of sources. Stronger networks help people to find the partners with the right skills and knowledge to develop ideas into funded research projects. These projects are capable of engaging wider audiences and capture more committed attention to be able to make a difference improving lives.

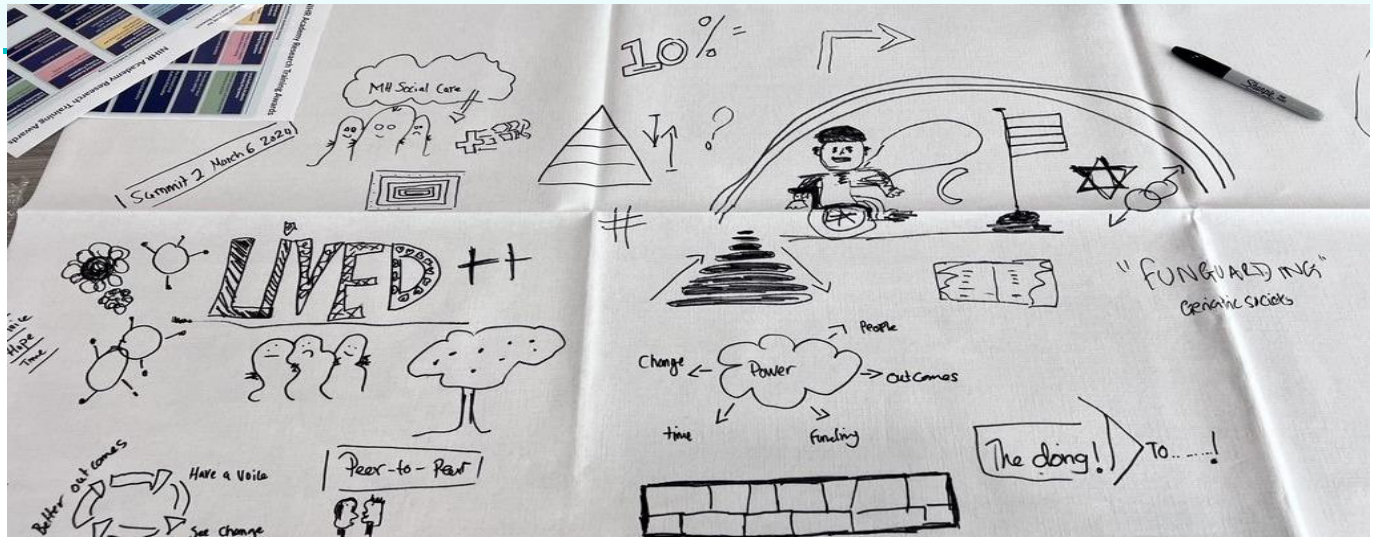
To conclude this section, **Bryn Lloyd-Evans, Professor of Mental Health and Social Inclusion at University College London** talked about the evolution of a mental health social care research idea into a proposal for funding. The research centered around people who are using mental health services who often speak about their desire for more intimate, loving relationships, but feel uncomfortable discussing this subject with care support services and staff. From this initial idea, a group drawn from people with lived experience of mental health problems, people working in MHSC, and researchers have come together to collectively define and develop the **CaIR Study: "Conversations about intimate relationships in mental health social care"**. The study, currently a proposal submitted to an NIHR funding stream, has been co-produced and stands as an exemplar of how we might collectively develop research in MHSC. In many ways it is leading the way in turning Grace's vision into a reality; a reality the Incubator wants to make more widespread.

The presentations of Liam, Grace and Bryn are reproduced in the appendices.

Plotting the route from where we are now… to Grace's vision of a bright future for mental health social care research

Building on the scene and vision setting from these presentations, we held group discussions on the essential ingredients for a bright future for MHSC research. We discussed key barriers and enablers, the role of the Incubator, and reflections on the research priorities from summit one. Notes were made on tablecloths and post-it notes and are summarised here.

There is a need to continue to clearly and forcefully articulate what MHSC is for ourselves and especially others including national and local decision makers, if we are to understand what we are trying to improve and how. This will help to continue to further define MHSC research priorities as we identify key evidence gaps. Linking with and learning from other initiatives and organisations will also help, such as professional bodies, knowledge brokers, and think tanks. A collective goal could be creating a social movement around advancing people's rights and addressing inequities related to mental health issues. This also means recognising that social interventions take time and commitment built on a network of sustained relationships.



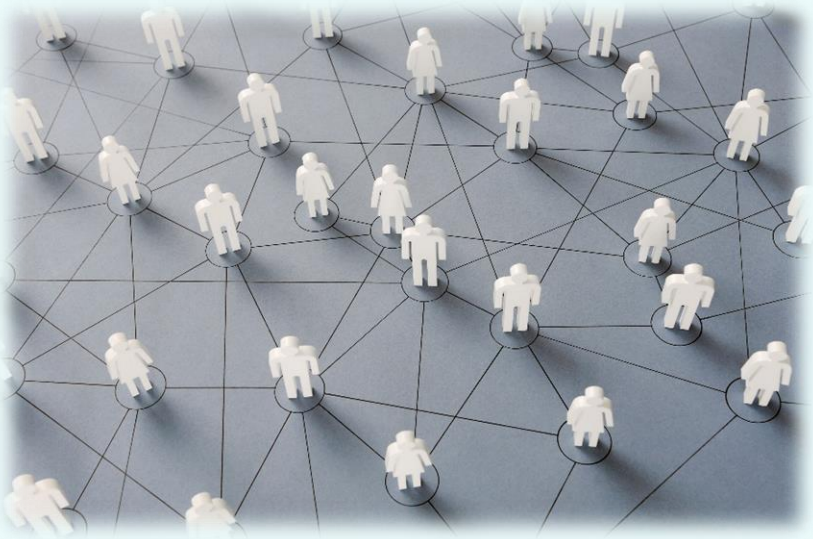
Articulating the case for MHSC will also mean identifying when and where benefits to people and systems are likely to be met. For example, more investment in MHSC would be expected to improve people's lives and have a beneficial impact on NHS resources. It could also positively impact welfare benefits. Setting this out in more robust detail will be invaluable for increasing MHSC investments.

Key barriers to moving forward with developing MHSC and related research will be a lack of investment in technology and routine data to inform better analysis and case building. In the future, joining data from statutory providers & community and voluntary sector organisations might yield a better analysis of the whole picture of investments, as well as a broad set of outcomes important to people for living a fulfilling life.

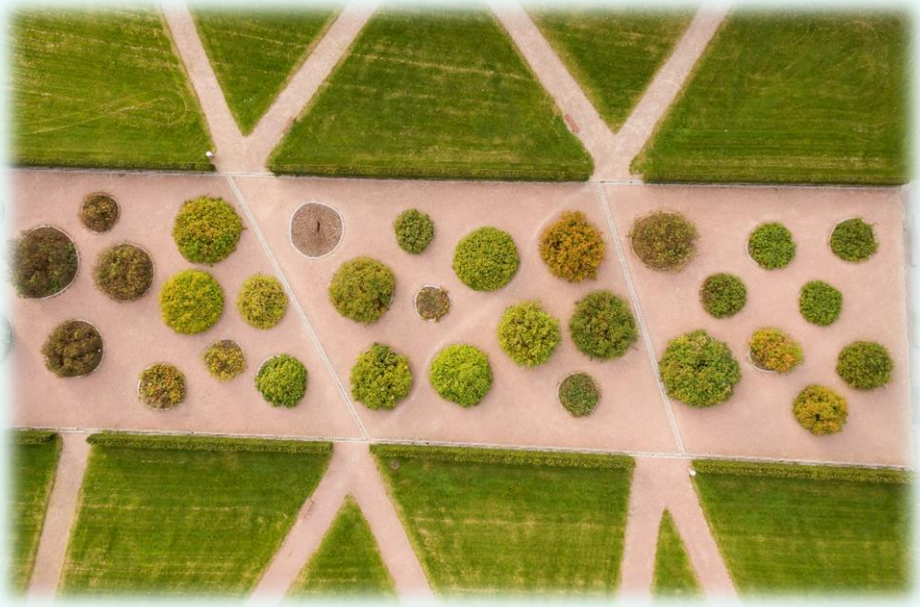
There is a need to continue to demystify research to people connected with MHSC. The Incubator is a helpful platform from which to start this. It can help people to see that research is important and that they can have a role in developing it. The Incubator can then help bring together the people and their ideas for future research, connecting ideas and expertise to develop robust and fundable research proposals, supporting people to see that they do belong in research and overcome any imposter syndrome they may feel. Demonstrating improvement in the research environment and from the research will be important. Plain language should be at the root of everything the Incubator and the network does to help widen engagement in research.

The need for methodological plurality in MHSC research was again stressed, including arts-based methods and different sites for research, such as a greater emphasis on community settings. Mapping and social geography may also be helpful in, for example, considering social capital and networks and impacts on mental wellbeing and recovery. Building alliances with colleagues in close fields such as public health and primary care would also be helpful, for example, to build capacity. Prevention is one increasingly shared agenda across these areas and MHSC.

Regularly and promptly identifying research opportunities, notably funding calls, is crucial to building capacity and the MHSC evidence base. The emphasis here will rest with MHSC academics within the MHSCI network as others start to learn about funding opportunities. The developing NIHR Research Support Service will help spread understanding about funding and how to develop good research grant applications.



Widening engagement is vital if we are to diversify the audiences engaged with the Incubator and research more generally. More seed funding to help engage diverse communities far out in their orbit of research would be helpful. Funding is also required for people with lived experience and community groups to lead MHSC research, as well as be paid for their involvement in other projects. We need to understand the barriers they face to securing this, especially the bureaucratic ones relating to flows of research funding, which could be potentially removed quickly. More pathways are required for people with lived experience to develop skills and careers as researchers.



There may be a case to explore for conducting more research outside universities as this may bring different perspectives and opportunities. There may also be a value for money case too, as university-based research is expensive, and other organisations may deliver research more cost-effectively.

Good principles of co-production are at the heart of good MHSC research. Recognising different expertise is important; and paying attention to who and what is dominating the discussion and whether this is appropriate and supportive of co-production should be fundamental to how MHSC research is planned and conducted.

The group recognised that academic careers are partly driven by system demands no matter what the motivations of individual academics. These might not obviously help drive good partnerships at times, but good co-production should still be a feasible goal in the longer-term development of MHSC research.

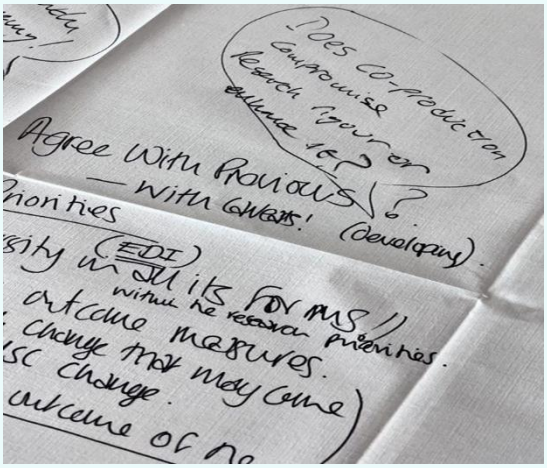
Commissioners of services also need to be brought more closely into MHSC research. There needs to be greater connection with system partners such as Integrated Care Boards to identify priorities and opportunities to develop evidence to improve local systems. Research needs to explore innovation and implementation if MHSC isn't to be stifled by rigid existing systems and a default to inflexible 'business as usual'.

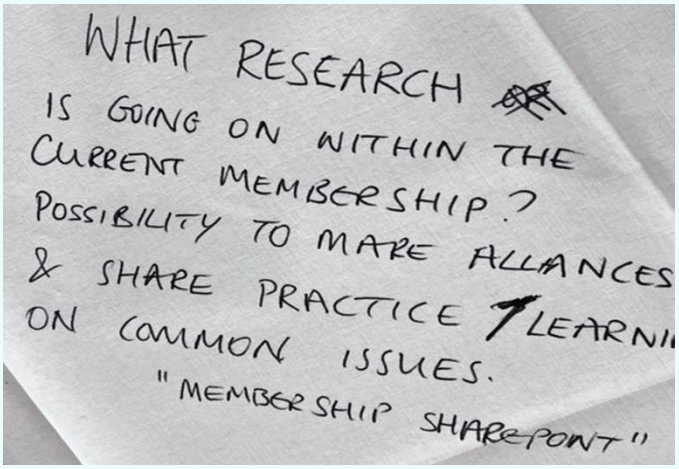
Endeavours to embed a research culture and infrastructure in local authorities have been developing with NIHR support. This is a welcome evolution, and it would be good to see similar initiatives within the community and voluntary sector. This might include, for example, Research Fellow opportunities in these organisations, and research exchange placements in university-based research teams. More development of practitioner academic career pathways is another potential initiative to develop in local authorities and community and voluntary sector organisations. Staff need protected time to develop research ideas. To underpin such developments, more needs to be done in local authorities and community organisations to support embedding research leadership commitment and responsibilities into senior management teams.

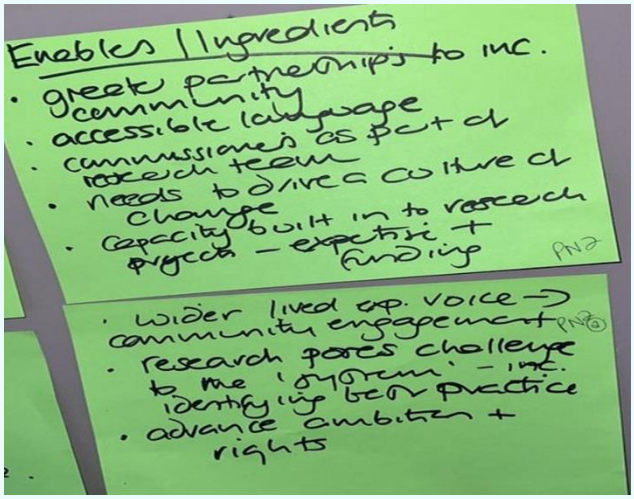
Breaking the cycle of a lack of investment, which has led to the present minimal capacity to develop new research proposals, will be a challenge. A lot will rest on a few researchers to get the early grants with public and practice co-applicants. Gradually, we would expect more capacity to develop further grants but in the short-term we may have more research priorities and little capacity to address them all. This may also require sensitive management of expectations of colleagues.

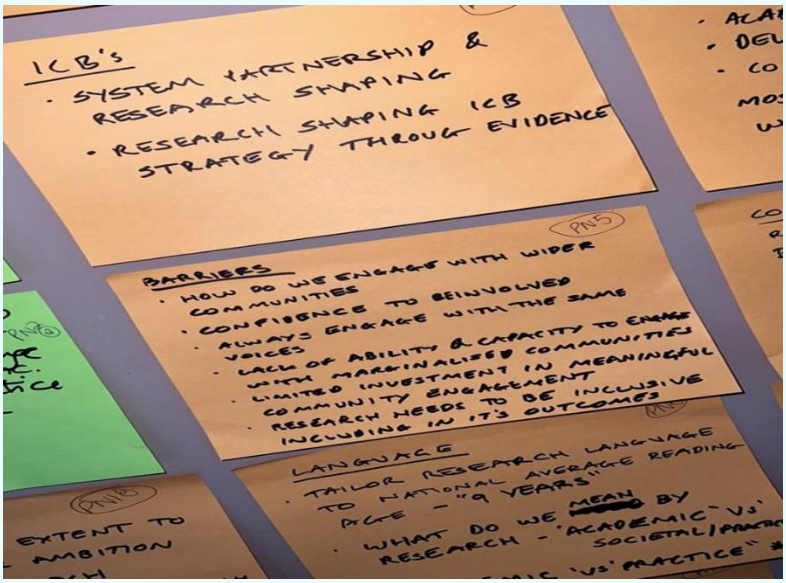
The group asked how the work of the Incubator and lessons learnt can be communicated across NIHR and help influence change there. The Incubator has already reached out to many people and organisations not connected to NIHR research and is helping to build more partnerships for research. As the Incubator extends this work, we need to consider how the lessons be shared across NIHR to inform similar new partnerships in other areas.

Tablecloths and Post-it Notes









The Economic Case for Mental Health Social Care

Michael Clark & Duncan Tree presented work they have started beginning to understand the economic case for MHSC. There is a need for an economic evidence base for MHSC to convince decision makers of its impact and the value of investment, as well as where to target this investment.

There is good evidence of the economic impacts of poor mental health, such as the estimated cost to UK economy of £117.9 billion annually (Mental Health Foundation and CPEC, LSE, 2022). We also have a reasonable picture of spending on NHS mental health care. The profile of spending on MHSC though, is less developed. Insights on this sit across different analyses, for example:

The mental health cost to social care is £1.2bn per year, whilst secondary mental health care expenditure is £13bn, and for primary care it is £2.3bn

The NHS spent about 17% of their NHS mental health budget on non-NHS providers in 2021-22, but this includes independent sector provision, as well as community and voluntary sector support.

On concerns around MHSC resources, there is the wider picture of spending on mental health care compared to other areas of health care. It has been estimated that addressing this 'parity of esteem' gap would require raising mental health spending from £12 billion in 2017/18 to £16.1 billion (2023/24) and £23.9 billion in 2030/31. If this were to be achieved, a concern then would be what to invest in.

One argument would be to invest more in MHSC, but there has been little economic evaluation directly of MHSC interventions. The risk then is that this field is overlooked, and more money goes to continuing with the same local systems and not supporting a more balanced biopsychosocial approach. There is, though, some helpful evidence around MHSC and the kind of work it does which could guide investment. For example:

Prevention initiatives: there is not huge evidence in general, but some interventions such as debt advice are shown to have a good economic return, and this could be delivered as part of enhanced MHSC in local systems.

The key aspects of recovery approaches of connectedness, hope, and optimism about the future, identity, meaning in life, and empowerment are all central to the understanding of MHSC and how it works.

Interventions and approaches we might describe as recovery-oriented, such as support to gain employment, welfare advice, housing support, have some economic evidence and, if they are to fully realise any increased investment, would be best being well-grounded in a true social perspective, linked to community, and connected in a more explicit social offer in local systems.

Conclusion

Positive change is happening. NIHR is supporting more social care research and has funded this Incubator. There are now more inclusive funding pathways for research projects and individual research career awards. There have also been helpful calls from NIHR for more work with communities, to address equality, diversity and inclusion. This direction of travel was seen as helpful by attendees, but more could still be done. The community of the Incubator would be keen to engage with NIHR decision makers about how this could be developed.

There is also more recognition of the challenge of implementing research evidence and changing local systems of care and support. Investment in the IMPACT centre at Birmingham university is helpful and begins to resurface and build on older experience of providing support to local sites to implement research evidence.

Having this second MHSC research summit meeting was seen as a huge signal of commitment to genuinely trying to build capacity in MHSC research. The fact so many people came to both summits was a sign of interest and commitment in the communities the Incubator is seeking to build partnerships with. For all parties, there was a feeling of starting to build relationships and a shared understanding of what MHSC research is and could be. These have given more secure foundations for developing the Incubator over the next three years.

Acknowledgments

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Appendix 1 – The Evolution of a Mental Health Social Care Research Theme – the CAIR project: Bryn Lloyd-Evans

UCL

The evolution of a mental health social care research theme – the CAIR project

MHSC Incubator Summit 06/03/2024

Prof. Brynmor Lloyd-Evans, University College London

UCL

This talk

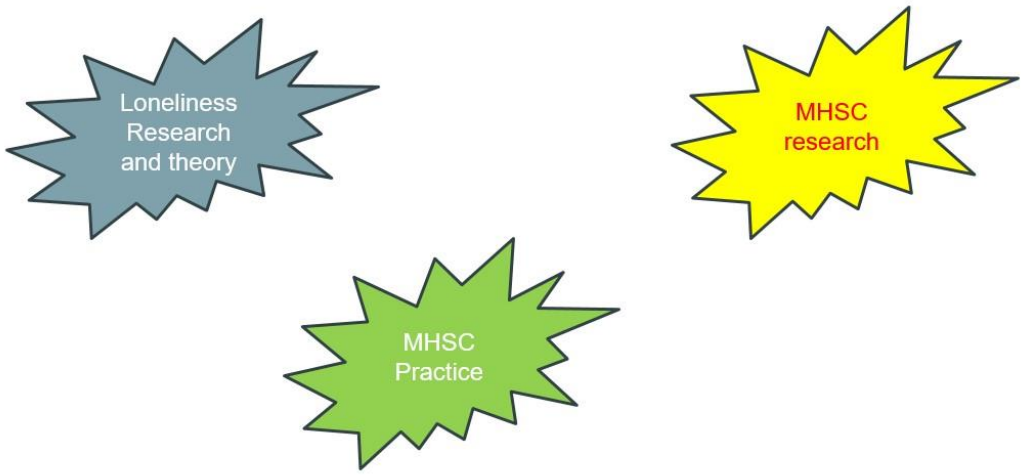
Description of a current MHSC research funding bid

- Origins of the idea
- How MHSC has shaped the bid and will be involved
- "Capacity-building" opportunities for MHSC research

The CalR Study: "Conversations about intimate relationships in mental health social care"

- Current research funding bid being reviewed by the new NIHR Research Programme for Social Care (RPSC)
- The issue: ***How can MHSC services support people to develop desired romantic and intimate relationships?***
- The study: ***To develop a web-resource for MHSC practitioners and people using services to support conversations about people's wishes for romantic and intimate relationships, and suggest options for support***

Where does the idea come from?



Loneliness Research

28% of people with mental distress experience chronic loneliness (Gov.UK 2022)
Loneliness predicts poor recovery from a range of mental health conditions (Wang 2018)
Romantic loneliness is most strongly associated with suicide risk (McLelland 2023)

Intimate	Relational	Collective
• A lover • A confiding relationship	• Friends • People to do fun activities with	• Feeling you belong in your neighbourhood or society • Feeling valued

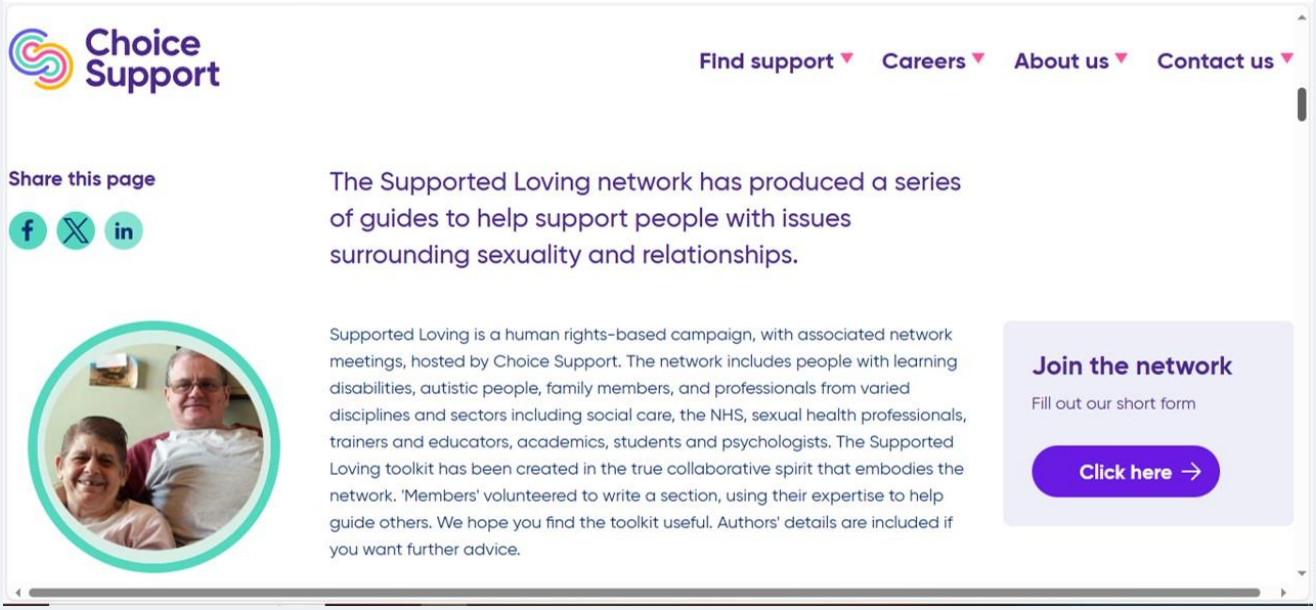
Dimensions of loneliness (Cacioppo 2014)

MHSC Research and Practice

- Two thirds of people with a serious mental illness are single (Thornicroft 2004). People with SMI rate satisfaction with their sex life very low (Laxhman 1017). Stigmatising beliefs about the desirability of people with mental health problems are common (Hughes 2019).
- People receive less support and opportunities to talk to staff than they would like about their needs for social relationships (Pinfold 2014)
- ***Help with feeling lonely*** and ***Help with finding a partner*** were among the most common unmet needs for people in mental health supported accommodation (Eager et al. 2023)
- MHSC and health staff perceive a wide range of barriers to having conversations about people's wishes for intimate relationships (Emery-Rhowbotham in prep)

- My experience in residential social care and CMHT social work: making friendships and relationships is a big challenge for many people using MHSC – and services often don't offer much support

MHSC lags behind other areas of social care?



The CalR Study

Application to new NIHR RPSC funding stream – submitted JAN-24

A 2-year study

Year 1: Qualitative interviews with 40 MHSC service users and 40 staff – video-recorded with consent

Year 2: Development and preliminary testing in 4 x MHSC services of a Social Care Talk web-resource for MHSC staff and people using services

Why Social Care rather than health services focus?

- The topic is a good fit: fulfilling relationships are a non-clinical need, a human right?
- Funding more likely from social care research?
- Social care practitioners in VSO settings may be more able to adopt new ways of working? – cf Connecting People study (Webber 2018)

CalR Study Team

Who?	Why?
Bryn Lloyd-Evans, UCL	Loneliness research, social care background
Claire Bates, Choice Support	"Supported Loving" ID relationships expertise
Mike Clark, LSE	Social care research expertise
Sharon Eager, UCL	Managed previous SUSHI and CaR studies – PhD student
Liz Hughes, Glasgow Caledonian	Sexual health, safety and trauma expertise
Frank Keating, QMUL	Qualitative and cultural expertise
Helen Killaspy, UCL	Clinical and supported housing expertise
Karen Machin, Assoc.MH Providers	PPI co-lead, lived experience + social care expertise
Isaac Samuels, Assoc. MHP	PPI co-lead, lived experience + social care expertise
Duncan Tree, Assoc. MHP	Social Care expertise and networking
Social Care Talk will provide technical help with developing the web-resource Social Care Talk	

MHSC practice partners

4 social care organisations will collaborate throughout the study: a named person to attend all study meetings and support staff and service user recruitment:

- **Choice Support** (Lisa Parle)
- **MindOut** - LGBT mental health charity (Rita Hirani)
- **Rethink** (Glenn Raymond)
- **Sandwell African-Caribbean Mental Health Foundation** (Rebecca Gardner)

And an 8-person MHSC Lived Experience Expert Group to collaborate throughout the study

How have MHSC partners contributed to developing the bid?

4 x collaborators attend study planning meetings and comment on draft application. MHSC practitioner involvement helps by:

- Ensuring we have credible plans for recruitment and testing the web-resource
- Helping access people who use services for PPI consultations
- Shaping the bid: e.g. suggestion for “community researchers” to help engage people using services

RPSC funding stream: social care research capacity-building

We have costed time for input from our MHSC partners in the study research costs. RPSC also allows up to 20% extra funding for “research capacity-building”.

Our plans:

- 4 x “research placements” for MHSC organisation staff: 1.5 days per month
- Interviewing and analysis skills training for lived experience group members
- 1 x UCL MSc in mental health research bursary + living stipend for a social care practitioner or service user
- Academic help with one service evaluation project for each of our four partners

Conclusion

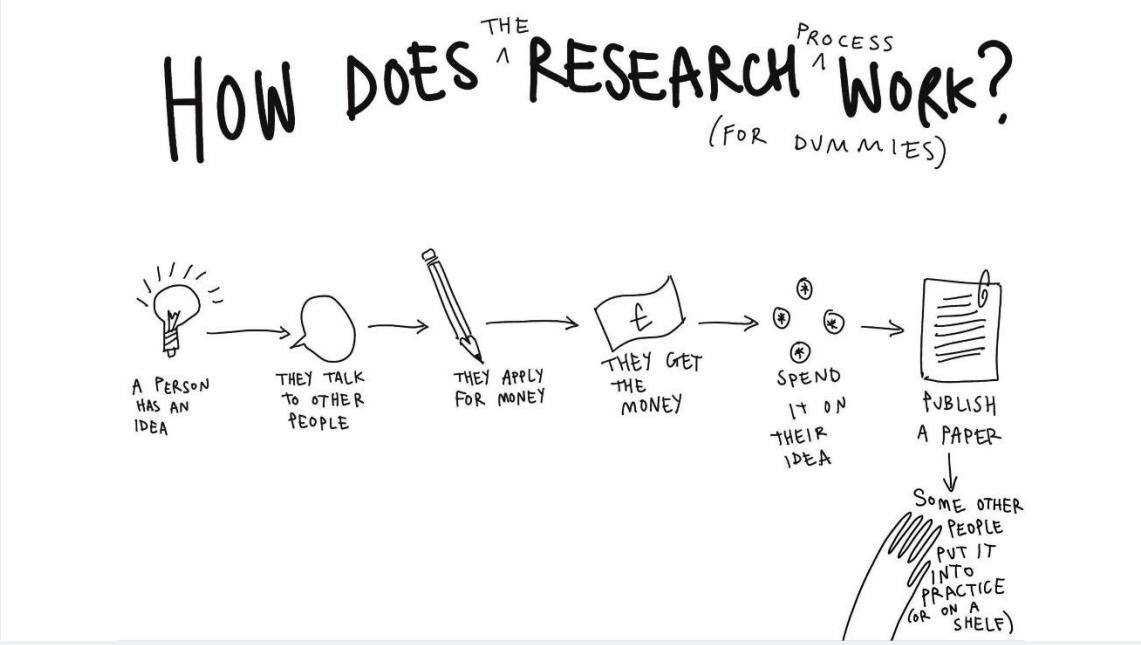
Growing recognition that more social care research is needed.

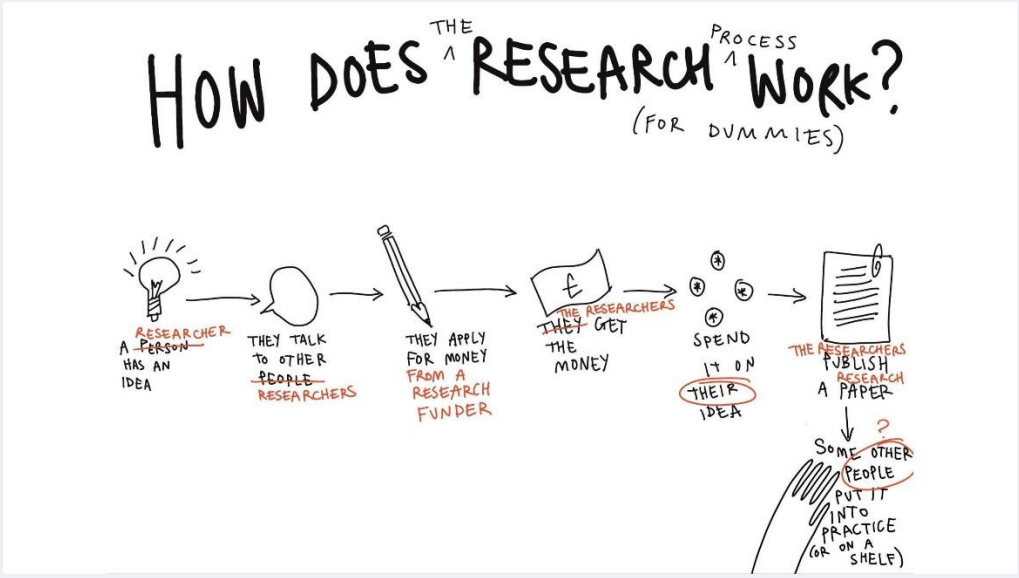
Opportunities to do research in social care settings are expanding:

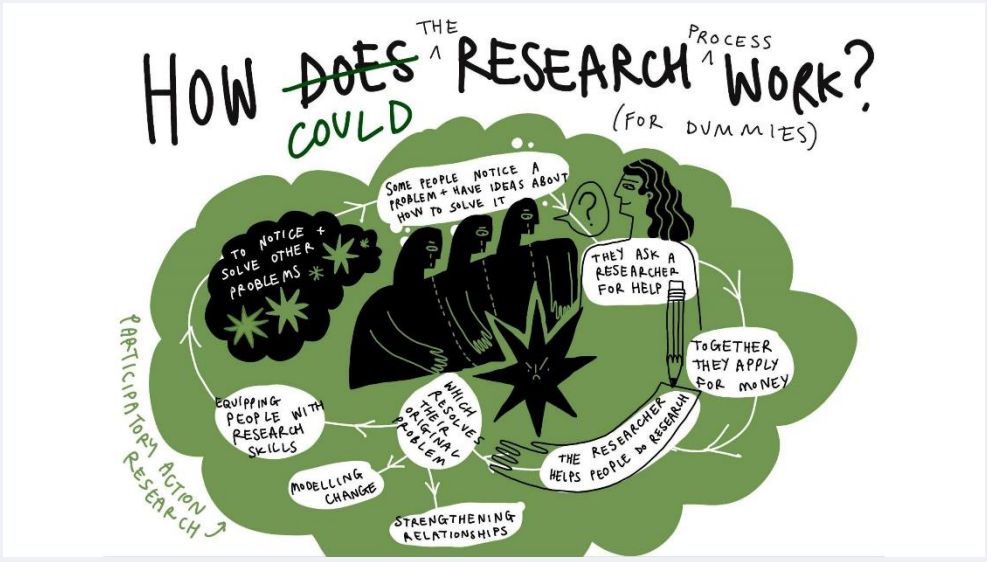
- Grant funding streams: RPSC, SSCR
- Individual career development: NIHR PLAF and DCAF schemes, SSCR fellowships

Collaborations between researchers and practitioners lead to better research. The MHSC Incubator can help develop these!

Appendix 2 – A lived experience perspective on mental health social care and research: Grace Collins

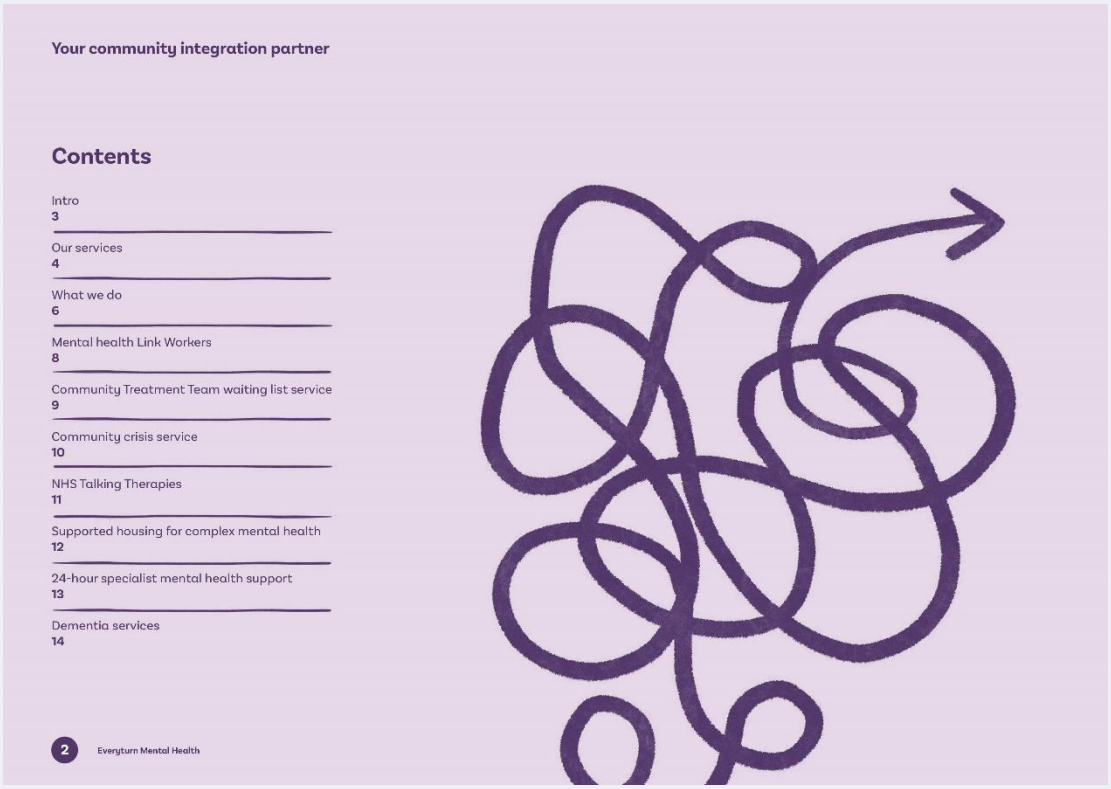



HOW DOES THE RESEARCH PROCESS WORK?
(FOR DUMMIES)
A RESEARCHER HAS AN IDEA
THEY TALK TO OTHER RESEARCHERS
THEY APPLY FOR MONEY FROM A RESEARCH FUNDER
THE RESEARCHERS GET THE MONEY
SPEND IT ON THEIR IDEA
THE RESEARCHERS PUBLISH RESEARCH A PAPER
SOME OTHER PEOPLE PUT IT INTO PRACTICE (OR ON A SHELF)


HOW DOES COULD THE RESEARCH PROCESS WORK?
(FOR DUMMIES)
SOME PEOPLE NOTICE A PROBLEM + HAVE IDEAS ABOUT HOW TO SOLVE IT
THEY ASK A RESEARCHER FOR HELP
TOGETHER THEY APPLY FOR MONEY
THE RESEARCHER HELPS PEOPLE DO RESEARCH
WHICH RESOLVES THE ORIGINAL PROBLEM
STRENGTHENING RELATIONSHIPS
MODELLING CHANGE
EQUIPPING PEOPLE WITH RESEARCH SKILLS
TO NOTICE + SOLVE OTHER PROBLEMS
PARTICIPATORY ACTION RESEARCH


WHO?
"COMMUNITY"
"GROUP OF PEOPLE"
SOME PEOPLE
ARE PLAGUED BY
NOTICE A PROBLEM
+ AREN'T BEING LISTENED TO
ARE TIRED/BURNED OUT
ARE INCONVENIENCED
ARE ISOLATED
ARE WORRIED THEY'RE MAKING A FUSS
ARE HOPING IT CHANGES ON ITS OWN
WOULD REALLY RATHER BE DOING SOMETHING ELSE
ARE MAKING DO WITH WHAT THEY HAVE
SHE HAS BEEN TRYING TO SOLVE THE PROBLEM FOR 5 YEARS, HER HEALTH HAS RECENTLY DECLINED + SHE HAS LITTLE SUPPORT
HIS JOB IS TO FIX THE PROBLEM BUT HIS CHARITY IS UNDERFUNDED
SHE HAS 20 YEARS EXPERIENCE SOLVING THE PROBLEM BUT HAS ONLY JUST MOVED TO THE AREA

Appendix 3 – A perspective from a mental health social care provider organisation: Liam Gilfellon



We're here so no one struggles alone

"We're now turning our vision to the future, to embrace the changing landscape of community mental health care."

Everyturn Mental Health was born of the NHS in 1986. From a single dementia care home, we have grown to provide a range of specialist, NHS-commissioned mental health services, including crisis support, NHS Talking Therapies, dementia care services, 24-hour specialist adult care, supported housing, and community wellbeing services.

Adam Crampsie
(He/Him)
Chief Executive

We support over 70,000 people across England every year.

We're now turning to the future, and the changing landscape of community mental health care. We are fully aware of the challenges facing the health and social care system. Increased demand, limited funding, strained capacity, and the aftermath of the Covid-19 pandemic are having a profound effect on the nation's mental and physical health.

Our unique position as a non-profit that has emerged out of the NHS means we can continue to be a close system partner, providing clinically excellent and innovative mental health services that put people and communities at their heart. We have embarked on an ambitious transformation programme across the organisation, including:

- A multimillion-pound investment in our 24-hour services for older adults and people with dementia.
- Working with our NHS Trusts to co-create fully integrated NHS crisis services.
- Significant investment in digital innovation and pioneering the use of technology and AI in the diagnosis and treatment of mental ill-health.

We know that no single organisation can do it all; we must understand our strengths and recognise the strengths of others. We can only meet the needs of our communities by sustaining robust relationships with the NHS and our VSCE partners. Our goal is always to partner with our health and social care colleagues as much as possible, to ensure that no one is left to struggle alone with their mental health.

Everyturn Mental Health is a national partner to the NHS. Our unique place as a non-profit means we can innovate and act as an extension to the NHS.

High-intensity specialist care

Lower-intensity support

Dementia services

24-hour CQC registered high-acuity services

For dementia and older person's functional mental health.

Housing and 24-hour nursing care

24-hour CQC registered services

Rehabilitation services for adults and older adults taking their first steps away from hospital or forensic services.

Supported housing services for people with serious mental illness

Providing houses and specialist mental health support.

Community and wellbeing services

Crisis services working in partnership with Trust crisis teams

Meeting psychosocial needs contributing to mental health crisis in the community.

Link Workers and Peer Support Workers

Delivery of community mental health transformation.

NHS Talking Therapies & employment services

Talking therapies & employment services

Integrated NHS Talking Therapies model with community mental health framework.

What we do

Mental health Link Workers

What — our highly-trained colleagues deliver mental health and wellbeing services across communities, often using their own lived experience of mental-ill health.

Why — we recognise that people often fall through the cracks, so we wrap our services around the person, reducing pressure on the system by preventing the need to access primary and secondary care services.

How — Our Link Workers work with people to help them learn strategies to improve wellbeing, increase their social networks, and improve their resilience to manage life events.

Community Treatment Team waiting list service

What — Our highly-trained Link Workers partner with Trust Community Treatment Teams (CTTs) to reduce the waiting times for people on the CTT waiting list.

Why — we understand the capacity and demand challenges impacting CTTs. Our specialist non-clinical workforce can reduce waiting times and create greater clinical capacity for those in need.

How — Our service provides practical, social, and emotional support as an alternative to traditional clinical approaches, alleviating the pressures on NHS CTT teams.

Community crisis services

What — we work in partnership with Trust's crisis teams to deliver practical and emotional support to people in crisis using a non-clinical workforce of Link Workers and people with lived experience.

Why — we recognise there is a capacity and demand issue with crisis services with many people in crisis, or on the verge of crisis, as a result of social issues. Our highly-trained non-clinical workforce will increase capacity in your crisis services, freeing up your clinical teams to focus on high-risk patients and their medical needs.

How — we work across the entire crisis pathway in partnership with Trust teams:

- Triage and assessment
- AI technology for rapid assessment and escalation
- Distress Brief Intervention
- 1:1 support for up to 12 weeks
- Problem solving and emotional support.

NHS Talking Therapies waiting lists

What — We work in partnership with NHS Trusts to reduce NHS Talking Therapies waiting lists across step 2 and step 3 treatments.

Why — As a non-profit national provider of NHS Talking Therapies, we understand that workforce challenges can lead to increased waiting lists. Using our national capacity and cutting-edge digital and AI technologies, we work with Trusts to dramatically reduce waiting lists and ensure people quickly get the help they need.

How — We use our national resource of practitioners to treat people on Trust waiting lists, starting with the longest waits. We also use our AI assessment and treatment tools alongside our therapists, making systems more efficient.

Supported housing for complex mental health

What — We provide specialist housing services for people who have complex mental health needs, including psychosis.

Why — People with severe mental illness often have complex needs which prevent them from living independently, leading to bed-blocking in acute and forensic services. Our solution allows Trusts to confidently discharge patients into our clinically-led supported housing.

How — Our clinically-led housing services help people to live as independently as possible in the community, with packages of support to suit their needs.

24-hour specialist mental health support

What — Our specialist clinical services are for people with complex mental health needs, who need intensive support and treatment.

Why — We work in partnership with Trusts to alleviate bed pressures in acute, long-stay, and forensic services, by providing an alternative to hospital. NHS mental health teams can confidently place patients into our care for treatment and support, as they take their first steps back into the community.

How — Our highly-skilled clinical and non-clinical teams deliver person-centred care in a safe, community-based environment, supporting our residents' journey back to independence.

Dementia services

What — We provide 24-hour sub-acute clinical services to people whose dementia causes complex behaviours and needs.

Why — We recognise that highly complex dementia patients can be a challenge for traditional care settings, putting pressure on NHS Trusts through frequent admissions, long stays, and delayed discharge. Our services reduce these pressures, leading to fewer admissions and rapid discharge into our specialist beds.

How — Our clinical services work across the full dementia pathway, from supporting people in their own homes, to providing respite care and assessments on behalf of the NHS, and long-term care for people with the most complex needs.

Mental health Link Workers

"It's been up and down and there have been times where I haven't been very nice to you. But you stuck with me and you didn't give up."

Through one to one and group support for a range of mental health needs, our Link Workers help people to learn coping strategies to improve wellbeing, increase social networks, and improve resilience to manage life events.

Link Workers help Trusts and communities

Our mental health Link Workers and Peer Support Workers provide valuable help in the community to those who need it. We connect medical and clinical treatment with practical and emotional support, to help people feel empowered and resilient.

Supporting specialist teams

We offer support to primary care and specialist secondary care services to alleviate pressures on demand and resource. By providing additional support to the traditional clinical treatments, we help Trusts and clinical teams offer holistic mental health support to people who need it.

Adaptable models

Our Link Worker model can be adapted to each area's need – from integrating with existing systems, to working in partnership to develop solutions that are right for the community.

Specialisms we have supported

Maternal – working with perinatal teams to provide practical and emotional support.

Antisocial behaviour – connecting social care, police, and care services to help alleviate wider community pressures.

Social prescribing – working within primary care to connect people with community assets, improve social inclusion and reduce isolation.

Employment services – helping more people get back into work, whilst managing their mental health.

Community Treatment Team waiting list service

Our innovative model of care delivery is highly replicable, provides a tangible solution to the national vacancy shortage across mental health services, manages increasing demand, and supports sustainability across Community Treatment Team waiting lists.

Reduce Community Treatment Team caseloads

With increasing caseloads for CTTs across the country, our waiting list service provides practical, social, and emotional support as an alternative to more traditional clinical approaches – alleviating the pressures on CTT staff.

Fewer patients waiting for clinical treatment

We have developed a program of non-clinical support, delivered by well-trained colleagues who provide people with practical help to relieve some of their mental health symptoms. This results in a significant decrease of patients waiting for treatment from CTTs.

Improving overall mental health and wellbeing of communities

Our goal for the waiting list service is to improve the health and wellbeing of individuals and communities. Our Link and Peer Support Workers stay in close communication with everyone they help, to make sure they feel supported every step of the way. Using clinically validated WEMWEBs data, we assess that our service is making a positive impact, and we continuously communicate with our partners to report on outcomes.

Signposting to improve mental health resilience

We create a signposting directory of community organisations and services, relevant to the ongoing support of people with serious mental illness. The directory enables our staff to direct people to services that will enhance their road to recovery.

"Having someone on my side to help me through the darkest days of my life... your service is a true lifeline."

Community crisis service

"There is no other service that offers what TIAC does or has such capacity to reduce our work in an immediate and compassionate, collaborative manner."

We're here to provide support to the increasing number of people experiencing mental health crisis. Our community-based crisis services provide practical and emotional interventions to help people through the issues or problems that are causing their distress.

Together in a Crisis (TIAC)

Our TIAC service provides wrap-around support to people experiencing crisis because of social and practical circumstances. Working alongside community crisis teams and home treatment teams, we help a significant proportion of people who would historically have been part of the statutory team caseload. People access the service via referral from NHS teams and in some areas there are options to self-refer.

People typically access the TIAC services for 12 weeks. Support is provided both remotely and face-to-face in the community. Our crisis Link Workers ensure that anyone experiencing crisis gets the level of help they need – from sourcing food or fuel vouchers, to finding accommodation or dealing with financial issues.

Distress Brief Intervention

As part of England's first DBI programme, we provide 1:1 support for up to two weeks for anyone experiencing emotional distress. We work in partnership with first responders to give people the tools and skills to manage their distress.

Safe havens

Our crisis safe havens help to release capacity on community crisis teams and psych liaison by providing a safe space for people to access support out of hours. By providing a physical space for people to visit in person when they are in crisis, our teams of well-trained colleagues can provide the emotional and practical support that's relevant to the individual.

Working with you to co-create the right service model for your communities

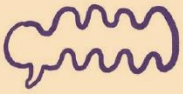
We work in partnership with mental health trusts to find the right integrated model of crisis support for them – from staffing crisis lines to free up NHS resource and increase capacity, to providing specific spaces for people to come to feel safe. We can adapt existing models and co-develop new solutions that fit the needs of the area.

NHS Talking Therapies

We're here to help people find their own path to feeling better. By working with other services in the community, we make sure that everyone gets clinically excellent support.

We connect communities

Our connection to wider community services is what makes us special. We offer more than just therapy. Through our personalised service, we help people become the parent, friend, and employee they want to be, and make whole communities feel better.



It's never 'one-size-fits-all'

We're not ones to tick boxes and try to push someone into a certain treatment channel just because it's easier for us. This is all about the person. We know everyone's journey to feeling better is different, and we confidentially talk someone through all the processes and guide them through options that help them with their mental health.

Easily accessible

We're one of the top-performing providers of therapy services in the country. People can access our service whichever way is best and easiest for them. Whether through a simple online form, a phone call to one of our friendly team members, or a chat with a GP, we're here to get everyone the help they need quickly and easily.

Clinical excellence

All our therapists are qualified and professionally accredited, offering the highest quality treatment through someone's journey to feeling better.

Digital Solutions

Our NHS Talking Therapies can be accessed via an AI referral tool on our website, which streamlines the assessment process. During therapy, patients can use our therapy support app, which allows them to complete clinical questionnaires prior to their sessions, record mood logs, and complete 'homework' in-between sessions to improve their likelihood of recovery.

"At all times the therapist treated me with courtesy and respect and listened to me."

Supported housing for complex mental health

We manage a portfolio of properties for people who have complex mental health needs, including psychosis. The service is clinically-led and is focused on helping people live as independently as possible in the community.

Everyone deserves to feel at home

Our residents' properties are their homes. We encourage people to make changes to their property to make it somewhere they truly feel at home. Visit and contact frequency is agreed collaboratively, so each person have a sense of control over their space.

Independence

A sense of independence is so important for people recovering from or learning to manage their mental health. We're committed to empowering individuals to live safely and confidently in the community.

We don't judge anyone for their past

Our support plans are focused on the individual's needs and goals for the future. We provide therapeutic and practical interventions that equip people with the skills they need to reduce reliance on care services.

Rehabilitation and recovery

Our services can be accessed by people with complex mental health issues that need a level of specialist support but don't need to be in 24/7 care.

As such, we work with residents referred from community settings and those stepping down from inpatient stays in hospital or 24/7 care homes.

"I finally feel at home."

24-hour specialist mental health support

Our 24-hour specialist services are there for people with complex mental health issues who need intensive support and treatment, alleviating the burden on hospitals.

Person-centered care for everyone

Our comprehensive assessment helps people identify their priorities and focus so we can develop treatment plans that are right for them, and ultimately improve their mental health.

Supporting the journey back to independence

We provide an important stepping stone that will help people to live independently and be part of the community. Our 24-hour support should never be a long-term solution and we work with individuals and organisations to ensure everyone is on the road back to the community.

Working with others

We know that keeping families and loved ones involved in care plans is one of the best ways to achieve our goals and help people to get them back to living in the community. We listen to everyone, to understand their concerns and needs, so we are all working together.

Crisis beds

We offer 24/7 nurse-led beds for people in crisis, as well as secondary beds to people who need short term intensive support (up to 4 weeks) to help them get through an immediate crisis. The beds offer an alternative to admission into the acute sector and provide a safe and reliable resource for community crisis teams to access 24/7.

"Staff respect me, listen to me and let me make my own decisions."

Dementia services

Our range of sub-acute dementia services provide care for people with complex behaviours and needs. We provide a bridge between hospital and traditional care settings, reducing hospital admissions and freeing up capacity by enabling hospital discharges.

Community Challenging Behaviour Service

Our team works with people who are presenting with challenging behaviours in their own homes and care homes. We provide intensive support to the person, their families, carers and care home staff to help ease the challenges and avoid admission into more specialist 24/7 care.

Respite beds

These beds are used for people who still live at home, but need to have some nights in 24/7 support to receive treatment and offer space for their carer. This reduces the carer's burden and the likelihood of them experiencing crisis themselves.

Assessment beds

Our assessment beds support people for up to 12 weeks, with the aim to get them back to their own home or into mainstream care. Our assessments result in a range of individualised support plans, providing a rich source of information on how to help the person and their family and carers and reduce challenging behaviour.

Complex stay

Our complex stay beds are for people whose behaviours have proven too challenging for non-specialist nursing homes, but do not require acute hospital admission. We aim to work with people for 6-12 months, with a view that after this extended stay, they will be able to move back to mainstream care.

"We feel as though we've got our mum back."

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