These case studies were supplied for a presentation about inclusion health nursing in 2018. All names have been changed.

Mary (Great Chapel Street nurse outreach)

Mary was an older lady with a past complex history of abuse and trauma, and no family. As a result, she had come to feel that she 'did not deserve' to be inside. When the street outreach nurse first made contact with her, she had already spent 9 years living on a bench by the Thames in all weathers. She collected anything she could find on the streets to assist her, and had numerous bags and packages with her. The local street outreach team had raised concerns regarding both her physical and mental health.

On the first of many nurse outreach visits Mary she said didn't want any help at all, but was happy to chat. At this stage she was judged to have mental capacity, but concerns regarding her vulnerability were evident. As a result, after this first contact, the nurse gradually developed a relationship with Mary based largely on the provision of hand creams (which Mary was happy to accept) and drinking cups of tea together. Over time it was established that the nurse would visit for a chat, bring some nice hand cream and then check her pulse and hydration levels.

Gradually the nurse built up a picture of Mary's key physical and mental health concerns, which included incontinence, suspected pressure sores on her buttocks, and possible schizophrenia, presenting with negative symptoms, as well as a clear evidence of self-neglect.

Eventually Mary deteriorated, and clear concerns regarding her mental capacity were evident. By this time a relationship of trust had been built, and a joint visit to the bench was arranged with the specialist outreach Psychiatrist. Mary was admitted via Mental Capacity Act assessment to a physical health hospital (supported by the nurse), and after this went to mental health hospital on a Section 2 (and later Section 3). Mary was found to have extensive gynaecological issues and anaemia on admission, as well as an underlying urinary tract infection. She was doubly incontinent and had extensive tissue damage from years of sitting wet in the cold wind. She was later diagnosed with a severe and enduring mental illness (schizophrenia with negative symptoms).

Mary now resides on a community treatment order in a supported housing setting.

Martin (KHP Pathway Homeless Team and GSTT Health Inclusion Team together)

Martin was a 44 year old man with alcohol dependence, and past diagnoses of bi-polar and learning disabilities on his GP records. Martin lived in a Southwark homeless hostel, and was a frequent attender of A&E services (33 times in one year). The majority of A&E attendances related to long term gastritis, abdominal pain and PR

bleeding, and nearly all involved LAS. Martin often presented in acute pain exacerbated by a panic type presentation. Once seen in A&E Martin was generally referred back to his GP practice (which he refused to attend), or self-discharged before medically recommended. Poor engagement with the GP was exacerbated by poor medication compliance. Martin had a mild cognitive impairment, anxiety and personality issues. He had previously been referred for escorted outpatient investigations by Groundswell, but refused to attend when the escort arrived, even when had been given several reminders.

Both the Health Inclusion team and Pathway teams were involved. Martin was visited at his hostel by the senior Pathway team nurse in an attempt to attempt to understand his issues, and discuss his reluctance to engage with the GP. The Health Inclusion Team also started to see him weekly to work on medication compliance, and do harm reduction, and health promotion work.

Martin stated that he felt the 'real doctors' were at the hospital, but was unable to explain his self-discharging behaviour. A community mental health team assessment was arranged with support from the HIT team, but the mental health team did not feel that he had 'treatable' mental health condition.

However, Martin was re-engaged with his brother after 18 months by the HIT team nurse, which he was pleased with, and this started to make a difference. Martin accepted a phone to maintain contact with the HIT team. Following further discussion, the Pathway team then coordinated a planned inpatient admission in consultation with inpatient medical staff, hostel staff and the HIT team for upper and lower gastrointestinal endoscopies (supported by the HIT team nurse).

Martin was then seen by the Pathway team OT. The OT identified significant attachment difficulties, fragmented communication between services involved in his care, anxiety and uncertainty about his future, a problematic relationship with food, the integration of 'sick' role into his identity, and an externalised locus of control, and identified a number of areas to work on. The OT then worked with the HIT team nurse to build an adaptive structure and timetable, and engage him with peer advocacy and alcohol treatment and the Recovery College.

In the following year Martin only attended A&E 5 times, and started to see his GP supported by the HIT team nurse. His medication compliance improved, and he started seeing his brother regularly.

Patrick (Westminster Homeless Health Team)

Patrick, a 46 year British man, became homeless in his early 30s following the breakdown of his marriage and had been sleeping on the street in one central London borough for most of this time. He had a long history of alcohol dependence and a previous episode of drug-induced psychosis. He was well known to the

outreach team, who had made multiple attempts to engage with him and find him accommodation. His keyworker was concerned that his refusals to consider housing were due to mental health issues. He had been seen by mental health teams in the past but his heavy drinking had prevented full assessment. Patrick was frequently seen in local A&E departments with intoxication and injuries sustained due to assaults. His health continued to deteriorate on the street.

The homeless health nursing outreach team encouraged Patrick to attend their day centre clinic regularly over a period of six months, providing dressings and antibiotics to treat an infected leg ulcer and supportive letters to assist with his benefit application. During this period his attendance to A&E reduced dramatically. The nurses also became worried about Patrick's increasing self-neglect, poor memory and disordered conversation. He disclosed other significant physical health problems but refused to see a GP. The nurses presented Patrick's case at the multi-disciplinary team meeting in the homeless specialist medical centre and received advice from the GP. The GP agreed that Patrick needed a psychiatric assessment and intravenous vitamins to treat possible alcohol related confusion. However Patrick refused to attend hospital. A mental capacity assessment was completed and as Patrick was found to be unable to retain or weigh information, the outreach nurse practitioner arranged for his admission under the capacity act, with the assistance of the police and ambulance service.

During Patrick's admission his care was co-ordinated by the ward medical team, neuropsychiatric team, social services and the safeguarding team. The homeless hospital discharge team were also involved to prevent discharge to the street. Patrick's confusion did not resolve after alcohol detoxification and intravenous vitamins, so he was eventually accepted into the care of the homeless mental health team and transferred to a psychiatric hospital for further assessment and medication. Several housing options were considered when he his condition had stabilised enough for discharge. After over 10 years on the street, Patrick accepted accommodation in a local hostel where he could continue to drink but had a safe place to live and a support network to monitor his health.

Lola (KHP Pathway team and JHT outreach mental health team)

Lola was a 78 year old lady with undiagnosed mental illness that had been NFA for 15 years, probably sleeping on buses, and in transport hubs, as she had never been picked by outreach teams rough sleeping. She may also have been supported by church members, because she had a strong Catholic faith and attended church frequently. She had multiple names and dates of birth, and repeated admissions had therefore gone un-noticed. She was often brought in by ambulance after being found wandering and incontinent, and had frequent attendances related to falls, minor head injuries and cellulitis. She had consistently refused to engage with services, and had

been previously viewed not to have a mental illness, and to have capacity to make her own decisions.

When the Pathway team first met Lola, her frailty and vulnerability was obvious. She was increasingly delusional and paranoid about her possessions during contact with the team, often accusing staff of stealing things. She often stuck her fingers in her ears if you tried to speak to her, demanded to speak to the Chief Executive, and made several attempts to leave.

The team then liaised with the Dagnija O'Connell from the Westminster Joint Homeless Team. Dagnija is a specialist worker for female entrenched rough sleepers. Dagnija had gathered detail about Lola, including her confirmed date of birth and past history. In partnership with Dagnija the team then got in touch with LR's family, and did extensive work on her case – contacting all professionals that had been involved. LR had lived with her mother for 15 years in Lambeth, but had lost this council accommodation after her death, and her distress over this appeared to be a trigger for a chronic deterioration in her mental health.

The team involved liaison psychiatry, but they did not feel she had a severe and enduring mental illness, despite the evidence of her behaviour long term. The team then organised a best interests meeting, involving hospital and community staff. The family attended and agreed that residential care under guardianship would be most appropriate plan of action. The family described a long history of very difficult behaviour, but clearly cared for her and wanted to help. This was a key step as it enabled the team to use the family view to influence Consultants and admitting teams. The challenge of advocating for the patient and 'holding her' was felt by the whole team, but the team enabled her to stay long enough for appropriate assessments to take place.

A DoLs was requested, but at the DoLs assessment the external assessor then recommended that LR should be sectioned and admitted to the Maudsley under a Section 2 (as had been originally thought by the team). All our information gathering was sent to the admitting Consultant Psychiatrist at the Maudsley. He then worked well with our team, and developed a clear understanding of everyone's concerns, mostly importantly LR's. LR was admitted for a period of assessment. She did not try to leave, although she did appeal her section (this was declined). LR has subsequently been discharged from the Maudsley, and housed in residential care close to a church where she can maintain her faith. She and her family are now very happy.