The Pathway model in a mental health setting

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The Pathway model in Mental Health Trusts

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@docsnot cops and Guardian

The challenge: piloting Pathway in Mental Health

- Pathway model not be
before
-
ple in the room

Q can we improve quality of care, health, housing and wider outcomes in homeless inpatients in a MH trust?

3 years of pilot funding from GStT and Maudsley with an academic service evaluation

Setting: South London and Maudsley

Methodology: Complex intervention

- Literature review
- Narrative of th

Flexible use of the MRC Framework

- egression analysis
- lient Service Use Inventory (CSRI): service use before and after

Words of wisdom

"What's your hypothesis?"

"Basing a programme of work on its ability to make or save money is the wrong premise; healthcare costs money, good health care costs more money"

"You cannot directly replicate a service between two different organisations – no matter how similar you believe they are"

Dr. Alex Tulloch: Consultant, Academic, All Round Boffin

Patient MR

- 55 yo
- Criminal justice history
- Alcohol dependence
- Several detoxes, rehab and periods stability
- Traumatic head injury following stabbing
- Organic Traumatic Psychosis – relapse with alcohol
- Cognitive impairment
- Evicted from local supported accommodation (no HRA)
- Borough issues between health, housing and social care

Pathway principals and values

- Advanced MHP – **role of the OT**
- Housing Worker – **NHS Funded from Voluntary Sector**
- GP – clinically led
- Business manager
- Senior clinical and operational management
- Academic support: Institute of Psychiatry and KCL

Embed, Engage, Educate

Service model

- Ward based audit: modify referral criteria
- NHS Spine, CHAIN, EMIS Web, Local linked care record
- Holistic assessments
- Close communication
- Cross sector collaborative working

Services we work with

Wards	Reablement Team (Southwark)	START Team	Southwark Law Centre	Bed management meetings	Local authority Housing Departments	St Mungos, The Passage, St Giles
GP surgeries	Street Outreach teams	Hostels	Place of Safety	Non-local authority housing providers	CMHTs	Health Inclusion Team (HIT)
No Recourse Teams	Hospital Social Work teams (Lambeth & Lewisham)	KHP Teams at Kings and GSTT	Routes Home	Night Shelters	Home Office / Immigration services / Embassies	Welfare teams – for benefits advice and support
Department of Work and Pensions	Police –Probation	OT department	Solicitors	Homeless Day centres	HIV Liaison Team	Other Mental Health Trusts

Wellbeing Hubs	Solidarity in a Crisis	Interpreter services	Food banks

Interventions

Findings: demographics

Table I Housing status at admission of patients referred to the service

Housing status	*Number*	*Percentage*
Rough sleepers	85	35.9
Sofa surfing	54	22.8
Living with family	29	12.2
Private rental accommodation	26	11
Living in a homeless hostel	9	3.8
Housed	5	2.1
Temporary accommodation	6	2.5
Other (night shelter, squats)	7	2.9
Unknown (discharged or transferred before assessment)	16	6.8

Cultural change, challenging negative attitudes, promoting a positive and inclusive approach and service development

Findings: health issues

- Severe mental illness 77%
- Emotionally unstable personality disorder 19%
- Suicidality and self harm 38%
- Trimorbidity 25%
- Alcohol misuse 24% Dependence 17% Drug dependence 13%
- Chronic diseases 14%
- High prevalence of hepatitis and HIV
- **1/3 under the age of 25**

Findings: Outputs

- 237 of 465 were accepted and seen
- 74% improved housing status
- 11% had housing loss prevented
- 24% homelessness application
- 28% supported accommodation
- Most seen by housing worker
- 95 GP letters

- 24% NRPF
- Increase in reported rough sleeping from 24% to 48% in year 1 to 2
- 34% no local connection to SLaM
- 30% offered reconnection
- 21% accepted
- Support given to all

Transitional support

- Recognises that time around discharge is higher risk (Windfuhr and Kapur, 2011)
- Lack of address was a barrier to linking patients with CMHTs for follow up
- Need to work with patients for a smoother transition and support
- Average time working with someone is 10 days after discharge
- Meaningful activity after discharge – support services, voluntary sector, peer support

Service e

- Logic mode
- Client Servi
  increase in
- Matched cc

and E and

ys

PJS Number: Date of Admission:

Date Completed: Patient Contact Number:

Please circle survey date`: Admission/ 3 month/ 6 month / 12 month

CLIENT SERVICE RECEIPT INVENTORY – HOMELESSNESS STUDY

1. In the last 3 months, what face-to-face contacts have you had with these professionals?

(Note: only record one-to-one contacts here; see next questions for group activities and inpatient care)

Care provider	*Have you had contact?* (circle)	*Usual location* 1 = GP 2 = Community centre 3 = Hospital OPD 4 = Own home 5= in patient	*No. of contacts in last 3 months*
A. General practitioner (GP)	*No Yes*		
B. Psychiatrist	*No Yes*		
C. Other doctor	*No Yes*		
D. Drug & alcohol advisor	*No Yes*		
E. Home treatment / crisis team member	*No Yes*		
F. Social worker	*No Yes*		
G. Mental health nurse	*No Yes*		
H. Other professional	*No Yes*		

2. In the last 3 months, have you been admitted to hospital as an inpatient? *Yes* or *No*

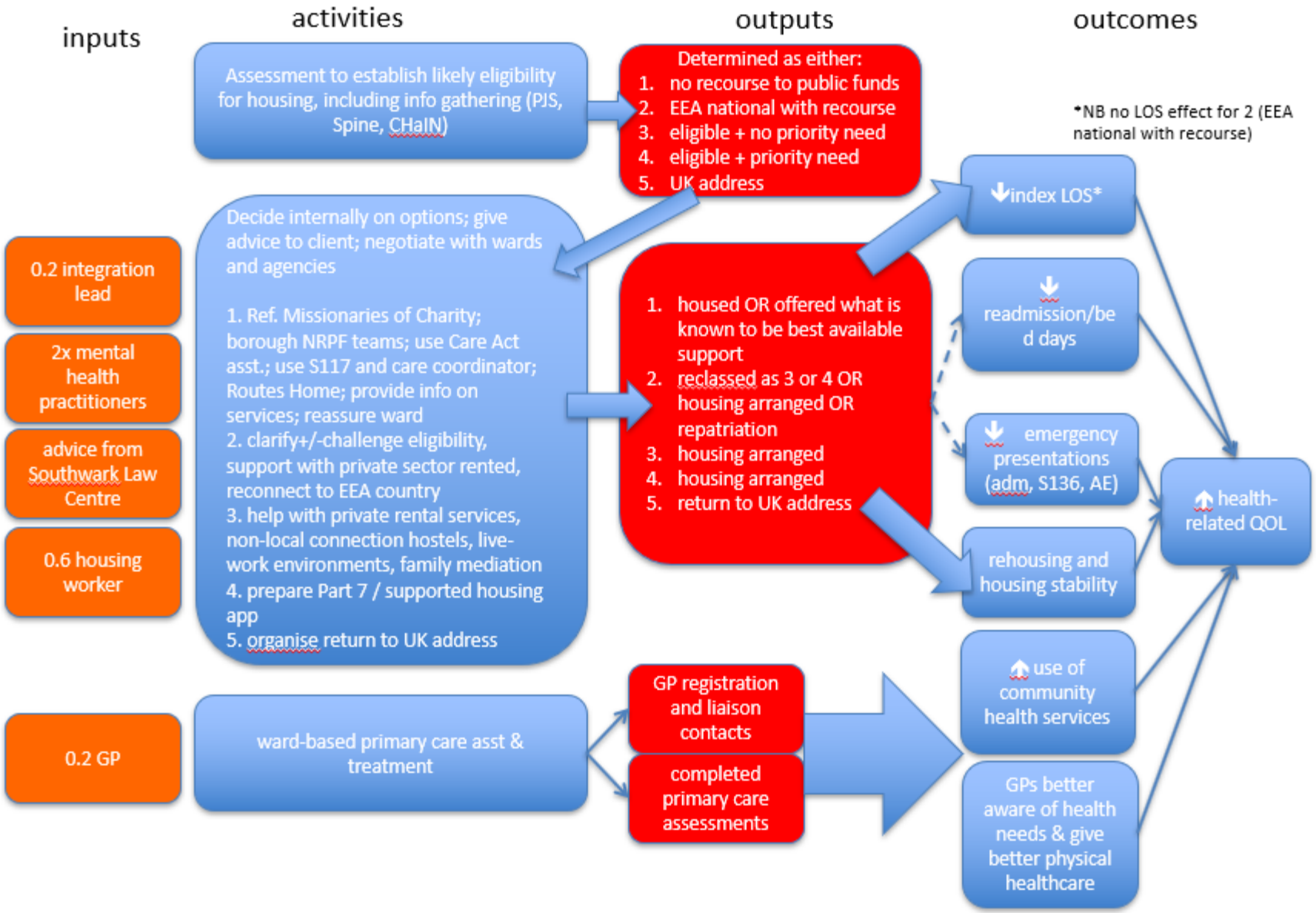
(please circle)

If yes:

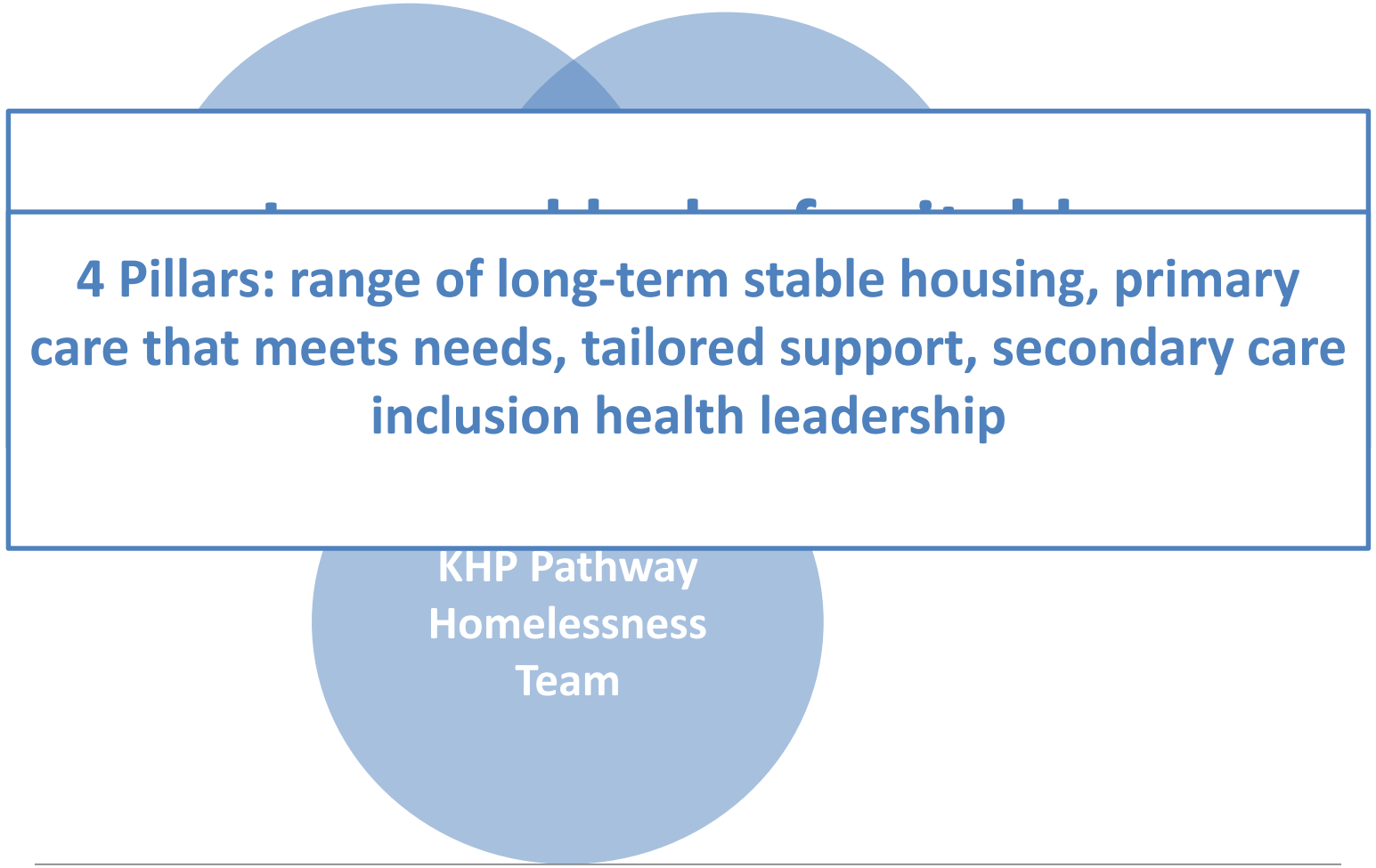
Name of hospital and ward	*Reason for admission*	*Dates*		*Total days*
		Admission	*Discharge*	

3. In the last 3 months, how many times have you been to A&E? _____

THANK YOU FOR YOUR TIME


inputs
activities
outputs
outcomes
Assessment to establish likely eligibility for housing, including info gathering (PJS, Spine, CHaIN)
Determined as either:
1. no recourse to public funds
2. EEA national with recourse
3. eligible + no priority need
4. eligible + priority need
5. UK address
*NB no LOS effect for 2 (EEA national with recourse)
0.2 integration lead
2x mental health practitioners
advice from Southwark Law Centre
0.6 housing worker
Decide internally on options; give advice to client; negotiate with wards and agencies
1. Ref. Missionaries of Charity; borough NRPF teams; use Care Act asst.; use S117 and care coordinator; Routes Home; provide info on services; reassure ward
2. clarify+/-challenge eligibility, support with private sector rented, reconnect to EEA country
3. help with private rental services, non-local connection hostels, live-work environments, family mediation
4. prepare Part 7 / supported housing app
5. organise return to UK address
1. housed OR offered what is known to be best available support
2. reclassed as 3 or 4 OR housing arranged OR repatriation
3. housing arranged
4. housing arranged
5. return to UK address
index LOS*
readmission/bed days
emergency presentations (adm, S136, AE)
rehousing and housing stability
health-related QOL
0.2 GP
ward-based primary care asst & treatment
GP registration and liaison contacts
completed primary care assessments
use of community health services
GPs better aware of health needs & give better physical healthcare

Pathway from street to home?



Comments from staff and patients

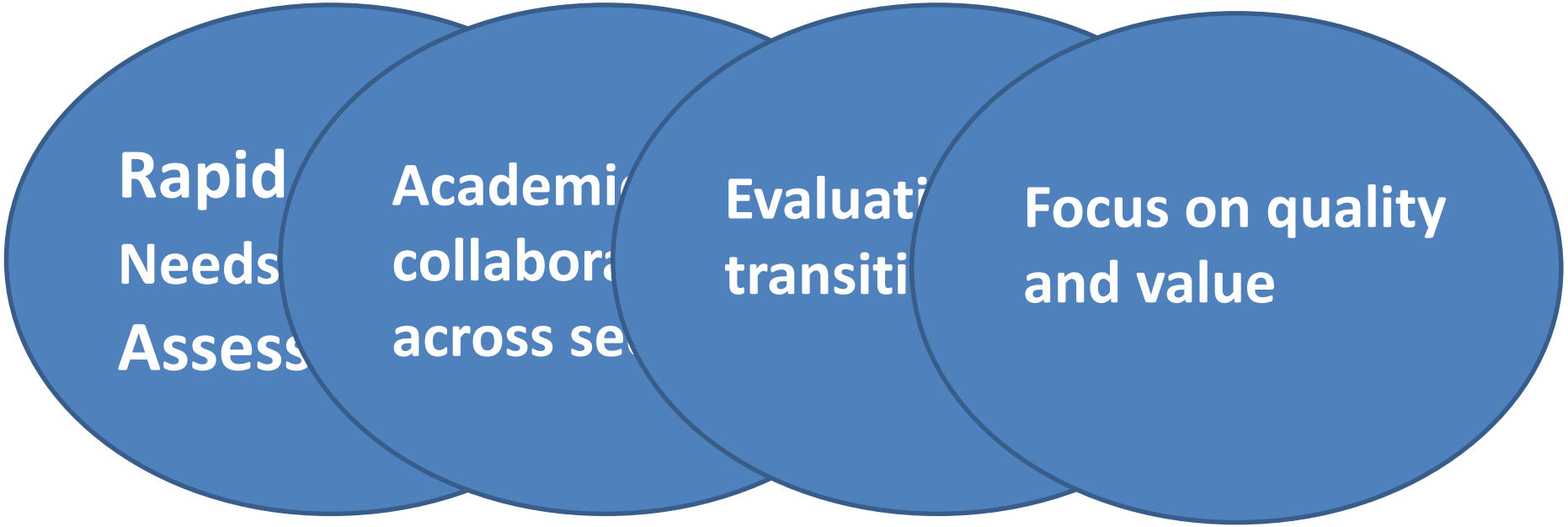
"inspired by your kindness I am this Christmas holiday volunteering with Crisis." (Patient)

"I feel happy inside and I've never felt like that before." (Patient)

"I've noticed a real change in the culture towards homelessness, most notably in the ending of the practice of discharging to the street." (Mental Health ward Nurse)

"Through successfully tackling the complex issues […] I have absolutely no doubt that this Team have paid for themselves many times over." (Consultant Psychiatrist)

Lessons and conclusions



Impact: Rosie's Story

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UCL INSTITUTE OF EPIDEMIOLOGY AND HEALTH CARE

UCL

The course will run from 25 April to 6 June 2019

Find out what students thought about the module:
www.ucl.ac.uk/homeless-inclusion-health-course

For more information, including fees and eligibility please contact **Eva Schaessens**
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www.pathway.org.uk/faculty

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