

Improving outcomes for homeless inpatients in mental health

**Zana Khan, Sophie Koehne,
Phil Haine & Sam Dorney-Smith**

Dr. Zana Khan
GP Clinical Lead, KHP Pathway Homeless Team
Pathway Fellow in Research and Education
Honorary Senior Lecturer, UCL
zana.khan@nhs.net



Background: Homelessness, Health and mental health

- Inclusion health groups
- Homelessness figures:
 - Government estimate 4,751 slept rough on one night
 - Research evidence estimates 24,000 rough sleeping
 - 170,000 people worst forms of homelessness – many children and families
- Mental illness affects most people experiencing, severe mental illness more likely & key reason for A and E attendance and admission
- Secondary care, homelessness and mental health: integrated care is needed and is effective but lack of services (Fraino, 2015, Stergiopoulos et al., 2017; Bauer et al., 2013)
- Pathway model not been tested in a mental health trust before

What is Inclusion Health?

Inclusion health (IH) aims to prevent and redress the harms of extreme inequity among the most vulnerable and excluded populations, through advocacy, policy, research, education, practice and service provision (Luchenski *et al.*, 2017).

Who are Inclusion Health Groups?

Inclusion Health Groups (IHGs) largely include **overlapping populations** experiencing homelessness, prison, people who sell sex and people with substance use disorders (Aldridge et al.)

Most experience mental health problems (Hard Edges 2015)

More widely, IHGs include migrants, victims of human trafficking, people experiencing domestic violence, Gypsies and Travellers and Roma.

The challenge: piloting a mental health Pathway

Homeless Team

- Data and HNA issues: homeless psychiatric admissions cost almost £2.7m annually across four boroughs (Hewett and Dorney-Smith, 2013)
- Admissions into mental health are different
- Long admissions: independently associated with a 45 per cent increase in length of stay (Tulloch et al., 2012).
- Service evaluation – getting the right people in the room

Objectives: show how we improve quality of care, health, housing and wider outcomes in homeless inpatients in a MH trust?

Take home messages

“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

Setting: South London and Maudsley

- large secondary mental healthcare provider
- four hospital sites providing inpatient provision
- over 2m people, mostly
- resident in inner-city areas
- 3-year pilot funding from GStT and Maudsley Charities
- Charitable funding for Southwark Law Centre advice

Methodology

- Literature review
- Narrative of the service development and critical review
- Routine data collection
- Integrated aspects of the service evaluation:
Statistical analysis and Client Service Use Inventory (CSRI)

Methodology

- Literature review
- Narrative of the service development and critical review
- Routine data collection
- Integrated aspects of the service evaluation:
Statistical analysis and Client Service Use Inventory (CSRI)

Service model

- Issues with needs assessment
- Referral criteria
- NHS Spine, CHAIN, EMIS Web, Local care record
- specialist expertise and more generic skill
- Holistic assessments and close communication
- GP registration, early engagement with CMHT, welfare and wider health needs e.g. substance misuse follow up

Multidisciplinary approach

Case formulation

- GP- Holistic clinical review, advise support admitting team.
- Housing Worker - specialist housing knowledge, rotations, advocacy at housing, knowledge of services
- Advanced MHP – backgrounds of working with patients with complex mental health issues, knowledge of mental health services and formulation of plan for how the team will work with that patient and manage risk
- Business manager
- Senior clinical and operational management
- Academic support

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
<div>Wellbeing Hubs</div> <div>Solidarity in a Crisis</div> <div>Interpreter services</div> <div>Food banks</div>						

Interventions



Findings: demographics

Table 1 Housing status at admission of patients referred to the service

<i>Housing status</i>	<i>Number</i>	<i>Percentage</i>
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

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

Findings: health issues

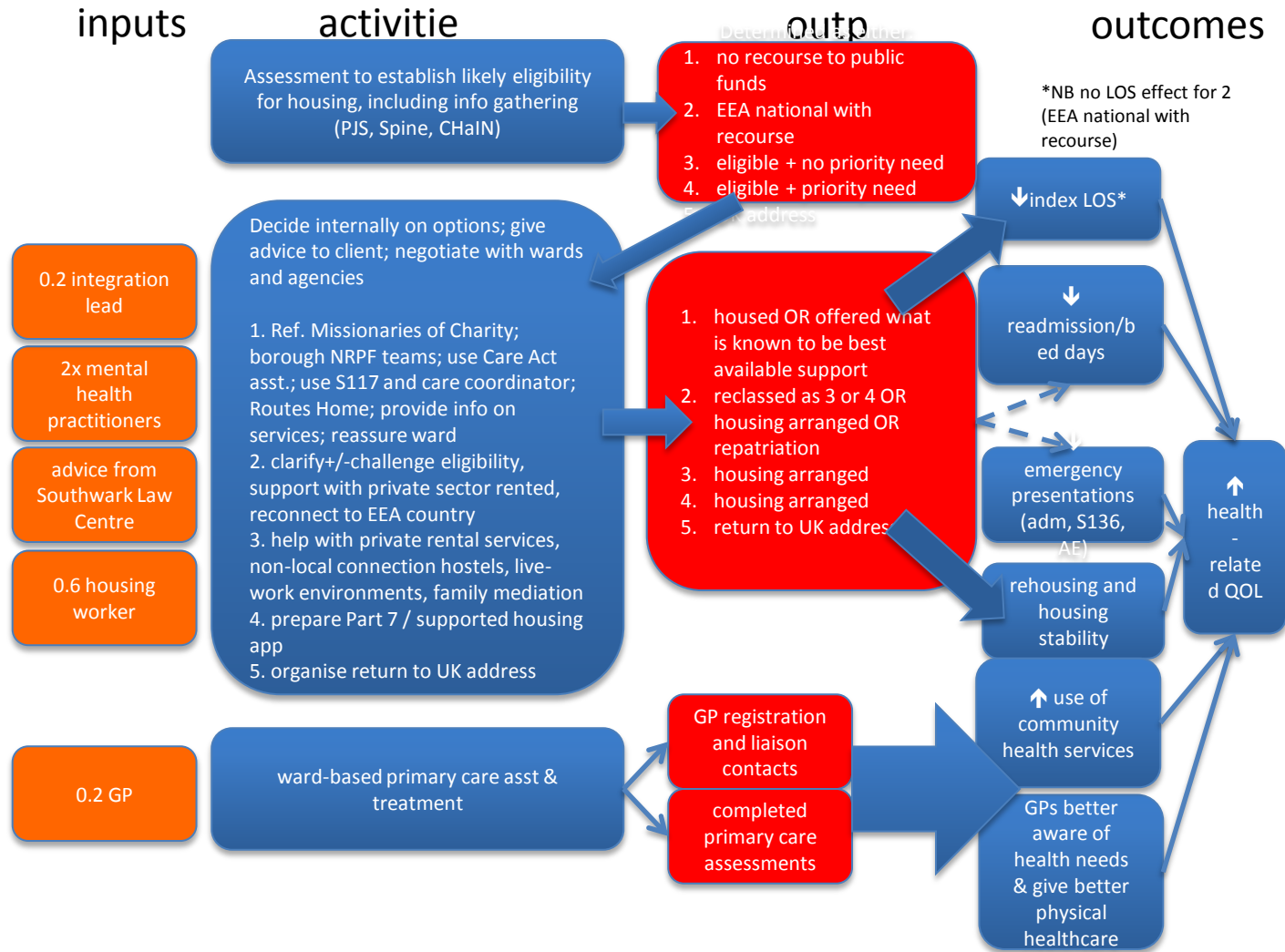
- Severe mental illness 77% psychosis 54 per cent, schizophrenia 12 per cent and bi-polar 11 per cent
- Emotionally unstable personality disorder 19%
- Suicidality and self harm 38%
- Trimorbidity 25%
- Alcohol misuse 24% Dependence 17% Drug dependence 13%
- Chronic diseases 14%
- High prevalence of hepatitis and HIV

Findings: Outputs

- 237 of 465 were accepted and seen
- 74% improved housing status
- 11% had eviction or housing loss prevented
- 24% presented to housing options
- 28% supported accommodation
- Most were seen by housing worker during admission
- 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

Service evaluation

- develop a “logic model” which links the operation of a service to activities, outputs and outcomes
- Pathway intervention should impact bed days, readmission to hospital and use of services after discharge
- develop an acceptable version of Client Service Receipt Inventory
- measure acute and community service use at admission, 3 and 6m intervals.
- Unit costs of services were then attached.



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 learnt

- Data collection is different and patchy
- HNA is important – ward-based audit is quick
- Academic collaboration is very beneficial
- Build relationships with wards and other teams
- Trimorbidity is common
- Data collection is important
- Focus on interventions
- Aim to gather qualitative data

Conclusions

- develop a “logic model” which links the operation of a service to activities, outputs and outcomes
- Pathway intervention should impact bed days, readmission to hospital and use of services after discharge
- develop an acceptable version of Client Service Receipt Inventory
- measure acute and community service use at admission, 3 and 6m intervals.
- Unit costs of services were then attached.



Do you help, care or advocate for the health of vulnerable or marginalised groups?

Homeless and Inclusion Health is a dynamic module developed and delivered by the Faculty for Homeless and Inclusion Health (affiliated to Pathway) and UCL's Institute of Epidemiology and Health Care. It offers an opportunity for those with an interest in excluded or hard-to-reach groups the chance to learn from world-class UCL researchers, experienced policy makers and service providers, and former/current members of these communities.

Short Course students will receive a certificate of attendance upon course completion. Taster course students will undertake assessments, and receive transferable UCL credits.

*It went above
and beyond my
expectations.*

*Wow, what
a brilliant
module!*

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**
e.schaessens@ucl.ac.uk

www.pathway.org.uk/faculty



