An integrated approach to tackling social exclusion of people with a mental health problem

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Structure of session

- Introduction and outline of the project (10 Minutes)
- Barriers to integrated working (20 Minutes)
- Insights around integration (5 Minutes)
- Barriers to inclusion (20 Minutes)
- Insights around inclusion (5 Minutes)

A: Introduction and outline

- Social exclusion of people accessing psychiatric mental health services, often presenting as frequent readmissions to hospital or living in isolation, often in crisis, in the community
- Our project operates in Glasgow, Scotland, and works with adults who have mental health problems, usually with a history of engagement in psychiatric services. As well as supporting people in the community, during Covid-19 pandemic, it worked to create a supportive discharge pathway for people who are leaving psychiatric hospital. Further, it can offer longer term support under self-directed support arrangements for those people who require longer term support.

Aims of the project

- to provide early intervention and preventative support to people living with a mental health condition in the community
- to provide a discharge support service to people leaving hospital, to reduce the chances of repeat or readmissions
- offer longer term support under self-directed support arrangements for those people who require longer term support

Funding

- The service funded in three different streams; a core, integrated mental health service (block funded by NHS and Local Authority); a complimentary add on discharge support service (block funded); and individual SDS support budgets (where people require longer term mental health support).

Who do we work with?

- The people who we work with have experienced multiple factors which have led to them being excluded; from poor mental health, trauma, homelessness, relationship breakdown, and a key aim of our role in working with people is towards inclusion; inclusion in community services (health and wellbeing) resources (education, interests) and social inclusion. The method through which this is achieved in through a model of community care, which in its design (integration with a range of partners) allows for a very flexible, early intervention or preventative approach which either reduces the length of someone's engagement with or avoids as far as possible prolonged engagement with statutory mental health services and any associated

Approach

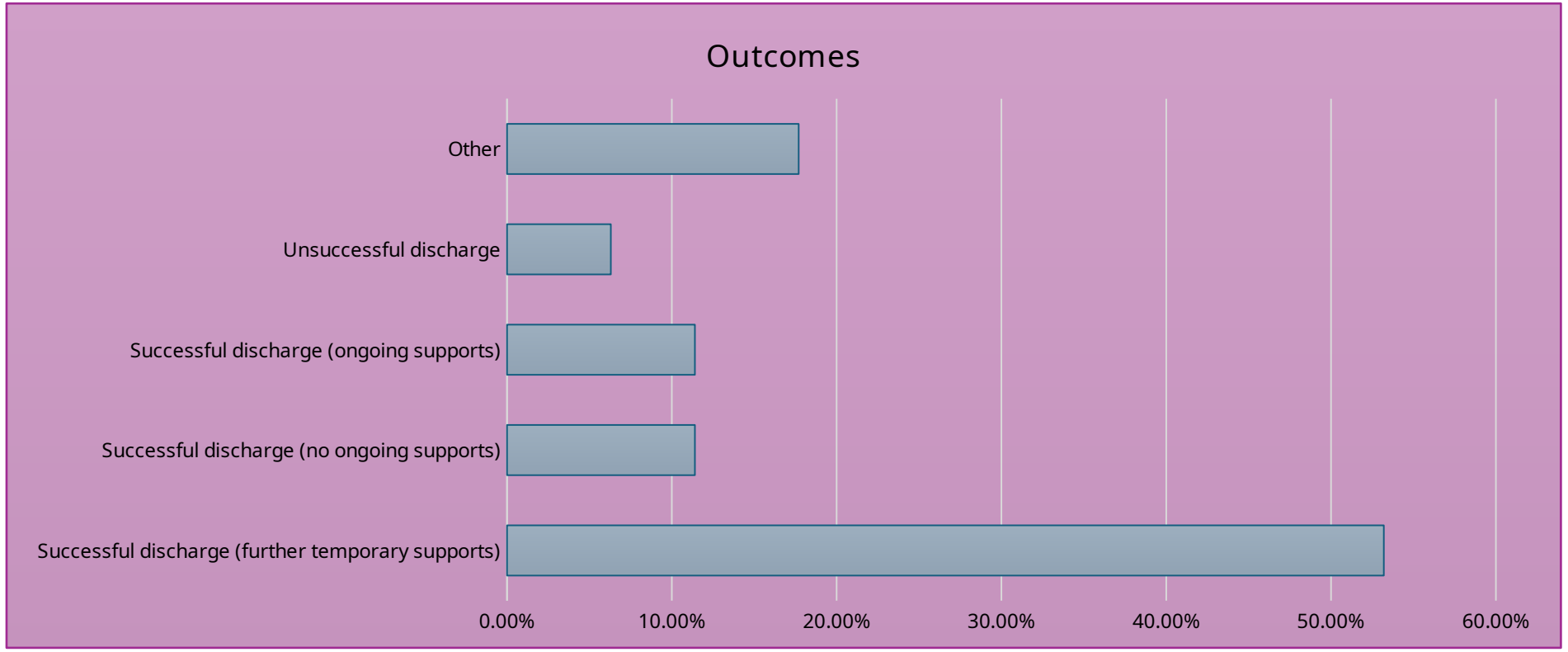
- Support Practitioners work to build relationships with people supported, generating trust. We identify key barriers to be overcome, or early support areas to be met, to ensure our support meets the needs and expectations of the individual supported. This process is continual – as the more practical issues are resolved, more profound areas of the person’s life with which they require support do often emerge. We generate a support plan, with the person, and this is flexible, in order that the person’s support can increase or decrease over time, as appropriate.

Partnership+

- We work alongside colleagues in the NHS (staff nurses and consultant doctors in hospitals, discharge coordinators, community psychiatric nurses), and the local authority (social workers, commissioners). Our workers are integrated into the community mental health teams, so working spaces in buildings are often shared, and multi disciplinary meetings are routine, effectively creating one team around the individual (despite the members of that team having various employers). As well as working with the NHS and social work, we will also work with housing colleagues, welfare rights officers, and other agencies depending on the needs of the person

Impact

- From October 2021 to August 2022 the discharge element of the project was evaluated (a review of its pilot stage):



Impact

- 76% of recorded individuals were successfully discharged. 2354.5 hours of was support delivered
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- The average time that support was delivered within the community was 66 days, which was spread over a range of 0 – 177 days.
- 100% of planned discharges happen earlier then they would otherwise, and some proportion of unplanned discharges managed to get back on track with a plan around their discharge.

Feedback

- “People were recognised as experts in their own experiences and aspirations. We saw examples of people who may otherwise have felt isolated or excluded being sensitively encouraged to increase their access to the community.” (Care Inspectorate)
- “The service provides a positive impact in the discharge of patients from hospital - Patients often feel significant stress and anxiety leading to discharge from hospital. Carr Gomm in-reach allows social barriers to discharge to be discussed, resolved, supported and positively planned for during the transition to community living again.” (Multidisciplnary Colleague)

B: Barriers to integrated working

- Small group discussions, participants reflect on barriers from their own contexts

C: Insights around integration

- Input to detail from the experience of the project the small, practical and sometimes human factors that affect integrated working

D: Barriers to inclusion

- Small group discussions, participants reflect on ways in which people can become socially excluded, and strategies for overcoming these

E: Insights around inclusion

- Input to detail ways of working to overcome barriers to inclusion, from the experience of the project