Mental Health User Voice
HOT TOPIC REPORT

Mental health support following discharge from hospital

March 2019- June 2019

In March 2019, the County Mental Health Action Group asked for some further research around peoples experiences of mental health support and discharge from hospital, both after physical and mental health induced inpatient stay.

This became a 'hot topic' and over a 4 month period peoples thoughts and experiences were proactively sought to inform this Hot Topic report. This report has been prepared for discussion and consideration at the July 2019 County Mental health Action Group. It reflects the comments received from service users and carers via our feedback system (8) and discussion held at each of the local networking meetings with wider stakeholders (114) across the mental health system.

What are the issues?

The interface with hospital and community

'Parity of esteem' as enshrined in the 2012 Health and Social Care Act, defines valuing mental health equally with physical health. After discharge from hospital with a physical health issue a district nurse will follow up your healthcare and with physical conditions there is often an average estimated recuperation period (e.g. 8 weeks for a fracture.) But mental health can be a variable long term issue. Mental health simply doesn't fit the physical model.

There was positive discussion about the Choice and Partnership Approach in secondary care and how it involves getting people in and out of hospital quickly, an example of a client-led service that is accessible and outcome focused.

Community mental health teams and A&E's modern matron are part of the leadership team, and regular meetings are able to review people attending A&E and the associated levels of risk. They are identifying people who are frequently presenting at A&E and looking at alternative support options for them. Current staffing levels and budgets do not have capacity to increase this.

The Forensic Outreach & Liaison Service has been in operation since April 2019, offering specialist high intensity support to reduce length of hospital stay and provide more support in the community. OTs work with people who have had an interaction with the law/criminal justice and social care workers assess people in hospital and consider risks for patients going out into the community.

We heard from a few carers who flagged up concerns about the mental health awareness of staff on general wards.

'Over the period, we've had experience's where the nurses on surgical wards have not had a clue how to handle my daughter because of her mental condition.'

Experiencing A&E

Over the period of March to June three people have fed back experiences related to Psychiatric Liaison and assessment at A&E.

'There is no mental health support from Psychiatric Liaison. You can wait for hours to see Psychiatric Liaison but there is no outcome following a ten minute chat. It feels like a means to no end. A brief action plan is written while you are with them but this feels like box ticking, there is no mental health input except for you to phone the Samaritans.'

'I saw the Liaison psychiatrist in August 2018 when in crisis. He said that they couldn't make it too comfortable for me to attend A&E or they were enabling me.'

'I now avoid A&E and go to a minor injuries unit instead (re self harm). This means I don't get any mental health assessment but this is preferable to being trashed.'

The challenges around returning home after discharge from A&E in the early hours of the morning are just as real for people with and without mental health problems, albeit the impacts may differ individually.

A person was assessed for risk of suicide at Hospital A&E. They waited for 8 hrs, were given diazepam and discharged at 11pm. The person had no way of getting home and sat in A&E waiting area overnight until she could get a bus at 8am.

Discharge planning and immediate support

Discharge planning now starts at the beginning of hospital admission. The community mental health team can hear from Psychiatric Liaison when someone is admitted to hospital via A&E or via family or other contacts. It was felt that the direct discharge process has a lot of information to create a smooth transfer into community mental health teams. If enough

notice is given by wards, the care co-ordinator will meet the patient before discharge. There is a daily report from the inpatient team and daily meetings with community/acute teams. One person gave us feedback about a member of staff on the ward with whom they had built a relationship, '*as a result I have engaged in treatment and agreed to a depo. I am feeling confident about my discharge later today*'.

In the local network meetings the Integrated discharge team was felt to be effective and organised. The importance of the correct professionals attending these meetings was recognised, including funders from both health and social care.

Some thoughts from discussion groups were to ensure that those organising discharge meetings at inpatient services:

- Have the contact details and invite relevant professionals involved in the patient's care
- Send email invites to monitored inboxes (i.e. team inboxes that are checked each day), rather than to individual professionals, who may be on leave/ miss emails.
- Are more flexible with timings (i.e. offer alternatives) to promote attendance
- Employ teleconferencing/skype/etc. to allow busy professionals to input into the meeting (particularly when discharging from a hospital in another area).
- Family could also use teleconferencing (when discharge meeting is out of area), if present with a local MH team
- CMHT Duty Workers could attend where Care Coordinators are unavailable
- '*All involved should be present and all should understand what needs to be done…by when and where. It is a principle that very much underpins Open Dialogue'*
- *'Heat/light/heating/food/benefits/medication/therapy……all need to be nailed down with all concerned*.'

Complex cases, are taken to the multi disciplinary team GP hub meeting, where many agencies are round the table, the aim being to best plan post-discharge support. Advanced KERS have a discharge Care Coordinator at Littlebrook, who will also provide day-to-day support post-discharge e.g. picking up prescriptions, but it was recognised that there are only 2 members of the team in DGS.
Local network meetings also reported feeling that the Emergency Discharge Planning Team, who provides a social care response is working well. There was some concern about funding in the future to keep this going.

KMPT has recently reduced its target to follow up discharge from 7 days to 72 hours. One person commented '*whilst timeliness is important it is the quality of handover that is paramount'*. If a person is not seen by the crisis team then they can get a care co-ordinator within the CMHT.

The Community Mental Health Service for Older People receive daily reports by email from the discharge team. A care co-ordinator is allocated, and contact is made within 48 hours of discharge from the ward. An OT/care co-ordinator will make a face to face visit within 7 days of discharge.

It was also recognised that someone may go into A&E in crisis and then after a few days feel better and not want secondary services. The discharge process is not able to '*force community referrals*' on people.

One Carer said '*the period following discharge from hospital, has real potential for suicide for the individual. When they are in hospital they have everything done for them and although they may say....."I want to go home" the actual reality of coping...especially if they are on their own...is really hard.*'

'In our experience, supported living customers are handed over to the crisis team for a short period after discharge and may or may not have access to the CMHT'

During the period March to June we heard 8 experiences about discharge from hospital.:

'I was told that the crisis team would call me at home every day for 3 days but they never called'

'One of my action plans said I had been discharged to a crisis cafe even though they were not open'

'When you are discharged from hospital support should always be offered but it sometimes feels that they cant get you out of the door fast enough to get an empty bed!

'I was discharged from St. Martins 10 days ago, since then I have had no follow-up contact with the CMHT. I feel totally let down by all support services'

'At a discharge meeting at St. Martins I was concerned that the consultant psychiatrist chairing the meeting showed extreme disrespect for the views of family members/carers in attendance by looking bored and uninterested in what was being said'

'My customer got released from Maidstone Priority House and he got a phone call the next day to see how he was doing. It was really good that he got that call'

'One person I work with was discharged without the next of kin being told and went home to an empty house'.

'My team specialise in working with those on forensic outreach and we have a discharge booklet that is used, we start working with the clients early on with the booklet. It has their coping methods in it too'.

There are a different set of issues around someone with a mental health problem being discharged from a physical health hospital admission. The person may only be seen at their 4 months review so often a care co-ordinator won't know they have a planned / emergency physical health admission. The only way for a care coordinator to find out that someone has been in hospital is if the person tells you directly. One local network meeting discussed talked about a recent experience of someone going in for planned surgery and the consultant making contract with the care co-ordinator before and after surgery to keep them informed. The care coordinator was then able to pick up immediately with the person on discharge from hospital. An example of where integrated care worked excellently.

'If anyone is admitted to hospital who is a carer and they are in for at least 24 hours, once they are discharged, they are entitled to two free weeks of care. It is called the hospital discharge service. Involve have funds for this but others such as Imago must have funds too. I used it for a carer with mental health issues who was caring for someone with mental health condition. It was hard to find someone to fulfil the role, but they did it.'

There is currently no system in place for Community Mental Health Service for Older People to be notified if someone is admitted for physical health problems.
The KMPT Occupational Therapy team is a separate team working outside of ward staff numbers. There is a directory of OTs so it should be easier to link with OTs.

These findings resonate with findings in recent reports from Healthwatch Kent, who found that an average of 27% of patients they spoke to in their research around discharge from general hospitals said they were unclear what care or support they would receive after being discharged or didn't get the care and support that they were promised.

'There have been issues with a lack of communication from the crisis team after discharge, for example, tenants have been given an appointment/home visit time but have not been contacted when the crisis team are running late; this has increased the tenant's agitation and lack of trust in services, not helped when the crisis team simply justify their lateness, rather than apologise for it'

Stepping up and down to inpatient stays

Discussion at local network meetings felt that there is a gap in provision between secondary and primary care, a need to a 'step down' from CMHT and Hospital, where the patient is discharged but still has access to care. Many people talked about situations where someone when first discharged from hospital was thought too complex for community rehab services or are not well enough to engage with groups/ volunteering (i.e. Social Prescribing). It is recognised that there are a range of KERS projects available, but individuals are often not well enough for these 12 week projects, or are not aware of the projects. KERS does not take referrals from Primary Care. Many agencies felt that there was more space within this process for other agencies, to either provide alternative or additional support to people.

Conversely there was discussion about clients who become unwell 6 months post-discharge from hospital and are back in primary care and start self-harming to get support. A step up 'fast track' for people who have been admitted in the past year to get support.

There was some positive feedback for a new signposting unit at Priority House which has 3 comfortable chairs and people can wait for up to 24 hours.

The Crisis Recovery Home Treatment team are able to make a face to face visit on the same day as someone is discharged, depending on time of day phone call is made, or next day. The person has to consent to receive contact and daily calls with Psychiatric Liaison confirm who has been seen by them. However out of area wards sometimes don't communicate with the Crisis Recovery Home Treatment team, so these people are not picked up.

Service users indicate that an increase in immediate access to talking therapy provisions; groups and 1:1 support would be beneficial to anyone who has been discharged.

'There is nowhere to go when you feel desperate, no phone line to ring unless it's 20 minutes limit with Release the Pressure.'

At the moment Psychiatric Liaison are recognised to be trying to discourage people from going to A&E. However, feedback suggests that people feel there is no meaningful alternative. There are crisis cafes but these have limited opening hours.

Housing

There has been a cluster of feedback in relation to housing and discharge from hospital, both from individual submissions of feedback, as well as in the local networking meeting discussions.

Concerns were raised about sheltered housing tenants and tenants with no family support who are discharged. They are considered more vulnerable and are the more likely to be readmitted. A concern was raised that social care are more likely to discharge to a housing provider.

'There can be a tendency to assume that because a person lives in a supported scheme, the staff here will be able to support them with their mental health. Whilst this is true at a very basic level, we are not specialist mental health workers and cannot provide the appropriate support. We cannot administer, monitor or even prompt the person with their medication, which can be problematic if a person is unable to manage this effectively themselves'.

Housing support workers talked about challenges in communicating with community mental health teams in terms of discharge planning and in ongoing communication about a persons mental health.

Local network meeting discussions cited cases of clients who lost their accommodation (bedsit, supported living, etc) while in hospital and when discharged have nowhere to live.

'A service user's mental health began to deteriorate and their support staff tried to make contact with their care coordinator at the CMHT. Messages were taken numerous times but nobody got back to the service user or the support staff. The service user continued to deteriorate until they ended up in hospital. At their discharge meeting from hospital the care coordinator said that they didn't think they had to respond to any of the messages they'd received from the service user or their support staff.

'After a resident had an admission to hospital we were advised by their CPN that they would be discharged on 3rd May, but we had a phone call at 2pm a week early. The resident was discharged without their CPN or their key worker knowing, and we knew she did not have keys to get into her flat. This may have meant that she would have been unable to get into the building and with someone with paranoia this is not a great start to being discharged'

'I would make a plea for our judgement/views to be taken more fully into account. We know our schemes – what support we can and cannot provide after discharge and beyond – and our customers, but too often find that our thoughts are not listened to'

Information

There was much discussion about the need to ensure information about available services is provided to patients on discharge from hospital. People mentioned that there used to be a comprehensive leaflet with all available sources of support/services for patients on discharge, and more recently, there was the Live It Well website. Now it is hard to get find all the information in one place. Some areas of Kent have LWK Community Navigators, who have this knowledge.

The 'Moving On' group at St Martin's gives information about available services to patients before discharge. Is this replicated at other inpatient sites?

Discussions recognised that it is not possible to follow up everyone who is discharged, and priority should be given to people assessed according to need, but it was felt that everyone should have some basic information when discharged about where to phone for support.

Primary care

Discussions looked at the potential for primary care (i.e. GPs) to alleviate pressures on secondary care, for example GPs administering depot injections. This currently happens in Maidstone. Is there possibility of more mental health nurses in primary care? There was a clear sense that a robust primary care system could alleviate demand for lower-level secondary care leaving secondary care for those with severe and enduring mental health conditions.

Medication

One person has fed back experiences relating to difficulties in post-discharge support with medication.

'I have had difficulty getting a prompt psychiatrist appointment to review new medications I have been prescribed since my discharge from hospital. My family have been trying to arrange this for me. I don't feel that these new tablets are working for me as I have been experiencing periodic suicidal ideation'

Continuity for the person

Services and people working within them can change when people are in hospital and the impact of staff coming and going from crisis and community mental health teams can have a negative impact on people.

'The support provided by the crisis team did not work for her. The lack of continuity and the feeling that they were rushing conversations with her because they needed to move on to the next person led to a lack of engagement. It took a considerable amount of work on our part before she started to receive the appropriate support. This was interrupted every time a care co-ordinator or other support person left, and frequently it was our team that were picking up the pieces and dealing with serious self-harm and physical health issues caused by an eating disorder'

The '*false expectation and hope*' of A&E Psychiatric Liaison teams was mentioned by more than one person in the period March to June. There was some discussion that Psychiatric Liaison could be '*more than a one off chat*', they could write reports or letters that would help someone when not under mental health services. The DSH team at Kent and Sussex were mentioned and recognised as wanting to help repeat attendees.

'Psychiatric Liaison can be counterproductive when they offer nothing and there are no services to refer to'

'A medical doctor will have referred a patient to psychiatric liaison and believe that this will result in help. But when the help doesn't exist that can lead to patients feeling cheated or that time was wasted when they are in a desperate place'

For system wide consideration

- Will planned changes to inpatient wards result in fewer beds and will this mean that people will be discharged who previously would not have been?
- Need to improve communication and develop communication channels and permissions between services to create one system for communication between general wards/ mental health inpatient wards and community mental health team/ named GPs / carers& families / key supporting community projects to enable better planned discharge support.
- Explore potential for a 'flagging' system to prompt discussion with patient about their ongoing mental health support during and after admission to physical wards and ensure permissions in place to follow up / initiate discussions with appropriate nominated support agencies, including GPs.
- Is it possible to set outcomes and patient satisfaction tests for Psychiatric Liaison?
- Should primary or secondary care services look to engage with people who are known, but not engaging? There is no Assertive Outreach function.
- Consider rolling out the administration of depot injections by primary care to alleviate some pressure on secondary care

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