Recovery Navigator Pilot Report

Background

The Lead Worker Peer Mentor programme came to an end in June 2019. Through the data collected as part of that programme (interviews with clients as well as statistics relating to A&E visits), it became evident that aspects of the model would be beneficial in an A&E environment to try to prevent inappropriate attendance at A&E as well as navigate those clients that had attended with multiple complex needs, into suitable services.

Using an underspend from the LWPM programme, Birmingham Mind seconded two full time Recovery Navigators to work within what was formally known as the Rapid Assessment Interface Discharge (RAID) team and is now known as the Liaison Psychiatry Team within the Queen Elizabeth University Hospital (QE), Birmingham.

The pilot commenced in January 2019 and ended to coincide with the end of the LWPM programme in June 2019.

Pilot Aims and Objectives

It was agreed that the main aims and objectives of the service would be to focus on some of the key social and environmental determinants of poor mental health that can lead people to seek support from Accident and Emergency departments/crisis services.

- To assist in helping in the reduction of diverted mental health admissions.
- Support and assistance with diverting individuals away from admission to hospital by providing, facilitating and navigation to more appropriate services including support around the catalysts of poor mental health that might include social crisis issues, e.g. risk of homelessness, social isolation, neighbour/landlord disputes, rent arrears, lack of funds.
- To give full advice on different issues which are likely to include a number of the following areas; mental health, homelessness and housing, substance misuse and recovery, offending and the criminal justice system, domestic abuse, relationship breakdown, welfare and housing benefits, debt, employment.
- Provision of support to enable improvement of 1-hour RAID assessments targets for individuals referred to the service as well as assisting in the improvement of 4 hour A&E targets.

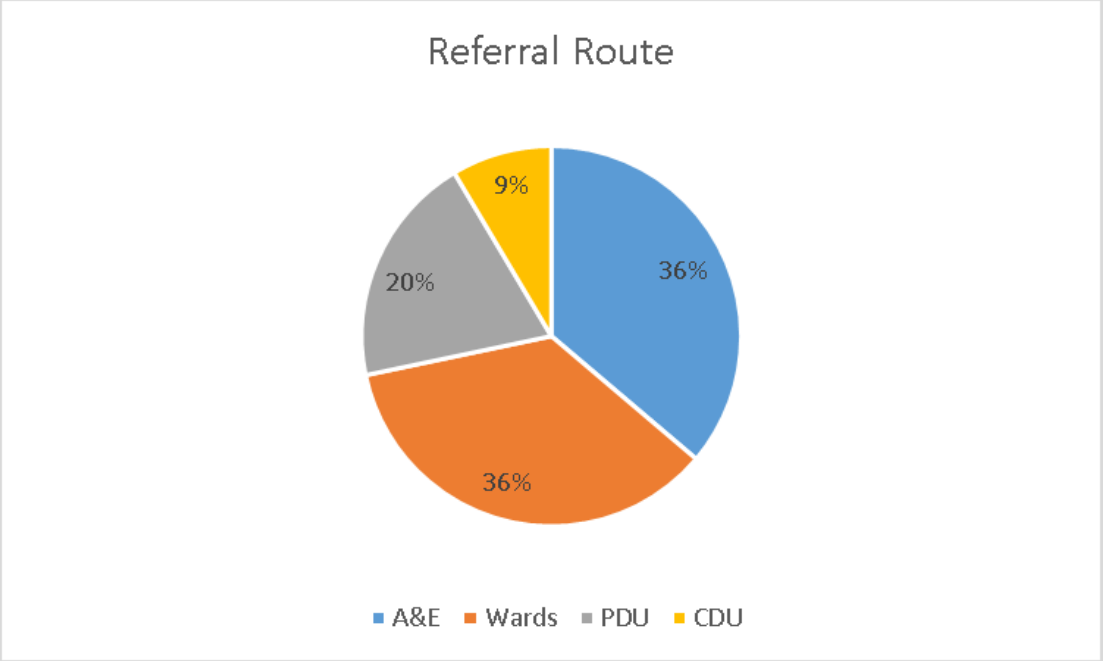
Recovery Navigator Roles and Responsibilities

- To encourage, inspire and motivate people accessing urgent care to promote their wellbeing.
- To support clients from urgent care in a timely manner by liaising with statutory and non-statutory services.
- To escalate any non-mental health related issues to RAID team manager at the earliest opportunity.
- Receive referrals from RAID where social support, housing needs are the primary issue for accessing services.
- To work in collaboration with RAID in imparting information to A&E to identify alternatives to crisis attendance.
- To build robust pathways in accessing other agencies.
- To support RAID, PDU, Place of Safety and other urgent care services in maximising throughput of service users to access the most appropriate support network.

1) Client and Service Breakdown

137 individual clients engaged with the Recovery Navigators during the six-month pilot (average of 23 new clients a month), referred from various units within QE Birmingham -

- 55 from A&E
- 54 patients on the wards
- 30 from Psychiatric Decisions Unit (PDU).
- 13 from Clinical Decisions Unit (CDU)
    - *A number of clients were referred more than once, which is why the client figure within the location breakdown is 152 and not 137.*



- 89 clients (65%) were already known to either of the two secondary mental health services (Birmingham and Solihull Mental Health Foundation Trust or Forward Thinking Birmingham) and had a care coordinator in place. It is therefore expected that these clients should seek support from their care coordinator and not attend A&E due to mental health concerns.

2) Reasons for referral

There were numerous reasons for referral to the Recovery Navigators of which community support, social isolation and homeless/accommodation issues were the most common referral reasons.

Referral reasons included –

- Support with social isolation
- Lack of adequate community support
- Debt advice
- Benefit advice
- Eviction/homelessness
- Benefits issues
- Signposting advice
- Advise on education or employment
- Alcohol support
- Wanting therapeutic groups

- Support for maintaining independence
- Anger issues
- Hoarding
- Support to register with GP
- Isolation
- Difficult family dynamics
- Clients presenting at A&E with a lack of knowledge of where else to go.

Reasons for referral were consistent across the different referral routes with no patterns being seen.

3) Recovery Navigator Interventions

Prior to the Recovery Navigators being in place, the Liaison Psychiatry Team would generally conduct an initial mental health assessment. If deemed suitable, the client would then be allowed to leave QE. Due to staffing priorities and workload, as well as a lack of specialist knowledge of support services, this would frequently result in the clients leaving QE without being adequately signposted to the support they required.

The Recovery Navigators added the knowledge and dedicated time to ensure clients were not allowed to leave the QE without appropriate support in place. Interventions offered varied depending on the reason for involvement.

The length of time a Recovery Navigator would spend with a client would also vary depending on the client's needs. This varied from a couple of light touch discussions, to taking weeks of contact with a client as well as numerous services the client was trying to access.

The Recovery Navigators –

- Liaised with existing housing providers in order to ensure clients were able to return to their tenancy.
- Signposted and referred to appropriate services such as housing providers and floating support.
- Took patients to view properties and presented with them to neighbourhood offices.
- Advocated on behalf of the client to ensure they received the services they were entitled to. This was face to face with services as well as phone calls and emails.
- Supported clients to create email addresses to enable sustainable communications with services.
- Supported clients with claiming universal credit.
- Liaised with client's families to ensure appropriate accommodation and networks.
- Liaised with GPs to ensure clients were registered.
- Navigated to alternatives to attending A&E such as crisis cafes.
- Advised colleagues on what support was available to clients.
- Took the clients in person to food banks, clothing banks, shops and support services.
- Reassured clients and gave emotional support.

4) Re-attendance levels

Re-attendance levels have been extremely difficult to capture. Some clients have re-attended, however these visits have been predominantly for physical health issues (and therefore A&E was the correct service for them to access).

It was also discussed that due to the excellent work of the two Recovery Navigators and the lack of alternative support known to some of the clients, the presence of the service could potentially lead to an increase in re-attendance (if the client was in need of further support and they trusted the Recovery Navigators, they would specifically return to A&E for that reason).

Due to the issues mentioned above, it has not been possible to investigate reasons for re-attendances.

5) Client feedback

Client feedback has been very similar to the feedback given by the Peer Mentors and Lead Worker clients. Feedback has included being thankful for interventions, being appreciative of the help and support of the Recovery Navigators, feeling as though the Recovery Navigators were the only people that listened to the clients and feeling as though they wouldn't have been able to access the services offered without the support of the Recovery Navigators.

6) Liaison Psychiatry Team Feedback

Discussions took place with Martin Luke (Clinical Nurse Manger), Fiona Nicol (Team Manager), Donna Henderson and Karolina Dobrowolska (Recovery Navigators).

The pilot has been a very good and helpful service. Although it is probably too soon to tell, it's well evidenced that there is a clear correlation between social deprivation, mental health issues and subsequent crisis presentations. This service has genuinely seemed to provide support in an area where there was a lack of knowledge and service provision.

Medical colleagues have expressed that at times they would have been unable to gain information and collateral without the support of the Recovery Navigators.

From speaking to members of the Liaison Psychiatry Team, it is believed that the Recovery Navigators have prevented clients leaving A&E without accommodation to go to, not knowing what support options are in place to support them and even to ensure they are clothed and fed.

It was discussed that clients would state that they were suicidal if they thought this would help them stay in the hospital for a longer period of time, even if they weren't suicidal. Having the knowledge to direct these clients into appropriate services reduced the instances of clients claiming that they were suicidal. It was also thought that medical staff would class clients as an emergency case if they believed them to be homeless/without accommodation to leave to, even if their conditions weren't suitable to be classed as an emergency. This would result in the client being able to stay at the hospital longer than was strictly necessary. Again, having the interventions of the Navigators has reduced the number of occasions medical staff have had to resort to this process.

The team felt improvements to the role could have seen even better results for clients. These included –

- The Recovery Navigators having access to RIO (NHS computer system) and an NHS email account
- The working hours should be beyond Monday to Friday, 09:00 – 17:00 to fit in with demand.
- The Recovery Navigators should have a petty cash budget for expenses such as taxis to visit clients at accommodation, food vouchers, electricity metre top ups etc.

7) Further Research -

Due to data sharing issues and access to the NHS computer system, in-depth client evaluation has not been possible. However, if access to the system was granted, or an NHS staff member were able to be allocated to continue with evaluation activity -

- Further analysis of client interactions and outcomes should be completed. This should include specifics on number of interactions, time spent with clients and their eventual outcome following intervention by the Recovery Navigators.
- Research should be conducted into those cases where a Care Coordinator was already in place (as a major aspect of their role should be preventing them attending at A&E inappropriately as well as signposting them to relevant support services). This should include such questions as why are the clients not accessing their coordinator and if they are accessing their coordinator, why are they still finding themselves in A&E?

- Review the sustainability of the Recovery Navigator inputs over a longer timeframe by monitoring the data of the clients. This should include re-attendance rates and reasons for re-attendance.
- A cost benefit analysis should be completed to review the associated costs of the Recovery Navigators against any cost savings made within A&E.
- An impact analysis of QE A&E since the pilot ended.
- Further research would be required to ascertain the impact on the four hour A&E time limit as this was not recorded during this pilot.

8) Testimonials from Queen Elizabeth University Hospital staff -

The Recovery Navigators were unquestionably vital to the support adjunct to our liaison service. We deal with complex mental and physical health issues, these are more commonly than not complicated by social and financial struggles. The Navigators were a brilliant platform to accelerate, support and guide our service users in matters, that if I'm honest, are not as accessible without them. They have streamlined and promoted our discharge planning, ensuring support in the community and preventing readmission.
I would very much promote their role returning.
Dr Shell Samnani
(Registrar with LP team)

I work outside Liaison Psychiatry as a discharge liaison nurse for Birmingham and Solihull Mental Health Trust patients admitted to out of area beds. Arranging discharge back to Birmingham can often be complex with these patients often having issues with accommodation.
I approached Donna (Recovery Navigator) as a source of local information and she was an amazing help. Her knowledge of the housing options for these patients helped me arrange timely and safe discharge at considerable savings for the local health economy. On average a private bed costs £500 per night and without Donna's help, admission would have been prolonged.
The savings was obviously important but being able to bring patients back to where they can access support from local Mental Health services and be closer to their family is invaluable to their continued recovery.
I was sorry to hear that this service was being suspended and hope that the likes of Donna and her colleague Karolina can work alongside us again.
Chris Mc Cay
Capacity Utilisation Clinician

I would like to provide some feedback on the Recovery Navigators who have recently been doing a pilot with the Liaison Psychiatry Team.
I found them a very helpful and effective addition to the service, they were able to engage with a variety of clients, some with complex mental health and social needs, and input into their care in a positive way, whether that be by liaising with housing providers or other community services which provide support to vulnerable and socially isolated people. I found them particularly helpful to bridge the gap for clients who needed support but would not readily be able to access this from community mental health teams.
I felt that the workers demonstrated good team working and good communication skills and would hope their employment with liaison psychiatry would be able to continue.
Rowena Jones
Consultant Psychiatrist

A very useful service that enabled staff to promptly address social needs with service users such as benefits, housing and additional support/occupation and leisure needs.
The Care Navigators were easily accessible and responded promptly to referrals.
There remains a high need for their service, and would ease some additional pressures placed on both the acute hospital and mental health staff, ensuring that service users' needs are addressed holistically.
Anna Williams
Psychiatric Liaison Nurse

9) Client Case Studies –
These case studies highlight common themes that were seen throughout the pilot, as well as showcasing the support given by the Recovery Navigators and the effects of that support.
They were written by the two Recovery Navigators.

Case Study 1 -
EK was a 50-year-old female patient referred to the Care Navigators via the Liaison Psychiatry Team. When I saw her initially, she was on one of the wards in the main hospital, undergoing a detox from alcohol. She lived in Cardiff where she worked as an Occupational Therapist. She moved to Birmingham with her new partner some time ago but it quickly became apparent that it was a toxic relationship.
EK said that alcohol was always her coping strategy as, for example, when she experienced a few close people dying in the past few years. After an argument with her partner, EK was found on the street very intoxicated and brought to hospital which led to the partner saying that he didn't want to see her back at the house and thus she became homeless. She had no family or friends to go to, and she admitted that she didn't even have a GP because her partner wouldn't let her register.
EK did not have a mental health diagnosis, but her alcohol use had a massive impact on her mental state deteriorating over the years, resulting in her being highly anxious and depressed.
EK was about to finish her detox the day after I saw her, and the ward staff stated that she would then be medically fit for discharge. The time pressure meant that she would have to present herself as homeless at the Neighbourhood Office. However, my impression of her mental state was that if she was to be placed in a hostel with no support (possibly among people who abuse alcohol), she would relapse and end up back in the hospital with another crisis. She shared that concern and was scared that this would happen and she felt very tearful, vulnerable and unstable. She was terrified of being put in homeless accommodation again, as she went through many of them before, and was once sexually assaulted in a hostel. She expressed that she wanted any help that is out there and she just needed support and navigation to stay clean from alcohol. I therefore decided to liaise with the ward staff, discuss the situation and argued that if appropriate support could be put in place for this lady at this point, it could prevent her returning to urgent care. My aim was not only to find this patient a roof over her head because she was homeless, but to put her into a service which would provide the support she required. It was agreed that she would be kept at QE for another couple of days and I would push for the process to be as prompt as possible.
I completed a referral to a charity organisation helping people recover from drugs and alcohol addiction. Two days later one of their workers came out and assessed her in the hospital. The next day, EK moved straight from the hospital to a 24-hour staffed supported accommodation for people who were recovering from drugs and alcohol. Service users take part in a full time 8-week programme of activities that provide vital support, within a therapeutic framework, to empower their abstinence which includes group therapy, motivational interviewing, 12-step mutual self-help,

mindfulness, Cognitive Behavioural Therapy, anger management and debt management. Upon completion of this programme EK would move onto a lower-needs supported accommodation as the second stage of her recovery. While she was in the hospital, we discussed her ambition of getting back into employment or doing some voluntary work in the future.
Almost four weeks after case closure (and two months after I first saw the client in the hospital) I received a phone call from EK. She wanted to express her gratitude for directing her in the right direction and not putting her in a hostel like other people did just to get her out of the hospital as fast as possible. She sounded like a different person - confident, cheerful and enthusiastic. She was speaking hopefully of her future.
She said *'This place is the chance I needed. And I wouldn't be here if it wasn't for you. My words can't say how much I want to thank you.'*
She informed me that she had now successfully completed the 8-week programme and moved on to a second stage accommodation. She expressed that she felt ready to start doing some volunteering or get back into paid employment, for which I had given her advice.

Case Study 2 –
SR was a 42-year-old woman who was referred to me after presenting in A&E with a mental health crisis and social issues. On initial contact with her she explained that she has lived in supported accommodation before, but they moved her into an independent flat and since then she hadn't received any support or input from the organisation. Initially, the action plan for me was to push things that maybe got missed by the housing provider and refer her directly to their floating support service. However, the situation the lady was in turned out to be much more complicated.
At the point when I got involved with SR's situation, her mental health had already been deteriorating for a long time. She had not been responding to any phone calls, not opening any letters, or letting people in for months. She wasn't under the care of any Community Mental Health Team (CMHT). Her benefits had been stopped and she was unaware of why or when this had happened. I contacted her housing provider who expressed that there were some issues with her tenancy and thus referral for floating support would not be possible. They instructed me to emphasise to her to contact them urgently.
For the first two weeks I had been liaising between SR and the housing provider daily, exchanging multiple phone calls with both sides. She was extremely anxious and reluctant to contact them, and she would only respond to my phone calls as she opened up to me and trusted me due to the rapport I established with her. Eventually, SR made contact with her housing provider and was told that she needed to move out as soon as possible, as they had a Section 21 Court Possession Order on her due to her owing £4000 rent to them and the bailiffs could come in any day. They gave her multiple reminders, deadlines and extensions, tried visiting her many times but she was not responding to any contact because of her anxiety levels. All of this perhaps wouldn't have happened if this lady was given the right support in the community, instead of being left to her own devices and spiralling down for months.
She was advised by her housing provider to hand in the keys, vacate the property, present herself at the Newtown Housing Options Office and complete a homeless application as soon as possible. The official eviction date was in five weeks time and it was explained that she could stay in the property until then. However, that would mean she would owe more and more rent on top of the massive debt she already had.
With my support and encouragement SR managed to overcome her fears and follow the advice. She was put in a hotel however, and told that the Council might not have the duty to house her as she made herself intentionally homeless by handing in the keys before the eviction date which was in five weeks time and until then she had 'a roof over her head'. This situation showed how the policies and procedures of different institutions and organisations (housing providers and the Council) clash with each other leaving a citizen in a hopeless situation.

Another important element of this situation was sorting out benefits. I explained to SR that in the meantime when we were waiting for the Council's move, we needed to get her back on benefits which would allow me to potentially put her in supported accommodation. I signposted her to the Universal Credit helpline and SIFA Fireside for support and guidance on her situation. I also managed to find out that her previous housing provider could provide free storage for her belongings so that she didn't have to pay for it.

SR also touched on another important element of her situation. Upon her visit to QE A&E department, she was referred to CMHT. After that she had an appointment with a doctor but was really confused as to what it was about and I agreed to look into this for her. Looking at her clinical notes, it turned out that the doctor referred her to the Home Treatment Team and she was currently awaiting allocation of a community psychiatric nurse (CPN), something she wasn't aware of during the appointment. This was yet another factor showing how this woman had been missed out by the system and not given the care and support she required which led to her current situation.

Five weeks after presentation at A&E, she had started getting some input from the CPN who was allocated to her.

This lady was the longest case I had had. She had been open to me for three months, yet the average period of time I was involved with patients for was for one to two weeks. Throughout these weeks I had been providing constant advocacy, liaison with her housing provider, emotional support and advise on housing and benefits. Looking back at the initial contact with SR, she was in a really poor mental state and with my support, reassurance and guidance along the way, throughout this whole process she gained resilience and was able to actively help herself in her situation. The last stage of my involvement with her took another couple of weeks due to sorting out her benefits but I remained in constant contact with SR throughout this. Once this was finalised, I had finally managed to complete my goal with this lady – I referred her to a high support mental health specialised supported accommodation.

Case Study 3 –

OH was a 21-year-old university student who presented to A&E with four impulsive alcohol-triggered suicide attempts within six weeks, and ongoing self-harm. He had been under the care of the city's mental health partnership for 0-25 year olds and was not happy with the quality and quantity of help he'd been getting from them. His friends from university also voiced concerns about the care he'd been getting from mental health services and described him as very reliant on them to ensure that he didn't harm himself. Overall, OH was a highly functioning young gentleman, a very proactive student, highly engaged in university life and involved in many things on campus. He had been waiting to receive student counselling for eight weeks (although when he'd previously accessed the service he said that he'd been dismissed for 'only being homesick').

Universities have dedicated support services for students who experience difficulties, yet my experience of working in QE Hospital and seeing student patients had shown that most students were unaware of them. I would always, therefore, explain and signpost them to these services. I made OH aware of University Mental Health Advisors Network and explained how to ask for allocation of an advisor. These advisors are different from the Welfare Advisors who focus on general wellbeing and academic progress of students. Mental Health Advisors specialise in supporting students who suffer from mental health problems during their degree. I also encouraged OH to utilise Nightline – a student crisis helpline led by students for students, which is open every night. Because OH tried university counselling services and was disappointed, I provided him with a number to the free community counselling/psychotherapy service which have a waiting list of 2-4 weeks in comparison to Healthy Minds (primary care NHS psychotherapies service) which has a waiting time of months.

Understanding that the patient had been discouraged from using counselling services I also informed him of an online alternative, a CBT tool website called MoodGym (if he would prefer this than face to face talking therapy).
OH thanked me a lot for all the resources and navigation I provided him with and said *'This is the kind of help I have been looking for and not getting for a long time'.*
I have seen quite a few student patients like OH in the months working in QE Hospital and it clearly highlights the high need and urgency for mental health support services for young people.

Case Study 4 –
MP was a 43-year-old Polish gentleman on one of the wards in the main hospital who caused himself a serious injury in an impulsive act. During an argument with his girlfriend, the patient impulsively stabbed himself in the abdomen. Along with an interpreter, I assisted a Liaison Psychiatry doctor in assessing the mental health of this patient and establishing what led to such a drastic event. The patient had not been known to mental health services in the UK and claimed that he never accessed mental health support when he lived in his home country.
From the assessment it became apparent that there were a number of social stressors which led to the crisis, of which the main one was prolonged tiredness and feeling overworked. As a person who came to this country with little English, MP had been working in a factory which meant hard physical work and long working hours. He drove 90 minutes to and from work every day and sometimes did extra hours to afford living, which left him with little time to rest or to spend with his partner.
Upon finishing the assessment, the doctor concluded that there was no significant presentation of mental health concerns but due to the seriousness of the act he committed, he was offered a Home Treatment Team. He declined saying that he didn't need it and he wouldn't be able to communicate with them anyway.
I took time to speak to the patient individually in his own language and I provided him with contact to a number of Polish counselling/psychotherapy services around Birmingham offering individual as well as couples' therapy. I also issued him a Birmingham Mind leaflet in Polish about how to speak to your GP about your mental health.
The situation of this patient showed how people from minority populations in the UK face obstacles in accessing mental health services to seek help due to language barriers and fear of not being able to express their needs.

Case Study 5 –
OC was a 24-year-old gentleman who presented to A&E with suicidal thoughts. He was living in supported accommodation but was claiming that he wasn't receiving any support or had a support worker allocated. He described the state of the accommodation as appalling. For the initial four weeks I had attempted to co-operate with his current housing provider to find alternative and more appropriate accommodation for him. OC felt vulnerable and unsafe in the house, as most of the people who lived there were older than him and had just come out of prison. OC admitted that he was actually threatened with a knife by one of the residents in the past. The staff did not even support him with addressing this issue with the police and hadn't made any attempts to comfort him after the trauma of this experience.
The housing provider turned out to be unreliable and stopped answering my phone calls. They also hadn't been doing things they had agreed to do, and were delaying the process of finding alternative accommodation for OC.
After weeks of consideration, OC decided to wait a couple of months until he turned 25 so that he would have more opportunities to find housing. He thanked me a lot for the offer of finding him other accommodation and I signposted him to additional support services and counselling in community. However, another issue arose in the meantime.

Upon his presentation at A&E, the registered Mental Nurse from the Liaison Psychiatry Team who assessed OC made a referral to the city's mental health service for children and young people aged 0 to 25 to follow up for an appointment within seven days of discharge. It had already been almost four weeks since his presentation at A&E when OC told me that he still hadn't been contacted by anyone at the service. This started a long spiral of constant phone calls from me in order to prompt the allocation of a mental health team for this patient. At first I was given the information that his referral was considered as routine and he should have been followed up within the period of four weeks, not one week. Yet, at that point, this four-week threshold had been breached anyway. A few weeks later, I was still making regular weekly phone calls to the service.

It's important to note that the client was completely unaware of any progress of his referral to mental health services other than the fact that I was constantly passing on information to him to keep him informed. In total, it had taken mental health services two months to make an initial contact with this client.