FACT SHEET 4
DEVELOPING INTEGRATED PATHWAYS FOR HOMELESS PEOPLE

This Fact Sheet is number 4 of 6, all of which link to and provide background information for the guidance on producing a protocol for the Admission and Discharge of People from Hospital.[1] The other Fact Sheets in the series are:

- Fact sheet 1 — Web based resources on homeless services or developing a hospital Intranet
- Fact Sheet 2 — The Housing Act and examples of letters to local authorities for medically vulnerable patients
- Fact Sheet 3 — Housing Status
- Fact Sheet 5 — Discharging homeless people from mental health wards
- Fact Sheet 6 — Service users with no recourse to public funds

The purpose of this fact sheet is to support health staff to:

- identify homeless people on admission;
- enable health staff to effectively manage people with complex health and social needs;
- assist health staff to work collaboratively with acute services, mental health,
- primary care and the voluntary sector;
- provide staff with guidance on appropriate measures which can support continuity of care following discharge.

Each of the sections of this fact sheet relate to the objectives outlined above.

IDENTIFICATION OF ACCOMMODATION STATUS ON A HOSPITAL ADMISSION

Recording accommodation status will identify people who are homeless, or at risk of becoming homeless. See fact sheet 3 on housing status for information on how housing status should be recorded.

IDENITIFYING AND PLANNING FOR SUPPORT NEEDS FOR PEOPLE WHO ARE HOMELESS

Your hospital discharge protocol should cover a detailed assessment of what the patient needs, and in the light of this assessment, a plan for providing the care and support required.

We recommend this assessment covers:

- patient's views

[1] 1 http://www.communities.gov.uk/publications/housing/hospitaladmission

- primary health care
- mental health
- drug and alcohol
- welfare benefits
- housing-related support

IDENITIFICATION OF INVOLVED AGENCIES/WORKERS AND EARLY LIAISON

Ask if the patient has a named worker (key worker, outreach worker, tenancy sustainment worker, mental health worker etc). Often they will have key pieces of information regarding the background of the patient. These workers within a homelessness agency may be best placed to give an overview of the person's needs and history; and should be identified and involved as quickly as possible. If a person is identified as homeless on admission, the protocol should identify who needs to be alerted and ensure that there is a clear line of responsibility and agreed response times to these referrals.

This could include:

- housing Options and advice
- outreach workers
- hostels
- tenancy sustainment teams
- day centres.

DRUG AND ALCOHOL DEPENDENCY

MANAGEMENT OF WITHDRAWAL STATES ON ADMISSION

On admission drug and alcohol misuse issues need to be identified. It is very important that anyone who is substance dependent is enabled to have their withdrawal symptoms controlled, in order that they do not self-discharge.

If a patient is on a known prescribing regime for substance misuse, there is a need to immediately contact the team or GP who has been prescribing for them, so that there is continuity with the patient's treatment.

If the patient is not on any current treatment for substance misuse, then the Substance Use Team linked to the hospital needs to be involved immediately, so that the patient can begin to have their substance misuse managed quickly and effectively.

If a referral to the Substance Use Team is not done, this can become a barrier to appropriate management which can:

- cause great anxiety to the patient
- cause the patient to self-discharge which will have a detrimental affect on the patient's health
- result in conflict between the patient and health team, which can have a negative impact on establishing a partnership approach to care.

MENTAL HEALTH NEEDS

INVOLVING MENTAL HEALTH SERVICES

Many individuals become homeless through mental ill health and/or because of physical health needs. All Trusts should ensure that the admitting nurse considers whether the person had mental health needs. Mental ill health is one of the named

vulnerability criteria for establishing priority for housing assistance. A specialist mental health assessment is often important to help access this quickly.
Information about the following is particularly helpful when referring to mental health services:

- Current and/or past contact with mental health services.
- A description of current mental health issues causing concern e.g. speech, thoughts, behaviour and any potential risk factors – self harm / suicide, self-neglect, vulnerability to being harmed or exploited by others, harm to others.
- Psychiatric jargon is not necessary.

ADVICE FOR PEOPLE WHO ARE HOMELESS, NOT IN CONTACT WITH MENTAL HEALTH SERVICES, OR THEIR STATUS IS UNKNOWN

The patient should be referred to the locally agreed mental health assessment team as soon as possible, e.g. the Liaison Mental Health Team. Clearly communicate any factors that indicate urgency, or that the person needs to be seen as a priority. This engagement of the mental health teams with the patient is important; otherwise the person will simply fall through the care net.

IF THE PATIENT IS ALREADY IN CONTACT WITH A COMMUNITY MENTAL HEALTH TEAM (CMHT)

Notify the team as soon as possible – people with serious mental health problems are often registered under the Care Programme Approach (CPA)1 and will have a named Care Co-ordinator, usually a Community Psychiatric Nurse (CPN) or a Social Worker. It is their responsibility to ensure that care is effectively organised, and it should be expected that they respond promptly to visit the person concerned, and to jointly work with the ward team.

A CPA Care Planning meeting can be requested as part of the discharge planning process. The resulting CPA Care Plan should detail the involvement of all services, contain a risk assessment, and a crisis plan.

If the patient is being discharged from a mental health ward see Fact Sheet 5

PRIMARY CARE

There may be local GP practices or nursing teams that provide specialist services for people who are homeless. These may provide outreach care into day centres and hostels. These teams may treat minor illnesses, prescribe medication, immunise, and also act as a bridge between mainstream services in the local area.

RECOMMENDED INTERVENTIONS

- Discover where the patient normally accesses their primary health care. If they are not registered, is there a GP or nurse led homelessness project (primary care and mental health) in the local area?
- If there is a specialist service in your area, inform the specialist team of the patients' expected discharge date and where you have requested that they be seen.
- Give the patient a copy of their discharge plan, so that primary health care staff can respond more quickly. The patient copy should be faxed / sent with the consent of the patient to the specialist team. This will optimize the patient's engagement with the discharge plans; e.g. giving them reassurance that scripting will continue.

- Substance dependency scripting on discharge: If the patient's substance use is being effectively managed on the ward, it is important that the GP or drug specialist team is clearly informed of the dose and type of treatment prescribed. This should be done verbally over the phone with a GP at least 48 hours prior to discharge; as the prescription needs to be hand written, the dose and type of treatment confirmed and documented within the patients' notes. It is unrealistic to presume that patients will be able to get appointments with GPs on the same day as the hospital discharge. Many patients receive their treatments via daily collections in community pharmacies. 48 hours notice allows time for this to be arranged between the GP and local pharmacy that provides this service. A follow up appointment should be arranged with the GP/specialist team, so that there are no disruptions to a patients' prescribing regime or management.

PREVENTING SELF-DISCHARGE

Whilst the aim should be to ensure that all people are discharged appropriately, there may be times when people will self-discharge.
Your protocol should identify the steps taken to discourage people who are homeless from self-discharge.

The main reasons for self-discharge include:

- care may not fully meet complexity of health and social need
- fear of losing temporary accommodation or benefits
- mental health problems
- drug and alcohol dependency
- discriminatory attitudes from staff and fellow patients.

WHAT TO DO IF A PERSON WHO IS HOMELESS SELF-DISCHARGES

It is good practice to inform any known agency or worker involved with the patient's care. If there is no known contact with any agency, it may be appropriate to alert local specialist homeless services (dependant on level of vulnerability and risk)

RESOURCES

See Fact Sheet 1 for online resources for homeless people and for details of developing your own specialist resources.

This fact sheet has been produced by Homeless Link and updated October 2010.
It relates to the CLG/DH guidance
Hospital Admission and Discharge: People who are homeless or living in temporary or insecure accommodation
(http://www.communities.gov.uk/documents/housing/pdf/154289.pdf)
The five other related fact sheets can be found on the
Homeless Link website (http://www.homeless.org.uk/hospitals

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