

'Pass the Parcel'

An **Investigation** into the
Hospital Discharge Arrangements
for **Homeless People**



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Discharge Arrangements
for Homeless People

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EXECUTIVE SUMMARY

BACKGROUND

This study investigated a perceived problem with unplanned hospital discharges of homeless people to Homeless Services. An independent consultant in conjunction with the Single Homeless Strategy Group undertook the work. The study took place between January and June 2001. It aimed to explore the problem from a range of perspectives, investigate the current situation, review the literature and make recommendations for developing and implementing an effective joint protocol on hospital discharge planning.

The methods used were qualitative: Interviews were carried out with a range of stakeholders, as well as a literature search, and survey of cases in the past year. There were four distinct phases: 1) mapping issues and current services; 2) exploration of external examples and resources; 3) a survey of cases; and 4) a multi-agency steering group was set up to devise and implement a joint protocol.

MAIN FINDINGS

In the main, the problem of unplanned hospital discharges of homeless people was perceived as a problem for Homeless Services. Health Services generally did not appreciate their own role in promoting the health and well-being of homeless people. There was a limited understanding among health professionals of the role and function of Homeless Services, which was often perceived as a 'bed booking service'. Some homeless people were discharged onto the streets or to Homeless Services with no planning whatsoever for their longer term social or housing needs.

There is some way to go in Tayside before embracing the philosophy and aspirations of the draft Health and Homelessness Guidance issued by the Scottish Executive Health Department earlier this year. In Tayside, homelessness was perceived as a housing issue. Interviews with key stakeholders identified shortfalls in services including inadequate resources allocated to community care assessment; pressures on hospital beds and a perception of homeless people as 'bed blockers'; and a lack of specialist resources for instance for detoxification treatment for homeless people with dual diagnosis and those who were generally considered to be 'difficult cases'. Finally, there was a suggestion that the attitudes of health staff to homeless people were less than ideal.

Interviews identified a number of themes/issues including:

- A lack of joint working and joined-up thinking locally but also at national policy level
- No shared perspective and therefore no common understanding of what the problem was
- A lack of individualised planning for some homeless people and poor access to community care assessment
- Poor coordination between agencies, with systems embedded in historical ways of working and cultures that militate against joint working
- Resource issues – inadequate resources allocated for community care assessment, and gaps in suitable accommodation and support options for people with multiple needs and what was considered as behaviour that was more challenging

- Attitudinal barriers and stigma associated with homelessness, resulting in poor treatment from health services.

Both official guidance and practice elsewhere suggested a number of features that should be present in hospital discharge protocols particularly in respect of homeless people. These included:

- Vulnerability to becoming homeless should be identified on admission to hospital
- Discharge planning should begin at the time of admission
- No-one should be discharged from hospital before support has been arranged
- There needs to be an agreed procedure or protocol for coordination and communication between agencies, sometimes this is through a designated worker or team
- There is good cooperation and collaboration between health, housing and social work
- Time is allowed for proper assessment of needs including community care needs
- Housing referral and/or discharge forms should be devised
- Identifying a key member of the team who will act as a keyworker or overall coordinator of the care package.

Despite developing a range of reception, assessment, direct access, move on and supported accommodation in Dundee to meet the needs of homeless people, there were gaps in provision. These were most notably for community care assessment and services to meet the needs of more 'difficult cases'. Many of those who sleep rough or are at risk of sleeping rough, also have mental health and alcohol problems. People who are homeless have diverse needs.

There are no local detoxification or rehabilitation facilities and while local authorities across Tayside have budgets to send individuals onto residential programmes, these funds are limited and there is no formal after-care in place for when they return. Although direct access hostels and the new Reception and Resettlement Project accepted people with drug and alcohol, mental and physical health problems, they did not offer specialist skills and interventions. Freeman (2000) has argued that is important to deliver "well defined interventions by trained staff" as an "essential element in the provision of effective (drug and alcohol) services". It is critical that the problems experienced by homeless people are addressed in a joined up way by services.

It was originally envisaged that the Reception and Resettlement Project at Brewery Lane would perform a clearing-house function for hostel beds, assess individuals' accommodation and support needs and make referrals to appropriate specialist providers. There was clearly potential for this facility to assume increasing importance in relation to planning hospital discharges of homeless people, in conjunction with the Council's Homeless Services Unit, the Lily Walker Centre (LWC).

From the case survey, a number of issues emerged including inappropriate use made of homeless units and the lack of consistent involvement of Housing in community care assessment when homeless people are being discharged from hospital. There are times however, when neither Social Work or Housing are informed of an individual's discharge arrangements.

RECOMMENDATIONS

The findings and review of the literature undertaken point to a number of recommendations which are:

1. In tackling many of the issues raised by this study, the Single Homeless Strategy Group and Joint Executive Group should explore whether it is feasible to adapt initiatives from elsewhere in Scotland, especially having a Housing Officer linked to the Community Mental Health Teams or a Homeless Person's Accommodation Officer responsible for coordinating all homeless referrals from hospitals. (Paragraphs 2.14 to 2.18)
2. There should be a consistent and ongoing assessment of needs amongst homeless people, which might take the form of an ongoing log capturing an individual's needs at any point within the network of homeless services. (Paragraph 3.8)
3. Consideration should be given to developing methods and mechanisms of community care assessment that are sensitive to the particular needs of single homeless people. This should be informed by all stakeholders including homeless people, Social Work, Housing, Health Services and Voluntary sector providers. (Paragraph 3.8)
4. The unmet needs of homeless people must be recorded and made available to planners, purchasers and providers of community care services to enable the development of appropriate future services for homeless people in response to identified need. (Paragraph 3.8)
5. Consideration should be given to developing flexible ways of involving workers responsible for addressing the housing and support needs of homeless people, including hostel staff, in community care assessments. This will require staff training and still recognises the central role of Social Work as budget holders in making the final decisions on the provision of community care services. (Paragraph 3.9)
6. An information pack should be produced for all patients on admission to hospital summarising hospital procedures and specific issues for homeless people. This should be available before discharge. (Paragraph 3.10)
7. A discharge care plan should be devised with all patients taking account of his or her views and those of any relevant agency involved including housing providers. No patient should be discharged from hospital until suitable housing and registration with a GP at least has been offered (Paragraph 3.10)
8. The profile of community care within homelessness services should be increased. The planned development for social care officers from the Drug & Alcohol Team to provide a link service to Dundee hostels will facilitate this by ensuring homeless individuals have better access to a range of community care information, advice and support. Considering a Social Work staff placement with the Reception and Resettlement Project could further strengthen this. (Paragraph 3.11)
9. An effective joint protocol regarding arrangements for the hospital discharge of homeless people, which states that no-one should ever be discharged to homelessness

must be devised, implemented, monitored and reviewed jointly by all agencies. The multi-agency steering group involving Health, Housing, Social Work and Voluntary Sector agencies to consider hospital discharge arrangements should build on the new generic hospital discharge protocol. (Paragraph 3.14))

10. The joint protocol should be part of a working agreement between all agencies and help to build good collaborative relationships. Consideration should be given to the staff and training resources required to implement the protocol including the possibility of a designated member of staff to deal with assessments of homeless people. (Paragraph 3.15)
11. A broader range of individualised accommodation and support accessible to homeless people needs to be created in Tayside. A chronic gap exists in meeting the needs of those homeless people with complex needs especially those with alcohol related psychoses and new ways should be found to meet this shortfall by community care commissioners and providers. This should include residential as well as community-based detoxification and rehabilitation services for homeless people with alcohol or drug problems, as well as addressing the need for after-care. (Paragraph 3.22)
12. As in other parts of the UK, there is an urgent need in Tayside to make some provision of 'high tolerance' accommodation for those who are having difficulty accessing other accommodation. More accommodation with support options should be available for homeless people with mental health problems that exclude them from mainstream tenancies, offering a range of choice in mainstream as well as in supported accommodation projects. (Paragraph 3.23 & 6.7)
13. Future service developments should aim to provide separate housing and support as this has been shown to leads to more individualised solutions. Any service development should involve service users centrally in planning. (Paragraph 3.25)
14. There should be regular direct links between hospital staff and homeless services providers as well as inter-agency training initiatives on homelessness issues to ensure that staff in all agencies are made aware of each others' services, their respective roles and responsibilities and how to make appropriate referrals. (Paragraph 3.26)
15. In discharging their duty to meet the health needs of homeless people, Health Services should ensure all hospital discharges are planned events so that individuals are not discharged back to homelessness or unsuitable accommodation that will hinder the success of other health interventions. (Paragraph 3.27)
16. The potential of the Reception and Resettlement Project at Brewery Lane in conjunction with the Lily Walker Centre, in performing a clearing house function for hostel beds, assessing individuals' accommodation and support needs and making referrals to appropriate specialist providers should be reviewed. (Paragraph 4.17 to 4.18)
17. Housing Services need to be centrally involved from the start in any discharge planning, given time to carry out a housing needs assessment and notified of the plan to discharge an individual at least 5 days in advance. This will require consideration

of effective arrangements for carrying out assessments and recording housing needs. (Paragraph 5.11)

18. The elements of positive hospital discharge identified throughout this study and summarised in paragraph 6.4, should be adopted across Tayside in the new protocol. This includes building good collaborative relationships between key agencies, ensuring early warning systems, ensuring adequate information is passed onto housing and support providers about the individual's health and social needs and details of the care plan, that sufficient time is allowed to plan properly and support packages are in place before individuals are discharged from hospital. (Paragraph 6.4)
19. Current structural barriers preventing effecting joint working on a shared problem should be addressed. This should include tackling the problem of organisations jealously guarding their own funds. Consideration should be given to the idea of pooled budgets to avoid 'passing the parcel'. (Paragraph 6.6)
20. Finally, any vision of how services should be developed has to centrally involve homeless people as well as voluntary sector providers. This has implications for current methods of planning and consultation with homeless people in Tayside. (Paragraph 6.7)

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SECTION 1: BACKGROUND

INTRODUCTION

1.1 Dundee City Council Housing Department Policy & Plans Section commissioned this investigation into the hospital discharge arrangements for rough sleepers and those at risk of sleeping rough, primarily focusing on Dundee but taking cognisance of Tayside-wide provision and issues. 'Rough sleepers and those at risk of sleeping rough' were taken to mean people who are roofless and vulnerable groups who have a history of, or are on the brink of sleeping rough.' According to the Dundee Rough Sleepers Initiative (1997), such groups typically include:

- "Single homeless people with alcohol or drug dependencies and mental health problems
- Young homeless people aged 16-21 years
- Rough sleepers wishing to access accommodation and services
- Hostel residents wishing support to move to alternative or mainstream accommodation"

1.2 The focus of this report is the discharge of patients from acute and other hospital wards including accident and emergency, rather than long-term resettlement programmes. Some people with mental health problems for example, are admitted to acute hospital wards often for short periods for psychiatric help, and later become subject to discharge arrangements. Others are admitted to accident & emergency and medical emergency wards for short periods. This is as distinct from the discharge arrangements being made for people leaving long stay hospitals after several years.

1.3 The work was undertaken by Julie Ridley as an independent consultant on a part-time basis from early January to end of June 2001, and funded by Tayside Health Board through the RSI allocation. By design it has involved a broad based investigation into current issues and problems, working towards developing joint agency protocols. Its purpose was to explore local problems and determine how best to achieve better co-ordination between housing, health and social work in respect of hospital discharges from the acute hospital sector. In the long term, it was expected this work would contribute to ensuring rough sleepers and those at risk of sleeping rough, received accommodation that was more appropriate and support to meet their individual needs.

1.4 At the time of the study, a multi-agency hospital discharge steering group had been meeting for over a year to discuss disparities in the operation of protocols across its hospitals and to rationalise, what at the time were seventeen different protocols, operating to varying degrees of success. It was important that the study built on the work already undertaken in an inter-agency context.

1.5 The problem of unplanned discharge of patients from acute hospitals to the Lily Walker Centre (LWC) or to direct access hostels is not a new problem, nor is it unique to Dundee. There was a perception that this was an increasing problem however, further exacerbated by perceived failings within the community care system. The study has inevitably touched upon the broader context of problems relating to community care implementation, particularly in respect of people with mental health problems. However,

there is not the scope, given the short timescale and limited resources for this project, to address these issues comprehensively. The primary focus remains on acute hospital discharge arrangements.

1.6 Four key questions were addressed by the study:

1. Were people with complex health and social needs being discharged from hospital to the Lily Walker Centre and direct access hostels in Dundee in an unplanned way, and if so why?
2. How could Health and the Local Authority (Housing and Social Work in particular) improve co-ordination and minimise unplanned hospital discharges?
3. What were the accommodation, health and support needs of the homeless individuals being discharged from hospital to the Lily Walker Centre and direct access hostels?
4. What was the match between existing service provision and the emergent patterns of need, and how should this be met?

Project Aim

1.7 The main aim was to investigate the problem of unplanned hospital discharge of homeless people in a critical and independent way, and to facilitate the development of joint protocols in the future. This work was undertaken in conjunction with the Single Homeless Strategy Group.

Objectives

1.8 Initial discussions with key stakeholders identified the following practical objectives;

- To explore and understand the perceived 'problem' from a range of different perspectives.
- To undertake an assessment of the way agencies were or were not, working together to meet the needs of homeless people being discharged from hospital.
- To identify examples of good practice in Scotland and wider.
- To assess how well current accommodation and support services were meeting identified needs, highlighting specific and unmet needs to inform future service planning.
- To evaluate current hospital discharge protocols against the needs identified and compare and contrast with national good practice guidelines and models adopted elsewhere.
- To facilitate the development of joint protocols.

Methods

1.9 The methods used in this investigation were largely qualitative to fulfil the aim and objectives of the project. The information and analysis presented in this report should contribute to future needs assessment. The main methods were face-to-face or telephone interviews, survey, literature search, and initiating a process of joint collaboration through a multi-agency steering group to develop joint procedures. The project had four distinct phases, though in practice these overlapped:

Phase 1: Mapping issues and current services

Phase 2: Exploration of external examples and resources

Phase 3: Case audits

Phase 4: Multi-agency steering group

Phase 1: Mapping issues and services

1.10 One of the initial tasks was to explore perceptions of, and definitions of the 'problem' from different perspectives, and to identify what services existed and any service gaps. This was to ensure the work undertaken was relevant and valid, and aspired to be of practical benefit to key stakeholders. Time was spent initially investigating local arrangements for discharging homeless people from hospital and this informed data collection for the case audits.

1.11 A total of twenty-five face-to-face or telephone interviews were held with a range of stakeholders in Dundee including key staff in the Housing Department Policy & Plans; the Lily Walker Centre; Special Needs Housing Committee; managers of direct access hostels; Homeless Persons Officers in Angus and Perth & Kinross Councils; the Outreach and Resettlement Team; Dundee and Perth & Kinross Councils Social Work Department managers, senior care managers and planners; Tayside Health Board; Tayside Primary Care Trust; Tayside University Teaching Hospital; and the Chair of the Steering Group on hospital discharge protocols in Tayside.

Phase 2: Exploration of external examples and resources

1.12 A basic search of relevant literature, policy documents, and national housing guidance was undertaken and information from other local authority Homeless Services resourced. At the time of the project, a generic Tayside-wide steering group was completing its work on a joint hospital discharge protocol. This and national guidelines on discharge protocols were examined, as well as national and local surveys of hostel residents and recent literature on health and homelessness.

Phase 3: Case Audit

1.13 A survey was carried out to identify the number and type of homeless individuals discharged from hospital to the LWC and direct access hostels during the past year. Requests for information were sent to the LWC, all Direct Access Hostels in Dundee, the Special Needs Housing Committee, the Cyrenians Outreach & Resettlement Team, and Social Work teams at Ninewells and Liff Hospitals as well as the Drugs & Alcohol Team. It was not surprising that overall numbers in any given year would be comparatively small as the main issue is the disproportionate difficulties these cases pose to homelessness provision. The survey identified instances of hospital discharges that were both 'planned' and 'unplanned',

and provided examples of existing arrangements that were working well and those not so. It also highlighted inadequacies in data collection in community care.

Phase 4: Multi-agency steering group

1.14 At the outset the overriding concern of the commissioners of this work, and indeed of many of the stakeholders interviewed, was to improve inter-agency working. As a result, a multi-agency steering group involving key stakeholders in Health, the Local Authorities and Voluntary Sector was set up, building on the work of the multi-agency steering group that had recently drafted a generic protocol for Tayside. This short-lived project group met for the first time on 31st May 01, and further meetings are planned to take place following completion of this study.

1.15 The remit of the group was agreed as:

1. With awareness of current issues and problems, to agree proper multi-disciplinary discharge arrangements for homeless people
2. To establish agreed multi-agency discharge procedures in relation to homeless people

1.16 Monitoring and evaluation of any protocol agreement was recognised as an important element of this process, and arrangements for developing a joint strategy require to be put in place.

SECTION 2: POLICY & PRACTICE CONTEXT

INTRODUCTION

2.1 This review sought to identify relevant literature including guidance, policy and practice papers regarding homeless people's experience of hospital discharge arrangements, as well as research on the community care experiences of homeless people. Literature specifically on homelessness and hospital discharge problems was scant. This section examines the key issues identified from previous research and guidance, including the failure of joint working in this area. It also outlines the policy guidance and studies that have identified good practice features and finally, highlights a number of examples of positive hospital discharge arrangements in Scottish local authorities.

HEALTH & HOMELESSNESS ISSUES

2.2 What is acknowledged across several studies is homeless people's poor access to health services and the higher than average use of accident and emergency departments (A&E) which is often inappropriate to need (Rosengard, 1997; Brandon, 1997; HAS, 1995). A study by Shelter (North, 1996) found over half the visits by both homeless men and women to A&E were inappropriate. Many rough sleepers have at some time stayed in long-stay hospitals, and a high proportion had been to hospital casualty wards (Kershaw et al, 2000). As homelessness can cause severe stress, incidents of deliberate self-harm were common (HAS, 1995). Homeless street drinkers have particular difficulties in accessing the services they need and while they may receive detox treatment when admitted to hospital for an accident or emergency, they do not receive appropriate support services when discharged (Social Exclusion Unit, 1998).

2.3 These and other studies also identify the high incidence of mental illness and alcohol problems among rough sleepers. The Social Exclusion Unit (1998) identified some 30-50% of rough sleepers to have mental health problems. It is common therefore for homeless people to experience short periods in hospitals and therefore to be subjected to hospital discharge arrangements. It is also acknowledged by several studies that these processes fail some homeless people. Anderson et al (1993) found that 1% of homeless people had been discharged from hospitals directly to bed and breakfast accommodation and a further 1% to rough sleeping or the streets. While an infrequent problem overall, as Rosengard (1997) asserts, it is inexcusable and goes against the grain of all good practice guidance (Scottish Office, 1994; 1997). Taylor (1992) concluded that procedures from point of admission to discharge were failing homeless people and required central government guidance specifically on homelessness. A number of factors can influence homelessness on discharge and these include not involving housing providers in planning, assessment and after care and that after-care support is inadequate so that any tenancies or family arrangements break down soon after discharge.

A JOINED-UP PROBLEM

2.4 Much of the literature on community care identifies a problem with joint working and none more so than in meeting the needs of homeless people. While the housing dimension of

community care has been firmly established (Scottish Office, 1994), studies such as Petch et al (2000) report that housing authorities and other providers are still not fully integrated into the process and in particular express frustration around partners' lack of understanding of timescale and stock issues. Rosengard (1997) comments that the tension caused from rationing of services and by disagreements over who is responsible for homelessness, are all too commonplace. In such cases, homelessness agencies and accommodation providers both statutory and voluntary often feel they are left 'holding the baby'.

2.5 The HAS (1995) report argued that because no one department or agency has sole responsibility for the total impact of government policy on rough sleepers, no agency has a specific remit to prevent the causes of rough sleeping or make sure that contradictions in policy, gaps and services shortages were addressed. Brandon (1997) and others point out the need to address homelessness as a diverse problem requiring a multi-agency and holistic response.

2.6 At the time this work was undertaken, major changes were taking place in housing policy and homelessness in Scotland and the UK, in particular renewed emphasis was being placed on joint working and a national health and homelessness coordinator was appointed to oversee implementation of good practice during 2001. Draft guidance on health and homelessness was issued in the Spring 2001 which asserted, "the key to making progress on homelessness lies in increased commitment from health bodies" adding a new requirement for the Unified Boards to produce 3-year action plans. HAS (1995) further underlined the need for intense coordination at local level.

2.7 Key policy developments since the early 1990s have encouraged the growth of targeted and specialist services delivered on a multi-agency basis to address housing, support and health needs. The Rough Sleepers Initiative in 1997 in Scotland and central government policies have encouraged local health authorities to assess the health needs of homeless people in their area, and this is further amplified by the recent draft guidance on health and homelessness.

CENTRAL GOVERNMENT GUIDANCE ON HOSPITAL DISCHARGE

2.8 General guidance on hospital discharges was contained in the NHS in Scotland (1993) guidance on good practice, which identified three key principles of good practice for the discharge of any patient from acute sector hospitals:

1. discharge should take place on the decision of the doctors concerned, as early as is consistent with clinical need;
2. discharge should not take place until any arrangements for post-discharge support that may be required are in place;
3. one member of the team caring for each patient should be given responsibility for ensuring that all necessary arrangements are made.

(NHS in Scotland, 1993, page 6)

2.9 However, this guidance was principally designed to meet the needs of patients discharged to home and to the care of GPs and primary health care teams and did not establish specific procedures for patients being discharged to care in the community. The

development of specific guidance in relation to community care was to be decided locally by health boards and local authorities.

2.10 The Scottish Office Circular (1994) provides clear guidance that hospital discharge protocols, particularly in relation to acute and long stay hospitals, should cover the need to ensure that accommodation and support services are in place for all patients before discharge from the hospital takes place. Specifically the Circular states:

"Patients should never be discharged to a homeless unit, though it is accepted that there are difficulties with patients who discharge themselves." (Para 3.24.1, page 13)

2.11 These pre-discharge considerations were also included in the March 1996 NHS MEL "NHS Responsibility for Continuing Health Care". The Code of Guidance on Homelessness (1997) further underlines the importance of advanced planning to ensure accommodation is available, and check to ensure previous accommodation is still suitable on discharge. This guidance also emphasises joint working and the importance of adopting an interagency approach. Effective liaison between Health, Local Authorities, other housing and support agencies in the voluntary and private sectors is necessary to ensure individuals do not become homeless on discharge from hospital.

GOOD PRACTICE ELEMENTS

2.12 In relation to discharge procedures, but particularly in the case of people with mental health problems, Taylor (1992) recommended a number of key elements should be present. These were:

- **Written information on admission to hospital** - Health boards should liaise with relevant agencies to produce an information pack for all patients admitted to hospital, which should address specific issues for homeless people, outlining possible courses of action prior to discharge;
- **Discharge care plan** - Every patient should have a discharge care plan taking account of his or her views and a community keyworker or coordinator should be responsible for ensuring relevant information from the care plan is available, whilst maintaining patient confidentiality, to the housing provider;
- **Written information on discharge from hospital** - A discharge booklet containing general information should be given to every patient prior to planned or sudden discharge containing information about housing and benefits, how to register with a GP, support in crisis, contact names and addresses for leisure, day services, training and employment opportunities and practical advice on problems with public utilities;
- **Discharge** - No patient should be formally discharged until suitable housing and registration with a GP have at least been offered.

2.13 Much of this good practice is reiterated in the new generic protocol for Tayside whose overall aim is to provide a multidisciplinary approach to discharge planning which will

ensure a seamless service to hospital patients transferring from acute care to community care. Its key objectives are:

- discharge planning is initiated within 24 hours of admission
- all agencies and professionals who will be involved in caring for the patient are involved in discharge preparation
- requirements for post discharge care, where applicable, will be addressed following an assessment of the patient's needs in conjunction with the relatives and carers
- systems are in place that will encourage meaningful communications between the multi agency team and patient/carer/relatives to enable continuity of care following discharge
- system to address the patient's identified care needs will be in place prior to the patient's discharge

EXAMPLES OF ARRANGEMENTS IN OTHER PARTS OF SCOTLAND

2.14 Similar problems are being experienced in other parts of Scotland but some have developed effective inter-agency procedures or protocols to deal with the event of discharging homeless people from hospitals. A brief description of some of these initiatives follows.

West Lothian

2.15 To address the lack of understanding of homeless provision by hospital staff and social work, the Homeless Services in West Lothian organised a seminar to explain how the homelessness services operated and raise awareness of service provision. The seminar was well attended by health staff at all levels and resulted in an agreement that no patient would be discharged without prior notice being given to the Homelessness Team via a named social worker based at the hospital. They also devised an assessment form that is completed on discharge and passed to Homeless Services.

Glasgow

2.16 Glasgow created a housing referral form and procedure to ensure that all potentially homeless people discharged from hospital would be assessed by a senior caseworker from Homeless Services. Emergency caseworkers provide a housing casework service to all hospitals in the area for patients who will be homeless on discharge. At least three days notice is expected prior to discharge to allow an opportunity for social work to complete the housing referral form. The caseworker arranges a visit to assess housing needs and requirements.

North Lanarkshire

2.17 Patients are only discharged from acute psychiatric care through a process of consultation and agreement with the Homeless Person's Accommodation Officer. If short notice, the housing officer will visit and assess housing needs of the individual and the care and support being offered. Decision to proceed with discharge is influenced by the response of the Homeless Person's Accommodation Officer and no-one is discharged without agreement between the council officers and hospital staff.

Inverclyde

2.18 The appointment of a housing officer to the Community Mental Health Team has resulted in a discharge protocol for discharges from acute hospital wards. On admission to hospital a patient assessment is carried out by the hospital based social work or health staff and part of this will determine the patient's current and future housing needs. If established that the person requires assistance finding suitable accommodation then the hospital discharge form is completed and signed by both applicant and referring agency. This assesses among other things, housing history, mental and physical and social health.

SUMMARY

2.19 In summary, both official guidance and practice elsewhere suggest a number of features that should be present in hospital discharge protocols in respect of discharging homeless people. These include:

- Vulnerability to becoming homeless is identified on admission to hospital
- Discharge planning starts from the time of admission
- No discharge is made from hospital before support has been arranged
- There is an agreed procedure or protocol for coordination and communication between agencies, sometimes this is through a designated worker or team
- There is good cooperation and collaboration between health, housing and social work
- Time is allowed for proper assessment of needs including community care needs and the individual's views are taken into account
- Housing referral and/or discharge forms are devised jointly by Social Work, Housing and Health
- A key member of the team acts as a keyworker or overall coordinator

2.20 Lessons can be learned from initiatives in other parts of Scotland briefly described in this report, and applied in Tayside to help address the issues raised by the literature review.

SECTION 3: MAIN THEMES FROM DIFFERENT PERSPECIVES

INTRODUCTION

3.1 In order to shape the investigation and deliver a valid piece of work, it was vital to consult extensively with a network of services in housing, health, social work and the voluntary sector about their experiences and definition of what was causing the problem. Over the course of three months during February to early May 2001, over twenty-five exploratory interviews, mainly face-to-face, were undertaken with stakeholders in health, housing and social work. Some interviewees also identified other key individuals to include and these were, as far as possible, approached for interview. The interview covered the following areas – defining the problem, explanations as to why it was happening and to which agencies, and identifying suggestions and ideas for improving and moving forward.

3.1 In the following paragraphs, the main emergent themes from these interviews are explored. However, a key finding was that definitions of 'the problem' differed according to the agency being consulted and that while the Homeless Services in all parts of Tayside were experiencing problems caused by poor practice in discharging homeless people from hospital, it was perceived as less of a problem by health service staff. Concerns about what was happening in the practice of discharging homeless people across Tayside covered the broad range of community care client groups, but most particularly, mental health; alcohol and drug problems; and to a lesser extent dementia. These concerns reflected specific unmet needs such as a perceived gap in locally based accommodation and support for people who were violent towards others and/or had alcohol or drug problems, and the low range of supported accommodation options available for people with mental health problems and dementia generally.

3.3 These interviews identified a number of themes/issues including:

- A lack of joint working and joined-up thinking locally but also at national policy level
- No shared perspective and therefore no common understanding of what the problem is
- A lack of individualised planning for some homeless people and poor access to community care assessment
- Poor coordination between agencies, with systems embedded in historical ways of working and cultures that militate against joint working
- Resource issues – inadequate resources allocated for community care assessment, and a lack of suitable accommodation and support options for people with multiple needs and challenging behaviours
- Attitudinal barriers and stigma associated with homelessness resulting in poor treatment from health services generally.

ISOLATED PERSPECTIVES

3.4 A key concern identified during the interviews was a lack of shared ownership of the problem. Agencies could more readily identify what responsibilities others had towards homeless people and were keen to pass this on, particularly when faced with making decisions about limited resources. The most apt way to describe this process was that it was like 'pass the parcel': Each agency wanted to avoid holding the 'parcel' when the music

stopped. In sheer frustration at the lack of adequate communication from health when homeless people were about to be discharged, and difficulties accessing suitable services or support, professionals from housing and social work resorted to quoting legislation or guidance at each other to prove beyond a reasonable doubt that the other, and not they, had prime responsibility to 'fix' the problem. As one person at the Lily Walker Centre admitted:

"agencies quote legislation at each other because they don't have anywhere suitable to put the person."

3.5 Public agencies have a clear statutory 'duty of care' towards homeless people, which would appear unfulfilled, particularly in the case of those who exhibit behaviour that is more challenging or require greater support. While the position that no-one should be discharged from hospital to homeless units cannot be disputed (Scottish Office, 1994), neither can the statutory duty of a Local Authority to meet the needs of homeless people in their area, including those who are vulnerable through mental health problems. Furthermore, revisions to Housing legislation imply a strengthening of this function. The diversity of health and community care needs of many homeless people discharged from hospitals mean that no single agency can deal with these issues alone.

3.6 It appeared to those in Housing and Social Work who were interviewed that Health Services had limited appreciation of the role and scope of Homeless Services in coordinating the care of homeless people other than that the Lily Walker Centre was a place to 'dispose of homeless individuals'. After the patient had been discharged, any issues or difficulties in meeting the health and social support needs of the person were not felt to be the concern of health professionals. A respondent from a direct access hostel comments:

"If they were homeless before they came into hospital, then they should go back there. Health don't see it as their problem."

HOSPITAL DISCHARGES TO INAPPROPRIATE ACCOMMODATION

3.7 There were inconsistencies with how long people were kept in hospital that were less to do with patient need than the judgement of individual consultants. Although most patients are discharged to suitable living accommodation, some people who are homeless are discharged to unsuitable accommodation. Interviewees gave examples of patients being discharged from hospital to unsatisfactory accommodation such as bed and breakfasts, hostels not suited to the person's needs, or unsatisfactory circumstances with family or relatives where this had originally contributed to the person's mental state. It was believed that a minority were discharged to rough sleeping. A major problem was being caused by unplanned discharges of patients with multiple needs to the Lily Walker Centre in particular, with Housing Services being left to manage not only the housing aspect but also the wider social and health needs of the individual.

INADEQUACY OF COMMUNITY CARE ASSESSMENT

3.8 A more fundamental gap in planning was suggested by some interviewees. Current assessment processes, including recording of unmet needs, were not providing the information required for planning. The resources allocated to carrying out assessment were

also felt to be inadequate and there were long waiting lists in some teams. Indeed, in the next section the difficulties in gathering descriptive data from Social Work and Housing for the purposes of this study are highlighted. Furthermore, discharge protocols in themselves, no matter how good, would not identify gaps in provision or unmet needs.

3.9 This finding confirmed Birrell's (1998) assertion that homeless people with multiple health and social care needs experience particular difficulties with community care assessments. People with multiple needs often cannot access appropriate community care assessment and feel they are "passed from pillar to post" (Birrell, 1998, page 3). Unless there is proper assessment of health and support needs, suitable support packages cannot be arranged and needs will continue to be unmet. It was suggested there were unresolved difficulties between agencies about the definition of 'vulnerable' patients, and this affected whether they even reached the stage of referral to Social Work for community care and housing assessment. Further, the organisation and segregation of community care into discrete client groups was creating obstacles for homeless people with multiple needs.

3.10 There was also a sense that in respect of homeless people, discharge planning did not occur at the point of admission as ideally it should, and that in some cases, it did not occur at all. The priority of Health was felt by the other agencies to be freeing up hospital beds, not the broader health, housing and support needs of people who were homeless. The consequences of this lack of individual planning were felt by Homeless Services in Dundee, Angus and Perth & Kinross who then struggled to meet the needs of homeless people with multiple needs with little or no information about their needs.

3.11 Community care generally has a low profile within homelessness services. Although in the recent past, placement of a social care officer from the Drug and Alcohol Team in homeless hostels in Dundee had achieved good results, this placement was withdrawn due to pressure on care management resources. Birrell (1998) suggested that homelessness workers need to be more aware of the availability, accessibility and relevance of community care services. Unmet needs for homeless people leaving hospital were just not being recorded. Without this information, planning of future services will be limited. Brandon (1997) affirmed that care planning is essential to homelessness but there was a need to focus this work more clearly.

SHORTCOMINGS IN JOINT PLANNING & WORKING

3.12 While 'Caring for People', 1988 and Modernising Community Care (1998) identified the need for effective joint working in community care, in reality, there was a lack of communication or coordination generally. This reflects the bigger national picture:

"shortcomings in communication and information sharing were particularly acute with regard to people receiving a community care assessment prior to hospital discharge." (Birrell, 1998, p27)

3.13 Poor information sharing between agencies about individuals' health and support needs on discharge exacerbates the problem. While agencies generally acknowledged that 'inappropriate' or unplanned discharges were a minority problem, as one interviewee stated, 'we shouldn't get too hung up on numbers, if one person is struggling in the community, that shouldn't happen'. In some cases, individuals had decided to discharge themselves 'against

medical advice' only later to present at the Lily Walker Centre for example. Although this clearly does happen, it was specifically discharges that were 'unplanned', with limited communication from health, that were the problem and the solution was believed to be in the hands of key agencies dealing with the health and homelessness of the person.

3.14 The need for an agreed protocol between agencies to prevent continuing homelessness and to address the needs of people with multiple needs, was obvious to many interviewees. There was also a need for monitoring and reporting framework of some description to ensure proper implementation. Part of the current difficulties arose from poor coordination between key agencies. This could be resolved through agreeing a joint protocol or procedure to ensure homeless people were not discharged to rough sleeping or homeless units.

3.15 Fine words on paper would not be sufficient however, any protocol would need to be part of a working agreement between agencies, and as one Social Work manager suggested, implementation may 'require designated people based at Ninewells to make this work'. Good collaborative relationships need to be built up and maintained. Absence of a coordinated approach was leading to disputes over responsibilities and poor outcomes for homeless people. While the focus of Health staff was felt to be on relieving 'bed blocking', the problem for Housing was typically how to meet the needs of people with multiple health and support needs – 'No-one has time. There's a lack of information and follow-on coordinated support.'

3.16 One of the identified problems was that of lack of understanding of the role of Homeless Services and hostels, which was further confounded by a sense that 'medical and nursing staff not being signed up to hospital discharge planning policy'. Without proper understanding of the intrinsic role of Housing in meeting community care needs, as well as Health accepting responsibility for continuing health care needs of homeless people, it is impossible to meet or plan to meet individuals' needs appropriately. This sometimes put people at risk, both the individual discharged from hospital whose needs were not met, and other residents who were affected by the person's behaviour.

3.17 It was suggested that mutual understanding and respect for the role and perspectives of different agencies needed to be created. Staff at the LWC and direct access hostels were often untrained to deal with complex mental health needs or drug or alcohol dependency. Yet there was an expectation among health professionals that it was acceptable to discharge people with multiple needs from hospitals to these services, often without supplying much or any information about individuals' health and other needs. Nor was there an appreciation that competent needs assessment took time to undertake: Health staff expected to discharge some individuals on the same day as notice was given, thus leaving little or no room for consideration of housing needs or finding suitable resources.

RESOURCE ISSUES

3.18 Several resource issues were raised as problems by interviewees from reductions in social work budgets leading to a bottleneck in responding to requests for community care assessment, particularly in the area of mental health to pressure on healthcare or community resources:

"Social Work are not resourced to prepare a care plan for everyone leaving Liff hospital. There's a waiting list for assessment" (Social Work respondent)

"It can seem like health staff perceive the problem as a waste of a valuable bed and once the person has left the hospital they are no longer health's responsibility" (Direct Access Hostel respondent)

"There's a dearth of appropriate accommodation and support for people with severe mental health problem." (Special Needs Housing Committee)

3.19 There was a chronic shortage of local detoxification treatment and rehabilitation for people wanting to change their drug or alcohol dependency. Currently Social Work and Health purchase these services from elsewhere in the country, which can create difficulties for individuals returning to Dundee. If, as is sometimes the case, such treatment lasts for a year, the individual will lose their accommodation if it is funded through Housing Benefits. This means they will be homeless when they return and may be forced to seek accommodation in direct access hostels. Few referrals were made to specialist services like TAPS by health staff on accident and emergency wards. Health services were described as "insular" and "institutional".

Community care assessment

3.20 There seemed to be insufficient resources to undertake care management and a need to create a short term breathing space while proper assessment of the person's accommodation and support needs was carried out.

Pressure on hospital beds

3.21 A key issue for Health was often the pressure on beds in acute wards – removing 'bed blockers'. A senior nurse manager at Liff commented, 'there would be immense problems created by a protocol if it meant a prolonged stay for hospital patients.' A senior official from Tayside Health Board commented that 'homelessness is not seen as a priority for health, seen as Housing and Social Work priority' and this is reflected in the lack of attention homelessness receives in either the HIP or the TIP. The primary issue for the Health Board was:

"Speed of discharge. We accept Health is perhaps not taking this issue seriously enough, it should be a shared responsibility, but there's just not enough disposal options."

'Difficult cases'

3.22 Finding appropriate accommodation and support for people with multiple needs and who are often perceived as 'difficult people' was a major problem facing all agencies. Those in Health perceived it to be for Housing and Social Work to find suitable options, rather than a joint responsibility. Access to appropriate resources was further undermined by poor communication and coordination and under-developed working relationships between the key stakeholders. In mainstream homeless and community care services, needs are often compartmentalised into single issues or problems, thus militating against finding a joint solution. When people did not fit the boxes, agencies were unable to meet their needs.

3.23 Resources to meet the accommodation and support needs for so-called 'difficult cases' characterised by Buglass (1988) as physical violence to self and others, verbal abuse, and alcohol problems, were felt to be sorely lacking. The response to individuals without a home, for example those banned from returning to hostels was 'the Homeless Persons Section suggested the social worker should go through B&B lists'. In the long term this was not felt to properly address individual needs. As in the Buglass (1988) study, there were a large number of those interviewed who had experience of people whom they felt unable to provide suitable support and for whom existing services were inadequate. The behaviour most difficult to tolerate was physical violence, especially in resources such as the Lily Walker Centre that were also providing support to families.

3.24 To meet the needs of such people is not easy. As already acknowledged, the difficulty is finding suitable accommodation for the individual with minimal disruption to others, and being able to meet their support needs:

"There is no resource for anti-social, violent clients. Then there are differences of opinions about diagnosis – psychiatric assessment almost always assesses them as not needing psychiatric services." (Social Work)

3.25 At the start of this assessment Comfort and Support in conjunction with the Outreach and Resettlement Team appeared to be providing a partial solution. However, in March 2001, the staff of this hostel moved into new premises at Brewery Lane, providing a mixture of temporary single accommodation and resettlement flats, and it will be for the future to reflect on how this has affected what is offered to difficult cases. It is now generally accepted in other fields like learning disabilities, that it is good practice to separate housing and support and this is a principle worth pursuing with future developments.

ATTITUDINAL BARRIERS

3.26 It was suggested by some interviewees that many health professionals generally perceived homeless people as "undeserving" or "unworthy", and received second-rate treatment. This was especially the case if there were alcohol or drug related problems. People with alcohol problems were "treated as an irritant on the ward". Other research studies have highlighted how hospital-based staff have little knowledge of community resources and assume that problems are chronic and static. It was suggested that there is little awareness of the problems of alcohol dependency combined with homelessness – "not only are some people smelly, they're belligerent and cause problems on the ward and so are not liked". Stigma is a major problem for people with mental health problems and even more so those who are homeless (HAS, 1995). Problems of homelessness may remain hidden by patients and subsequently their needs overlooked. Many homeless people have bad experiences of medical services and therefore a reason to be secretive.

3.27 The Glasgow Review Team's Report (2000) found that homeless people felt they were not well received when they tried to use health services. The Team received reports of inadequate treatment or poor reception at accident and emergency departments. A recent draft guidance on health and homelessness issued by the Health Department, argued that it is difficult to tackle health problems effectively when people are living in poor accommodation

and the success of vital services even where they are available, can be undermined if people are discharged back into hostels or inadequate accommodation.

SUMMARY

3.28 A number of key themes have been identified in this section. Hospital discharges of homeless people were experienced mainly as a problem for homelessness services, not health services and they had little appreciation of their own role in promoting the health of homeless people generally. Difficulties with targeting resources resulted in agencies 'passing the parcel'. There was limited understanding among health professionals of the role and function of Homeless Services, which were often perceived as a 'bed booking service'. Homelessness is perceived as a housing issue in Tayside and there is still some way to go to embrace the philosophy and aspirations of the draft health and homelessness guidance.

3.29 Interviews also identified resource issues including inadequate resources allocated to community care assessment, particularly for mental health, pressures on hospital beds and a perception of homeless people as 'bed blockers' and a lack of specialist resources especially for detoxification and rehabilitation treatment for homeless people with dual diagnosis. Finally, there was a suggestion that the attitudes of health staff to homeless people were less than ideal, and this was their general experience of health services.

SECTION 4: HOMELESS SERVICES LANDSCAPE IN DUNDEE

INTRODUCTION

4.1 The needs of single homeless people in Dundee are addressed by partnership working between statutory and voluntary agencies coordinated by the Single Homeless Strategy Group. The Housing Plan (page 24) describes a 'network of temporary accommodation designed to provide crisis, medium and long-term temporary accommodation catering both for single persons and families', and many new services have been developed in recent years under the Rough Sleepers Initiative. The Housing Department's statutory homeless function is discharged by the Lily Walker Centre.

4.2 The range of accommodation and support in Dundee now includes reception and resettlement facilities as well as outreach support, a furniture project and a rent deposit scheme to assist people wanting to rent accommodation in the private sector. In the paragraphs below, the main reception and emergency/temporary accommodation, move on and supported accommodation for homeless people are described. Mention is also made of specific health services to support people with alcohol and drug problems. Only accommodation services for adults are included which does not include specialist day centres such as the Wishart Day Centre.

RECEPTION & EMERGENCY/DIRECT ACCESS ACCOMMODATION

Reception and Resettlement Project – Brewery Lane

4.3 This relatively new project provides reception, rapid referral and resettlement services, together with direct access/emergency accommodation. This is targeted especially at single homeless people who have been excluded from direct access hostels and offers both accommodation and an agreed resettlement programme. It was envisaged that this project would fill gaps 'for a resettlement service for individuals with challenging behaviour' and make a 'major contribution to the resettlement process as a whole' (The Dundee Reception and Resettlement Project, undated paper).

4.4 The project is specifically aimed at two distinct groups: the rapid referral service is aimed at all rough sleepers and single homeless people; and the accommodation and resettlement support is aimed at individuals with mental health, alcohol or drug problems who, because of their chaotic lifestyle, violence and challenging behaviour, have been refused access to all direct access hostels.

Dundee City Council's Homeless Services Unit – Lily Walker Centre

4.5 The Lily Walker Centre run by the Council's Housing Department, discharges the statutory homeless function under Part II of Housing (Scotland) Act 1987 by providing assessment, advice, information and accommodation for homeless people. In addition to families and pregnant females, this includes homeless people who are vulnerable due to mental illness, disability, old age or other reason and people who are recently discharged from hospital.

4.6 While use of bed and breakfast accommodation is avoided as far as possible, there are a few private B & Bs offering temporary accommodation to homeless people in the City.

4.7 Information collated by Dundee City Council Housing Policy & Plans indicates that take-up of places in direct access/emergency accommodation in Dundee tends to be high (between 89-95% occupancy), with some hostels operating most of the time at full capacity. Although all direct access hostels have residents with drug/alcohol problems, mental health and other community care problems, none of the following provide specialist detox treatment or rehabilitation for people with these problems. Three direct access hostels provide temporary accommodation in addition to the LWC and Brewery Lane. These are Dundee Cyrenians Soapwork Lane, Dundee Survival Group Foundry Lane a night shelter for males aged 16+, and the Salvation Army's Strathmore Lodge.

MEDIUM STAY/'MOVE ON' ACCOMMODATION

4.8 A range of medium stay/move on accommodation is provided in Dundee, offering 107 places. This is provided by the Salvation Army at Strathmore Lodge and Clement Park Lodge, Jericho house, NCH Stopover, the Council's Honeygreen project and its homeless network flats dispersed throughout the city..

SUPPORTED ACCOMMODATION

4.9 Supported accommodation providing full time support and/or has a structured resettlement programme is provided through five individual providers: Dundee Cyrenians provide supported accommodation for single homeless people at the Seagate Project; Dundee Survival Group; NCH supported living project provides supported accommodation for homeless young people; Positive Steps Partnership has a number of individual units of supported accommodation in locations throughout Dundee, building towards 50 units by 2002. It provides furnished flats with a package of personal care and support to single homeless people with drug or alcohol problems, mental health problems, HIV and learning disabilities. SAMH also provides supported accommodation.

COMMUNITY CARE ASSESSMENT

4.10 Homeless people with drug/alcohol problems, mental health problems or other disabilities are assessed for community care services by care managers based in a number of Social Work teams principally the First Response Team at Ninewells Hospital, the team of care managers based at Liff Hospital, and a specialist drug/alcohol team.

4.11 The Special Needs Housing Committee in Dundee initiates and coordinates assessment of housing and support needs, and make decisions on housing allocations with attached care plans.

OUTREACH & RESETTLEMENT SUPPORT

Cyrenians' Outreach & Resettlement Team

4.12 The outreach & resettlement team established in 1998 and managed by Dundee Cyrenians, refers rough sleepers to accommodation providers, provides a resettlement programme with clients of direct access hostels, liaises with support agencies to highlight needs especially in relation to community care, and provides outreach resettlement support to individuals in their own homes. By definition the team works with some of the most difficult to place people. The team works with accommodation providers to maximise the number of permanent tenancies and provides resettlement/follow up support to these tenants.

Social Work support services

4.13 Many current hostel users have community care needs including drug or alcohol problems, mental health problems, learning disabilities and physical disabilities and HIV. The Social Work drug and alcohol team provides specialist intervention and assessment and care management to individuals, families and carers who are experiencing problems relating to drug or alcohol use. In addition to community care assessment, the team is able to refer on to specialist services including detox and rehabilitation services, and offer specific individual counselling approaches.

4.14 There is also a service funded from RSI and Crisis grant to help homeless people gain access to accommodation in the private rented sector through a rent deposit guarantee scheme.

Table 1: Summary table of homeless provision by type of accommodation offered: direct access/move on/or supported accommodation

| Name of provision | Type of accommodation | | |
|----------------------------|-----------------------|---------------------|---------------------------|
| | Direct Access | Medium stay/move on | Supported |
| Soapwork Lane | 32 | 0 | 0 |
| Seagate Project | 0 | 0 | 15 |
| Brewery Lane | 20 | 0 | 0 |
| Strathmore Lodge | 45 | 5 | 0 |
| Clement Park House | 0 | 25 | 0 |
| Jericho House | 0 | 11 | 0 |
| NCH Stopover | 0 | 6 | 0 |
| NCH Supported Living | 0 | 0 | 4 |
| Dundee Survival Group | 14 | 0 | 10 |
| Positive Steps Partnership | 0 | 0 | 27 |
| SAMH | 0 | 0 | 11(6 outreach, 5 in unit) |
| Lily Walker Centre | 21 | 0 | 0 |
| Honeygreen Project | 0 | 10 | 0 |
| Homeless network flats | 0 | 60 | 0 |
| TOTAL | 132 | 107 | 67 |

4.15 In addition to the Homeless Services, there are Community Mental Health Teams offering multi-disciplinary support to people with mental health problems and two main specialist health services provided for people with drug and alcohol problems: the Tayside Alcohol Problems Service, Tayside Primary Care NHS Trust and the Drug Problem Centre.

As a secondary health care service, TAPS aims to provide health care and treatment for people with alcohol related problems in Tayside. Interventions include individual therapy, care/treatment package, psychiatric assessment and support and guidance for relatives/carers. The Drug Problem Centre (DPC) provides a range of professional services including needle exchange.

4.16 There are also a small number of houses in multiple occupancy, private sector enterprises that are unregulated but increasingly subject to regulation. Many people have been displaced from such accommodation in recent years and this has created new demands on existing emergency, move on and supported accommodation.

SUMMARY

4.17 Despite developing a range of reception, assessment, direct access, move on and supported accommodation in Dundee to meet the needs of homeless people, there appears to be limited resources for care management, and a limited range of specialist treatment services in the area for those with drug and alcohol problems. There are for example, no local detoxification or rehabilitation facilities and while local authorities across Tayside have budgets to send individuals onto residential programmes, these funds are limited and there is no formal after-care in place for when they return. Although direct access hostels and the new reception and resettlement project accept people with drug and alcohol, mental and physical health problems, there is no specialist provision. Freeman (2000) argued that it was important to deliver "well defined interventions by trained staff" as an "essential element in the provision of effective (drug and alcohol) services".

4.18 It was envisaged that the Reception and Resettlement Project at Brewery Lane would perform a clearing-house function for hostel beds, assess individuals' accommodation and support needs and make referrals to appropriate specialist providers. There is clearly potential for this facility to assume greater importance in relation to planning hospital discharges of homeless people, in conjunction with the Council's Homeless Services Unit.

SECTION 5: CASE AUDIT 2000/2001

INTRODUCTION

5.1 During March-May 2001 a survey of planned and unplanned hospital discharges to Homeless Services during the previous year from 1st April 2000 to 31st March 2001, was carried out. Forms were sent to all the direct access hostels, the Lily Walker Centre, Outreach & Resettlement Team, Social Work Teams at Ninewells, Liff and the Drug/Alcohol Team, and the Special Needs Housing Committee. Its purpose was to substantiate and illustrate the problems being faced by Homeless Services in relation to hospital discharges.

5.2 Completed returns were received from three of the homelessness services – the Lily Walker Centre, Clement Park House and the Dundee Survival Group- and care management teams at Liff and Ninewells hospitals. On 24th April, the Senior Care Manager for the Drugs/Alcohol Team wrote that there were no new cases referred to this team during the reporting period. Whilst the Comfort and Support Centre had reported problems in 1999, there were no relevant statistics available for the reporting period. This was similar for the Outreach & Resettlement Team.

5.3 The paragraphs below summarise the findings of this survey.

KEY FINDINGS

5.4 As expected, while not a major problem in quantitative terms, unplanned discharges from hospital to homeless services and direct access hostels had a disproportionate impact on these services. In short, the key issues raised by the survey were that:

- Basic information recorded by the LWC and direct access hostels was generally low key, thus making it difficult to substantiate a problem;
- The greatest difficulty regarding unplanned discharges was experienced by the LWC;
- Individuals discharged from accident and emergency wards in particular had been declared 'medically fit' for discharge, but more often than not there was no assessment of housing or social needs;
- There was evidence of both planned and unplanned discharges. Good as well as bad practice existed, arising from the different criteria for accessing services and the quality of individual inter-agency relationships;
- Assessment of homeless people's housing and support needs in many cases was as basic as 'assessed as statutory homeless' and there was room for creating a more comprehensive housing assessment in community care;
- The information gathering drew attention to poor sharing and coordination of information about individuals being discharged;

- There was a small number of 'difficult cases' who challenged all agencies, mainly due to their violent behaviour and alcohol problems;
- Guest houses were used as a last resort but considered to be an unsuitable option for people with multiple needs, especially when violence is an issue.

5.5 From the table below it can be seen the majority of homeless people were discharged from Ninewells or Liff hospitals. In the case of the Dundee Survival Group (DSG), five out of eight were referred to them from the Lily Walker Centre, and are therefore duplicated in the figures for the LWC. Discharges to Clement Park on the other hand were exclusively from Liff Hospital and direct to this hostel. Further, as Clement Park is not a direct access hostel, all discharges were planned.

5.6 Respondents indicated that all had been discharged as 'medically fit' or 'ready for discharge' by health services staff, apart from two individuals who had self discharged against medical advice and subsequently presented at the LWC.

Table 2: Number of individuals by homeless service discharged from specific hospitals between 1st April – 31st March 2001

| Hospital discharged from | Lily Walker Centre | Dundee Survival Group | Clement Park | Total |
|--------------------------|--------------------|-----------------------|--------------|-----------|
| Ninewells | 16 | 4 | 0 | 20 |
| Liff | 9 | 0 | 8 | 17 |
| Murray Royal | 0 | 1 | 0 | 1 |
| Sunnyside | 0 | 2 | 0 | 2 |
| Strathmartine | 1 | 1 | 0 | 2 |
| Ashludie | 1 | 0 | 0 | 1 |
| TOTAL | 27 | 8 | 8 | 43 |

5.7 Just over half of the discharges to the LWC were felt by staff at the Centre to be 'unplanned'. In all these cases, the LWC was either informed on the day of discharge or the person arrived at the Centre unannounced. The greatest number of these was from Ninewells (8 out of 16 were unplanned discharges), and Liff (5 out of 9 were unplanned discharges). There was one unplanned discharge to the LWC from Strathmartine Hospital. Six out of eight were felt by the DSG to have been planned, that is, the DSG had been given some notice however short, and an appropriate level of information about the person's health and support needs. The two unplanned discharges at the DSG were received from Strathmartine and Sunnyside Hospitals.

5.8 The majority of individuals discharged from all hospitals to these particular services were male, but the proportion of females is perhaps higher than in the general single homeless population. (67% male: 33% female). The age profile of those discharged varied from 18 years to over 60 years as is shown in the following table:

Table 3: Age range of homeless people discharged from hospitals to Homeless Services

| Age range | Number |
|----------------|-----------|
| Under 20 years | 2 |
| 20-29 | 7 |
| 30-39 | 13 |
| 40-49 | 5 |
| 50-59 | 13 |
| 60+ | 3 |
| TOTAL | 43 |

5.9 Over half (56%) of cases were assessed by respondents to have mental health problems. These ranged from 'psychiatric issues' to 'schizophrenic illness'. A third had severe alcohol problems, and a quarter, a physical health problem such as asthma, angina, or fractured limbs. The following table summarises the results:

Table 4: Type of health problems identified by survey respondents

| Specific problems | LWC | DSG | Clement Park | TOTAL | |
|---------------------|-----|-----|--------------|--------|----|
| | | | | Number | % |
| Mental health | 12 | 4 | 8 | 24 | 56 |
| Alcohol misuse | 9 | 4 | 1 | 14 | 33 |
| Physical health | 6 | 4 | 1 | 11 | 26 |
| Behavioural | 5 | 0 | 0 | 5 | 12 |
| Physical disability | 3 | 1 | 0 | 4 | 9 |
| Drug misuse | 1 | 0 | 2 | 3 | 7 |
| No information | 1 | 0 | 0 | 1 | 2 |

5.10 While data was not collected in Perth & Kinross and Angus, discussions with the Homeless Persons Officer in each Council confirmed that the problem was perceived to be similar in that the difficulties created were disproportionate to the size of the problem. These councils experience most problems with the Murray Royal and Sunnyside Hospitals, though the situation in Perth & Kinross had recently improved with the implementation of the mental health panel.

5.11 In general, problematic or unplanned hospital discharges were those where:

1. The individuals concerned had a history of violence and 'behavioural' problems that were difficult for any service, including health services, to cope with;
2. There was no prior involvement of the Housing Department in assessing individual needs;
3. There was little or no notice given to homelessness services before discharge. Individuals tended to be discharged and either present at, or Homeless Services were notified of the discharge the same day.

5.12 The following three individual case studies involving discharges from different hospitals in Tayside illustrate the nature of 'inappropriate' or unplanned hospital discharge, how individuals' needs were not met, and the challenge of 'difficult cases'.

Case Study 1

5.13 The following case study illustrates inadequate communication and the difficulties meeting the needs of people with challenging behaviour.

5.14 In December 2000, a 40 year old woman was discharged from Strathmartine Hospital with no prior warning to either Social Work or Housing. This woman was said to have "a long history of problems concerning her mental state" and was well known to the Housing Department and homeless hostels. Although assessed as 'statutory homeless', her case was still to be assessed by the Special Needs Housing Committee while she remained in Strathmartine. Previous placements in homeless hostels and the LWC had ended badly "due to client's extremely challenging behaviour".

5.15 In December 2000, she was driven from Strathmartine Hospital to the LWC and left on the pavement outside with her belongings in a couple of black bags. When the LWC contacted the hospital they were informed that her behaviour in the hospital had been unacceptable (e.g. smashing windows) and she had requested discharge from hospital. They had obliged by bringing her to the LWC. The woman became very distressed and although a place was temporarily found at the DSG where the staff found her needs too complex to meet, she was subsequently readmitted to Strathmartine Hospital and there is now a fear that events will repeat themselves.

Case Study 2

5.16 This case illustrates how difficult it can be for rough sleepers to access appropriate health services:

5.17 In January this year, a 35 year old male was discharged from Ninewells accident and emergency department to the LWC after a brief telephone call from the First Response Team, a faxed Homeless Application Form, and handwritten brief details and a phonecall from a staff nurse to enquire about a bed. This man had been taken by Police to Ninewells after being found lying unconscious in the street. He had alcohol problems and was in a poor state of health, and had been assessed by a CPN as having "possible underlying depression". As he was banned from most direct access hostels and others were full, he was discharged back to the streets. The LWC was full and there were concerns about booking this man into a 'family centre' due to his history of 'challenging behaviours'.

Case Study 3

5.18 This case study from the then Comfort & Support hostel, again illustrates the problems caused by inadequate communication, and poor understanding of the role of homeless provision. It refers to an incident in 1999.

5.19 A staff nurse at the Perth Royal Infirmary telephoned asking if she could "book" someone in. C&S advised that this was not their procedure and later that day the patient arrived by ambulance at the door. The ambulance driver informed the hostel that the man had a bed with them but the hostel refused to admit someone without a full referral giving details of his medical history etc. The driver was advised by his controller to leave the patient and carry on with his other duties. However, the coordinator of C&S was unhappy

with this situation and telephoned the ambulance controller. The LWC were made aware of the situation and eventually the Medical Coordinator at the PRI apologised for the mix up between the care manager and the medical team and the patient was taken back to the PRI for an appropriate discharge to be arranged.

SUMMARY

5.20 From this survey, a number of issues have been identified including the inappropriate use made of homeless units and the lack of consistent involvement of Housing in community care assessment when homeless people are being discharged from hospital. There are times however, when neither Social Work or Housing are informed of an individual's discharge arrangements. The role of the LWC and the new Reception and Resettlement project appear to be little understood by health professionals.

SECTION 6: DISCUSSION

6.1 Whilst service boundaries remain rigid, homelessness continues to be perceived as primarily a Housing issue, even within a local authority and despite community care legislation promoting joined-up thinking and joint working. As Taylor (1992) recommended, Housing Departments require to review procedures for assessing vulnerability under the homeless persons legislation and take account of social as well as medical factors. The new health and homelessness guidance should provide a clearer steer for how joined up services might develop in the future.

6.2 Recent Health Department guidance on health and homelessness identified the need to increase awareness of homelessness in mainstream services. A lack of understanding of homelessness can influence the responses of professionals. This investigation supports the assertion in the guidance that training and other events should be used to increase awareness of the needs of homeless people and to foster a better understanding of the roles of different professionals. The guidance identifies the need to include training on homelessness in the professional education of health care staff. Regular direct links between hospital staff and housing providers could improve and influence practice in relation to homeless people. Training and inter-agency work hold the key to changing the negative perceptions and attitudes of some professionals towards homeless people.

6.3 There is an urgent need for more effective joint planning and joint working within community care to meet the needs of homeless people. Overall, sharing of information is under-developed and happens on an ad hoc individual basis. Information systems and methods of collecting information appear to be inadequate for planning appropriate support. Community care assessments of homeless people's needs were often sketchy. Good practice in terms of hospital discharge protocols were not being adhered to locally – homeless people were being discharged to homeless units and there were major gaps in assessing individuals' housing and social support needs. A rationalisation of local protocols was taking place at the time of the study, culminating in a single generic protocol to be applied across Tayside. This should now be built upon by drafting a sub section specifically dealing with homelessness.

6.4 The elements of positive hospital discharge protocols identified throughout this study were:

- Good collaborative relationships built up between professionals in health, housing and social work;
- Early warning of future discharge plans to allow social work and housing to undertake a proper assessment of needs;
- Information about an individual's health needs provided including physical and mental health problems and disabilities and details of the care plan;
- Sufficient time allowed to plan properly;
- Proper support packages in place before the person was discharged from hospital.

6.5 A service culture that compartmentalises needs both in terms of single agency solutions and in the perception of homelessness as a Housing problem, does not serve homeless people well. Poor communication and coordination between the main agencies of health, housing and social work were found in this study to be creating unnecessary obstacles to appropriate care. If a homeless person has one problem then it is easy to support them, but if as many of the people this study touched upon, they have multiple needs then it is vital that problems are tackled from an inter-agency perspective.

6.6 As Thompson (1996) says there is a need to break down the structural barriers which lead departments and organisations to jealously guard their funds and not take on responsibility for an individual who could be passed on to another agency. They prefer instead to pass the parcel. This is not however, an effective way forward. Future solutions may require pooled budgets.

6.7 There were insufficient accommodation and support options when looking to discharge 'difficult cases' from acute hospitals with the result that they often fell through the net, sometimes it was not clear what had happened to them, presumably they were discharged to rough sleeping. Similar to other areas of the UK, there is a need in Tayside to make some provision of 'high tolerance' accommodation for those who are having difficulty accessing other accommodation. Yanetta (1999) in reviewing the RSI concluded that this is a key element to any strategy for eliminating rough sleeping. This study did not explore the perspectives of homeless people themselves. In building a vision of how services should be developed however, it would be important to involve homeless people. Given that this was one of the original aspirations for the development at Brewery Lane, this vision should quite critically involve the voluntary sector.

6.8 Finally, the Health Advisory Service (1995) report outlined eight elements of good practice in providing community mental health services for homeless people that could be applied to the range of services in Tayside:

1. drop-in services with self referral – services needing no appointment
2. liaison and advocacy roles emphasise the requirement for an holistic approach to service commissioning and provision
3. work in partnership with voluntary and community groups
4. emphasis on listening
5. effective information and publicity
6. multi-agency working
7. high quality clinical expertise with built in evaluation
8. outreach work and out-of-hours services

SECTION 7: KEY RECOMMENDATIONS

The findings and review of the literature undertaken point to a number of recommendations which are:

- 7.1 In tackling many of the issues raised by this study, the Single Homeless Strategy Group and Joint Executive Group should explore whether it is feasible to adapt initiatives from elsewhere in Scotland, especially having a Housing Officer linked to the Community Mental Health Teams or a Homeless Person's Accommodation Officer responsible for coordinating all homeless referrals from hospitals. (Paragraphs 2.14 to 2.18)
- 7.2 There should be a consistent and ongoing assessment of needs amongst homeless people, which might take the form of an ongoing log capturing an individual's needs at any point within the network of homeless services. (Paragraph 3.8)
- 7.3 Consideration should be given to developing methods and mechanisms of community care assessment that are sensitive to the particular needs of single homeless people. This should be informed by all stakeholders including homeless people, Social Work, Housing, Health Services and Voluntary sector providers. (Paragraph 3.8)
- 7.4 The unmet needs of homeless people must be recorded and made available to planners, purchasers and providers of community care services to enable the development of appropriate future services for homeless people in response to identified need. (Paragraph 3.8)
- 7.5 Consideration should be given to developing flexible ways of involving workers responsible for addressing the housing and support needs of homeless people, including hostel staff, in community care assessments. This will require staff training and still recognises the central role of Social Work as budget holders in making the final decisions on the provision of community care services. (Paragraph 3.9)
- 7.6 An information pack should be produced for all patients on admission to hospital summarising hospital procedures and specific issues for homeless people. This should be available before discharge. (Paragraph 3.10)
- 7.7 A discharge care plan should be devised with all patients taking account of his or her views and those of any relevant agency involved including housing providers. No patient should be discharged from hospital until suitable housing and registration with a GP at least has been offered (Paragraph 3.10)
- 7.8 The profile of community care within homelessness services should be increased. The planned development for social care officers from the Drug & Alcohol Team to provide a link service to Dundee hostels will facilitate this by ensuring homeless individuals have better access to a range of community care information, advice and support. Considering a Social Work staff placement with the Reception and Resettlement Project could further strengthen this. (Paragraph 3.11)
- 7.9 An effective joint protocol regarding arrangements for the hospital discharge of homeless people, which states that no-one should ever be discharged to homelessness

must be devised, implemented, monitored and reviewed jointly by all agencies. The multi-agency steering group involving Health, Housing, Social Work and Voluntary Sector agencies to consider hospital discharge arrangements should build on the new generic hospital discharge protocol. (Paragraph 3.14))

- 7.10 The joint protocol should be part of a working agreement between all agencies and help to build good collaborative relationships. Consideration should be given to the staff and training resources required to implement the protocol including the possibility of a designated member of staff to deal with assessments of homeless people. (Paragraph 3.15)
- 7.11 A broader range of individualised accommodation and support accessible to homeless people needs to be created in Tayside. A chronic gap exists in meeting the needs of those homeless people with complex needs especially those with alcohol related psychoses and new ways should be found to meet this shortfall by community care commissioners and providers. This should include residential as well as community-based detoxification and rehabilitation services for homeless people with alcohol or drug problems, as well as addressing the need for after-care. (Paragraph 3.22)
- 7.12 As in other parts of the UK, there is an urgent need in Tayside to make some provision of 'high tolerance' accommodation for those who are having difficulty accessing other accommodation. More accommodation with support options should be available for homeless people with mental health problems that exclude them from mainstream tenancies, offering a range of choice in mainstream as well as in supported accommodation projects. (Paragraph 3.23 & 6.7)
- 7.13 Future service developments should aim to provide separate housing and support as this has been shown to leads to more individualised solutions. Any service development should involve service users centrally in planning. (Paragraph 3.25)
- 7.14 There should be regular direct links between hospital staff and homeless services providers as well as inter-agency training initiatives on homelessness issues to ensure that staff in all agencies are made aware of each others' services, their respective roles and responsibilities and how to make appropriate referrals. (Paragraph 3.26)
- 7.15 In discharging their duty to meet the health needs of homeless people, Health Services should ensure all hospital discharges are planned events so that individuals are not discharged back to homelessness or unsuitable accommodation that will hinder the success of other health interventions. (Paragraph 3.27)
- 7.16 The potential of the Reception and Resettlement Project at Brewery Lane in conjunction with the Lily Walker Centre, in performing a clearing house function for hostel beds, assessing individuals' accommodation and support needs and making referrals to appropriate specialist providers should be reviewed. (Paragraph 4.17 to 4.18)
- 7.17 Housing Services need to be centrally involved from the start in any discharge planning, given time to carry out a housing needs assessment and notified of the plan

to discharge an individual at least 5 days in advance. This will require consideration of effective arrangements for carrying out assessments and recording housing needs. (Paragraph 5.11)

- 7.18 The elements of positive hospital discharge identified throughout this study and summarised in paragraph 6.4, should be adopted across Tayside in the new protocol. This includes building good collaborative relationships between key agencies, ensuring early warning systems, ensuring adequate information is passed onto housing and support providers about the individual's health and social needs and details of the care plan, that sufficient time is allowed to plan properly and support packages are in place before individuals are discharged from hospital. (Paragraph 6.4)
- 7.19 Current structural barriers preventing effecting joint working on a shared problem should be addressed. This should include tackling the problem of organisations jealously guarding their own funds. Consideration should be given to the idea of pooled budgets to avoid 'passing the parcel'. (Paragraph 6.6)
- 7.20 Finally, any vision of how services should be developed has to centrally involve homeless people as well as voluntary sector providers. This has implications for current methods of planning and consultation with homeless people in Tayside. (Paragraph 6.7)

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