

## FACT SHEET 5

# DEVELOPING ACCOMMODATION PATHWAYS FOR MENTAL HEALTH IN-PATIENTS WHO ARE HOMELESS

This Fact Sheet is number 5 of 6, all of which link to and provide background information for the guidance on producing a protocol for the Admission and Discharge of People from Hospital.<sup>1</sup> The other Fact Sheets in the series are:

- Fact Sheet 1 Web based resources on homeless services or developing a hospital intranet
- Fact Sheet 2 The Housing Act and examples of letters to local authorities for medically vulnerable patients
- Fact Sheet 3 Housing Status
- Fact Sheet 4 Developing integrated care pathways for homeless people
- Fact Sheet 6 Patients with no recourse to public funds

### TARGET AUDIENCE

This factsheet is intended to support professionals who work with inpatients on psychiatric wards who are at risk of homelessness

### STRATEGIC CONTEXT

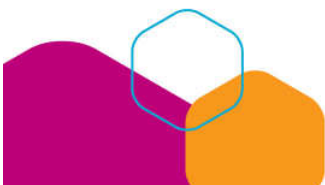
The previous Government and the London Mayor of London committed to ending rough sleeping by 2012 and much progress has been made. Effective hospital discharge pathways are an essential element to achieving this aim.

### PREVENTING ROUGH SLEEPING OR OTHER HARM

Ward staff should be aware of homeless service users being perceived as 'difficult to engage' by services or non-concordant with treatment. They may need to remain in hospital longer than average due to a multiplicity of needs. Discharge must be 'safe and timely' and to appropriate accommodation. Discharges from hospital to the streets or to no fixed abode should be considered a Serious Untoward Incident (SUI).<sup>2</sup>

<sup>1</sup> <http://www.communities.gov.uk/publications/housing/hospitaladmission>

<sup>2</sup> Incident reporting in the NHS focuses on any occurrence which has the potential to cause serious harm, where there has been a service failure, and where the likelihood exists that public or media interest will result in damage to the NHS.



## PARTNERSHIP AND PROTOCOLS

Protocols and staff roles will need to have been agreed at a local level to enable ward staff to act appropriately and consistently. These should include:

- A health and housing services discharge protocol with agreement regarding information exchange, and joint working. Two examples are the Newcastle and Bristol Hospital discharge and homeless prevention protocols<sup>3</sup>
- Access to the internet to use [Homeless UK](#) or local directory of housing schemes and services (see Fact Sheet 1)
- A local supported housing referral pathway, and eligibility and referral procedures (including review and appeal systems) agreed locally between health services, the local authority and housing providers
- Supported housing procedures which are clear, consistent and accessible (including standard forms, policies regarding timescales for supported housing referrals, and clear roles of accountability e.g. Camden housing provider resources<sup>4</sup>
- A Delayed Transfer of Care Protocol ('delayed' service users entered on a 'register' and protocol outlines key processes and responsibilities)
- Specialist Roles: Delayed Transfer of Care Coordinator role (to lead on specific aspects and improve practice). Housing Liaison/link Worker (to work between housing and health services)
- A Safeguarding Adults policy (focus on service user vulnerability at home, potential abuse and exploitation). e.g. development of a police liaison policy<sup>5</sup>

## GOOD PRACTICE CHECKLIST

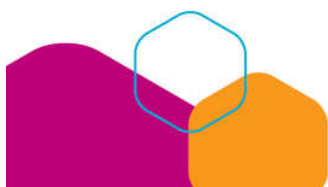
### a) Admission

- Ensure Home Treatment Teams have undertaken the initial assessment and care plan as per their responsibilities (which will include housing status, purpose of admission, blockages to discharge, and any potential to become 'delayed' on the ward)
- Record housing status (tenure) on admission i.e. 'street homeless' or threatened with homelessness, or in temporary or unsettled accommodation (Factsheet 3 provides more information about recording housing status).

<sup>3</sup> [www.newcastle.gov.uk/wwwfileroot/nhf/HospitalDischargeProtocolfinalHousingResourcePackupdatedFeb09.pdf](http://www.newcastle.gov.uk/wwwfileroot/nhf/HospitalDischargeProtocolfinalHousingResourcePackupdatedFeb09.pdf)  
[www.homelessdirect.org.uk/policyandinfo/issues/rsportal/bristolhospital](http://www.homelessdirect.org.uk/policyandinfo/issues/rsportal/bristolhospital)

<sup>4</sup> - [www.camden.gov.uk/ccm/content/housing/general-housing-information/supporting-people/hostels-pathway---provider-resources.en](http://www.camden.gov.uk/ccm/content/housing/general-housing-information/supporting-people/hostels-pathway---provider-resources.en)

<sup>5</sup> <http://www.rdash.nhs.uk/wp-content/uploads/2009/11/9.-Police-Liaison-Policy.pdf>



- If street homeless or at risk of homelessness on discharge, contact the relevant local authority's Housing Options team to alert them to the situation. This provides the time and opportunity for them to assist and prevent homelessness prior to discharge. Press for statutory assessment under the homelessness legislation (Part 7 of the Housing Act 1996). See Fact Sheet 2 for details of local authority duty to house homeless people.
- Make contact with housing support workers, either in temporary accommodation (such as in a hostel), floating support. If the individual has been sleeping rough, check if they are known to local street outreach team.<sup>6</sup>
- Ensure arrangements for sharing information with housing support workers are in place, including inviting them to care planning meetings.
- Complete basic housing assessment on the ward, either by housing options or by ward staff.
- Ensure eviction prevention work commences if appropriate (risks to tenancy) by care coordinator, named nurse or housing link worker (if in place).
- Housing Benefits (Benefits Agency) informed of admission and discharge, and effect of hospital admission on welfare benefits clarified to service user.<sup>7</sup>
- If service user has been evicted, check if there has been an 'end of tenancy' report from previous (supported) housing provider i.e. reasons for eviction.
- Ensure service user is allocated a care coordinator within 7 days of admission, and a Named Nurse (and Associate Nurse) on day of admission.<sup>8</sup>
- Ward Information on housing options, support and advice available and accessible to service users: [Homeless UK](#) and [Homeless London](#)<sup>9</sup> (See Factsheet 1 for further web based resources).

#### **(b) Inpatient care**

- Social Needs checklist completed (including basic welfare rights check). Ensure access to specialist welfare rights advice and assessment, including debt advice (e.g. The Mortgage Rescue Scheme and Homeowner Mortgage Support)
- Report disrepair and environmental health issues at home to landlord and/or environmental health. Offer advice about disrepair and other issues<sup>10</sup>

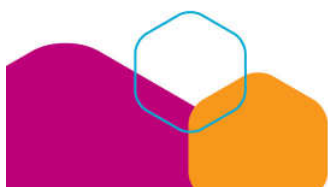
<sup>6</sup> Through CHAIN if London based - Combined Homeless and Information Network 0207 710 0562 [www.broadwaylondon.org/CHAIN/AccessToCHAIN](http://www.broadwaylondon.org/CHAIN/AccessToCHAIN) or London Street Rescue [www.thamesreach.org.uk](http://www.thamesreach.org.uk).

<sup>7</sup> [www.direct.gov.uk/en/DisabledPeople/HealthAndSupport/Hospitals/DG\\_4000474](http://www.direct.gov.uk/en/DisabledPeople/HealthAndSupport/Hospitals/DG_4000474)

<sup>8</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_083647](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083647)

<sup>9</sup> <http://www.homelessuk.org> and [www.homelesslondon.org](http://www.homelesslondon.org).

<sup>10</sup> [www.adviceguide.org.uk](http://www.adviceguide.org.uk) <http://england.shelter.org.uk>



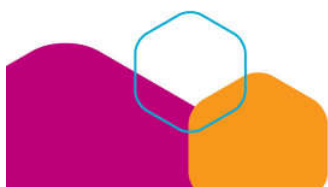
- Consider home assessment visit to verify condition of property
- Key ward meetings: formulation of multi-disciplinary team meeting after 72 hours (includes summary of housing situation)
- Ward reviews and professional meetings (ensure housing and housing support professionals invited)
- Delayed Transfer of Care/Bed Management Meeting held (main focus is on list of homeless, unsettled accommodation clients)
- Care Plan and statement of need – includes housing issues, and risk of homelessness (consider if Section 117 of Mental Health Act 2007 applies)
- Assessments: community care assessment under NHS and Community Care Act 1990) and risk assessment (incorporates housing aspects and how risk impacts on housing) completed (ensure tri-morbidity assessed, as mental and physical health problems co-exist with substance mis-use)
- Occupational Therapy Activity Daily Living Assessment (ADL) completed if appropriate. Check if there is there ongoing therapeutic inpatient work on core skills preparing for discharge.
- Mental Capacity assessment completed if appropriate
- Consider Carer's Assessment/family involvement (share information and include carer in planning meetings)

### **(c) Housing related referrals**

- Floating support and practical support referrals completed (if needed) for specialist housing related support e.g. 'Grime Squad', de-clutter of home, escorting to appointments, etc
- Information Sharing Protocol<sup>11</sup> or agreement between the Mental Health Trust, the Housing Department and housing support organisations in place
- Ensure that clients consent (to additional information being passed over to housing services) is in writing
- Ensure all housing communications recorded in progress notes clearly

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<sup>11</sup> [www.housingcorp.gov.uk/server/show/ConWebDoc.12842](http://www.housingcorp.gov.uk/server/show/ConWebDoc.12842)



- Provide key documents for housing services, proof of identity, income, benefits, plus clinical documentation, risk assessment, ADL, core assessment
- Clinical reports to clarify that client is 'fit for discharge' and, where statutory homelessness assessment is being made, provide information about the service user's mental health that may have a bearing on whether they are 'vulnerable' for the purposes of the homelessness legislation. (see Fact Sheet 2 for examples of letters)
- Consider 'Choice Based Lettings' allocation process (and assistance with online application process)
- Supported Housing referrals and assessments in place including service user preparation, escorting to appointments, and use of the appeals process
- Referrals to specialist services: Dual Diagnosis, Employment and Training, counselling services (see new guidance<sup>12</sup> from NMH DU on homeless clients and likelihood of deprivation and trauma in their early life)
- Presentation to Mental Health Funding Panel if service user requires residential care or a bespoke package of care. Panel checklist in place listing essential key clinical documentation required (core/risk assessment, care plan, statement of need, ADL,
- Forensic report, plus care plan from placement, statement of need and timescales for resettlement, move-on from placement)
- Continuing care assessment to ascertain if continued NHS healthcare and NHS-funded nursing care is required
- PALs is there to ensure that the NHS listens to patients and helps to resolve their concerns. They can offer advice and representation.<sup>13</sup> For legal advice or representation approach MIND's legal line.<sup>14</sup>
- For service users with no recourse to public funds, ensure direct liaison with local authority and access to specialist legal advice. (see Fact Sheet 6)

#### (d) Discharge process

- Discharge checklist in place (include checking if service user has access to a 'habitable' home, working utilities, travel arrangements, money, G.P registration)
- Medical discharge summary by ward doctor includes housing status on discharge
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<sup>12</sup> <http://www.nmhd.org.uk/complextrauma>

<sup>13</sup> Patient Advice and Liaison Services - [www.pals.nhs.uk](http://www.pals.nhs.uk)

<sup>14</sup> tel: 0845 225 9393 email: [legal@mind.org.uk](mailto:legal@mind.org.uk)



- If discharge is against medical advice (DAMA), record housing situation or temporary address
- Discharge CPA meeting, including discharge planning
- Discharge care plan and crisis contingency plan (housing and housing support), 7 day aftercare (face to face contact) and follow-up target (include focus on any ongoing housing issues). This is reinforced by the National Suicide Prevention Strategy for England (2002)
- Significantly housing and support services come within the Mental Health Act's Section 117. Local Section 117 procedures and guidance can ensure that housing provision is a key component of after-care provision

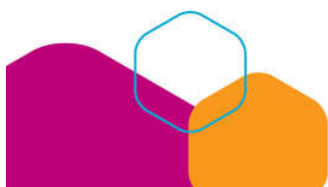
#### **Section 117 Aftercare responsibilities**

Section 117 (Mental Health Act 1983) places on Health Authorities (Primary Care Trust's) and social services authorities a statutory joint duty to work together to provide aftercare services (*these are free as there is no power to charge*) for all patients who have been detained in hospital under a treatment Section of the Mental Health Act (Section 3 – Admission for Treatment, Section 37 – Hospital Order with Home Office restrictions, and Section 47 and 48 – Transfer of prisoners, remand prisoners to Hospital). Local Authorities have a duty to provide whatever after-care services are assessed as necessary '*until such time as the Health Authority and the Local Authority are satisfied that the person concerned is no longer in need of such services*' (Mental Health Act 1983, Section 117/2)

- Community Treatment Orders allow doctors to place conditions on the treatment of detained patients who are discharged from hospital, and this can include specifying where a patient lives. No one on a Community Treatment Order (CTO) should be discharged from Section 117
- Support and encouragement with social inclusion and community participation

#### **(e) Delayed Transfer of Care (DToC) clients**

Service users who are 'medically fit for discharge' but who are delayed on the ward for social or accommodation purposes are classified as Delayed Transfer of Care or Delayed Discharges. It is a Department of Health requirement that all DToC's are prioritised and reported to the Strategic Health Authority.





## Commissioning Support for London

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The five other related fact sheets can be found on the Homeless Link website:  
<http://www.homeless.org.uk/hospitals>

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