A Social Work Practice Perspective on addressing Homelessness for Mental Health Service Users

'There's no place like home'

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Building a Better Health Service | Seirbhís Sláinte Níos Fearr á Forbairt

Introduction to Kildare West Wicklow MHS

Population
Approx. 240,000

Lakeview Unit
29 beds

DOP, Portlaoise
up to 10 beds

High Support Hostels
23 beds

VFC- 73 beds
as per 2016
census figures

Challenges Identified

Delayed Discharges

- **Baseline data:** On 7th July 2015 our baseline data indicated that **34%** of occupied beds in Lakeview Unit on this date were delayed discharges. *"An individual is considered to be delayed in their discharge if they are considered by their treatment team to be fit for discharge, but were awaiting appropriate accommodation".*

- **Reasons for delayed discharges:** On analysis of data from the Service User's Individual Care Plans, it was evident that there were two reasons for delayed discharge: lack of access to accommodation for homeless service users and challenges in identifying and accessing specialist care placements .

- **Requirement for cross-sectoral approach:** In relation to the cohort of Service Users with delayed discharges due to homelessness, this problem could not be resolved by the HSE in isolation as it crossed boundaries with other community based services i.e. Local Authority.

Legislative & Policy Context

Housing Act 1988

- Section 2, Defines Homeless to include those living in a hospital, county home or other such institution and is unable to provide accommodation from his/her own resources.

Housing (Miscellaneous Provisions) Act 2009

- Section 37
- Each Housing Authority must prepare an Action Plan to address Homelessness

Regional Management Group

- Establish the Regional Homelessness Consultative Forum- meets quartley
- Preparation and Monitoring of the Homeless Action Plan
- Review Homeless presentations across the HAP Scheme
- Discharge Policy from Hospitals and Prisons
- Oversight, governance and implementation of Homelessness Action Plan

Homeless Action Team (HAT)

- An MDT Approach to solving the needs of homelessness persons/families and facilitates proactive interagency case management
- To respond to the needs of client in emergency accommodation holistically
- To reduce duration of stay in emergency accommodation
- To reduce the cyclical nature of homelessness
- To ensure co-operation between agencies

Housing First (Rebuilding Ireland Action Plan)

Aims to support a person experiencing homeless into permanent housing as quickly as possible without any preconditions and to provide support on any issues e.g. addiction/ mental health once housed.

Method

- **Responsibility for Housing:** The government Department tasked with responsibility for housing is the Local Authority in each area, in our case Kildare County Council. The only way for our Service Users to access accommodation is through Kildare County Council. With this in mind we were cognisant of the fact that we needed to build a relationship and form a partnership with Kildare County Council Housing Department in order for our service to be able to address the issue of delayed discharges due to homelessness.

- **Relationship building:** Our method of relationship building was to apply our clinical knowledge to a systems problem i.e. our initial step was to address the underlying problem of breakdown in communication. I secured a place as the Mental Health Service Rep on the Kildare County Council Homeless Action Team (HAT).

- **The HAT:** This is a Multi Agency group, chaired by the Local Authority which meets monthly to discuss cases of people who are homeless and have various other complex needs e.g. mental health difficulties, addiction, forensic history.

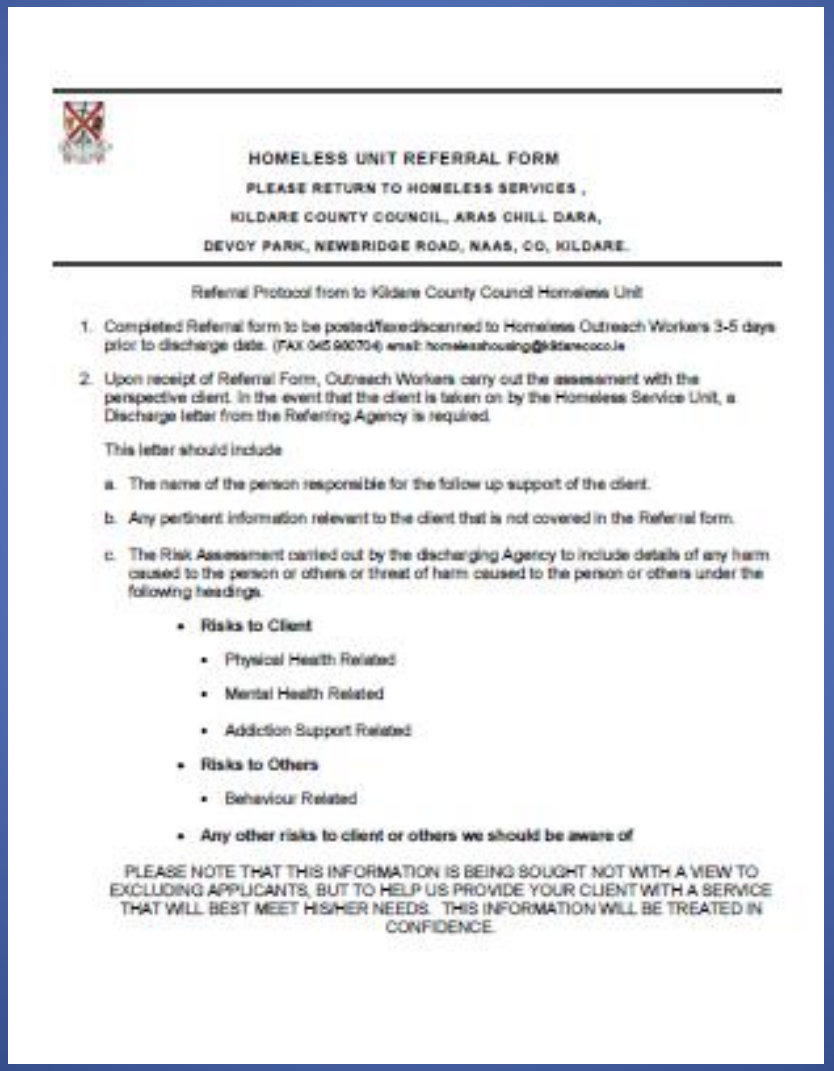
- **Pathway:** I have been attending HAT meetings on a consistent basis since 2018. I shared expertise and knowledge and opened communication channels between our service and Kildare County Council. Over time a level of trust developed and we agreed on the shared goal of achieving a pathway for Service Users from MHS to access homeless services at time of discharge.

Implementation

- **Engagement** - We worked in partnership with Kildare County Council and in consultation with relevant stakeholders (Consultant Psychiatrists, Nursing Staff and Social Work Team) with oversight from the HAT and under the governance of the Policy Committee, to develop a Referral Form which would act as a key communication tool between the Service User, the Mental Health Service and Kildare County Council.

- **Consent re: Data Sharing:** One of the key issues identified during these consultation meetings was how to achieve a balance in relation to giving enough information that the Local Authority are able to accurately assess risk in order to identify a suitable accommodation option, while maintaining a level of confidentiality for the Service User. It was agreed to integrate a signed consent section at the end of the form to ensure that the Service User is fully aware of the exact information that is going to be shared and the purpose it will be used for.

Referral Form



HOMELESS UNIT REFERRAL FORM

PLEASE RETURN TO HOMELESS SERVICES ,

KILDARE COUNTY COUNCIL, ARAS CHILL DARA,

DEVOY PARK, NEWBRIDGE ROAD, NAAS, CO, KILDARE.

Referral Protocol from to Kildare County Council Homeless Unit

1. Completed Referral form to be posted/faxed/scanned to Homeless Outreach Workers 3-5 days prior to discharge date. (FAX 045 900704) email: homelesshousing@kildarecoco.ie
2. Upon receipt of Referral Form, Outreach Workers carry out the assessment with the perspective client. In the event that the client is taken on by the Homeless Service Unit, a Discharge letter from the Referring Agency is required.

   This letter should include

   a. The name of the person responsible for the follow up support of the client.

   b. Any pertinent information relevant to the client that is not covered in the Referral form.

   c. The Risk Assessment carried out by the discharging Agency to include details of any harm caused to the person or others or threat of harm caused to the person or others under the following headings.

      - **Risks to Client**
        - Physical Health Related
        - Mental Health Related
        - Addiction Support Related
      - **Risks to Others**
        - Behaviour Related
      - **Any other risks to client or others we should be aware of**

PLEASE NOTE THAT THIS INFORMATION IS BEING SOUGHT NOT WITH A VIEW TO EXCLUDING APPLICANTS, BUT TO HELP US PROVIDE YOUR CLIENT WITH A SERVICE THAT WILL BEST MEET HIS/HER NEEDS. THIS INFORMATION WILL BE TREATED IN CONFIDENCE.

Discharge Pathway for Service Users who are Homeless
Lakeview Unit, Kildare West Wicklow Adult Mental Health Service.

Identify Need

- At initial Individual Care Plan review, identify the service users accomodation needs as part of the preliminary discharge plan.

Provide information

- If the Service User is homeless, explore options and explain the process of referral to Kildare County Council Homeless Team in order to support them to access emergency accomodation at time of discharge.

Refer

- Identify the most appropropriate MDT members to complete the referral form in collaboration with the Service User.
- Agree an estimated date for discharge in partnership with the Service User.
- Send the Referral Form to Kildare County Council Homeless Team.

Assessment

- Kildare County Council Homless Team give a committment to provide an assessment within 5 working days of receiving the referral.
- An Outreach Worker from the Homeless Team meets the Service User at Lakeview Unit to complete their assessment and discuss accomodation options.

Discharge

- The Outreach Worker contacts the Service User and nominated MDT member directly to inform them of the decision and to make an offer of emergency accomodation.
- At this point the Service User can acept the offer of emergency accomodation or decide to find their own accomodation on discharge.

Problem:

Delayed Discharges for Service Users who are Homeless

Why?
Because: No accommodation options for discharge
Lack of coordination, communication and planning

Why?
Because: No protocol in place
Lack of consistent approach to discharge

Why?
Because: Breakdown in trust and communication with Local Authority

Resolution:

No incidents of Delayed discharge due to Homelessness in our service

Local Authority provide accommodation option
Implement agreed protocol
Integrate agreed protocol in service's relevant PPPG

Seek governance oversight from Services PPPG Committee
Seek consensus through consultation with relevant stakeholders

Build trust, develop a collaborative working relationship with Local Authority

Key Learning Points

- **Discharge Planning begins at point of admission-** effective discharge planning is a significant piece of work that requires time to ensure all required aspects are considered

- **A clear protocol that is integrated into the services Discharge Policy-** ensures consistency and guidance for all staff

- **Co-ordinated and Consistent approach-**fosters open communication channels between all relevant stakeholders

- **Transferability-** This discharge pathway can be replicated across all acute healthcare settings once there is effective communication among all relevant stakeholders, a commitment to building and maintaining relationships with the Local Authority and consensus on the shared goal; to improve access for Mental Health Service Users to accommodation at time of discharge and in doing so delivering a higher quality of care.

- **Care, Compassion and Trust-** Our service demonstrates care and compassion for Service Users through our commitment to ensuring they have appropriate accommodation at time of discharge. We build trust through clear and open communication and by developing all plans in partnership and collaboration with the Service User. This increases our ability to deliver a higher quality of care.

- **Results- Improving access for our Service Users** to their basic human right-accommodation at time of discharge and access to their local Homeless Team. It has supported our service to **deliver a higher quality of care** to our Service Users.

Pathway to Allocation

Complete Housing Application

- Accessing Support from SW with required documents
- Access to Commissioner of Oaths

Submit Application

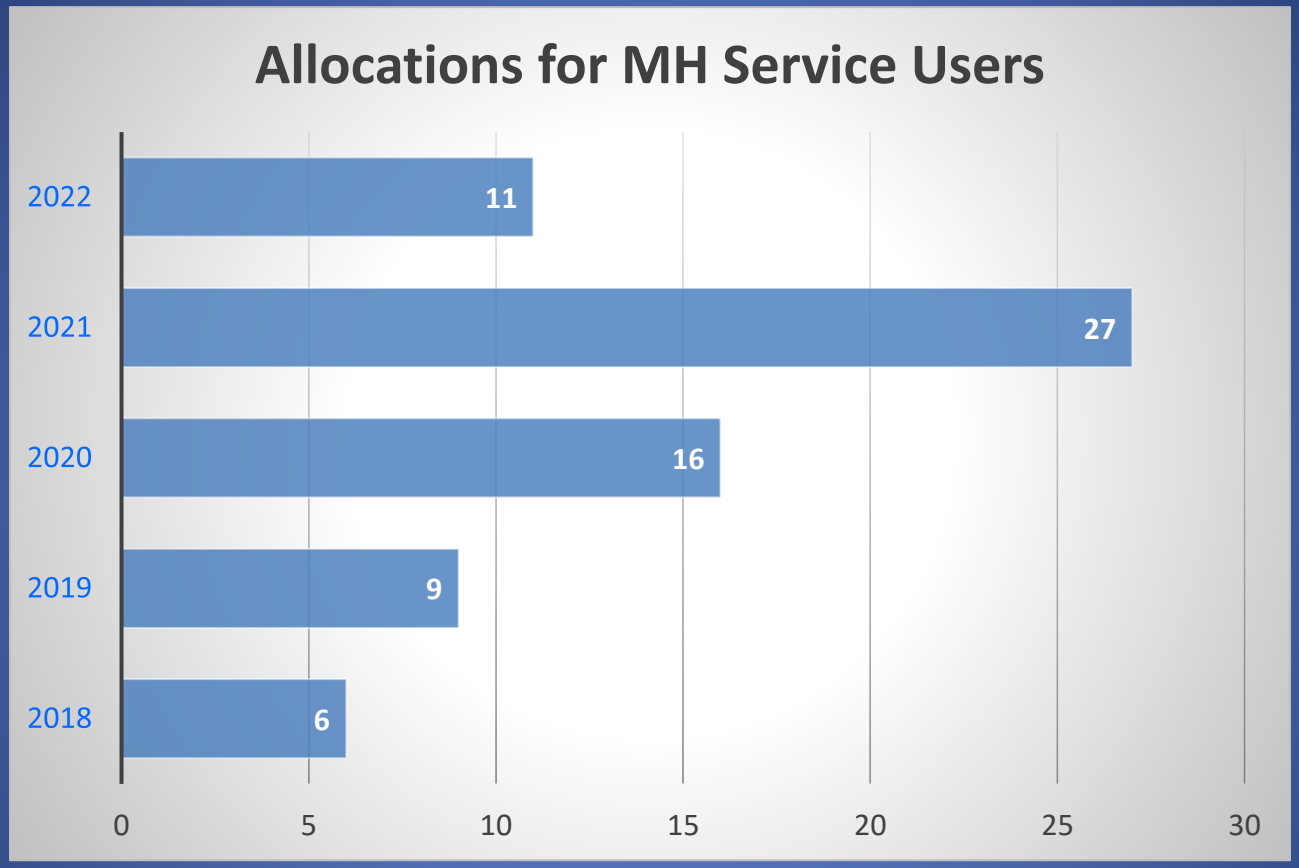
- Direct contact with member of Allocations Team
- Confirm receipt and timeline for assessment
- Follow up until confirmation received that SU is on Housing List

Follow on Support

- Support with accessing Emergency Accommodation
- Support to negotiate HAP system
- Advocacy for allocation directly with Allocations Team or through HAT
- Referral to Creating Foundations HSW
- Referral to Housing First

Continued Support from CMHT, HSW, TSO etc. to ensure Tenancy is maintained

Results



- 69 allocations in total in past 5 years, 12 were for Hostel Residents
- Housing First started in 2020- 2 of total
- 8 of 2021 total are HF
- 2 HF 2022 to date
- This data does not include The Mental Health Property Transfer Project (8 in KWWMHS)

Discussion/ Q & A