Preventing Delayed Transfer of Care and accessing settled Housing:

Good practice for inpatient mental health services

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1 Introduction and Executive Summary

This paper considers good practice to ensure safe, timely and appropriate discharge from inpatient mental health services for service users who are clinically 'fit for discharge' but who are delayed on the ward (delayed transfer of care patients). It is focused on adult mental health services (for those aged 18 – 65 years), but will have relevance to all inpatient mental health services. It sets out some of the key elements that will assist in reducing delayed transfers of care, and provide commissioners and practitioners with a framework to improve someone's experience of acute mental health care.

A key message is that health services should regard housing needs as central to the care they deliver not the responsibility of some other agency. Across inpatient and community mental health services delayed discharge, accessing and sustaining accommodation is 'everyone's responsibility'. Developing effective alternatives to admission is good for service users and preventing delayed discharges ensures the appropriate use of costly acute admission beds in the locality.

'A lack of appropriate housing can be a significant contributor to delayed discharge from hospital. A lack of housing or support can also lead to increased readmission rates, over-use of residential care and, in some cases, the use of out of area or other high-cost services. Investment in housing and housing-related support can contribute significantly to reducing demand on acute and specialist services' - (Practical mental health commissioning 2011)

1.1 Target audience

Commissioners, inpatient staff, mental health practitioners within the multidisciplinary team, and housing services.

1.2 Strategic context

Acute inpatient care is expensive, and is best used judiciously and appropriately. In 2001/2, there were 3,202 adult acute admission mental health beds in London. In 2008/9, the total was 2,830 (a fall of 10%) and this total has continued to fall. As occupancy rates are high, and as crisis resolution and home treatment teams increasingly manage service users at home, the inpatient population has become characterised by patients with very severe mental health problems. An accommodation pathway project in Leeds (2009) found that 30-40% of people admitted to acute wards require support with accommodation. London has a higher rate of admissions for people with a diagnosis of schizophrenia than the rest of the country, and the region also has higher rates of service users detained under the Mental Health Act. With the demand on in-patient beds being high it is imperative that costly delays do not occur for those who are 'fit for discharge'. However 'home treatment' can only work if the service user has a home.

A cautious indicative cost of delayed transfer of care in London is 19 million per year based on Department of Health figures for 2009. The estimated average inpatient psychiatric over-night bed stay nationwide is £280 (London Health Observatory indicative costs as of March 2010), and the figure in London is expected to be higher.

The NHS could save money if a Trust was to book a superior double room in the Dorchester, Park Lane per night*. Under such an arrangement, a service-user could benefit from continental breakfast, marble bathroom, private lobby, plasma screen and internet access.

* The weekend rate at the Dorchester as advertised on www.yourreservation.net on 12 March 2010. The cost of the Superior Queen room is £275.62 inclusive of continental breakfast.

1.3 Recovery and Social Inclusion

'Inpatient services must be conceived as stepping stones for inclusion, not departure points for exclusion' (Creating accepting communities, MIND Enquiry, S.Dunn,1999). Improving discharge pathways (including consideration of appropriate accommodation) from mental health wards is 'key' to promoting recovery and social inclusion. 'No Health Without Mental Health' (HM Government, 2011) highlights the importance of efficiency and prevention across the acute care pathway avoiding unnecessarily long hospital stays.

There is a strong link between prolonged lengths of stay for mental health inpatients and the risk of social exclusion. However, opportunities for active community participation, engagement and re-integration can be promoted from a mental health inpatient environment. For example, contact can be made with training and welfare organisations, the local learning and skills council, further education colleges, employment, sports and leisure services, Citizens Advice Bureaux, befriending groups, and the police.

Homelessness is a health issue because mental ill health is a cause and consequence of homelessness. Being homeless and without shelter, safety, or security puts one at risk of poor mental health (of being admitted to hospital), and poor mental health puts one at risk of homelessness. Department of Health guidance on the discharge needs of people who are homeless states that all hospitals should ensure that people are not discharged to inappropriate accommodation, nor discharged as homeless, nor become homeless as a result of their hospital stay. Housing is central to a recovery focused pathway.

1.4 The consequences of delayed discharges and overcrowded wards include:

For service users

- Potential delays in admitting appropriate at risk patients or premature discharge of others
- Increased risk of dependence on inpatient care (institutionalisation), loss of coping skills and skills for independent living
- loss of employment and risk to tenancy
- Damaged/loss of key relationships and social support networks e.g. partners, friends, family, and work colleagues
- Stressed, bored and anxious inpatients
- Risk of increased frustration and increased risk of aggression and violence on
- wards

For staff

- Negative impact on morale, retention and recruitment
- Overstretched staff and limited staff patient engagement

For commissioners

- Additional unnecessary costs of inpatient care for individuals
- Additional unnecessary costs associated with funding places additional to existing contracts (private sector beds)

- Potential additional costs of placing service users out of their local area (out of area placements)

1.5 Department of Health definition of Delayed Transfer of Care

A mental health delayed transfer of care occurs when a patient is ready to depart from acute mental health care and is delayed. A patient is ready for transfer when

a. A clinical decision has been made that patient is ready for transfer *and*
b. A multi-disciplinary team decision has been made that patient is ready for transfer *and*
c. The patient is safe to discharge/transfer.

(Source -SITREPS 2003/4 Definitions and Guidance/Dept of Health Version 1: Sept 2003)

2 Commissioners

2.1 The importance of preventing delayed transfer of care for commissioners

Commissioning more effective services which meet and support housing needs will deliver better management of local health systems and will be a sound financial investment. It will also help in the provision of better quality, and more productive and innovative services, contributing towards the prevention of relapse in people who have used mental health services. The QIPP programme (Quality, Innovation, Productivity and Prevention) in the NHS aims to improve quality and productivity, whilst engaging staff, applying best practice and measuring benefits.

A new commissioning structure will see clinical commissioning consortia take on responsibility for commissioning the bulk of primary and secondary mental health services, supported by a National Commissioning Board. The need for services to provide effective assessment and discharge arrangements should be reflected in health, social care and wellbeing strategies and relevant contracts for service provision. Health and Wellbeing Boards will be the vehicle for health and wellbeing strategies and the provision of rehabilitation, recovery and reablement services.

This section highlights some of the contributory factors and obstacles influencing delayed discharge and preventing settled accommodation for individuals in hospital, and looks at how commissioners can work to assist access to services, and commission services which reduce health inequalities.

A shortage of local housing options

Alternatives to hospital admission and discharge options ought to be coordinated by local partnerships ensuring effective choices and access for users of services (to housing provision and housing options). This is largely managed through Supporting People, which is the government programme for funding, planning and monitoring housing-related support services. It is important that commissioners of health services are active participants in these forums, highlighting needs that are not met and gaps in provision. Commissioners of health services can directly commission specialist provision or work alongside local authority colleagues to joint fund appropriate provision, such as ‘step-down’ or intermediate provision.

With the current culture of ‘throughput’ which characterises the inpatient pathway people who need longer hospital stays or further intensive treatment and rehabilitation can be at risk of being discharged pre-maturely from the acute ward. Therefore commissioners and providers may wish to sustain or develop local rehabilitative facilities which are able to provide specialist recovery orientated longer-term engagement with service users. Allied to this is the case for an active community rehabilitation team, especially as the gap between inpatient service provision and supported housing can be difficult to manage. If supported housing schemes and community rehabilitation teams work effectively to promote recovery and independence this is likely to lead to less need for costly ‘Out of Area Treatments’. Nevertheless there may be a case for maintaining a limited amount of inpatient rehabilitation beds for service users who require interventions in this setting.

When designing services, commissioners and providers need to address the needs of excluded groups who are not engaging with services e.g. people with drug and alcohol needs. Such individuals with a multiplicity of needs also require housing services, which are comfortable, safe and personalised e.g 12 bed hostel in Richmond, **http://spearlondon.org** . Often such service users do not meet individual agency service thresholds despite the scale of their problems, and they find themselves without access to settled housing and housing support.

Lack of interagency collaboration and coherence between health, social care and housing

Collaborative working is essential to ensure that the role of housing in care pathway planning is recognised and prioritised. The Joint Strategic Needs Assessment (JSNA), considers the wider determinants of health, identifies current and future health and wellbeing needs and informs future service planning. Mental health and wellbeing are public health issues and housing, for instance, is as important in tackling mental health problems as health services. Mental health services must be integrated with housing services and housing related support services.

Health and social care commissioning decisions are underpinned by Local Area Agreements and strategies such as a local Mental Health Accommodation Strategy. It is part of the commissioner’s role to stimulate discussion, lead the agenda on health and wellbeing issues, and contribute to conflict resolution between agencies. Collaborative commissioning is characterised by working with clinicians, the multi-disciplinary team and community partners (local authority, housing, third sector, service users and their families and carers) in planning and designing services (service specifications). Commissioners can stimulate the market by encouraging voluntary sector provision which invests in local need e.g. supported housing and housing link services. Commissioners have an important role in managing the local health care system by effective use of resources, encouraging improvement and innovation.

Poor clinical practice, concentrating on patient containment rather than therapeutic opportunities

Patient centred services improve the patient experience across the care pathway; listen to and consider the needs of the public, patients and carers, their housing aspirations and priorities e.g as well as accessible housing options, patients may want to raise issues around housing choice and preference in terms of location.

Inadequate integrated working across inpatient and community mental health services, and a dis-connection between inpatient and community teams remains an obstacle preventing settled accommodation. Commissioners may engage Trusts in a dialogue regarding

recruitment, skills, retention, and workforce solutions, and encourage training and programmes to support staff development, increasing quality and capability.

Strategic planning groups

Strategic planning groups (e.g. Mental Health Partnership Board) can provide strategic direction for local acute care services and monitor the interface between community teams and acute inpatient services. Their role is to build relationships with commissioners, local (social care) partnerships and strategic decision making groups. Such groups can assist commissioners to identify pressures on inpatient services, evaluate strengths and weaknesses of acute care services; encouraging scope for improvement in reducing length of stay and delayed discharges.

2.2 Data for analysing and planning

Delayed discharge summaries can assist commissioners by providing information and evidence on the effectiveness of hospital discharge arrangements. Such reports can include:

- basic information on ethnicity, section 117 aftercare status, borough of origin
- housing status, on admission and discharge, for all service users
- numbers of people with 'no recourse to public funds' on the wards
- for service users classified as delayed transfer of care, the reason for the delay and the responsibility for the delay (this may change according to where the service user is on the care pathway)
- overall bed days delayed

In addition Commissioners may want to monitor housing outcomes such as numbers discharged to temporary accommodation, unsettled accommodation, and the destination for the 'no recourse to public fund' service users.

Commissioners will want to be informed about long-term delayed service users, who have not been placed. This will inform service planning if for instance a pattern develops regarding certain service user groups (e.g. service users with dual diagnosis in need of high supported accommodation or intensive rehabilitation).

This data will feed through to a range of local planning initiatives, such as the Joint Strategic Needs Assessment. Trusts are able to collect and utilise information which will inform discharge planning and support the case for the availability of appropriate and alternative housing, support and care options i.e to highlight where a shortage of accommodation exists or where the wrong 'mix' of provision is an obstacle to discharge.

2.3 Sit Rep Reports on delayed transfer of care for Department of Health

Since April 2006 weekly situation reports (SitReps) have included details of delayed transfers of care in all non-acute and mental health NHS trusts. These codes categorise the reason and responsibility for the delay. Every Trust provides data for their Strategic Health Authority on the number of service users who are delayed and the reason for the delay. MHMDS (Mental Health Minimum Data Set) and SitRep data on delayed discharges supports commissioning and service remodelling.

Within the current rules service users who are ready for discharge/transfer from acute inpatient care are delayed either due to a lack of health or social care provision (i.e. some

failure by the health service or local authority). Which service is responsible for each individual delay should be agreed jointly (and mechanisms must be in place to ensure this occurs) between the local authority and the health authority. This is an opportunity for constructive joint working.

Problems with current SitReps data collection

The main challenges with delayed transfer of care data are firstly ensuring consistency of classification (i.e clear agreement over the issue of when a service user becomes officially a delayed transfer of care patient). Secondly, Department of Health acute categories could be revised for the mental health (non-acute) sector, so that a clear list of mental health appropriate reasons for each delay exist.

3 Good Practice

3.1 The integrated acute care pathway

An 'integrated' acute care pathway refers to integrated working arrangements between services and agencies, so hospital and community elements of the acute care service work together to support the service user from initial referral to discharge from acute services.

Agreed threshold for admission

Admission must be purposeful, therapeutic and safe (Acute inpatient mental health service review, Healthcare commission, 2007). The lack of a clear role and purpose for acute inpatient care is a contributory factor influencing delayed discharge. Mental health services need to be clear what risks constitutes an "acute" episode, requiring inpatient psychiatric treatment; what can appropriately be supported by 24-hour crisis resolution/home treatment teams both in terms of preventing admission and in facilitating early discharge.

Key aspects of acute inpatient care and practice:

- Multi-disciplinary ward practice is the basis for productive and therapeutic engagement, working towards timely, safe, and appropriate discharge
- Crisis resolution/home treatment teams undertake the gate keeping role for admission and facilitating early discharge
- Critical to good care planning must be a multi-professional comprehensive risk assessment informing any decision to admit
- The initial assessment, risk assessment and care plan ought to include priority needs and interventions and any indications of any blockages to discharge.
- A 72 hour Formulation meeting (focusing on the initial care plan, priority needs, purpose of admission, factors likely to block discharge identified) is good practice
- It is a requirement that a core or comprehensive (health and social care needs) assessment be completed for all inpatients (NHS and Community Care Act 1990) and this assessment must be updated prior to discharge
- The holistic assessment must establish accommodation needs, and encompass issues associated with housing, homelessness and resettlement
- Physical health needs should be assessed within 72 hours
- A 'transfer of care' can be arranged if the patient is an 'out of area' service user who should be appropriately transferred to their own locality (*e.g. Mental Health Act*

section 136 'place of safety' service user, brought in by the Police with a connection to a community mental health service in another locality)

- Some people admitted to acute inpatient wards may be eligible for transfer to Mental Health care of Older people's services if the primary issue is age related illness

3.2 Assessments and housing

'In practice, assessments often concentrate on clinical needs and fail to address social needs such as housing, employment, income or social networks. In fact these factors are crucially relevant in terms of both the presenting problem and the treatment approach' (Dual diagnosis toolkit mental health and substance misuse - A practical guide for professionals and practitioners, Rethink/Turning Point, 2004)

Social Needs checklist and Welfare Rights advice

Wards must ensure that a social needs checklist incorporating accommodation issues and welfare rights is completed within 48 hours of admission. Skilled welfare rights assessment, advice and debt advice should be available to inpatients. Some benefit entitlements (Job Seekers Allowance, Disability Living Allowance/Attendance Allowance) will change whilst someone is in hospital so it is best to take expert advice.

- On admission it is crucial to record current housing circumstances and status and to be clear regarding tenure (e.g whether local authority, housing association, or private tenant, owner-occupier, or living with family). If possible ascertain what level of security of tenure (if any) the service user has (e.g. Secure, Assured, Assured Short-hold tenancy, lodger with licence, owner with mortgage, etc) and whether they can return home.
- It should be standard practice for ward staff to be able to arrange a specialist housing assessment (possible from a housing officer or housing liaison worker) for all service users who are homeless, threatened with homelessness (e.g uninhabitable property) or living in unstable accommodation.
- Information gathering regarding immigration status and recourse to public funds (is the service user in receipt of benefits and therefore have recourse to public funds?) will assist subsequent housing assessment and any decision in respect to eligibility for housing services.
- A housing assessment is an ongoing complex investigation, therefore the newly admitted patient may require some time to stabilise before this can begin in order for this to be productive. In the interim potential information sources include the care coordinator, carer or family member. The service user may already be in contact with a housing support worker, either from temporary accommodation (such as in a hostel) or through a floating support service.
- All housing related communications must be recorded in progress notes (e.g. progress regarding housing applications) in concise, factual and accurate manner, identifying the professionals involved, their job title and contact details. Where possible this information should be consistent with the information that may be required by Housing Options at a later date.
- The ward doctor should include a brief description of housing circumstances and history as part of the discharge summary.
- Progress notes and medical summaries should record past key events and incidents accurately, taking care describing housing related risk areas so that known criminal convictions and breaches of tenancy conditions are recorded factually.
- It is important to try and make contact with the current landlord if appropriate to ensure there is clarity regarding whether the service user is being evicted (and why)

from current accommodation or not, and if legal action is being taken against their tenancy, and exactly what stage this has reached.

- Inform the Benefits Agency of admission, and ensure that housing benefit (local housing allowance for private sector clients) and council tax benefit review forms are completed.
- Inpatients who are owner occupiers with a mortgage may benefit from the Governments homeowners mortgage support or the mortgage rescue scheme (see references).
- If a service user has been a rough sleeper then the relevant local authorities street outreach team should be contacted (or London Street Rescue **www.thamesreach**.org.uk) as they may be known to them as a 'Verified Rough Sleeper' i.e. on the CHAIN Combined Homeless and Information Network (**www.broadwaylondon**.org/CHAIN).

Assessments of social functioning in relation to housing need

The occupational therapy Activity of Daily Living Assessment (ADL) will establish a service user's ability to cope with the activities of daily life and what type of ongoing support and care package they will need. The assessment should conclude with a recommendation regarding what type of housing service would suit the service user.

Risk assessment

Risk Assessments ought to be continuous, revised and updated for discharge planning purposes ensuring a balanced approach so that stability and progress are identified. Housing providers (landlords) have their own particular perceptions of risk and therefore mental health professionals are encouraged to specify what elements of risk will impact on housing (this may allow the risk assessment to be used for supported housing referrals avoiding duplications) :

- environmental risk (noise, hoarding)
- anti-social behaviour (illicit drugs, alcohol abuse)
- offending history (sexual offences, fire risk, *'arson' should only be used if convicted*)
- history of violence, aggression (neighbour problems)
- disrepair, lack of utilities, damage to property (tampering with fixtures/fittings)
- ability to manage tenancy and cope with activities of daily life
- ability and support needed to maintain good mental health e.g. medication adherence
- ability to manager finances, pay rent (and manage utilities, electricity key, water rates, council tax)
- ability to have direct payments or personalised care to access support to maintain tenancy
- vulnerability to exploitation, safeguarding issues, and ability to manage risk of harassment from local abusers (e.g. drug dealers, illegal occupants/squatters)

Discharge against medical advice (DAMA), or absent without medical advice (AWMA)

There are a range of reasons why people discharge themselves or go absent (e.g. feeling unsafe on the ward). Every effort should be made to find out and record where the service user is staying (i.e. if they have a temporary address). Absconding and absence prevents obvious problems for discharge planning. The aim is to ensure that communication, co-ordination and planning continues (although service user is 'out of sight' they are not 'out of mind'). The multidisciplinary team must decide when to discharge a service user who is

absent, ‘in absentia’, leaving no lack of clarity regarding whether the patient is on leave or has been discharged from leave.

People with challenging behaviour, coupled with drug or alcohol use, are more likely to self discharge. Staff must guard against unwitting discrimination towards ‘unpopular’ groups on the ward in order to speed up their discharge i.e persistently disruptive, chaotic service users, personality disorders, or service users who are often mistakenly perceived as having no clear ‘mental health diagnosis’ or being ‘in the wrong place’.

Refusal to be discharged

On occasions a service user will refuse to be discharged. The reasons for this should be explored as this could be housing related i.e one reason why service users are unwilling to leave hospital relates to safety fears, unwillingness to return to an environment where they are vulnerable or lonely, which may be uninhabitable or characterised by disrepair.

It may be appropriate for the service user to return to their previous abode, with the re-assurance and undertaking that alternative, more suitable accommodation will be actively investigated by the care coordinator.

> Police Liaison Policy -inpatient units should develop links with community police (local mental health police liaison) who can deliver a message against drug abuse, and work with wards on reducing illicit drug use in the hospital. Police liaison may be able to support discharge if the service user is partly in hospital as a refuge, in order to flee intimidation or harassment (e.g ‘debts’ owed to a drug dealer) Example - www.rdash.nhs.uk/wp-content/uploads/2009/11/9.-Police-Liaison-Policy

The management of discharge from hospital against medical advice and refusal of discharge will involve consideration of Safeguarding Adults (Adult Protection procedures) and guidance to frontline staff on recognising and dealing with abuse. Nevertheless a hospital inpatient does not have the right to stay in hospital indefinitely and this must be made clear to them by the clinical team.

The patient has the right to make a complaint to Hospital Managers or to the Health Service Ombudsman if they feel they are being prematurely discharged. All unsatisfactorily planned discharges increase the chances of re-admission, especially as unresolved accommodation issues are likely to increase the chances of costly readmission.

3.3 Key protocols and processes

Care Programme Approach

If community allocation is required a care coordinator ought to be allocated within 7 days of a referral being received.

It is important that the purpose of inpatient meetings is clear, and that professionals differentiate between ward rounds, care programme approach meetings, professionals review meetings and discharge planning meetings. A care programme approach meeting should be held within 7 days of admission.

It is important that housing professionals attend key meetings or at least contribute

information to the meeting, especially if they know the service user (e.g. warden, area housing officer, residential care home manager, anti-social behaviour officer). Understandably housing staff can see themselves as the unacknowledged 'backstop' or 'safety net' of community care.

A housing plan should be part of the care plan for all service users so that housing related/accommodation and resettlement needs, and how to address them are given priority. That way housing matters are always included on the Care Plan for all service users and all progress notes relating to housing issues are clearly flagged up or headed as housing or accommodation related.

> Daily discharge handover
>
> Production of a daily sheet, which includes all patient names, with Delayed Transfer of Care (DToC) patients highlighted, and a brief sentence summarising the current blockages to discharge

Discharge policy

No-one should be discharged unless and until those taking the decision are satisfied that he or she can live safely in the community, and that proper treatment, supervision, support and care are available. Each professional group and agency will be required to work within their professional framework and be accountable for their actions, ensuring hospital discharge is safe, and to a suitable setting. It may be appropriate for someone to be discharged to unsettled accommodation such as a homeless hostel with a care plan in place, but it is not acceptable to discharge in the expectation that the service user will be sleeping on a friends floor, or 'sofa surfing'. Any discharge to NFA (No Fixed Abode) should be considered a Serious Untoward Incident.

Delayed Transfer of Care Protocol

The purpose of having a Trust Delayed Transfer of Care protocol (which can be part of the Discharge Policy) is to set out the main principles and processes that will prevent delays during an admission (including timescales and key responsibilities). In addition to this the protocol will clarify which service users are to be classified as 'delayed' and the procedure for entry onto the delayed transfer of care register.

Escalation process

An escalation and disputes resolution procedure (for disputes between localities, departments, services) should be part of the Delayed Transfer of Care Protocol in order to resolve issues around disputed responsibility for finding and funding a particular placement.

An escalation process will only be effective if it is agreed at a senior Board level (health, housing and social services), is concise and specific (i.e who the issue is to be escalated to, with procedure and timescales for resolution).

A written summary of the dispute should be compiled, including recommendations for resolution, and forwarded to senior staff. A designated officer (e.g Delayed Transfer of Care Coordinator) should ensure that escalation cases are pursued.

Resources panels (mental health funding/placement panels)

The structure and purpose of panels varies according to locality i.e joint health and local authority panels or a panel managed by the mental health trust on behalf of commissioners. All panels should have accessible terms of reference which will include information about the purpose of the panel, its composition and frequency as well as an appeals and 'escalation' procedure. All residential care placements and bespoke care packages will have to be agreed by the relevant local commissioning panel. Panels do not have to convene as 'virtual panels' can flexibly respond to urgent cases for placement.

It is good practice for funding or placement panels to disseminate a clear checklist of the panel requirements i.e. what documents are essential for submission to the Panel. In order to maximise efficiency, panels can access existing reports from the electronic care records.

- care plan and statement of need
- comprehensive assessment and risk assessment
- mental capacity assessment
- continuing care assessment
- prospective residential care placement support plan and costings

It is essential that care coordinators who present cases to panel's are fully aware of the panel requirements, are trained, prepared and supported (the Panel checklist can be 'signed off' by the line manager or a senior staff member).

Funding decisions must be put in writing to the multi disciplinary team, ensuring transparency and clarity. If a request for a particular placement or funding is declined by the panel, the panel must provide reasons for the decision; and advice and guidance (as decisions may be subject to Judicial Review).

Continuing care assessment (for full or partial NHS funding)

Care coordinators and lead professionals should all have continuing care assessment training so they are proficient in carrying out a continuing care assessment using the Decision-Support Tool for NHS Continuing Healthcare (mandatory from 1 October 2007).

Delayed Transfer of Care (Bed Management) operational meeting

Progress with delayed transfer of care service users should be monitored by a weekly bed management meeting. It is vital that this meeting is made a priority, to ensure proper representation and attendance. The meeting can cover:

a. The Delayed Transfer of Care Register (officially delayed service users)
b. The Accommodation List, including service users not yet classified as 'fit for discharge' (but who are homeless, or who have accommodation issues which may cause them to become delayed)

The meeting will produce action points, and attendees are expected to bring information or communicate updates, providing meaningful contributions, sending a deputy or representative if they are unable to attend themselves. It is suggested that a representative from the housing department or the housing liaison officer is asked to be part of the meeting and they are empowered to make decisions on behalf of the local authority.

Strategic Delayed Transfer of Care Meeting

Holding a more strategic Delayed Transfer of Care Meeting is a option with the purpose of reviewing protocol and practice so as to improve collaborative working and current processes.

In addition 'reflective practice groups' can re-appraise individual long term Delayed Transfer of Care patients, within a 'no blame' safe context, with a view to understanding the reasons behind problematic pathways and practices. This can be an opportunity to recognise the frustrations of the work, describe experiences, reflect on them, and apply learning outcomes.

3.4 Service user and carer involvement

From a carers perspective it is often the 'carers that pick up the consequences of discharge'. It is often the family/carers that are aware of the risk issues at home, the risks of returning home, and the day-to-day difficulties. On occasions professionals can lack empathy with carers, seeing them as colluding with admission, or holding up discharge by being unavailable. Healthwatch England will be based within the Care Quality Commission and local Healthwatch will act as an independent consumer champion.

It is argued that the role and status of carers and family is often not acknowledged despite their pivotal position. Carers/family do not necessarily know how the mental health system works. Having a dedicated member of inpatient staff to lead on carer and family issues is an option, so as to open up the possibility of specific family work. Despite often tenuous accommodation arrangements, an active negotiation process with the family may assist the service user to safely stay with the family.

A carer's assessment is an entitlement for people providing 'regular and substantial' care. Therefore there is a duty to offer assessment and include this in the service users care plan.

Legal advocacy, advice and representation

There are statutory rights to advocacy under the Mental Capacity Act 2005 (Independent Mental Capacity Advocate - IMCA) and the Mental Health Act 2007 (Independent Mental Health Advocate - IMHA) and staff have a duty to inform service users of these rights.

There is a duty on NHS and local authorities to involve an IMCA when making decisions about long term accommodation for service users without capacity. The IMCA becomes involved in decisions around admissions to a care home or supported living scheme with a duty to ask if the placement is in the best interests of the service user.

3.5 No Recourse to Public Funds inpatients

'No recourse to public funds' applies to people who are subject to immigration control, do not have the right to work, have no entitlements to welfare benefits, public housing or home office asylum support. It is important that discharge pathways for destitute people from abroad who have no recourse to public funds are in place. This is a complex area and this paper does not intend to cover this area in a comprehensive manner as a separate more detailed briefing is required on this subject.

Access to housing can be problematic with a range of service users such as asylum seekers, failed asylum seekers/overstayers, people from A8/A2 countries (Eastern Europeans from the Accession countries, and Bulgarian's and Rumanian's). Applicants will be required to have a right to reside in the UK and may also be required to meet the 'Habitual Residence Test for eligibility for benefits and housing assistance. It is expected that

as from 2012 any A2/A8 national who is seeking work will be able to claim jobseekers allowance (without having to show that they were employed for 12 months).

The London Reconnection Project helps vulnerable rough sleepers from Central and Eastern Europe to return to their home countries (**www.thamesreach**.org.uk/whatwe-do/15ondon-reconnection-project). Service users without access to benefits and housing should always be advised to access legal advocacy, engage the services of a specialist (Immigration) solicitor and to have a current legal claim for 'leave to remain' if appropriate.

Service users may be entitled to local authority support (accommodation and subsistence) in a number of circumstances. Under section 21 of the National Assistance Act 1948 local authorities have a duty to support destitute individuals who by reason of age, illness, disability or any other circumstances are in need of care and attention (who need to be 'looked after'). Where service users are in the country unlawfully it may be unlawful for local authorities to withhold or withdraw support if it causes a breach of their human rights Human Rights Act 1998). This may apply to service users with Post Traumatic Stress Disorder and to service users who cannot safely return to their country of origin. Service users who have been detained formally under the Mental Health Act 2007 (in the main section 3 Inpatients) should have their community care needs met under the Section 117 Aftercare regulations of the 1983 Mental Health Act (revised 2007). Entitlement and need depends on evidence being established via completion of an assessment of need by a qualified professional such as a social worker, community mental health nurse or doctor.

Another possible route into accommodation is via Section 4 support (Immigration and Asylum Act 1999) where short term support is available, usually by dispersal outside of London, if the person is taking steps to leave the country. The UK Border Agency can also provide advice on Voluntary assisted return.

Effective discharge planning in this *area depends on partnership working between mental health services and the local authority,* voluntary sector organisations and with Central Government agencies i.e UK Border Agency, National Asylum Support Service, and Ministry of Justice. In reality these are national issues, yet it appears that the onus falls on local services to provide solutions (albeit temporary). It is suggested that commissioners raise the profile of this issue and work to clarify who is eligible for local authority assistance, who is able to access national assistance, and what are the local and national duties to assist people who are destitute.

R (on the application of SL) v Westminster: High Court of Justice, Court of Appeal (8th.June.2011)
The service user with an allocated care coordinator required 'care and attention' for the purposes of the National Assistance Act 1948, and the Court ruled that they were also entitled to accommodation as it would be absurd to provide assistance without the provision of accommodation (either through UKBA/NASS or the Local Authority).
To view a full transcript of the judgement, http://tinyurl.com/3mv9o4g

3.6 Post discharge

When service users are discharged from hospital, there must be face-to-face contact within 7 days and intensive support in the first 3 months after discharge (if this is agreed in the care plan). If contact is not possible or only telephone contact can be made the reasons must be documented. The 7 day follow up after discharge target is primarily part of suicide prevention

but is also part of more general post discharge work which will include housing, employment, educational/vocational, and benefit entitlement needs being addressed.

Appropriate review timescales will be in the care plan but good practice suggests arranging a formal review one month after discharge to ensure all interventions are in place and any shortfalls are addressed.

If an individual has been accepted for a housing related support service (floating or accommodation based), a housing related support worker will be allocated and the support worker will case manage any outstanding housing issues working with the care coordinator. The housing support worker will agree a move-on plan with the service user and care coordinator, and attend CPA review meetings, keeping the coordinator appraised of any housing issues.

Section 117 (Mental Health Act) after-care responsibilities

Anyone who have been detained in hospital under treatment sections 3, 37, 47 or 48 of the Mental Health Act 2007 (MHA) is entitled to aftercare under section 117 of the Mental Health Act. The relevant NHS *and* local authorities have a duty to provide whatever after-care services are assessed as necessary. Significantly, housing and support services do come within the S117 remit.

It is recommended that each locality has its own Section 117 Protocol, and that this is clear that a key component of after-care provision is housing provision. Community Treatment Order's 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 currently on a Community Treatment Order (CTO) should be discharged from Section 117.

4 Partnership

4.1 Health and Housing Discharge protocol

Partnerships and collaboration are built on trust, respect and cooperation. In practice health and housing services, and providers from the Voluntary sector have varying priorities, and a lack of understanding of pressures, roles and priorities can exist.

Partnership working will benefit from a hospital discharge protocol drawn up between health and housing services at a senior operational level. This agreement can include processes to improve:

- exchange of information between housing and health services including management structures
- housing services access to local community mental health services and mental health assessments
- agreed local procedures for how inpatient services/community services access housing services and housing assessments
- how homelessness services and ' temporary housing' are accessed, re-accessed and sustained
- how housing services alert health services if they are concerned about a tenant (early intervention)
- representation of housing service personnel on multi-disciplinary/CPA Meetings
- preventing eviction and sustaining service users in accommodation

- information exchange on duties of housing services and mental health services, ‘duty of care’
- joint training for housing and mental health staff
- disputes between mental health services and housing services

4.2 Housing related practical support to the wards

One good practice model is to have a specialist housing officer or housing liaison worker in place to work between the mental health and housing services e.g having a Housing Officer employed jointly by Housing and Health.

Additionally, housing link services and floating support can be very successful pre and post discharge, performing a resettlement role and improving health and Wellbeing (working flexibly such as one visit a week or one a month depending on need). Good quality personalised outreach care is popular with service users, is cost effective; prevents admission, facilitates discharge, and provides a ‘safety net’ for the statutory sector mental health services. Schemes can be joint funded by health and local authority partners.

Delays to discharge can be prevented by practical and preventative action to sustain accommodation and social inclusion whilst the service user is in hospital by:

- addressing rent arrears, taking action to reverse eviction proceedings where appropriate, working with other professionals involved in the service users care
- attending care planning meetings, participate in joint home visits with home treatment team staff, and benefit from regular collaborative review meetings with mental health services
- escorting service user to appointments and supporting them during appointments (e.g. at the HPU, supporting an application to get priority housing or rehousing, attending furniture projects, applying for a Community Care Grant)
- liaison with the local authority (private sector housing advice) regarding environmental health issues (and statutory breaches)
- reporting disrepair to the landlord - structural problems, lack of heating, the need for aids and adaptations, insulation
- starting an enablement programme over a particular period which can support the discharge plan, work on core skills, and provide a package of assistance at home

The Camden and Islington re-ablement team

The team provides intensive support over a 6-8 week period to improve service users' independence and reduce the need for ongoing support from mental health teams. Following discharge from hospital or recovery centre support can be provided around:

- Daily activities such as shopping, cleaning & cooking (prompting)
- Benefits and housing issues
- Reducing isolation
- Emotional support
- Accessing local community services, leisure activities and education
- Budgeting
- Managing medication (prompting)
- Attending appointments
- Registering with a GP
- *Blitz & deep clean*

Inpatient and community services need to be aware of the local process for arranging for a quote for cleaning and clearance work and payment. It is advisable to have in place a local procedure so that essential items and services can be purchased (prevention fund) and authorised without delay. e.g The 'A Team' at the Six8four centre in Haringey http://www.haringey.gov.uk/index/social_care_and_health/mental_health/dayservices/684centre/theateam.htm

Information sharing protocol

An Information sharing agreement between health and housing services (see references re Housing Corporation example) will ensure that Data Protection Act 1998 principles are followed and risks to applicants, household members and organisations are considered.

An information sharing consent form is part of the information sharing Protocol and should be in place on the wards so the service user can give written permission to allow information to be provided to housing authorities and shared between housing providers (note NHS Code of Practice for confidentiality and 'broader public interest').

4.3 Supported Housing pathways and procedures

Supported Housing referral procedures and pathways must be clear and accessible in order to fill empty bed spaces efficiently. For example note LB Camden 'Good practice guide to mental health pathway services, 2007 (see references). It is important for information regarding voids to be collated, shared and circulated promptly so service users are matched to appropriate spaces as early as possible. A single point of referral for supported housing will avoid a 'scattergun' approach to referrals.

There must be clear guidelines on making and responding to referrals which incorporates timescales to avoid waiting to be referred and assessed. Lengthy assessment processes, and variation and duplication with assessment procedures are to be avoided, as are arguments about information and confidentiality. All decisions on referrals to supported housing schemes, including acceptances and rejections must be given in writing explaining the reasons for decisions. Referral procedures will include a list of essential referral documentation, acceptance and rejection procedures with timescales, and appeal

procedures. An example of a joint protocol between health, housing, and the voluntary sector is the Leeds protocol (see housing references).

Mental health services and supported housing services may wish to negotiate the 'release' of accommodation for those patients awaiting discharge, by ending the placement of a long term patient whose discharge is not imminent (based on an agreement that suitable alternative accommodation will be offered so as not to disadvantage the long term inpatient). This is a potentially sensitive area as the 'rights' of the service user and their personal view has to be balanced against the best use of resources.

Localities (boroughs) should consider producing *and maintaining* a comprehensive directory of mental health and housing services for their area, incorporating all housing options and clearly defined pathways. This will enable effective use of supported housing, better access to social housing and private rented accommodation.

A range of housing provision to meet local need

…….'*general needs social housing and supported accommodation cannot any longer be seen as separate worlds. Rather, they must be seen as part of a continuum of housing services …A "whole systems" approach to meeting housing and support needs of those with mental health problems needs to encompass this whole range; and developing closer relations with housing services must be a priority for any comprehensive local mental health accommodation strategy*' (At Home: A study of mental health issues arising in social housing NIMHE 2006)

Examples of housing provision:

- Owner-Occupation (mortgage)
- General needs mainstream social housing (registered social landlords, local authority,housing association)
- Shared ownership and private sector leasing
- Rent Deposit schemes, Accredited Landlord/private sector leasing schemes
- Housing related floating support (flexible)
- Supported accommodation (high, medium and low with access to on-call/out of hours facilities)
- Core and cluster supported schemes
- Sheltered housing (extra care sheltered)
- Respite care
- Family or Adult Placements
- Intermediate 'step-down' rehabilitation provision
- Residential care (The Care Quality Commission, www.cqc.org.uk**,** publishes reports on Residential Care Home's)
- Crisis centre provision (e.g. **One Support** provide an integrated services consisting of a short stay residential service, crisis night centre and crisis phone line, and link with statutory Crisis Response and Resolution Teams & specialist support agencies)

'Hard to place' service users

Some service users are described as having 'serial failures' (at risk of lapsing into homelessness) in terms of their previous tenancies, and such service users are going to be

'hard to place'. It is good practice in relation to 'failed' supported housing tenancies for the housing providers to complete an 'end of tenancy report' outlining a summary of the service users placement and the reasons why the placement ended (with a chronology of the service users housing history).

It is good practice to prepare the service user for the assessment 'interview' for supported housing which will be overseen by the service provider, ensuring the service user is aware of the supported housing referral process, by talking through the standard areas which the interview will focus on (and the need for openness and honesty particularly in respect to drug and alcohol issues).

If the service user appropriately engages with specialist support services (e.g drug, alcohol, or IAPT services) they are more likely to be considered for or to be seen as able to sustain a tenancy/placement.

4.4 Homelessness

Applications for housing assistance considered under the homelessness legislation (Part 7 of the Housing Act 1996). If a service user is likely to be homeless or at risk of homelessness on discharge, then they are entitled to a statutory assessment under the homelessness legislation (Part 7 of the Housing Act 1996).

Homelessness and local connection
If the service user will be homeless or at risk of homelessness on discharge, it is advisable to find out the service user's housing history and whether he or she has a 'local connection' in the local authority district/borough; e.g. is or has been resident by choice; is employed in the area; has family links in the area, or there are special reasons. Most housing authorities work to guidelines that suggest at least 6 months residency in the last year or evidence of 3 years living in the area over the last 5 years (but local variations may apply).

Housing authorities must consider all applications for help, and even if the service user does not have a local connection with the district, the housing authority cannot refuse to consider an application for help under the homelessness legislation. An authority can only consider referring an applicant to another authority, if they are satisfied that the applicant is eligible for assistance (some categories of person from abroad are ineligible), unintentionally homeless and in priority need and also satisfied that he or she does not have a local connection with their district and does have one somewhere else in Great Britain. And even then, they must secure temporary accommodation until it is agreed which local authority will take full responsibility for the case.

In all cases, housing authorities must consider whether they have reason to believe the applicant may be homeless or likely to become homeless within 28 days. If there is reason to believe, the authority must make inquiries and decide whether any duty is owed under the homelessness legislation. The authority must notify the applicant in writing of its decision, and of the applicant's right to ask for a review if dissatisfied.

Interim duty to accommodate

Where a housing authority decide that an applicant is eligible for assistance, homeless through no fault of their own and falls within a priority need group, the authority must secure suitable accommodation until an offer of settled housing can be made.

The Code of guidance on homelessness (Part 7 Housing Act 1996) sets out the person's rights with respect to accessing interim accommodation. If authorities have 'reason to believe' (i.e they do not have to be satisfied) that an applicant may be homeless, may be eligible for assistance and may be in 'Priority Need', then they have an immediate interim duty to ensure that suitable accommodation is available until they complete their enquiries and decide whether any substantive duty is owed under the legislation). Further information: www.communities.gov.uk/publications/housing/homelessnesscode

Vulnerability (Priority Need)

Case law has established that, when determining whether an applicant's circumstances make him or her vulnerable, the local authority should consider whether, when homeless, the applicant would be less able to fend for him or herself so that he or she would suffer injury or detriment in circumstances where a less vulnerable person would be able to cope without harmful effects.

People suffering from a mental illness or disability who are discharged from hospital are likely to be vulnerable and therefore in priority need. Housing authorities should have regard to advice from medical professionals or care providers in deciding on vulnerability, and should take into account the link between disability and housing difficulties, but the final decision on whether a particular applicant has a priority need rests with the authority.

Local procedures

Although local authorities must 'have regard to' the code of guidance in practice there is a good deal of local interpretation of housing legislation, so it is essential to agree local procedures overseeing circumstances when an inpatient has to present to the Homeless Persons Unit/Housing Options (for emergency housing, advice and assistance). This can be part of the 'Discharge Protocol' agreed with Housing Services (which can include a clear summary of what housing services can offer). One component of this will be agreeing the core or essential documentation which is required when a service user presents at the Homeless Persons Unit. Service users should have appointment times with Housing services, and where possible they ought to be escorted and supported in the process.

The 2011 Local Government Ombudsman report (Homelessness: how councils can ensure justice for homeless people) urges Councils to avoid:

- Placing the burden of proof on the applicant
- Deferring an application or delaying consideration of a homeless application
- Insisting applicants complete a specific form or be interviewed by a specialist assessment officer

It will be necessary to provide clinical reports to clarify that the service user 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 the service user is 'vulnerable' for the purposes of the homelessness legislation. Guidance on how to write a helpful supportive clinical letter to the housing department can be found at www.homelessdirect.org.uk/policyandinfo/issues/health/discharge/factsheets/Factsheet2

Service users may be eligible to access the local housing waiting list (facilitated by the local authority housing service) and possibly take part in the online Choice Based Lettings allocation process. Mental Health services will need to ensure that inpatients have access to the internet, and support is available to assist them navigate the allocation system.

Local authorities must also 'have regard to' government guidance with respect to injured service personnel ensuring they are given high priority, including access to key worker schemes, and that they are not disadvantaged by the restrictive rules around 'local connection'.

5 Roles

Leadership and authority

Cohesive management and leadership of local mental health services is an essential aspect of recovery focused services. It should be clear which manager has the lead responsibility for overseeing Delayed Transfer of Care/bed management issues.

Responsibility for delayed discharges rests with the multi-disciplinary team in general but senior inpatient and community staff are responsible for showing leadership and putting systems and practices in place in order to prevent delays and solve problems (including performance managing and supporting practitioners).

Strong leadership will ensure that confusion over who oversees and carries out specific aspects of the work is avoided. Locally services may wish to be prescriptive and specify which tasks are the responsibility of which professional, but essential good practice entails clarity on who does what, and the recording of actions and outcomes in the care plan and progress notes of the service user.

Workforce capability and solutions

Some reports have referred to a de-valuing of inpatient services and questioned the current status of inpatient staff. Attention must be paid to workforce competency, capability, and the skill mix. Managers should review inpatient recruitment, retention, rewards and the supervision arrangements of inpatient staff e.g. promoting service user posts within their services such as Support Time and Recovery workers (DH 2010) or Peer Supporters.

5.1 Key roles

Role of Care Coordinator

Under the Care Programme approach one of the primary roles of the care coordinator is co-ordinating transfer of care or discharge for service users. It is vital that the care coordinator makes weekly visits to see their service user whilst they are on the ward. The initial meeting should be within 72 hours of admission. The care coordinator should see their service user regularly 'regardless of setting'. If the allocated care coordinator cannot attend an important CPA meeting an acting stand-in care coordinator should attend in order to progress the discharge process.

Care coordinators have a care management role, not only coordinating support packages but having responsibility for accessing appropriate resources. Care coordination is a complex skilled role and much variation exists in the workforce in terms of experience, skills and knowledge.

Named Nurse/Primary worker (and Associate Nurse)

The Named Nurse (who should be allocated on day one of admission) must be a trained First Level Nurse (recommended caseload maximum of 5). The Named Nurse is responsible for updating the inpatient care plan, risk assessment, and they are best placed to oversee the local 'discharge checklist' (which can include items such as medication, money, travel, access to home, confirmation that the home is habitable, any outstanding housing related issues, copy of care plan and follow up appointments).

The ability of the patient to manage their *medication* at home will be assessed and arrangements made as appropriate to ensure ongoing adherence. Access to ward pharmacy expertise can help the discharge medication plan i.e. a simple therapeutic daily regime, patients fully advised of reason for medications, side effects, safe monitoring, possible interactions with caffeine, nicotine, street drugs etc, and possible provision of personalised care delivery of medication by support workers

The Named Nurse plays a key role within the inpatient team for ensuring that there is no loss of momentum with discharge planning even if there is a change of care coordinator (awaiting re-allocation due to re-structure or sickness, leave). The existence of a Named Nurse protocol will clarify and enhance the role (for example Named Nurse Protocol – North East London NHS Foundation Trust).

Ward Manager

The ward manager is responsible for all patients on their ward and must be able to report back accurately on the progress with all service users who are delayed on the ward. The ward manager will ensure that an information pack is on the ward for service user and carers, which will provide information regarding who to contact regarding housing issues and benefits advice.

Delayed Transfer of Care Coordinator

Specialist posts, taking an operational lead on delayed discharge, are cost effective e.g a Delayed Discharge Coordinator with experience of mental health and housing issues, who can work collaboratively between agencies and services. One model is to utilise a nurse and a social worker to jointly oversee the health and housing pathway. Success depends on having clear remits for the posts, outlining specific responsibilities with respect to data collection, reporting, staff training, dispute resolution and responsibilities for particularly problematic discharges. To re-iterate, it is crucial that there is clarity and clear accountability in the area of delayed discharge, so the team always knows who is doing what.

Peer support

Studies have shown the value of the 'expertise of lived experience' and using peer support workers to help service users 'navigate' community facilities on discharge. The Peer support worker can provide hope, empathy and understanding, be a role model, and give access to practical coping strategies and problem solving skills.

Peer support in Australia

A mental health peer support service was introduced with the aim to reduce hospital admissions and lengths of stay and improve early discharge support.

The evaluation looked in particular at bed days saved, crisis service contact, A&E presentations, and readmission rates. The study concluded that using peers to provide support to consumers at this stage of their recovery appeared highly effective as an adjunct to mainstream mental health services, results in substantial savings to mental health services, and has much potential for a greater recovery focus and improved collaboration with GPs. Reference Lawn, Smith & Hunter 2008

Further Reading and References

No health without mental health: A cross-government mental health outcomes strategy for people of all ages (DH 2011) Supporting document – The economic case for improving efficiency & quality in mental health	
Improving discharge from inpatient mental health wards: a good practice toolkit	Dept of Health (2007)
Action on Mental Health, A guide to promoting social inclusion	ODPM (2004)
Refocusing the Care Programme Approach, policy and positive practice guidance	Dept of Health (2008)
Acute care programme	website -www.virtualward.org.uk or www.acutecareprogramme.org.uk/silo/files/delayed-transfers-of-care-of-acuteand-nonacute-mental-health-patients.doc
	Healthcare Commission (2007)
Acute inpatient mental health service review, Final assessment framework	
Mental Health Integrated Care Pathways	(ICP) – Acute (2008)
The pathway to recovery, a review of NHS acute inpatient mental health services	Commission for Healthcare Audit and Inspection (2008)
Mental health policy implementation guide: Adult acute inpatient care provision	Department of Health (2002)
Enabling recovery for people with complex mental health needs	Royal College of Psychiatrists (2009)
Recovery Tools -WRAP tool (Wellness, Recovery and Action Plan)	(http://copelandcenter.com)
Mental Health Recovery Star	(http://www.mhpf.org.uk/recoveryStarResources.asp)
Department of Health (2006) From values to action: the Chief Nursing Officer's review of mental health nursing.	Star Wards (starwards.org.uk)
Practical mental health commissioning (2011) A framework for local authority and NHS commissioners of mental health and wellbeing services	www.jcpmh.info
Using personal experience to support others with similar difficulties (A review of the literature on peer support in mental health services),	Together, J. Repper & T. Carter (2010)

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Responsibility and Accountability, Best practice guide	Dept of Health (2010)

Housing references

Accommodation Pathway (Hospital Discharge) Project Report. Leeds PFT	Leeds City Council, Volition and NHS Leeds. April 2009
Combining Health and Housing for Recovery: Joint protocol between Leeds City Council and Leeds Partnerships NHS Foundation Trust to provide housing options and housing related support to people in mental health inpatient settings	NHS Leeds, Volition and housing related support services (June 2010)
Code of guidance on homelessness (Part 7 Housing Act 1996)	Department for CLG
Camden housing provider resources	http://www.camden.gov.uk/ccm/content/housing/general-housinginformation/ supporting-people/hostels-pathway---provider-resources.en
Access to Housing	Information Sharing Protocol (Housing Corporation 2007)
Getting Through – Access to Mental Health services (for people who are homeless or living in temporary or insecure accommodation	Dept of Health (2007)
Healthcare for single homeless people	Dept of Health (2010)
Housing LIN Briefing – Understanding Homelessness and Mental Health	Office of the Chief Analyst, CSIP (2007)
Homeless UK and Homeless London	http://www.homelessuk.org which links to www.homelesslondon.org
Housing Rights information	http://www.housing-rights.info
CHAIN	http://www.broadwaylondon.org/CHAIN
'My Landlord wants me out'	Communities and Local Government (2009)
Mortgage assistance website	http://mortgagehelp.direct.gov.uk

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