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Situating and understanding hospital discharge arrangements for homeless people

The importance of specialist hospital discharge arrangements for homeless people has been widely documented (see, e.g. Whiteford and Simpson, 2015; Albanese *et al.*, 2016; Cornes *et al.*, 2018). Much of the work that has emerged to date has been dispersed across a broad range of disciplinary fields (e.g. emergency medicine, healthcare administration, public health and housing studies), and in consequence of this there has been a tendency to speak to discrete audiences rather than, say, an explicit concern with fostering inter-disciplinary dialogue. In the extant literature, four main features stand out. The first is the tendency to provide descriptive rather interpretative accounts of the role of specialist homeless healthcare teams. The role of clinicians features prominently in such accounts, while the experiences and reflections of homeless patients have often been relegated to the margins. The second feature is the overt focus on hospital administrative data. In such analyses, hospital episode statistics (e.g. ED presentations, inpatient admissions and emergency readmissions) are commonly used to illustrate the rates of healthcare utilisation among people who are homeless or at risk of homelessness. The third characteristic is the cost of hospital services for homeless patients and/or the effectiveness of community-based healthcare interventions (McCormick and White, 2016). The fourth tendency is to examine medical respite care for homeless people (Doran *et al.*, 2013). Research in this area has consistently demonstrated the efficacy of medical respite for homeless people in terms of contributing to decreases in ED presentations as well as reductions in the number of unplanned inpatient days followed up by a period of recuperative care.

Existing scholarship devoted to the issue of hospital discharge protocols and policies for homeless people have tended to start from the position that people who are homeless often experience poor hospital discharge arrangements (Blackburn *et al.*, 2017). Strong and continuous evidence has shown how unsafe discharge arrangements are costly at both individual and societal levels, with many people who are homeless entering a cycle of hospital readmission, which in turn serves to compound existing health inequalities. Among practitioners and scholars, there is a discernible (and oftentimes explicit) critique of “patient dumping” – a phenomenon in which homeless patients are discharged not to temporary housing, but to the streets. Indeed, the failure to discharge homeless patients into appropriate accommodation is understood to lead to a cycle of poor health and episodic healthcare use. This lack of coordinated care inevitably leads to emergency readmission and prolonged lengths of hospital stay. These factors, by degrees, place a significant burden on over-stretched and under-funded healthcare systems. Framed in this way, poor discharge practices and policies are commonly considered to be a moral and economic abomination.

Viewed from the other end of the telescope, specialist hospital discharge arrangements for homeless people are understood to be predicated on two overarching and intertwined concerns: first, a concern with turning off the spigot of “patient dumping” and, second, a concern with actively engaging with the often complex and seemingly intractable housing and health needs of people affected by homelessness. These twin aims are, it is argued, best achieved through ensuring that housing and health needs are considered at the point of admission, during treatment and post-discharge. Together, these concerns and aims have created a common narrative and policy agenda in the four main countries in the Anglosphere (i.e. the USA, Canada, Australia and the UK).

How did this happen? To understand and contextualise the growing interest in homeless hospital discharge, we must place it in the context of the paradigmatic shift towards auditing in healthcare;

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rising levels of homelessness and associated patient complexity, and a desire among clinicians and practitioners to achieve the appropriate balance between organisational interventions and a compassionate orientation towards the care and support needs of vulnerably patients such as people who are homeless. This impulse to practise ethically and in a compassionate setting is, in many important respects, the signal feature of specialist hospital discharge arrangements for homeless people. Such specialist initiatives, and homeless health and care provision more generally, can be better understood as a repudiation of routine forms of care.

The issue of specialist hospital discharge arrangements for homeless people shows how policy ideas travel and transform local practices. This internationalisation of homeless healthcare has been driven, in significant part, by a network of practitioners and scholars committed to sharing learning and best practice across national borders and clinical frontiers. This international exchange of ideas is perhaps best exemplified by the UK Faculty for Homeless and Inclusion Health's annual symposium on health, homelessness and multiple exclusion. The Boston Health Care for the Homeless Programme and Health Care for the Homeless Pittsburgh can and should rightfully be seen as the progenitors of this movement by virtue of their ground-breaking work and longstanding commitment to ensuring that homeless people have access to comprehensive healthcare. The field of homeless healthcare continues to evolve, and it has now developed its own nomenclature under the conceptual and clinical scaffolding of "inclusion health" (Pathway, 2018 for a detailed exposition). Underlying this change in language and shift in perspective is a clear recognition that, to take just a few examples, asylum seekers, migrants, sex workers and Gypsies and Travellers, also face significant barriers to effective healthcare. Put crudely the centre of gravity has shifted in small but perceptible ways from the USA to the UK. Central to this shift has been the work of the Pathway charity. In practice terms, Pathway embodies a simple and successful model of enhanced care coordination for homeless patients admitted to hospital. It operates across ten hospitals in England and has an international outpost in Perth, Western Australia. Pathway can thus be understood as a symbol as well as a reality of a different type of healthcare engagement with homeless people, and it is as a reality that it has had its most profound impact.

In the UK, particularly in the English context, knowledge and understanding of the importance of the discharge needs of homeless patients has quickly metastasised through a series of national and local evaluations (see Homeless Link, 2015 for exegesis), government-sponsored funding streams (DoH, 2013), and programmes of academic inquiry[1]. Whilst it would be misleading to suggest that full nationwide coverage has been achieved, it is certainly the case that discharge planning for people who are homeless has moved from the periphery to the mainstream in policy formation and practice delivery in England if not necessarily across the whole of the UK (Whiteford and Simpson, 2016). Visible traces of this can be seen in both the government's rough sleeping strategy (MHCLG, 2018) and the NHS long-term plan. At the same time, specialist homeless hospital discharge schemes have been emasculated by the UK Government's ongoing austerity drive. This issue in and of itself deserves further attention.

This special issue of *Housing, Care and Support* brings together seven individual papers, which articulate and analyse different facets of hospital discharge arrangements for homeless people. The collection opens with an examination of hospital discharge planning for Canadians experiencing homelessness (Buccieri *et al.*). This is then followed by an exploration of the GP role in improving outcomes for homeless patients (Khan *et al.*). This then gives way to a critical appraisal of a collaboration between an inner-city hospital, specialist homeless GP service and a Housing First initiative in Perth, Australia (Woods *et al.*). The focus then shifts to a review of medical respite care in the UK (Dorney-Smith *et al.*) before giving way to a companion piece of sorts which provides a detailed discussion of a medical respite care facility in Melbourne, Australia (Gazey *et al.*). Following this is a fairly expansive, and in many ways a deeply personal, account of the difficulties of establishing a homeless healthcare team in a district hospital in the south-west of England (Glennerster and Sales). The collection concludes with a close appraisal of the first clinically-led, interprofessional Pathway homeless team in a mental health trust in England (Khan *et al.*). Taken together these papers, all argue persuasively and passionately for the importance of coordinated and comprehensive discharge planning for people who are homeless, and in doing so offer important and opportune insights.

Note

1. www.kcl.ac.uk/sspp/policy-institute/scwru/res/hrp/hrp-studies/hospitaldischarge.aspx

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