Appendix 9: Step down programs to assist appropriate discharge from hospital into housing

Launch Housing supports the provision of 'step down' programs that support the timely transition to appropriate housing when people exit hospital following a mental health episode.

Hospitals play an important role for people experiencing homelessness	
Growing service demand	While the number of client accessing homelessness services in Victoria has increased by 36% (2011-12 to 2017-18), the percent accessing hospital psychiatric and rehabilitation services has increased 58% over the same period.[i]
St Vincent's Hospital Melbourne (SVHM)	A 2015 evaluation by SVHM of its patients experiencing homelessness highlighted the prevalence (upon episode commencement) of drug and/or alcohol use causing mental and behavioural disorders (22%), schizophrenia or schizoaffective disorder (21%), injuries and fractures (10%), post-operative (non-orthopaedic) (9%) and other mental health disorders (8%). Comorbidities were common among the cohort of patients experiencing homelessness.[ii]
Frequent use of emergency beds	People who experience homelessness are among the most frequent presenters to emergency departments. Their rate of unplanned hospital admissions is high. The average stay is longer too.[iii] They are frequently admitted to hospital for conditions that could have been more effectively managed in a primary care setting.[iv]
Inappropriate hospital discharge	Post-discharge care is often not an option for patients with "no fixed address". As a result patients experiencing homelessness face either longer inpatient admissions or are discharged when too unwell for the challenges of living on the street.[v]
City of Port Phillip Street Count	Launch Housing's evidence of rough sleeping in the City of Port Philip found that people were discharged from hospitals back to sleeping rough on the streets. In one case, a 26-year-old man had been hospitalised 17 times in six months, with no resolution to his homelessness. Additionally, despite frequent contact with health services (hospitals and emergency departments) over a six month period, for a number of the people sleeping rough, there was little improvement to their health and wellbeing[vi].
Housing as a necessary precondition for discharge	An important precondition is for hospitals and the general mental health system to engage with programs that connect patients to housing and social supports.[vii] Stable housing allows people the mind space to begin to think about managing their lives.[viii] For example, a Canadian study on follow-up care for people with a co-occurrence of mental health and homelessness noted that adequate housing is a necessary condition to enable the benefits of community care to be realised. And concluded that *"the findings presented in this study indicate a compelling need to address housing as an integral component of hospital discharge planning".*[ix]

There are positive examples of integrating health and homelessness services

Planning for appropriate post-discharge housing	Early identification of homeless persons in the hospital setting and appropriate discharge planning would lessen the risk of an individual being discharged into homelessness.[x]
HomeGround Mental Health Discharge Pilot Program (HMDPP)	The HMHDPP (2006) targeted people experiencing homelessness who were at risk of readmission or had had repeated readmissions to the St Vincent's Acute Inpatient Unit. A key issue noted in the review of the pilot program[xi] was the need for sufficient time to plan for post-discharge mental health supports as well as the need to source housing that would facilitate recovery, and enable ongoing engagement with mental health support.

Medical respite

There is generally a lack of step-up and step-down programs for people experiencing homelessness, especially for people who are rough sleeping[xii]	Medical respite provides residential short-stays for people experiencing homelessness who require a period of convalescence or monitoring and stabilisation of a health condition. Medical respite services that provide step-up/step-down sub-acute healthcare in a residential setting appear to be promising interventions, especially when linked to good discharge planning practices.
Supporting timely transition to appropriate housing	Step-down programs support the timely transition to appropriate housing when exiting hospital following a mental health episode. This requires hospitals to widen the scope of their interventions that address the social determinants of health, such as homelessness and poor housing.[xiii]
Research evidence supports medical respite for people experiencing homelessness	There is now a substantial international body of research describing approaches and confirming the benefits of medical respite – usually defined as intermediate care for people experiencing homelessness leaving hospital, or at risk of imminent hospital admission.[xiv]
Lancet evidence review	A recent Lancet evidence review also confirmed the benefits of medical respite[xv]. Medical respite programmes that provide patients experiencing homelessness with a suitable environment for recuperation and follow-up care on leaving hospital reduce the risk of readmission to hospital, and the number of days spent in hospital.
Systematic review	A systematic review of American research into intermediate care for people experiencing homelessness showed that medical respite programs reduce future hospital admissions, inpatient days, and hospital readmissions. They also result in improved housing outcomes.[xvi]

The Cottage is a local example of medical respite	St Vincent's Hospital runs Sister Francesca Healy Cottage (The Cottage) which is a supportive, home like environment offering a range of services to people who are homeless or at risk of homelessness. It aims to provide holistic, recuperative care to clients with a nursing need, as an alternative to staying in hospital. Such important services are in short supply.
Bringing medical respite and permanent supportive housing together	The Better Health Through Housing Program (US) brings together effective hospital discharge planning and access to permanent supportive housing. Participants to the program are placed in 'bridge units' or step-down respite and are assigned case managers who assist them with their transition into permanent supportive housing.[xvii]

[i] This analysis is an extended version of this Vincent care blog post: https://vincentcare.org.au/stories/latest-news/352-from-hospital-into-homelessness

[ii] See discussions, stats, and author profiles for this publication at: https://www.researchgate.net/publication/320014059 St Vincent's Hospital Melbourne Homelessness Programs Evaluation Report. An evaluation of ALERT, CHOPS, The Cottage and Prague House. See discussions, stats, and author profiles for this publication at: https://www.researchgate.net/publication/320014059 St Vincent's Hospital Melbourne Homelessness Programs Evaluation Report. An evaluation of ALERT, CHOPS, The Cottage and Prague House.

[iii]Wood, L., (208) Hospital discharges to 'no fixed address' – here's a much better way, The Conversation: https://theconversation.com/amp/hospital-discharges-to-no-fixed-address-heres-a-much-better-way-106602

[iv]See discussions, stats, and author profiles for this publication at: https://www.researchgate.net/publication/320014059 St Vincent's Hospital Melbourne Homelessness Programs Evaluation Report. An evaluation of ALERT, CHOPS, The Cottage and Prague House. See discussions, stats, and author profiles for this publication at: https://www.researchgate.net/publication/320014059 St Vincent's Hospital Melbourne Homelessness Programs Evaluation Report. An evaluation of ALERT, CHOPS, The Cottage and Prague House.

[v]Wood, L., (2018) Hospital discharges to 'no fixed address' – here's a much better way, The Conversation: https://theconversation.com/amp/hospital-discharges-to-no-fixed-address-heres-a-much-better-way-106602

[vi] 'City of Port Philip Street Count 2018 Final Report' (2018), Launch Housing: https://www.launchhousing.org.au/site/wp-content/uploads/2018/06/Report-City-of-Port-Phillip-Street-Count_June-2018.pdf

[vii]Wood, L ., et al (2019) 'Hospital collaboration with a Housing First program to improve health conditions for people experiencing homelessness', Housing Care and Support, Vol. 22, Issue 1, pp 27-39

[viii]Kuehn, B.M (2019) Hospitals Turn to Housing to Help Homeless Patients, JAMA March 5, Volume 321, Number 9

[ix]Currie, L.B. Patterson, M.L, Moniruzzaman, A, McCandless, L.C, and Somers, J.M. (2018) Continuity of care amoung people experiencing homelessness and mental illness: does community follow-up reduce rehospitalisation? Health Serv Res; vol 53, issue 5, pp 3400-3415.

[x]Sax Institute (2017) Homeless at Transition, An Evidence Check rapid review brokered by the Sax Institute for the NSW Family and Community Services and FACSIAR: https://www.saxinstitute.org.au/wp-content/uploads/Homeless-at-transition.pdf

[xi] Homeground, 2006, Mental Health Discharge Program Review – Nov 2006, Homeground, Melbourne.

[xii] Samantha Dorney-Smith, S., & Hewett, N (2016) Options for Delivery of Homeless 'Medical Respite' Services, KHP Pathway Homeless Team Scoping Paper

[xiii] Wood, L ., et al (2019) 'Hospital collaboration with a Housing First program to improve health conditions for people experiencing homelessness', Housing Care and Support, Vol. 22, Issue 1, pp 27-39

[xiv] Samantha Dorney-Smith, S., & Hewett, N (2016) Options for Delivery of Homeless 'Medical Respite' Services, KHP Pathway Homeless Team Scoping Paper

[xv] Stephen W Hwang, Tom Burns. Health Interventions for People who are Homeless. Lancet 2014; 384: 1541–47

[xvi] Doran KM, Ragins KT, Gross CP, Zerger S (2013) Medical respite programs for homeless patients: a systematic review. J Health Care Poor Underserved; 2013;24(2):499-524)

[xvii] See program description in: Annals of Emergency Medicine, Volume 72, No. 45, October 2018