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Improving hospital discharge arrangements for people who are homeless: a realist synthesis of the intermediate care literature

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Improving Hospital Discharge Arrangements for People who are Homeless: A Realist Synthesis of the Intermediate Care Literature

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Improving Hospital Discharge Arrangements for People who are Homeless: A Realist Synthesis of the Intermediate Care Literature

Abstract

This review presents a realist synthesis of 'what works' in intermediate care for people who are homeless, focusing on 'time limited' interventions designed to support hospital discharge and prevent readmission. The overall aim is to fill a gap by updating and expanding an earlier synthesis of intermediate care that did not review the literature on homelessness. The earlier synthesis was completed in 2013 and reviewed the literature on intermediate care 'generically' and in relation to older people and patients with heart failure, chronic obstructive pulmonary disease (COPD), stroke or cognitive impairment. The omission of the homelessness literature may reflect the fact that specialist intermediate care services designed specifically for people who are homeless are a relatively recent development in the UK. In 2013, investment by the Department of Health stimulated the growth of 52 new or expanded homeless intermediate care (hospital discharge) schemes and empirical research on these is emerging.

(Words 151)

Key Words: homelessness, hospital discharge, intermediate care, medical respite, transition of care, realist systematic review

What is known about this topic

- Long term homelessness is characterised by 'tri-morbidity' (the combination of mental ill health, physical ill health and drug and alcohol misuse).
- Hospital discharge is often problematic for people who are homeless with high rates of readmission.
- Much is known about the design an delivery of intermediate care services for older people, but less is known about how to meet the transitional care needs of people who are homeless.

What this paper adds

- A synthesis of 'what works' in the design and delivery of specialist intermediate care services for people who are homeless
- New knowledge from the field of homelessness as to how intermediate care for all service user groups might be strengthened. For example, the need to encompass longer term health and well-being goals alongside those for 'physical reablement'.
- A reconceptualisation of the intermediate care concept which is designed to prevent these short term services from becoming 'blocked'.

Introduction

This article reports the findings of a realist synthesis of what works in intermediate care for people who are homeless. The review builds upon an earlier synthesis of intermediate care that did not include the literature on homelessness (Pearson et al., 2013 & 2015). The earlier review focused on the literature on intermediate care 'generically' and in relation to older people and patients with heart failure, chronic obstructive pulmonary disease (COPD), stroke or cognitive impairment.

The paper begins with an overview of recent developments in intermediate care for people who are homeless, explaining why realist synthesis has particular utility when it comes to reviewing the literature in this field. We then outline the search strategy and the methods used to synthesise the literature on homelessness, before discussing how this additional evidence 'speaks' to the conceptual framework for intermediate care proposed by Pearson and colleagues (2013; 2015). In the final section, we draw out the implications for service development and future research, and also make recommendations about possible refinements to the original conceptual framework.

Intermediate care and homelessness

In the United Kingdom (UK) from 2001 onwards, intermediate care has been a way of supporting patients who are ready to leave hospital yet require further support at home. Considerable variation in the design, definition, and configuration of intermediate care services has been permitted at local levels. According to the Department of Health (DH) (2009) intermediate care is a function rather than a discrete service, so it can incorporate a wide range of different services, depending on the local context of needs and the facilities available. The primary stated objective of intermediate care is to support 'Anyone with a health related need through periods

of transition' (DH, 2009 p10). While intermediate care was designed originally to meet the needs of older people, policy guidance suggests that no one should be excluded on the basis of age, or ethnic or cultural group, and that people who are homeless should be eligible for this service (DH, 2009 p4).

Long term homelessness is characterised by 'tri-morbidity' (the combination of mental ill health, physical ill health and drug and alcohol misuse) (Hewett, Halligan and Boyce, 2012). People who are homeless experience chronic illnesses and long-term health conditions similar to or higher than people 15 to 20 years older who are not homeless (Ku et al., 2014). In England, homeless people attend Accident and Emergency (A&E) departments five times as often as those who are not homeless, are admitted to hospital three times as often, and stay in hospital three times as long. This results in unscheduled care costs that are estimated to be eight times higher than for patients who are not homeless (DH, 2010).

While there was some development of 'medical respite' services for people who are homeless in the United States (US) and mainland Europe, reported from 2006 onwards (Doran et al. 2013), it was not until 2013 that a concerted effort was made to extend the reach of intermediate care in England. In 2013, the Department of Health launched the 'Homeless Hospital Discharge Fund' (henceforth HHDF) DH, 2013). This short term grant funding programme made available £10 million to nurture local partnership working between the voluntary sector, NHS and local government. It was partly a response to the startling figure that 70% of people who are homeless were being discharged from hospital back to the streets without having their housing or on-going care needs being properly addressed (Homeless Link and St Mungos 2012). In total 52 intermediate care 'type' schemes were funded through the HHDF. According to an early evaluation report by Homeless Link (2015), the schemes fall into two broad categories:

(i) ***Housing-led Schemes****:* These focus primarily on securing accommodation for people who are homeless on discharge from hospital. They are usually staffed by 'Housing Link Workers' (ideally co-located at the hospital) possessing specialist knowledge of housing legislation and local housing options. Staffing roles include addressing broader health and wellbeing outcomes by means of advocating for and supporting people who are homeless to engage with the full range of local primary care, mental health, drug and alcohol and social care services.

(ii) ***Clinically-led Schemes***: These are usually GP or nurse led and involve 'in reach' (ward rounds) with a weekly multi-disciplinary team meeting. They provide advocacy and support and have a dual aim of improving the quality of (hospital) care for people who are homeless, while reducing delayed or premature discharges. Housing workers (often seconded from the voluntary sector) and 'peer navigators' (former homeless people) may work as part of the team to address wider housing and support needs. These schemes are often referred to as 'Pathway Discharge Teams' in acknowledgement of the Pathway Charity that pioneered this way of working (Hewett, Halligan and Boyce, 2012).

With the exception of the inner-London schemes that cater for much higher numbers of people who are homeless, most HHDF schemes are small in scale, comprising 1-3 staff. All provide short-term transitional support. However, the length of time that service users can be supported varies considerably. Some schemes provide a 'brief intervention' to organise the discharge itself, while others provide up to three months

of intensive resettlement support. Others have access to earmarked 'discharge beds' in local homeless hostels, while yet others provide follow-up support in the community or back on the street if it has not been possible to arrange accommodation.

The HHDF also funded a small number of capital investment schemes targeted at developing new residential ('medical respite') intermediate care facilities. Medical respite is an American term for recuperative care which is targeted at people who are too sick to be out on the street or to stay in a traditional shelter, but who are not sick enough to warrant inpatient hospitalisation (Doran et. al., 2013).

In some areas HHDF funding supported the development of multiple schemes enabling a clustering of activity, and the creation of 'step down' pathways of support in which people move though a specialist hospital discharge scheme to a residential intermediate care facility and then on to their own accommodation (see, for example, Lephard, 2015).

Effectiveness and cost-effectiveness

There is mounting evidence about the effectiveness and cost-effectiveness of intermediate care for people who are homeless both in the UK and internationally. Time limited care coordination interventions that link people who are homeless with sources of ongoing support during critical transition points have been shown in randomised controlled trials to have an enduring positive impact on a range of outcomes such as reducing rehospitalisation (Sadowski et al. 2009; Tomita and Herman, 2012) and improved quality of life (Hewett et al., 2016). A systematic review of 'medical respite' found that it can result in improved health and housing outcomes

for service users who are homeless, as well as reductions in hospitalisations and hospital readmissions (Doran et al., 2013). Studies consistently show homeless intermediate care schemes to be cost-effective or cost neutral (Hendry 2009; White, 2011; Hex and Lowson, 2014).

It is now widely accepted as 'good practice' to make some form of specialist provision for the discharge of homeless people from hospital (Dorney-Smith et al. 2016). However, less is known about how to implement such schemes in particular local contexts that may differ in important ways from these original effectiveness studies (Pearson et al., 2015). It is argued that working towards a 'standardised model' is undesirable in this field because different areas will have different levels of homelessness and different resources (Housing LIN, 2009). As the DH (2009) points out, 'Intermediate care should provide the function of linking and filling the gaps in the local network' (p10) leading to what Medcalf and Russell (2014) term 'independent local pathways of care'.

Realist synthesis

Realist synthesis is an increasingly popular approach in reviewing and synthesizing evidence for a range of complex interventions in health and social care services (Reeves, 2015). Central to the realist method is the identification and refinement of propositions about how a programme is supposed to achieve its intended outcomes, known as 'programme theories'. Programme theory is operationalised as ideas about (i) what works; (ii) how to remedy any identified deficiency; and (iii) how the remedy itself may be undermined (Pearson et al., 2015).

Pearson et al.'s (2015) synthesis scoped the literature on intermediate care identifying over 10,314 sources for potential inclusion. It aimed:

> 'To provide an evidence-informed 'road map' of the complex set of factors that decision-makers should consider to make [a service] as effective as possible in any given local context. It can also be used as a diagnostic checklist to highlight weaker areas of existing provision… [and] can also inform the focus of future research' (Pearson et al., 2015, p14).

The review generated an extensive list of 'programme theories' for testing and refinement. An iterative Delphi style technique was then used to arrive at a 'conceptual framework' for intermediate care. This identified three programme theories as having most 'explanatory power' when seeking understanding of how intermediate care works to improve outcomes for service users in a wide range of contexts. According to this conceptual framework, improved service user outcomes are achieved when:

- (Programme Theory 1): The place of care and timing of transition to it, is decided in consultation with service users, based on the pre-arranged objectives of care and the location that is most likely to enable the service user to reach these objectives;
- (Programme Theory 2): Health and social care professionals foster the self-care skills of service users and shape the environment so as to re-enable service users;
- (Programme Theory 3): Health and social care professionals work in an integrated fashion with each other and carers (Pearson et al., 2015 p7).

Methodology

Search terms

In undertaking this review, we applied the same methodology and search strategy as outlined by Pearson et al. (2015), but extended the scope of the search to include 'homelessness'. While Pearson's search strategy used what they believed to be a comprehensive list of phrases relating to 'intermediate care', we extended the scope of this search to encompass ['medical respite'] and ['homelessness AND 'hospital discharge' (schemes)] and ['homelessness AND 'delayed discharge'.] This is because the term 'intermediate care' is not widely or consistently used in the homelessness sector. The search terms used are shown in Figure 1.

Electronic searches were carried out for peer-reviewed articles published in English from 2000 - 2016 in the Medline, Medline in Process, Embase, Social Policy and Practice, HMIC, British Nursing Index, The Cochrane Library, Cinahl and Assia. We searched the 'grey' literature through relevant websites (e.g. Department of Health; Homeless Link), as well as through the internet using the Google search engine. We also contacted over 52 intermediate care services for homeless people in England seeking copies of any local evaluations and project reports.

<Insert Figure 1 about here>

Inclusion and exclusion criteria

Intermediate care is a complex term that can encompass a wide range of different service configurations and functions. In determining the scope of their review, Pearson et al. (2013) helpfully distinguish between conventional 'hand overs' of care between providers and interventions that have been specifically designed to support service users' transitions (p26). The inclusion criteria for this present review was that

articles and reports should describe specific 'interventions' to support homeless service users in transition and that the intervention should encompass most of the key characteristics of intermediate care (see Figure 2). A small number of additional articles was included which considered homeless health or hospital discharge more generally, but only where they raised issues about the need for intermediate care (see, for example, Medcalf and Russell, 2014; Parker-Radford, 2015).

The searches yielded 43 references of which 25 met the inclusion criteria. Additional hand searching revealed further articles. Internet searching and direct contacts with intermediate care projects yielded 13 (grey literature) reports. These were mostly project reports and or small scale external evaluations. In total, 47 reports and articles were included in the synthesis.

Synthesis

Each source was read by at least two members of the research team and reviewed with regards to how it 'spoke' to Pearson's et al.'s (2015) conceptual framework. A data extraction *pro forma* was designed to allow the evidence to be carefully mapped against each of the three programme theories. This included space for identification of any new programme theories.

When reviewing the literature, we sought to identify programme theories that were both explicitly argued and those that were tacit or implied (making it clear which was the case). Papers were assessed based on the same realist 'quality' criteria utilised by Pearson et al (2015). This makes distinctions between those that are 'conceptually-rich' (with well-grounded and clearly elucidated theories, ideas and concepts), 'thick' (a rich description of a programme, but without explicit reference to

theory underpinning it), or 'thin' (weaker description of a programme, where discerning a programme theory would be problematic).

Table 1 (online resource) summarises the articles and reports (n=47) that were included in the review, the methods they used, their 'richness rating' and to which programme theories they 'spoke'. Most of the literature fell into the 'thick' category, with few papers including a theoretical perspective. The final stage of the synthesis was then to take the evidence as a whole and to reflect on the overall utility of Pearson's et al.'s (2015) conceptual framework, highlighting where any changes or refinements could be made.

Ethical considerations

This realist synthesis was funded by (funder) as the first stage of a two year comparative study of hospital discharge arrangements for homeless people in England. The review stage was completed between September 2015 and March 2016. Ethical approval for the study was secured from the National Research Ethics Committee [REC Ref: 16/EE/0018].

Findings

Programme Theory One: The place of care and timing of transition to it are decided in consultation with the service user

The literature on homeless intermediate care confirms the central importance of consulting with service users about all aspects of their care and support. In an early feasibility study, Lane (2005) noted that a particular advantage of intermediate care

was its focus on person-centred care rather than disease management, and that this could benefit homeless people, who are often familiar with and respond well to individually tailored care, as in supported housing. Poor outcomes, such as 'self-discharge', are a significant problem where there is a failure to tailor care and support to the specific needs of homeless people (Bauer et al., 2012; Hewett, Boyce and Halligan, 2012; Kelly et al., 2013; Medcalf and Russell, 2014; Albanese, Hurcombe and Mathie, 2016; Dorney-Smith and Hewett, 2016).

Engagement as a distinct mechanism

However, what additionally emerges from this literature is the importance of 'engagement' as a distinct mechanism for underpinning more formal consultative or collaborative care planning processes. As Halligan and Hewett (2011 p1) observe, 'It is only once a relationship is established that the hard work of planning community support and negotiating with housing, social care, health care providers and the voluntary sector can begin'. Discussing a 'nurse-led' residential intermediate care scheme, Dorney-Smith describes how:

> 'A key feature of this [intermediate care] model has been the high level of engagement work undertaken. Clients have often been difficult to engage… Up to one month of engagement work has been allowed before quitting to accommodate for the suspicion and distrust that often presents in these clients' (2011 p1196)

In an RCT which evidenced reduced hospital readmission rates and other positive outcomes for 150 homeless psychiatric patients receiving a care coordination intervention (compared to usual care) it was suggested that the relationship with the social services worker may have been as equally an important mechanism in

delivering these positive results as securing housing tenure and stability (Tomita and Herman, 2012).

Several studies highlight the difficulties of working with homeless people in the Accident and Emergency department (H3, 2015). Having little time to establish relationships with both staff and service users is often suggested as a key explanatory factor in accounting for this (Lewis 2015, p9).

Tackling stigma and discrimination

Pearson et al.'s (2015) review highlights the training of staff in the specific skills needed to deliver person-centred care as an important mechanism in the delivery of successful intermediate care. However, in homeless intermediate care 'cultural distance' emerges as a complicating factor. Drury (2008), for example, describes how the daily lives of health care providers and homeless people are so different that they become cultural strangers, fearfully avoiding contact with each other. Cultural distance often creates the 'gaps' which specialist intermediate care is then expected to fill. Whiteford and Simpson (2015a), for example, describe how some district nurses will not provide care inside hostels because they are perceived as 'dangerous places'.

Many people who are homeless experience stigma and discrimination in hospital (Parker-Radford, 2015). Backer, Howard and Moran (2007) advise that this requires attention as part of good discharge planning. Indeed, while many of the HHDF schemes focus on 'delayed discharge' in order to meet commissioners' requirements for whole systems working (Gillespie, 2016), the more immediate practice objective is often the prevention of premature discharge (see for example, Wade, 2014). Some argue that the skill set for achieving this is rooted in psychologically informed

approaches to facilitate both engagement and the management of challenging behaviour:

> 'At times [the homeless intermediate care team] observes situations that will be familiar in our current climate – premature discharges, low thresholds being employed for bad behaviour (with no management techniques being tried or employed), and inexperienced staff effecting the overall quality of discharges.' (Dorney-Smith et al, 2016 p221)

Compassionate kindness, dignity and respect are also valued:

> 'A visit from an empathetic team, dedicated to the care of homeless patients in the hospital can transform this [poor experience]. The simple act of visiting the patient demonstrates that the hospital is acknowledging their particular needs, someone is observing how they are treated, they are not alone. The patient has an advocate and intermediary, and the staff are supported in the ways in which they can positively contribute to a better outcome for the patient.' (Halligan and Hewett, 2011 p2)

Many of the (specialist) homeless intermediate schemes funded as part of the HHDF perceived it as part of their role to offer mentorship and training to educate (mainstream) hospital staff about working with homeless people. However, the grey literature suggests that this learning quickly evaporates without a 'continuous and consistent presence' (Hochron and Brown, 2013: Charles et al., 2015). This may indicate that 'specialist schemes' are not addressing the root cause of problems and that more needs to be done to ensure that the sporadic pockets of good practice extend to all areas (Medcalf and Russell, 2014 p353). In older people's care, there have been national policy initiatives to 'root out' age discrimination (Department of Health, 2001).

> 'While there is an understanding of the holistic perspective for elderly people, the attitude for complex homelessness cases… was often reported to be "They walked in here - why can't they walk out." (Housing Lin, 2009)

Place of care

The strongest correlate of hospital readmission among homeless people is discharge location (Kelly et al., 2013). Kertesz et al. (2009) showed discharge to a medical respite facility was associated with significantly lower odds of readmission than discharge to 'own care' (including homeless shelters). Discharge to supportive housing has similar benefits (Sadowski et al., 2009).

Pearson et al. (2015) reported that the characteristics of the local health and social care system could significantly limit care options for service users. This was evidenced in the homeless literature, with people who are homeless having little opportunity to influence decisions about their place of care because few options were available:

> 'In [Town A], the discharge scheme had access to short stay accommodation... In [Town B] there was a lack of interim accommodation and this often resulted in clients being referred to 'bed and breakfast.' (Housing LIN, 2014 p6)

People with complex multiple needs including homelessness are recognised as being especially 'difficult' to place. They often account for delayed discharges and high numbers of excess hospital bed days (Dorney Smith and Hewett, 2016). Doran et al. (2013) report that many US respite schemes will not admit homeless people

who continue to drink due to their 'challenging behaviour'. Crucially, mechanisms for intermediate care may only work if there is adequate community care provision:

> 'Having a specialist [homeless worker] does not eradicate delayed discharge if appropriate community care is not available. However, it does tend to highlight where the gaps exist… Wet houses tend to be available for people who are fairly independent but finding placements for people who continue to drink and have disabilities is much harder' (Housing LIN, 2009 p16)

The notion that intermediate care might itself fill some of these gaps raises questions about scope and remit and how far this should extend into the territory of longer term care. According to Laere et al. (2009), the high mortality rate among users of a Dutch medical respite scheme might be explained by the fact that the homeless population in Amsterdam most commonly comprises of people with mental health problems who would have been admitted to mental health institutions 20-30 years ago, and long-term opiate users and alcoholics who are not able to live independently and depend on fragmented services. Many intermediate care schemes for homeless people currently provide palliative care to compensate for the lack of provision elsewhere (Laere et al., 2009; Hendry, 2009; Whiteford and Simpson, 2015a).

Generic or specialist?

It is suggested that mainstream intermediate care facilities do not currently meet the needs of people who are homeless (Dorney-Smith, Hewett and Burridge 2016). The argument for 'specialist' provision stems in large part from the challenges of co-housing people with different problems and vulnerabilities (Lephard, 2015). For example, Lane (2005) charts the advantages and disadvantages of admitting 'homeless people' with drug and alcohol problems to mainstream intermediate care.

On the one hand, it is considered that when someone is in recovery they are not exposed to the hostel environments in which drug and alcohol use is commonplace. On the other hand, it is recognised that people with drug and alcohol problems have the potential for 'challenging behaviour' and can be disruptive to other users of intermediate care services:

> '[Homeless] Service users felt the [mainstream intermediate care] service would not be able to cope with homeless people's substance use problems and this was the main barrier to them accessing this option, although others felt this option would be good as it would give people the chance to have a break from drinking.' (Lane 2015 p5)

Rather than being understood in the context of patient choice and the need for person-centred care planning, debates around 'place of care' may be conflated with potentially discriminatory assumptions about the characteristics of different user groups. For example, Lane (2005) reports how some GPs and hostel managers he interviewed expressed concerns that *'homeless people'* would not mix well with other users of intermediate care who *'tend to be elderly and extremely fragile both emotionally and physically'* (p44), thus overlooking the potential for people with dementia to also exhibit challenging and disruptive behaviour. That blanket assumptions are made about 'older people' and 'homeless people' may confirm the concept of cultural distance described above.

Safe spaces for women

A study of early exit from medical respite reported that 'respite structure' (rules and regulations) could make some service users feel uncomfortable, and may account for

why up to a third of people leave medical respite earlier than planned (Bauer, 2012). Women in this study were significantly more likely to leave respite before discharge completion than men. According to Bauer (2012), given the prevalence of victimization among homeless women, the association of trauma to fear and social withdrawal, re-traumatization from lack of privacy, sense of scrutiny, or power dynamics may all contribute to earlier exit among female service users. This indicates that gender specific treatment models or women-only spaces may enhance retention outcomes.

Programme Theory Two: Professionals foster the self-care skills of service users and shape the environment so as to re-enable them

One of the key objectives of intermediate care is that people should not be admitted straight from hospital to long-term care without the opportunity for 'reablement', 'recuperation' and 'rehabilitation' (DH, 2009). The optimum time frame for intermediate care is considered to be between two to eight weeks. In England, most local authorities (sometimes working in partnership with the NHS) provide a non-means tested 'reablement' service for a period of six weeks after which there will be a financial charge for the social care element. The purpose of reablement overlaps with intermediate care in that it helps people who have experienced deterioration in their health and/or have increased support needs to relearn the skills required to keep them safe and independent at home (SCIE, 2012).

Reablement and physical rehabilitation needs

A feasibility study reviewed the case load of a specialist homeless primary health care team in Ireland to assess the need for a specialist homeless intermediate care centre (O'Carroll et al., 2006). It found that 15% of homeless people on the caseload

had mobility and disability problems attributable to healthcare needs such as stroke, hip replacement, fracture or amputation.

In the literature on homeless intermediate care, 're-enablement' or 'reablement' were not mentioned. Many studies reported difficulties collaborating with adult social care which may indicate that local authority reablement services are not easily accessible to people who are homeless (Hewett, Halligan and Boyce, 2009; Lewis, 2014; Homeless Link, 2015; Whiteford and Simpson, 2015a; Dorney-Smith and Hewett, 2016). Reports also suggest that homeless people's physical rehabilitation needs are not well catered for (Housing LIN, 2006; St John's Ambulance, 2010; Whiteford and Simpson, 2015a).

> 'Just because you are homeless does not mean that you haven't got rehabilitation needs. We sometimes struggle to get patients [into rehabilitation] not because they are homeless but because of their age. Those kinds of services don't exist for patients under fifty-five.' (View of one case manager quoted in Whiteford and Simpson 2015a, p130)

'Reablement' environments

Mainstream residential intermediate care facilities in care homes or in hospitals often provide access to specially adapted environments, such as a 'training kitchen', in which people can relearn activities of daily living. A complaint arising from service users in one (specialist) hostel based intermediate care facility for homeless people was boredom due to the lack of any kind of structured daily activity (Hendry, 2009). More recently, Pathway teams in London have employed occupational therapists to address this risk by promoting meaningful activity (Dorney-Smith et al., 2016). There remains however, a recognised need for improved disability access in many UK homeless hostels.' (Dorney-Smith and Hewett, 2016)

Recovery

There is emerging consensus in the homeless intermediate care literature that to stop the 'revolving door' of hospital readmissions, support for homeless people needs to extend beyond the discharge process itself, and into the community either by means of a residential 'step down' facility or 'floating support' arrangement (Charles et al., 2015; Dorney-Smith and Hewett, 2016; Gillespie, 2016). However, what is less clear is the ideal timeframe for such arrangements which may be termed intermediate care.

In the literature on specialist homeless intermediate care, 'recovery' from drug and alcohol issues and/or mental health issues emerges as the primary rehabilitative focus. O'Carroll et al.'s (2006) feasibility study, for example, found that 48% of the case load had addiction problems, 33% had mental health problems and 17% dual diagnosis. However, the setting of goals around 'recovery' raises further questions about the accepted timeframes for intermediate care. Dorney-Smith (2011), for example, charts how service users' health deteriorated when they were discharged from a nurse led intermediate scheme that provided between six to eight weeks of support:

> 'It is important to recognise that this is a 'long game' for many homeless clients …The starting point is about finding a way to get clients' to believe they have something to live for which is why the building of relationships is so important… But progress from this stage might be quite slow. One systematic review suggested that even 24 months may not be long enough to generate sustainable change.' (p1197)

Resettlement

The six to eight week time frame for intermediate care is further brought into question by the multiple overlapping nature of the transitions facing service users who are homeless (i.e. from 'hospital to home' and from 'homelessness to housed'). Managing the transition from 'homelessness to housed' encompasses both the practical aspects of securing accommodation as well as meeting what are termed 'resettlement needs' (Crane, Joly and Manthorpe, 2016). Indeed, there are many parallels to be drawn between 'reablement' and 'resettlement' work with the latter being 'housing' rather than 'social care' led. Both share the aim of *'doing things with rather than for people'* and have the overall aim of promoting independence. It might even be suggested that 'resettlement' work has a broader more personalised focus than 'reablement' as it is often encompassing of both 'citizenship goals' (such as securing employment, education and volunteering opportunities) as well as those linked to reablement and the promotion of 'self-care'. Describing a (specialist) residential intermediate care facility for homeless people in northern England (providing up to three months of resettlement support) Lowson and Hex capture this broader aspiration:

> 'It gives people the opportunity to make real life changing decisions, and to have a real go at their lives, improving their life chances and quality of life as well as improving independence [with] daily living tasks.' (2014 p37)

In Pearson's et al.'s (2015 p9) review it is noted that one drawback with (mainstream) intermediate care is that it has tended to prioritise a desire for service users to attain certain functional goals within a specified time period over service users' self-knowledge and desire to reach a wider set of goals over longer, less clearly defined time periods.

Programme Theory Three: Health and social care professionals work together in an integrated fashion with each other and carers

Housing as the 'third pillar' of intermediate care

UK intermediate care has been delivered primarily as a health and social care service (Pearson et al., 2015). The HHDF highlights the role of housing services in delivering improved health and well-being outcomes and consequently, the importance of housing professionals working alongside health and social care professionals. Several grey literature accounts report that hospital staff appreciated this resource, especially in terms of its potential to free up their time:

> '[Housing Link Workers] applied their knowledge of local authority [housing] eligibility criteria… This was knowledge that most hospital workers said that they did not have… which meant that, before [the implementation of the scheme] they had struggled with finding accommodation for homeless patients.' (Charles, 2015 p33)

One report of a 'Housing Link Worker' scheme describes extending its remit beyond 'homeless people' so that support could additionally be provided to older people who were being delayed in hospital due to 'housing issues' (White, 2011).

Multi-disciplinary team skill mix

An early evaluation of the HHDF concluded that those schemes taking a multi-disciplinary team approach were more effective in delivering improved health and housing outcomes than those which provided access to housing in isolation (Homeless Link, 2015; Albanese, Hurcombe and Mathie, 2016). Without the benefit

of a nursing post, some of the housing link worker projects described difficulties in engaging with what they described as the 'medical model' (SERI, 2014). A nurse link worker role is mainly focused on case management rather than the delivery of clinical interventions (Dorney-Smith and Hewett, 2016).

The 'skill mix' also appeared indicative of different 'occupational lenses' or types and levels of comprehensiveness around how homelessness might be addressed. While the focus of the Housing Link Worker schemes was often on housing and benefits advice with 'referrals on' to primary care and other agencies, Hendry (2009) describes how staff in one medical respite scheme saw it as their role to begin to unpick 'years of neglect'. In this scheme service users received a full assessment under one roof, including a full screen blood test, screening for sexually transmitted diseases, medication compliance work, pre-detox work, smoking cessation, mental health, social services, occupational therapy referrals, benefits advice, and chiropody.

Involving carers and family members

In none of the material reviewed was there explicit reference to family members and carers being involved in discharge and intermediate care support planning. However, there were some accounts of 'reconnection work' (Lewis, 2015) which is seen as important in linking homeless people back to their home towns where they may have a 'local connection' and therefore a better chance of securing housing and social care support.

Mechanisms for integrating services

For many of the HHDF projects, integration into the hospital setting was described as challenging (Homeless Link, 2015). Formal protocols were important, but the main problem was sustaining them (Housing Lin, 2009). Successful ways of doing this and raising awareness about the schemes more generally included having the scheme championed by senior hospital staff and actively promoting the scheme through posters, leaflets and contact cards (Albanese, Hurcombe and Mathie, 2016 p10). Co-location and being 'a face' on the ward was thought to help ensure the flow of referrals and ease of communication (Housing LIN, 2014; Charles et al., 2015). Participating in ward rounds, attendance at weekly hospital staff meetings to discuss patient discharge planning, and running reflective practice and training sessions for hospital staff on the subject of homelessness were also considered helpful.

Once the referral pathways were established in HHDF schemes, hospital staff seemed to appreciate being able to 'hand over' responsibility for the homeless people on their wards. A hospital staff member described her view of the benefits of a Housing Link Worker scheme as follows:

> 'They sit alongside the patient in the middle and they coordinate all those links out to the other services… a bit like a spider diagram… and without them being there coordinating that, none of those links happen and the patient sits in isolation.' (quoted in Charles et al. 2015 p26)

Advocacy as an additional key mechanism

While integration and coordination are foregrounded as key mechanisms for the successful delivery of intermediate care (Pearson et al., 2015), the homeless specific literature suggests that advocacy ('arguing the case') may be equally important (Albanese, Hurcombe and Mathie, 2016). Many grey literature accounts of the HHDF

schemes alluded to the impact of austerity and depleted budgets which meant reduced availability of housing and longer term care and support. Consequently:

> 'Existing community services… defend their budgets by rigidly restricting access to a defined 'local' population – this renders care coordination particularly challenging for homeless people, who often have weak or no ties to any locality and lack documentary proof of any entitlements.' (Dorney-Smith and Hewett, 2016 p11)

Towards a refined conceptual framework

The additional evidence presented above appears then to broadly support the validity or usefulness of Pearson et al.'s (2015) conceptual framework for understanding 'what works' in intermediate care. This is with regard to three key programme theories: the importance of consulting with service users (PT1), working in ways which are enabling (PT2) and ensuring integration (PT3). However, it might be suggested that these three 'programme theories' are likely to be implicated in the successful delivery of many other health and social care services. Herein, lies a potential limitation of the current framework in that it may not answer some of the more complex or nuanced questions facing commissioners of specifically intermediate care.

The first challenging question to emerge from this review is how to maintain the integrity of intermediate care as a 'time limited' intervention. This issue arises where there is a need to encompass multiple and overlapping rehabilitative and resettlement goals which may require housing solutions underpinned by much longer term or continuing health and social care support. Indeed, the issue of 'time frame'

and scope is relevant to commissioners of intermediate care for both older people and people who are homeless. It is acknowledged that the rehabilitation of older people has sometimes fallen short because it has often prioritised short term reablement goals linked to 'physical functioning' over and above those for inclusion and citizenship. Meanwhile, intermediate care for people who are homeless has reversed the 'occupational lens' prioritising loner term resettlement and recovery outcomes over and above those for reablement. How to encompass these different needs and vulnerabilities under a single service banner is a significant additional challenge, with the danger that 'specialist' provision starts to confirm cultural distance (e.g. 'elderly people' are quiet and frail, 'homeless people' are challenging and disruptive).

These issues are compounded in times of austerity, when the integrity of intermediate care is further compromised by the need not just to 'fill the gaps' in local provision but on occasions to substitute for the widespread loss of longer-term support services. As Backer, Howard and Moran (2007) suggest, discharge planning and intermediate care will have little impact unless housing and other services are available. It is recognised that this poses perhaps the most serious threat to the viability of intermediate care as a service organisation and delivery construct. If the boundaries with longer term care start to blur, then intermediate care risks quickly becoming 'blocked' (Poymow et al. 2005; Dorney-Smith et al., 2016).

In terms of a refined 'conceptual framework' that might address some of these issues, a US study is particularly insightful. The study reports the findings of a randomised controlled trial (RCT) of a clinically-led case management intervention called 'Critical Time Intervention' (CTI)(Herman et al., 2011; Tomita and Herman, 2012). CTI was designed to provide emotional and practical support over a nine month period with the primary objective of preventing homelessness among people being discharged from a psychiatric hospital. In CTI, intermediate care is

conceptualised as comprising three distinct phases:

> Phase 1: Transition to the community – focuses on engagement and relationship building - providing intensive support and assessing the resources that exist for the transition from in-patient care to community providers.
>
> Phase 2: Tryout -is devoted to testing and adjusting the systems of support. And assessing whether or not they are working as planned. By now community providers are assumed to have adopted primary responsibility for delivering support.
>
> Phase 3: Transfer of care – focuses on completing the transfer of responsibility to community resources that deliver long term support (Herman et al., 2011 p715)

The findings of the RCT which compared the outcomes of those receiving the CTI intervention to those receiving standard care suggested that this brief, clearly focused intervention led to a reduction in the risk of homelessness that was evident nine months after the intervention ended. In accounting for 'what works', consultation (PT1), enabling (PT2) and integration (PT3) are all implicated in CTI, but the cornerstone of the approach is a potential fourth programme theory (PT4). Namely,

> *'Maintaining continuity of care during critical transition periods while responsibility gradually passes to existing community supports that will remain in place after the intervention ends.'* (Herman et.al, 2011p714)

In CTI, 'scope' is clearly defined as being about the management of transitions rather than specific kinds of 'needs' or 'gaps' in existing provision. It is thus generic in that it can be applied to all client groups and can potentially be operationalised in any given local context since the aim is to 'weave together' the resources and infrastructure that are already in existence. The 'time frame' for the intermediate care intervention is also determined not by any rigid 'service led' criteria but by the adaptive capacity

of the local context to meet the person's needs. It might be added that where CTI becomes 'blocked' (i.e. there are no appropriate services to take over responsibility) then this should ring alarm bells for commissioners that there are 'cracks' in local provision.

Indeed, CTI also seems to encapsulate the *'how to'* of what Parker-Radford (2015) terms a 'transition of care approach'. This has the additional advantage of shifting the focus of the 'organisational lens' from the acute sector to the management of a much wider range of transitions (e.g. 'prison-to-community' and 'armed forces-to-civilian'). It is therefore potentially key to continuity and seamless care as seen from the perspective of people who use services.

Conclusion

Pearson et al.'s (2015) conceptual framework proved a useful heuristic device for synthesizing the literature on intermediate care for people who are homeless. It worked as a 'coat hanger' on which a wide range of evidence could be hung and critically appraised. It has also helped lay the foundations for future research and hypothesis testing as regards a number of proposed programme theory refinements (these are highlighted in *italics* below). To summarise, the additional evidence presented in this review suggests that improved service user outcomes may be achieved in intermediate care for all service user groups including people who are homeless when:

> (Programme Theory 1): The place of care and timing of transition to it, is decided in consultation with service users [*ibid*]… *'Engagement work' is recognised as a distinct mechanism for underpinning these more formal consultative or collaborative care planning processes.*

(Programme Theory 2): Health, *housing* and social care professionals foster the self care skills of service users and *ensure that rehabilitation and recovery are encompassing of outcomes linked to both physical reablement and broader health and well-being objectives for inclusion and citizenship*

(Programme Theory 3): Health, *housing* and social care professionals work in an integrated fashion with each other, *ensuring local advocacy support is available.*

(Programme Theory 4): Continuity of care is maintained during critical transition periods while responsibility gradually passes to existing community supports that will remain in place after the intermediate care episode ends.

The limitations of the review are that while we have outlined our search strategy judgments have been made about the interpretations of the findings. Identifying programme theories and mechanisms from sources that are not explicitly theory driven, or do not provide adequate descriptions of the services, is also problematic. Nevertheless, using realist synthesis to build 'conceptual platforms' which can guide future intervention development about 'what works' for whom and in what circumstances may be an important step in complementing more traditional evidenced based approaches which often leave these questions unaddressed.

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Figure 1: Search Terms
Homelessness AND
'hospital discharge' (scheme)
'delayed discharge'
'Intermediate care'
'Hospital at home'
'Admission avoidance' (scheme)
'Early discharge' (scheme)
'Step-down' (care)
'Step-up' (facilities)
'Geriatric day hospital' (day care)
'Rapid response' (team)
'Intensive rehabilitation' (service)
'Recuperation facilities' (residential or nursing home)
'Integrated home care team'
'One-stop primary care centre'
'Nurse-led'/ 'Consultant-led'/ 'GP-led'/ 'Physician-led' (schemes/ inpatient units)
'Residential (care) rehabilitation'
'Supported discharge'
'Day (centre) rehabilitation'
(Acute care) 'at home'
Hospital in the home
'Rehabilitation at home'
'Community Assessment and Rehabilitation Teams' (CARTs)

‘Re-ablement’

‘Restorative care’

To this list we added the term ‘medical respite’ as it is often applied to residential based intermediate care schemes for homeless people.

Figure 2: Working definition of intermediate care used for screening sources of evidence (Pearson et al., 2015)

Purpose: Supports transition (e.g. hospital to home); occurs at a critical point (i.e. on the cusp of the shift from independence to dependence, at the point of acquisition of a chronic illness or disability, or at the intersection of illness and frailty)

Functions: A bridge between (i) locations; (ii) health or social care sectors (or within these sectors); (iii) health states. Views people holistically, as individuals in a social setting. Time-limited (e.g. 72 hours; 2 weeks; 6 weeks)

Structure: Designs and embeds new routes through services (which enhance sensitivity to needs and wishes of service users)

Content: Treatment or therapy (to increase strength, confidence and/or functional abilities); Psychological, practical and social support; Support/training to develop skills and strategies

Table 1: Included studies (n=47) and their use in the review

Key

- ✓ **PT1** Supports/Refines Programme Theory 1: The place of care and the timing of transition to it is decided in consultation with the service user.
- ✓ **PT2** Supports/Refines Programme Theory 2: Health and social care professionals foster the self-care skills of service users and shape the environment so as to 're-enable' service users.
- ✓ **PT3** Supports/ Refines Programme Theory 3: Health and social care professionals work in an integrated fashion with each other and carers
- ○ Links to an explanatory note.

Typologies
CL = Clinically led (multi-disciplinary case management)
HW = Housing Link Worker or Housing led (case management)
SW = Social Work led (multi-disciplinary case management)
MR = Medical Respite (residential)

All studies relate to homeless service users unless stated otherwise.

Authors [country]	Data Collection	Type	No. of Participants	PT1	PT2	PT3	Notes (e.g. significantly refines or surfaces new programme theory)
Conceptually Rich							
Herman et al. 2011[USA] & Tomita and Herman, 2012 [USA]	Randomised Control Trial	CL	150	✓	✓	✓	New PT 4: Health, housing and social care professionals proactively manage continuity
Medcalf and Russell, 2014 [UK]	Review of Homeless Health Initiatives	CL	N/A			✓	Note on PT3: Conceptualises IC integration within broader homeless health pathways
Whiteford and Simpson, 2015b [UK]	Exploratory case analysis	CL	18			✓	Refine PT3: Knot-working identified as useful theoretical concept for understanding process of integration
Thick							
Bauer et al., 2012 [US]	Retrospective Study	MR	860	✓		✓	Refines PT1: Draws attention to need for women-only spaces
Charles et al. 2015 [UK]	External Evaluation	HL	104	✓		✓	
Doran et al., 2013	Systematic Review	MR	13 (articles)		○	✓	Note on PT2: Only one scheme listed access to physiotherapy

Dorney-Smith, 2011 [UK]	Economic Evaluation	CL	34	✓		✓	Refines PT1: Work is needed to establish engagement before consultation. Refines PT3: Advocacy is key where no agency wants to take responsibility.
Dorney-Smith and Hewett, 2016 [UK] Dorney-Smith, Hewitt and Burridge 2016 [UK]	Feasibility Study	MR	53	✓	○	✓	Note on PT2: Highlights long term care needs often not being met. Refine PT1: Highlights potential of Psychologically Informed Environments (PIE)
Dorney-Smith et al. 2016 [UK]	Project Report	CL	N/A	✓	○	✓	Note on PT2: A recent development within Pathway Teams is to include access to occupational therapy
Drury, 2008 [USA]	Participant Observation	HL	60	✓		✓	Refines PT3: Advocacy is key where no agency wants to take responsibility.
Gillespie, 2014 [UK]	Project Report	HL	N/A	✓		✓	
Hendry, 2009 [UK]	Economic Evaluation	MR	34	✓		✓	Refines PT1 – Work is needed to establish engagement before consultation with service users can take place.
Hewett, Halligan and Boyce, 2012 [UK] & Halligan and Hewett, 2011 [UK]	Descriptive Case Study	CL	N/A	✓	○	✓	Refine PT3: Advocacy is key where no agency wants to take responsibility. Note on PT2: Highlights difficulties engaging adult social care - potentially accounting for why reablement overlooked.
Hochron, and Brown, 2013 [US]	Exploratory case analysis	CL	N/A			✓	
Homeless Link, 2015 & Albanese, Hurcombe and Mathie, 2016 [UK]	External Evaluation of HHDF Programme	All	52	✓	○	✓	Note on PT2: Highlights difficulties engaging adult social care - potentially accounting for why reablement overlooked.
Housing LIN & DH, 2009 [UK]	Case Studies x3	HL & CL		✓		✓	
Lane, 2005 [UK]	Feasibility Study & Literature Review	MR		✓	○	✓	Note on PT2 raises issues around accessibility to physical rehabilitation.
Lewis, 2015 [UK]	External Evaluation	HL	10	✓	○	✓	Note on PT2: Highlights difficulties engaging adult social care - potentially accounting for why reablement overlooked.

Lowson and Hex, 2014 [UK] & Lephard, 2015 [UK]	External Econ. Evaluation & Project Report	CL + MR	39+	✓	○	✓	Note on PT2: Highlights how resettlement can encompasses aspects of reablement.
O'Carroll et al., 2006 [IRE]	Feasibility study	MR	N/A	✓	○	✓	Note PT2: notes many hostels exclude people with mobility issues
Parker-Radford, 2015 [UK]	Policy Review & Survey		184	✓	✓	✓	Advocates transition of care approach
Sadowski et al. 2009 [US]	RCT	SW+ MR	407	✓	○	✓	Note on PT2: Records an improvement in physical functioning from baseline for both intervention and control groups
Van Laere, Wit and Klazinga, 2009 [Holland]	Statistical case study	MR	629		○	✓	Note PT2: Notes that MR providing palliative care
Whiteford & Simpson 2015a [UK]	Exploratory case analysis	CL	18	✓	○	✓	Note on PT2 – Describes lack of access to physical rehabilitation/reablement services
Thin							
Buchanan et al. 2006 [US]	Cohort study	MR	225			○	Note PT3: Skilled nursing not provided, highlights role of 'volunteer health providers'
Danahay, 2014 [UK]	Project Report	HL	N/A			✓	
Doran et al., 2013 [USA]	Chart Review	MR	113	✓			
Doran et al, 2015 [USA]	Action Research	MR				✓	
Forchuk et al. 2008 [Canada]	RCT	HL	14			○	Refine PT3: Housing advocacy plus fast track income support seen as main mechanism
Gundlapalli et al. 2005 [US]	Descriptive case analysis	MR	N/A	○			Note PT1: Describes eligibility criteria linked to a range of MR provision in one county – consulting with service users not mentioned
Hewett et al., 2016 [UK]	Randomised Control Trial	CL	414				Effectiveness and cost effectiveness study
H3, 2015 [UK]	Project Report	HL	N/A			✓	
Kertesz et al., 2009 [US]	Retrospective Cohort study	MR	743	✓			
Lamb and Joels, 2014 [UK]	Case Study	CL	N/A	✓		✓	
Rae and Rees, 2015 [UK]	Phenomenological		14	○		○	Makes case for IC, focusing on importance of engagement and need for improved coordination

Poymow et al, 2005 [Canada]	Cohort Study	MR	140		✓		Note on PT2: One of few studies to list availability of physiotherapy on consultation
Redman, 2010 [UK]	Project Report	CL	N/A	✓	○	✓	Note on PT2: Highlights difficulties in meeting 'physical needs'
SERI, 2014 [UK] & Housing LIN (94), 2014, [UK]	External Evaluation	HL	Not given			✓	
Shelter and Coastline Housing, 2016 [UK]	Project Report	HL	N/A	✓		✓	
Wade, 2014 [UK]	External Evaluation	HL	8	✓		✓	
White, 2011 [UK]	External Economic Evaluation	HL	N/A				Provides evidence on cost effectiveness using HES data
National Health Care for the Homeless Council (2008)[US]	Policy and Practice Review	MR HL	N/A		✓	✓	