These case studies were used to promote the topic of the 2017 conference:

RACHEL – When it goes wrong…

Integration is a much needed characteristic of services supporting homeless people that isn't always achieved.

Rachel was 5 months pregnant with addiction and mental health issues when she was first placed in a bed and breakfast by a London Housing Options team - she lost her previous accommodation after benefit sanctions. However she was placed out of area, separating her from the workers that had supported her to access this new accommodation. She was left isolated, and a long way from her health support – and was then exploited by new neighbours.

Fortunately a peer advocacy organisation was able to continue working with her, and got her registered with a local GP. This was a 'luck of the draw situation' – many people would not get this support. The peer advocacy organisation then supported her to attend 24 appointments after this. During this time Rachel was moved to 4 different bed and breakfasts, and saw a variety of different professionals. Rachel was a victim of sexual assault which had resulted in her pregnancy, and had no family support. Despite 24 appointments Rachel did not access mental health support during this period.

Rachel was assigned a social worker to work in the interest of the unborn child. Communications between her social worker, support worker, drug worker and midwife were disconnected, with no one agency appearing to take the lead. The peer advocacy organisation ended up brokering the relationships between these agencies and Rachel herself.

At 8 months pregnant the peer advocacy organisation was asked to take Rachel to hospital to have her pregnancy induced. This was a Friday afternoon and on picking up Rachel, the peer advocate was told by B&B staff that Rachel would not be able to return. When concerns were raised with the Local Authority by the peer advocacy organisation, they were told this was because a decision had now been made that Rachel was intentionally homeless. Despite protests the peer advocacy organisation was told that if she was discharged from the hospital over the weekend, she would need to call the Local Authority out of hours number.

Rachel was eventually induced on the Monday, and gave birth on the Tuesday. Two days after the birth an interim care order was sought by children's services and this was successful. Rachel was separated from her baby and discharged from hospital that day at 7pm. She had nowhere to go and returned to rough sleeping. Rachel did not receive any post-natal care in the days because the community midwife was unable to contact her. When a midwife did get in touch with her by phone Rachel told her she had been sleeping rough and was having suicidal thoughts. The midwife called the police who went to look for her, but they were unable to find her.

The peer advocacy organisation attempted to make a referral to a specialist Women's project to find Rachel appropriate accommodation and support. However the referral was not accepted, due to a lack of some of the 'essential' referral information required. Instead Rachel was placed back in a bed and breakfast by Housing Options. Rachel does not currently have access to her child, and a revolving door situation is likely.

This conference considers how services can better integrate to support clients with complex needs, and give people like Rachel a fair chance of recovery.

PATRICK – When it goes right…

People who are homeless need significant coordinated support, and sometimes this is achieved.

Patrick became homeless in his early 30s following the breakdown of his marriage. A long history of alcohol and drug dependence, and a severe mental health episode then led to rough sleeping. His health continued to deteriorate on the street, and Patrick was frequently seen in local A&E departments with intoxication, and injuries from falls and assaults. Patrick became acutely disconnected from society, and numerous attempts by the outreach team to work with him failed.

As time passed concerns for his mental health and capacity increased. Obvious self-neglect, poor memory for times and events, and disordered conversation developed. Numerous teams became aware of Patrick and tried to assist – but it gradually became apparent that only a coordinated whole systems integrated approach would work, as he had 'multiple complex needs' – a common tag attached to some people, where a client's needs extend beyond the capabilities of one team. Patrick was refusing to see a GP.

In this case, a community nursing team based in a day centre took the lead. A relationship was gradually built by undertaking wound care, and giving support to return to claiming benefits. A coordinated effort from the nurses, a GP and psychiatrist that provided advice, the outreach team, an outreach nurse, and eventually the police and London Ambulance service enabled him to be admitted under the mental capacity act, which probably saved his life.

Once in hospital the neuropsychiatric team, social services and safeguarding, addictions, and homeless hospital discharge team then became involved, as well as the ward team – and in the early days of his care a significant effort was required to prevent self-discharge from everybody involved. Patrick's confusion did not resolve after alcohol detoxification and intravenous vitamins, so he was eventually transferred to a psychiatric hospital for further assessment and medication.

The supported housing team then became involved, and several housing options were considered. After over 10 years on the street, Patrick accepted accommodation in a local hostel where he could continue to drink, but had a safe place to live and a support network to monitor his health. At least 9 separate teams had been involved in his care, and this had involved significant coordination.

This conference considers how teams can continue to better integrate to ensure people like Patrick can continue to have their needs met.