The high rate of self-discharge from Accident and Emergency departments in people experiencing homelessness with proposed responses

June 2025

Sam Dorney-Smith, Dr Sam Regan de Bere, Theo Jackson, Dr Ayla Cosh, Jayne Barrett, Dr Alastair Green & Dr Elspeth Carruthers

Pathway
Homeless & Inclusion Health

Authors

- Samantha Dorney-Smith, Pathway Fellow, *samantha.dorney-smith@nhs.net*.
- Plymouth data: Dr Sam Regan de Bere, Academic Lead for Medical Humanities / Lead for Patient & Public Involvement, Peninsula Medical School, Plymouth, *samantha.regandebere@plymouth.ac.uk*.
- National Pathway teams' data: Theo Jackson, Research and Data Lead, Pathway, *theo.jackson@pathway.org.uk*.
- Cardiff data: Dr Ayla Cosh, Clinical Director Cardiff and Vale Health Inclusion Service, *ayla.cosh3@wales.nhs.uk*; Jayne Barrett, Primary Healthcare Nurse Cardiff Council Homeless MDT, *jayne.barrett@wales.nhs.uk*.
- London data: Dr Alastair Green, *alastair.green4@nhs.net*; Dr Elspeth Carruthers, *elspeth.carruthers@nhs.net*.

Table of Contents

Introduction 4

Mortality and morbidity in people experiencing homelessness 4

Challenges for people experiencing homelessness whilst in A&E and hospital 5

Method and findings: self-discharge in homeless and vulnerable populations 7

Data Analysis 8

Attendance and discharge experiences of No Fixed Abode and Addictions Patients at Derriford Hospital, Plymouth 8

'Pathway' homeless and inclusion health teams' data 9

Case series of people experiencing homelessness who self-discharged, Cardiff, Wales 11

Self-discharge case note audit in a London hospital emergency department 13

Summary of self-discharge rate data findings 14

Discussion 15

How can care be improved? 16

Resources and training to help improve care for people experiencing homelessness in Accident and Emergency 16

Provision of trauma informed care and communication 16

Recognise whether self-discharge is in fact self-neglect 16

Undertake mental capacity assessments 17

Other actions to take 18

Conclusion 20

References 21

Introduction

Self-discharge from an Accident and Emergency department or a hospital ward takes place when someone chooses to take their own discharge before this has been agreed with the clinical service provider. This can happen with the knowledge of the clinical service provider (where a discussion takes place, but the patient decides to leave, despite being offered reasons to stay longer), or without (where a patient takes their discharge without the active knowledge of the clinical service provider sometimes called 'absconding'). It can also happen before or after clinical assessment if the self-discharge takes place from A&E.

There is relatively little written about the causes and implications of self-discharge, but research indicates that 2-3% of the general population self-discharge from hospital each year in the UK [1]. Because they do not complete treatment, patients who self-discharge have been shown to be at high risk of returning to hospital, experiencing longer stays and worse health outcomes as a result, and costing more [2].

Prior research indicates higher rates of self-discharge for patients facing multiple forms of disadvantage, such as homelessness, mental health problems and addictions issues [2-4].

This paper follows up on this work by further documenting self-discharge rates for people experiencing homelessness in a variety of settings and from a variety of NHS locations (Plymouth, Cardiff, Leeds, London) in order to consider whether high self-discharge rates in this group is a ubiquitous finding.

It also considers what has been learned about effective and appropriate responses to improve care in this area, particularly in respect to responses in Accident and Emergency departments.

Mortality and morbidity in people experiencing homelessness

Office of National Statistics data shows that the average age of death of people identified as homeless on their death certificate in 2021 was 45.4 for men and 43.2 for women [5]. 35% of the recorded deaths were from drug overdose or poisoning, and 13.4% were from suicide. Evidence also shows that people experiencing homelessness suffer far higher rates of common chronic diseases than in the general population. In a study of 600 people experiencing homelessness that died in English hospitals between 2013 and 2017, the biggest killers were cardiovascular disease (30.1%), cancer (20.8%) and respiratory disease (16.9%) [6].

A key reason for this is that people experiencing homelessness have poorer access to health care. For example, patients without photo or address identification are frequently wrongly turned away from GP registration [7,8]. As a

result, they are known to attend A&E departments more frequently [9], often with more advanced health conditions.

High self-discharge rates may represent a further barrier to healthcare access for people experiencing homelessness. In the context of such poor health outcomes, self-discharge from hospital health services by people experiencing homelessness is potentially of serious concern.

Challenges for people experiencing homelessness whilst in A&E and hospital

Many people find Accident and Emergency departments and hospitals stressful and anxiety provoking. However, people experiencing homelessness have additional challenges that could make them more likely to self-discharge.

These include;

- Perceived stigma – research undertaken by Raes & Ree, 2015, and Gunner et al, 2019 outline how people experiencing homelessness often feel stigmatised when accessing health care, and how they worry about meeting negative attitudes, and staff reactions to their housing status, appearance, cleanliness etc [10,11]
- Fear – People experiencing homelessness say they worry about the worst-case scenario when attending hospital. This is particularly relevant in the context of having poor access to preventative health care and screening in the past and high-risk factors. Fear can also include anxiety about NHS charging for some non-UK nationals [12]
- Background mental health issues - In a large survey in 2022, 82% of people experiencing homelessness reported some form of mental health [13]
- Alcohol and drug withdrawal - 6 in 10 people sleeping rough had a drug or alcohol problem in 2018 [14]
- Being in pain - In a peer led study 62% of people experiencing homelessness reported currently being in physical pain, and 53% said they experienced chronic pain [15]. It is known that pain is sometimes overlooked in people who are withdrawing from alcohol or drugs.
- Neurodiversity – A study found that 12% of people experiencing homelessness have autistic traits [16]
- Language – 47.5% of people seen sleeping rough in London 2021-2022 were non-UK born [17]
- Literacy – A study in 2010 showed that 55% of participants reported having difficulty filling in forms [18]. A further study in 2014 showed that 51% people who are homeless lack the basic English skills needed for everyday life [19]

- Brain injury and cognitive deficits – People experiencing homelessness are ten times more likely than the general population to have experienced a moderate to severe traumatic brain injury [20]

Method and findings: self-discharge in homeless and vulnerable populations

As stated in the introduction the term self-discharge covers several different scenarios – self discharge before and after clinical assessment, and with or without clinician engagement. Unfortunately, there is no current standard way in which these different scenarios are recorded and differentiated in hospital records the UK. In addition, there is no routine requirement for hospitals to return self-discharge rates from A&E or hospitals in the UK.

As such, the data presented in this paper have been measured in slightly different ways, and come from anonymised needs assessments, service quality improvement work, and key performance indicator data from Pathway teams. The reasons for obtaining the data, methodology, and caveats on the data are explained in each case.

Data Analysis

Attendance and discharge experiences of No Fixed Abode and Addictions Patients at Derriford Hospital, Plymouth

Dr Sam Regan de Bere with Dr Suzanna Nunn and Mr Clive Rowe

A needs assessment was undertaken to examine hospital services attendance behaviours amongst individuals experiencing homelessness and/or addictions in Plymouth. The work was motivated by anecdotal evidence that suggested high rates of incomplete care episodes for people classed as being homeless or having No Fixed Abode in the emergency department (ED), inpatient settings (IP) and for outpatient appointments (OP).

Three sets of self-discharge data were compared for the period 01/12/2018 – 30/11/2019:

- 'No Fixed Abode' (NFA) / Addictions cohort – this cohort was defined as patients registered on University Hospitals Plymouth NHS Trust patient records as either being identified as 'homeless' (e.g. recorded as NFA or living in a homeless hostel) or having a specific addictions ICD10 code.
- PL1 cohort - the PL1 postcode cohort included all people presenting from the most deprived postcode area of the city (based on Indices of Multiple Deprivation 2018 scores). This included areas of the city in which homeless / NFA patients were known to reside.
- PL - General Plymouth population, identified as anyone presenting with a PL postcode.

The data collected in the study show that the NFA / Addictions cohort had much higher rates of self-discharge from the all settings, compared to the most deprived area of Plymouth (PL1) and the wider Plymouth cohort (Table 1). Overall, 14.8% of all NFA/Addictions cohort members identified in the data pull self-discharged from either ED or IP settings.

Table 1: *Self discharge rates at Derriford hospital, Plymouth 01/12/2018 – 30/11/2019*

Location of self-discharge	NFA/Addictions cohort	PL1 cohort	PL cohort
Emergency Department (ED)	15.2%	6.0%	4.0%
Inpatient setting (IP)	13.8%	2.8%	1.6%
Outpatient setting (OP)	24.2%	7.7%	4.7%

N.B. the data presented for outpatient settings are when a DNA (did not attend) is recorded in the record.

The qualitative element of the study (consisting of interviews and focus groups with people experiencing homelessness and healthcare staff) highlighted issues with stigma and discrimination, the intense and stressful nature of ED spaces, long waiting times (which were identified to be particularly difficult for substance misuse patients), and a lack of specialist support generally for patients with complex needs within the hospital.

This data, and a wider needs assessment, led to the commissioning and set up of specialist, multi-disciplinary 'Pathway' homeless and inclusion health team in late 2022, which now covers acute and community settings.

'Pathway' homeless and inclusion health teams' data

Theo Jackson

'Pathway' homeless and inclusion health teams are NHS employed specialist teams, that are supported by the Pathway charity. These teams provide targeted care coordination for people experiencing homelessness when they come into hospital, in order to maximise the benefit of the admission, and ensure discharges are safe, effective and sustainable. The Pathway charity sees self-discharge as a failure of care and works to avoid this wherever possible.

For each referred patient, Pathway teams collect a range of patient-level information, including housing status at admission and discharge, demographics, high level patient needs (e.g. mental health, addictions) and discharge outcomes. These data are used primarily for service evaluations, business cases and quality improvement for individual teams, but are also aggregated for wider research and policy work.

Data was collated and analysed for the period 1 April 2022 – 30 March 2023 for the purposes of this article. The dataset used in this analysis contains records of 2186 referrals for patients experiencing homelessness across 6 Pathway teams (5 London based, 1 Leeds – all teams for which a full set of data was available).

Across the 6 teams, overall self-discharge rates ranged from 12.9% to 18.2%, and for the whole cohort (n=2285) the self-discharge rate was 14.6%. Overall, a higher rate of self-discharge was identified for ED patients (16.6%) compared to Inpatients (13%) (Table 2).

Table 2: *Pathway teams' summary self-discharge data 1 April 2022 – 30 March 2023*

	Overall self-discharge rate	Inpatient self-discharge rate	Emergency department self-discharge rate
Team 1	12.9%	12.8%	13.3%
Team 2	13.2%	10.1%	21.9%
Team 3	13.6%	8.1%	17.2%
Team 4	14%	8.4%	17.2%
Team 5	14.9%	16.1%	13.8%
Team 6	18.2%	16.9%	24.4%
Total Cohort	14.6%	13%	16.6%

Patients who are referred to Pathway teams often present with complex combinations of physical health, mental health, addictions and safeguarding needs (for example, 55% of all referrals had addictions support needs). As shown in Table 3 below, patients with mental health needs, addictions needs and safeguarding concerns displayed higher rates of self-discharge than those without. The same was true for those who were rough sleeping on admission. Although further research is needed, the data presented here suggest that patients with more complex needs may be at higher risk of self-discharge.

Table 3: *Pathway teams' self-discharge data linked to support needs 1 April 2022 – 30 March 2023*

	% with this need who self-discharged	% without this need who self-discharged
Mental Health	15.3%	12.9%
Addictions	17%	10.7%
Mental Health + Addictions	16.9%	11.2%
Safeguarding Concerns	15.6%	11.9%
Rough Sleeper (admission)	21.1%	13.3%

Self-discharging from hospital may also prevent patients experiencing homelessness from receiving housing support from hospital staff (either via the statutory Duty to Refer or alternative advocacy). Table 4 shows that, for inpatients, a greater reduction in rough sleeping was seen amongst patients who did not self-discharge.

Table 4: *Pathway teams' self-discharge data linked to returns to rough sleeping 1 April 2022 – 30 March 2023*

Inpatients	Rough sleeping on admission	Rough sleeping on discharge	% change in rough sleeping
Self-Discharge - Yes	73	49	- 33%
Self-Discharge - No	235	68	- 71%

Case series of people experiencing homelessness who self-discharged, Cardiff, Wales

Dr Ayla Cosh, Jayne Barrett

In response to concerns about poor outcomes for people experiencing homelessness, data was collected locally from Cardiff and Vale Emergency Unit on usage by people experiencing homelessness. Patients were searched for using 'NFA', or any of the frontline homeless hostel addresses. Results showed that between April 2019 and March 2020 620 homeless individuals visited the Emergency Unit (EU) a total of 1,170 times, equating to 1.9 attendances per patient (this compared to 1.4 times in the general population). This increased usage of the Emergency Unit for the population was also reflected in the National Welsh data where 2020 figures from Public Health Wales show EU attendance in the homeless population was 562 per 1000 population compared with 83 per 1000 population in the general population. The concern was that despite this increased use of emergency services, it was felt that many patients were still not getting the holistic care that they needed. A key reason for this was felt to be a pattern of high self-discharge rate in this patient group.

In response, a case study analysis of 5 individuals who had self-discharged and/or absconded was conducted, in order to consider ways to improve care, and profile good practice. A summary of one of these cases is presented in Box 1.

In addition, a series of questionnaires was conducted, asking people experiencing homelessness about their access to healthcare and Emergency Unit experience, to which 30 people responded.

The case studies and questionnaires demonstrated a need for a trauma informed and flexible approach to patients experiencing homelessness and a need for joined up care between the hospital and community. Frequently, service users specifically requested more flexible services to better meet their needs in the Emergency Department e.g. more sensitivity to alcohol and substance misuse withdrawal, greater understanding of the need to smoke, better interpretation services, better pain management etc. Based on these results and the case studies, various ways to improve healthcare access for

homeless individuals are being explored, including the enhancement of existing community provision, but also specialist homeless nursing input into the emergency unit.

Box 1: Case study

Patient A – female in her 20s living in a hostel

In Local Authority care as a child, and opioid dependent by age 14. Several custodial sentences. She was not registered with the local GP, due to her moving in and out of practice boundary areas.

She attended the Emergency Unit with a cough, shortness of breath and chest pain. Her D Dimer was raised, but she self-discharged due to opioid withdrawal before having a VQ scan. The next day she returned to the hospital where due to the wait, she left again due to opioid withdrawal. The same pattern occurred on day 3.

On day 4, she attended a GP outreach clinic at one of the hostels. The GP arranged with the medical team and the radiology the exact time of the scan so she could attend via taxi without waiting. She was diagnosed with a pulmonary embolism, was given Clexane, and discharged with a prescription to collect, and advised she would be contacted to attend outpatient clinic. However, this arrangement fell through as she did not pick up the prescription, and her phone number was not working. She then attended the GP clinic again on day 7 having only had one dose of Clexane.

Support from the outreach health care team

The outreach GP then prescribed daily Clexane and the nursing team taught her how to administer it, ensuring she had an adequate supply, and arranged regular (but flexible) visits and appointments. The persistence of the healthcare team and hostel support staff were instrumental in building trust. She then completed a three-month course of Clexane and was supported to attend an outpatient appointment and register with a GMS practice.

This case illustrates the importance of health outreach into hostels, allowing longer contact times with these patients, and the need for a partnership approach between Emergency Units and specialist primary care.

Self-discharge case note audit in a London hospital emergency department

Dr Alastair Green, Dr Elspeth Carruthers

A case note audit on recurrent self-discharges from an emergency department of a London hospital. Data was gathered on all patients aged 18 and over attending the emergency department between March and September 2022 whose outcome was coded as 'left before assessment' or 'left before treatment complete'. Cases were limited to patients who had self-discharged more than once. Notes were reviewed for the first 30 patients who met the inclusion criteria, and data was extracted on demographic details, documentation of self-discharge, and vulnerabilities.

Of the 30 patients 70% were male. 93% self-discharged between 2 and 5 times. 73% left the department before initial assessment, and 27% left before treatment was completed.

Overall, 60% of notes did not contain documentation specifically relating to the self-discharge. Where documented, reasons given for wanting to self-discharge included feeling better, long waits, and planning to come back the next day when it was less busy. However, in 83% of cases no reason for the intention to self-discharge was recorded. In 87% of cases, no discussion around the person's mental capacity was documented. Only 10% had evidence of a signed self-discharge form. 17% had a documented mental health condition, 17% had a documented substance misuse disorder and 27% had documented evidence of another vulnerability, however it is likely this was under-recorded. Many of these individuals are thought to have homelessness issues but this was not evident on the notes. In 27% of cases, there was documented attempt to make contact with the patient after self-discharge, with some positive outcomes in terms of continuation of health care.

This audit demonstrated that documentation around self-discharge was poor and required improvement. It was therefore difficult to draw conclusions about motivations or what could be done to prevent self-discharge per se.

However, the audit outlined a clear opportunity to improve both documentation, and processes - in order to understand and develop interventions to reduce self-discharges, and ensure safe process around self-discharge. It also suggested that there was a positive gain in ensuring self-discharging patients are contacted for follow-up.

Summary of self-discharge rate data findings

Data from the two sources in this article are consistent with the previous findings of Moss et al [3] and Paudyal et al [4], where Emergency Department discharge rates were 14.8% and 18.4%. Table 5 below presents data from two of the above sources compared to two previously published articles, all investigating self-discharge rates amongst people experiencing homelessness.

Table 5: *Self discharge rates in homelessness cohorts*

	Moss et al	Paudyal et al	Plymouth	Pathway
Time period	2013 - 18	2014 - 19	2018-19	2022-23
Total ED attendances	109,254	3271	2482	823
Total ED self-discharges	15,940	601	378	137
% ED self-discharge	14.6%	18.4%	15.2%	16.6%
Total IP Admissions	N/A	N/A	1155	1363
Total IP self-discharges	N/A	N/A	159	177
% IP self-discharge	N/A	N/A	13.8%	13%
% overall self-discharge	N/A	N/A	14.8%	14.4%

Across the 4 pieces of work the average self-discharge rate from ED settings is 16.2%. Despite the limitations of each dataset, the consistency in self-discharge rate across sources and the large sample sizes for each indicate that these figures are an accurate representation of self-discharge rates for this cohort.

Evidence is limited regarding self-discharge rates in the general population. However, Moss et al [3] found that a greater percentage of people experiencing homelessness left before treatment than the general population (15% vs. 4%). By means of comparison, a recent seven country European study revealed average self-discharge rates of 11.9% in patients attending for substance misuse issues [21].

Discussion

The studies presented in this paper suggest higher rates of self-discharge amongst people experiencing homelessness, and people with mental health problems, addictions issues, and other vulnerabilities in line with previous research in this area. As these studies consider different settings and locations, it is suggested that this finding is ubiquitous. The Plymouth work is particularly important, in drawing out the increased impact of homelessness and addiction on self-discharge, and showing that higher self-discharges rates do not arise from deprivation alone. When combined with the self-discharge rates in 2 prior studies an average self-discharge rate of 16.2% is suggested, this means that on average 1 in 6 presentations are not receiving treatment.

The studies also demonstrate that improvements in care are needed to meet the needs of these clients e.g. in the areas of the management of alcohol and substance misuse withdrawal and pain, trauma informed care, and safer, more robust, self-discharge processes involving effective mental capacity assessments. Long waiting times have also been identified as a key driver of self-discharge, particularly in people with addictions.

Self-discharges prevent patients from accessing healthcare. For patients experiencing homelessness, they also prevent patients from receiving referrals to the Local Authority under the Homeless Reduction Act (2017) and/or housing advocacy from hospital discharge teams. They are likely to negatively affect health outcomes and increase the likelihood of emergency reattendances to hospital. In the context of high mortality and morbidity rates, reducing self-discharges for this population group is a key priority. The Pathway data demonstrates that housing outcomes for people experiencing homelessness who self-discharge are unsurprisingly significantly worse.

One study suggests that many clinicians understand and empathise with the reasons why patients self-discharge [1], and want to help. It is also true that local traditional primary care services are not set up or resourced to provide the types of community services that are needed which is why this group often and up in the emergency department at crisis point. However, the current capacity challenges in Accident and Emergency departments [22] mean that even although self-discharge rates across all populations are increasing, that it is hard to respond in bespoke ways.

Despite this, as a group of practitioners, we propose that self-discharges in disadvantaged groups should be seen as a suboptimal outcome, of particular concern. We propose that audits of self-discharge reasons and rates, and introducing simple care improvements to assist people experiencing homelessness and other vulnerable groups to stay, could be seen as an effective measure of hospital culture.

How can care be improved?

Resources and training to help improve care for people experiencing homelessness in Accident and Emergency

NHSE published a toolkit in 2022 to assist health care practitioners improve in A&E: https://www.england.nhs.uk/publication/supporting-people-experiencing-homelessness-and-rough-sleeping/

Fairhealth / Pathway have also published a free on-line training module on homelessness, self-discharge, self-neglect and mental capacity assessments for A&E staff in 2023, that is also very relevant to staff working on short stay or admissions wards. https://www.fairhealth.org.uk/course/homelessness-ed

Provision of trauma informed care and communication

A key tool to combat self-discharge is ensuring that trauma informed approaches are being implemented [23] which focus on thoughtful and skilled communication and engagement, and the active removal of environmental triggers. 9% of the general population have experienced four or more Adverse Childhood Experiences (ACEs) [24], and we know these are very common in people experiencing homelessness. Exposure to ACEs negatively impacts communication and engagement in adult life. Staff need to be made aware of the effects of trauma on people experiencing homelessness and plan their approach to care to avoid re-traumatising patients and help to build engagement and trust. As part of this there also needs to be active planning to reduce the barriers to care that arise from language, literacy, neurodiversity, brain injury, addictions, pain and mental health as described in the earlier section.

Recognise whether self-discharge is in fact self-neglect

Self-discharge is often an indicator of self-neglect. Self-neglect was recognised as a safeguarding concern in the Care Act in 2014. Self-neglect is a lack of self-care to the extent that it is life threatening. This includes neglecting to care for one's personal hygiene, health, safety or surroundings, and any inability to take action to avoid future harm. It often involves a failure to seek help or access services in the first place and may be present in those who self-discharge.

Many deaths in people experiencing homelessness are known to have involved safeguarding failures [25], and 45% of these deaths involve self-neglect [26]. Many also involve addictions. Reports reviewing these safeguarding failures often point to underlying discrimination and assumptions being made about

people experiencing homelessness and perceived 'unwise choices', and a lack of understanding of self-neglect. Failures regarding mental capacity assessments, a lack of connections being made between involved partner agencies and a lack of coordinated plans being made are also implicated [25]. If you have been unable to prevent someone from self-discharging consider whether they need a safeguarding referral for self-neglect.

Undertake mental capacity assessments

People who self-discharge should have their mental capacity assessed regarding this decision.

However, it is recognised that even in a trauma informed environment the conversations and mental capacity assessments that are required when people self-discharge, can take a long time and can be very challenging to deliver. Patients are often unwilling or find it difficult to engage. In these situations, difficulties in undertaking the assessment should be highlighted to senior staff, and subsequent responses agreed together, rather than (as sometimes happens) simply referring to prior mental capacity decisions. A Multi-Disciplinary Team discussion, and escalation of concerns using standard organisational processes may be needed.

Caution also needs to be taken with the concept of the 'presumption of capacity'. When someone refuses to engage in the decision-making process, and/or they are difficult to communicate with, and it is not possible to complete an assessment, the Mental Capacity Act is often used to say that we must assume the person has mental capacity. This is not the correct interpretation, particularly if there is an immediate concern about a high risk of harm.

As noted by House of Lords Select Committee in its post-legislative scrutiny of the MCA 2005 in 2014:

> *'The presumption of capacity, in particular, is widely misunderstood by those involved in care. It is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm. In some cases this is because professionals struggle to understand how to apply the principle in practice. In other cases, the evidence suggests the principle has been deliberately misappropriated to avoid taking responsibility for a vulnerable adult.' (para 105) [27]*

If someone is leaving an A&E department with serious health problems, who has not been proved to have mental capacity around this decision, Deprivation of Liberty Safeguards can be considered. Although it is a commonly held view that a DOLS process cannot be undertaken in A&E, because the person is not yet admitted to hospital, this is not accurate. The Law Society [28] is clear that you can use DoLS in A&E and scenarios are presented.

'Although most people's stay in A&E is of short duration, as the scenarios below show, this does not of itself mean that a deprivation of liberty cannot occur during such a stay.'

Although it is unlikely this process will be used in an A&E setting regularly, a care plan for a frequent attender who regularly self-discharges (where there are concerns that the person is self-neglecting and deteriorating in their health status) might include a suggestion to consider a DOLS procedure for a future presentation.

It is also important that anyone undertaking mental capacity assessments in people experiencing homelessness understands the prevalence of frontal lobe injuries on decision making and its impact on behaviour and executive capacity. People with acquired brain injuries often present with impairments to executive functioning. Such individuals may struggle in practice to plan, organise and initiate activities that they are perfectly well able to describe being able to do. They can fail to act or carry out actions to protect themselves from harm - such people can 'talk the talk, but not walk the walk'. In this case of someone with a frontal lobe brain injury it may be necessary to get collateral information from other services to get an accurate assessment of mental capacity.

Other actions to take

Other actions that can be taken to improve care in Accident and Emergency departments include:

- Find out if you have specialist inclusion health services and/or practitioners and street outreach teams locally and make contact with them
- If no inclusion health services exist consider contacting your local public health team to discuss the need for a needs assessment to gather evidence on new approaches – your local primary care providers will appreciate this support
- Provide up to date information on community support throughout the hospital

- Introduce a ‘safe discharge checklist’ in A&E [29]
- Red flag frequent attenders who are homeless and self-discharge and review their cases
- Ensure your hospital complies with the statutory ‘Duty to Refer’ people experiencing homelessness to the Local Authority with their consent [30]
- Proactively identify people’s housing status in clinical assessments, in order to identify people experiencing homelessness early on in an admissions
- Support GP registration by providing ‘My Right to Healthcare cards [31]
- Identify a homelessness / inclusion health lead in the hospital / in key clinical areas
- Undertake a formal audit of current care provision e.g. self-discharge
- Consider whether your hospital need specialist staff or a specialist service e.g. a ‘Pathway’ team (https://www.pathway.org.uk/)

Conclusion

This article has outlined that high self-discharge rates are associated with homelessness, as well as addictions and mental health problems, and that this has damaging effects on this vulnerable population accessing appropriate healthcare. Associated qualitative work suggests that improvements in care are needed in Accident and Emergency departments to reduce the rates and impacts of this self-discharge on mortality, morbidity and overall health costs.

References

1. Machin LL, Goodwin D, Warriner D. An Alternative View of Self-Discharge Against Medical Advice: An Opportunity to Demonstrate Empathy, Empowerment, and Care. *Qualitative Health Research*. 2018;28(5):702-710. doi:10.1177/1049732318754514
2. Albayati A, Douedi S, Alshami A, Hossain MA, Sen S, Buccellato V, Cutroneo A, Beelitz J, Asif A. Why Do Patients Leave against Medical Advice? Reasons, Consequences, Prevention, and Interventions. Healthcare (Basel). 2021 Jan 21;9(2):111. doi: 10.3390/healthcare9020111
3. Paudyal V, Ghani A, Shafi T, et al. (2021) Clinical characteristics, attendance outcomes and deaths of homeless persons in the emergency department: implications for primary health care and community prevention programmes. Public Health; 196:117–23.
4. Moss C, Anslemi L, Sutton M (2023) Emergency department outcomes for patients experiencing homelessness in England: retrospective cross-sectional study, *European Journal of Public Health*, Volume 33, Issue 2, April 2023, Pages 161–168, https://doi.org/10.1093/eurpub/ckac191
5. Office of National Statistics (2022) Deaths of homeless people in England and Wales: 2021 registrations. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2021registrations
6. Aldridge R et al. (2019) Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England. Welcome Open Research. Available at: https://wellcomeopenresearch.org/articles/4-49
7. Doctors of the World, United Kingdom (2018) Registration refused: a study on access to GP registration in England - update 2018. Available at: https://www.doctorsoftheworld.org.uk/wp-content/uploads/2019/08/Registration-Refused-final.pdf
8. Friends, Families and Travellers (2021) Locked Out: 74% of GPs refused registration to nomadic patients during COVID-19 Pandemic. Available at: https://www.gypsy-traveller.org/news/locked-out-74-of-gps-refused-registration-to-nomadic-patients-during-covid-19-pandemic/
9. Matthew Bowen, Sarah Marwick, Tom Marshall, Karen Saunders, Sarah Burwood, Asma Yahyouche, Derek Stewart, Vibhu Paudyal (2019) Multimorbidity and emergency department visits by a homeless population: a database study in specialist general practice British Journal of General Practice; 69 (685): e515-e525. DOI: 10.3399/bjgp19X704609
10. Rae, B.E. & Rees, S. (2015) The perceptions of homeless people regarding their healthcare needs and experiences of receiving healthcare. Journal of Advanced Nursing 71(9), 2096–2107. doi: 10.1111/jan.12675
11. Gunner E, Chandan SK, Marwick S, Saunders K, Burwood S, Yahyouche A, Paudyal V. Provision and accessibility of primary healthcare services for people who are homeless: a qualitative study of patient perspectives in the UK. Br J Gen Pract. Aug;69(685):e526-e536. doi: 10.3399/bjgp19X704633. PMC6650120.
12. British Medical Association (2019) BMA says charging regulations for overseas patients are threatening the quality of NHS care. 18 April 2019.

https://www.bma.org.uk/news/media-centre/press-releases/2019/april/bma-says-charging-regulations-for-overseas-patients-are-threatening-the-quality-of-nhs-care
13. Homeless Link (2014) The unhealthy state of homelessness https://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf
14. St Mungos (2020) Knocked back: Failing to support people sleeping rough with drug and alcohol problems is costing lives Available at: https://www.mungos.org/publication/knocked-back/
15. Groundswell (2018) Out of Pain. Breaking the cycle of physical pain and homelessness Available at: https://groundswell.org.uk/wp-content/uploads/2018/10/Groundswell-Out-of-Pain-Full-Report.pdf
16. Churchard, A., Ryder, M., Greenhill, A., & Mandy, W. (2018). The prevalence of autistic traits in a homeless population. Autism, 1362361318768484
17. CHAIN ANNUAL REPORT GREATER LONDON APRIL 2021 - MARCH 2022 https://data.london.gov.uk/dataset/chain-reports
18. Thamesreach (2010) Turning the Key: Portraits of low literacy amongst people with experience of homelessness. Available at: https://thamesreach.org.uk/wp-content/uploads/2017/07/Turning-the-Key-Literacy-Report.pdf
19. St Mungos (2014) Reading Counts: why English and maths skills matter in tackling homelessness Available at: https://www.mungos.org/publication/reading-counts-english-maths-skills-matter-tackling-homelessness/
20. O'Connor T, Panenka W, Livingston E at al (2022) Traumatic brain injury in precariously housed persons: Incidence and risks Lancet eClinicalMedicine 2022;44: 101277 Published online 1 February 2022 https://doi.org/10.1016/j.eclinm.2022.101277
21. Vallersnes, O.M., Dines, A.M., Wood, D.M. et al. (2023) Self-discharge during treatment for acute recreational drug toxicity: an observational study from emergency departments in seven European countries. Int J Emerg Med 16, 86 https://doi.org/10.1186/s12245-023-00566-1
22. RCEM (2022) Tip of the Iceberg: 12 hour stays in the Accident and Emergency Department. https://rcem.ac.uk/wp-content/uploads/2022/06/Tip-of-the-Iceberg-12-Hour-Stays-in-the-Emergency-Department.pdf
23. Brown T, Ashworth H, Bass M, Rittenberg E, Levy-Carrick N, Grossman S, Lewis-O'Connor A, Stoklosa H. Trauma-informed Care Interventions in Emergency Medicine: A Systematic Review. West J Emerg Med. 2022 Apr 13;23(3):334-344. doi: 10.5811/westjem.2022.1.53674. PMID: 35679503; PMCID: PMC9183774.
24. Bellis, M.A., Hughes, K., Leckenby, N. et al. National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England. BMC Med 12, 72 (2014). https://doi.org/10.1186/1741-7015-12-72
25. Homeless Link (2021) Adult Safeguarding and Homelessness: Learning from Safeguarding Adult Reviews. Available at: https://homelesslinkstage-1b54.kxcdn.com/staging/media/documents/Learning_from_Safeguarding_Adult_Reviews_2021.docx.pdf
26. Preston-Shoot, M (2021) Effective work with adults who self-neglect and/or experience homelessness: the evidence base from research and reviews. London SAB. Available at: http://londonadass.org.uk/wp-

content/uploads/2021/11/London-SAB-Conference-evidence-base-for-self-neglect-and-homelessness.pdf
27. UK Parliament (2014) Mental Capacity Act 2005: post-legislative scrutiny - Select Committee on the Mental Capacity Act 2005. Available at: https://publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/13904.htm
28. Law Society (2019) Identifying a deprivation of liberty: a practical guide The hospital setting. Available at: https://www.lawsociety.org.uk/topics/private-client/deprivation-of-liberty-safeguards-a-practical-guide
29. NHSE (2022) Supporting people experiencing homelessness and rough sleeping. Available at: https://www.england.nhs.uk/publication/supporting-people-experiencing-homelessness-and-rough-sleeping/
30. Gov.UK (2018) A guide to the duty to refer. Available at: https://www.gov.uk/government/publications/homelessness-duty-to-refer/a-guide-to-the-duty-to-refer
31. Groundswell (2019) 'My right to healthcare' cards. Available at: https://groundswell.org.uk/resources/healthcare-cards/#:~:text=What%20is%20a%20'My%20right,GP%20practice%20is%20not%20acceptable.