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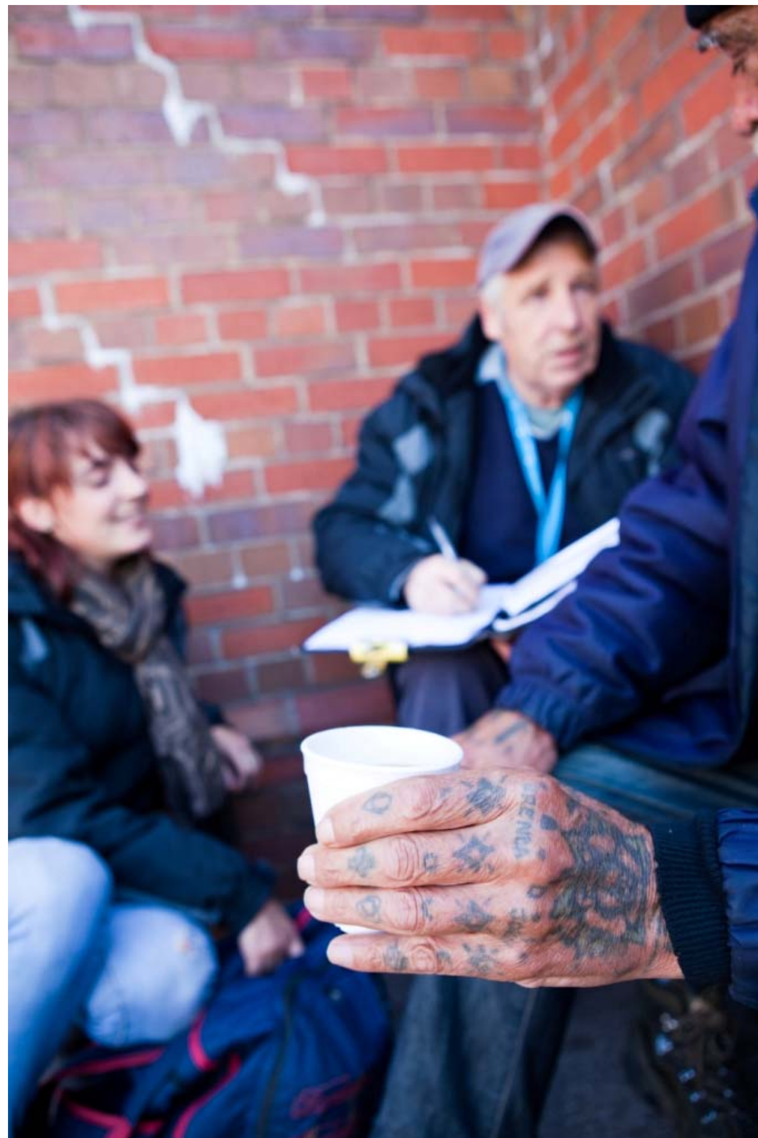
SEPTEMBER 2011

ROUGH TREATMENT FOR ROUGH SLEEPERS –

An investigation into the way that medical treatment for homeless people could improve.



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Introduction - **Health and homelessness**

There is powerful evidence that some people will live shorter lives than others and spend a greater proportion of that shorter life in poor health. The Marmot report[1] clearly links health inequalities to wealth inequalities. These differences are then often explained by looking at the determinants of health, especially lifestyle behaviours, to explain the differences in mortality and morbidity between different groups in society.

This document takes a slightly different approach. It looks at the experience homeless people have of using health services and the impact that this has on their health. It focuses on whether by offering health services in a different way homeless people may have better health outcomes. The last 20 years have seen an increasing awareness of the importance of iatrogenic illness, particularly hospital borne infections and pharmaceutical interactions. We hope therefore that in discussing the negative impact of certain models of healthcare on homeless people we will not be seen as being critical or arrogant. On the contrary, we hope that the experience of Brighter Futures might contribute to a shared learning in which more sympathetic and appropriate medical interventions could be used throughout health services to could contribute widely to reducing health inequalities.

There is a remarkable consistency across the population of homeless people throughout England in the illnesses they suffer from, the way they use health services and their attitudes towards their health.

"It is well recognised that homeless people face barriers accessing mainstream services and experience high and complex health needs. These people often have the highest health needs, the poorest health outcomes and can require the most costly services if left untreated."[2]

In order to address these issues of poor health outcomes and need for costly treatments, we need to understand the relationship between homelessness and poor health. Over the last ten years government policy has had a strong focus on reducing rough sleeping and homelessness. This has led to a lot of research into why people become homeless and particularly why some end up rough sleeping.

Some of the links between homelessness and ill health may seem to be self-evident. The circumstances of many homeless people are apparently conducive to poor health. Living on the streets without access to shelter, warmth, a healthy diet and being vulnerable to assaults and attacks means that homeless people are at greater risk of poorer physical and mental health. However, whether or not these factors are the main cause of illness is not actually clear. The Department of Health (DOH) Chief Analyst noted that two thirds of chronic conditions suffered by homeless people are known to have existed prior to someone becoming homeless and that personality disorder, post traumatic stress disorder, complex trauma and conduct disorders amongst children are strong predictors of homelessness. This paper explores the relationship between health and homelessness, concentrating on how homeless people use health services and whether we could spend our resources more effectively.

Gill Brown

September 2011

Chapter ONE:

Who is homeless: the effect of oppression and stigma

The group of people who are referred to as homeless is not homogenous and neither are their experiences the same. A woman escaping domestic violence who takes her children with her to a refuge will be different from the heroin addict who sleeps rough. People who are homeless are not necessarily rough sleepers. People can be classed as homeless under legislation whilst they continuing to occupy a home.

In the study of the health needs of single homeless people,[3] the Office of the Chief Analyst in the Department of Health referred to five different groups of people all of whom could be classed as homeless.

1. People who lived in overcrowded or unfit homes.
2. “Priority” individuals in temporary accommodation. The priority comes from their right to be housed under homelessness legislation.
3. Sofa surfers or squatters.
4. Individuals in the hostel system.
5. Rough sleepers.

The report was concerned with the experiences of the last three groups on this list, sofa surfers, hostel dwellers and rough sleepers. This report also noted that Stoke Primary Care Trust (PCT) was in the top 30 PCTs for hostel dwellers per head of population.

Inclusion Health[4] was produced by the Social Exclusion Unit looking specifically at how certain groups of socially excluded people accessed health services. They looked specifically at the experience of:

1. Sex workers.
2. Mental health.
3. Gipsy, traveller and Roma communities.
4. Drug and alcohol.

5. Learning disability.
6. Homeless and rough sleepers.
7. Some offenders.
8. Asylum seekers and refugees.

More recently the Department for Communities and Local Government (CLG) published a report on a programme which looked at adults who were chronically excluded[5]. Rather than looking at identifying groups they identified particular characteristics associated with chronic exclusion.

1. Risk of self harm, neglect, harm to others, crime.
2. Lack of resilience – trauma, illness, disability, emotional development.
3. Lack of positive relationships, personal, agency, due to poor social skills, abusive and exploitative relationships.
4. Lack of a consistent other adult in whom they can trust.

These characteristics of chronic exclusion have also been found in people living in hostels and sleeping rough who are described as having complex needs.[6] This report is concerned primarily with the health needs of hostel dwellers and people who sleep rough; we also include street sex workers in this group. We believe that street sex work is how most homeless women "sleep rough".

Having defined the group of people we are referring to when we talk of homeless people, the next question to ask is, is there any relevant link between health conditions and social conditions? In other words is there a link between certain illnesses and social attitudes that leave people at greater risk of homelessness and if so why? How certain groups are stereotyped and oppressed and the work of Goffman, Phelan and Link on sigma may hold some importance clues.

Oppression, stigma and health.

Goffman[7] identified three basic forms of stigma:

1. Overt or external deformations, such as scars, physical manifestations of anorexia nervosa, leprosy or of a physical disability or social disability, such as obesity.

2. Deviations in personal traits, including mental illness, drug addiction, alcoholism, and criminal backgrounds.
3. Tribal stigmas. These are traits, imagined or real, of ethnic groups, nationalities, or religions that are deemed to constitute a deviation from what is perceived to be the prevailing normative ethnicity, nationality or religion.

These three basic forms of stigma are really just the excuses used by the powerful to oppress their fellow human beings. The mechanism by which society denies people the equality that is due to them is called oppression. Oppression is where a group of people systematically deny someone else the right proudly and powerfully to be themselves on the basis of that person's membership of a particular group. Characteristics are falsely assumed to apply to all members of the group. Stereotyping is the way people are stigmatised, their identity lost and individuals become oppressed. Oppression is usually, but not exclusively, perpetrated by groups which are seen as being more powerful than their target. It is clear that the excuses identified by Goffman allow the oppression of people with alcohol and drug addictions as well as physical or mental health problems, and that this often leads to homelessness or rough sleeping.

Link and Phelan[8] analysed data from the USA in which multiple stigmatising factors were taken into consideration in relation to self esteem. They found that stigma could explain a full 20% of the variance in self-esteem beyond the effects of age, sex and years of education. They also noted that the extent to which a stigmatised person is denied the good things in life, and suffers more of the bad things, has been posited as a source of chronic stress with consequent negative effects on mental and physical health. The added harm done by alcohol and drug misuse leads to a host of associated health problems which reinforce the downward spiral of poor health in homeless people.

Chapter TWO:

The health of homeless and excluded groups

Reports into the health needs of socially excluded people have reported that:

Only 30% of Irish travellers live beyond their 60th birthday.[6]

85% of street sex workers report heroin use and 87% crack cocaine use.[6]

People with a learning disability are 58 times more likely to die prematurely than the general population.[6]

Hepatitis B & C infection amongst women in prison is 40 and 28 times the rate of infection in the general population respectively.[6]

The greatest health needs are found in those hostels residents who are described as at the "first stage" up from the street and amongst people who sleep rough.[5]

Homeless people experience higher levels of premature mortality. Someone who sleeps rough has a life expectancy of 42 years.[9]

These issues are hardly marginal. In terms of people with a dual diagnosis, which creates a complexity of needs, it is estimated that seven out of ten people who walk through the doors of a drug treatment centre also have a mental health need.[10]

Locally research into the health needs of homeless people in Stoke[11] found:

80% of homeless people smoke compared to 31% in the general population.

20% drink at least 4 times a week and consume more than 40 units of alcohol in each session.

Almost three- quarters have a mental health difficulty and over a third of these report 5 or more mental health issues.

56% of people with a mental health diagnosis report they use drugs and or alcohol to self medicate.

Over a third of homeless people take drugs or are in recovery.

Women have more health problems than men.

Lesbian, gay, bisexual and transgendered people reported more health problems than other homeless people but received less treatment.

Other major health conditions show a far higher morbidity than the general population

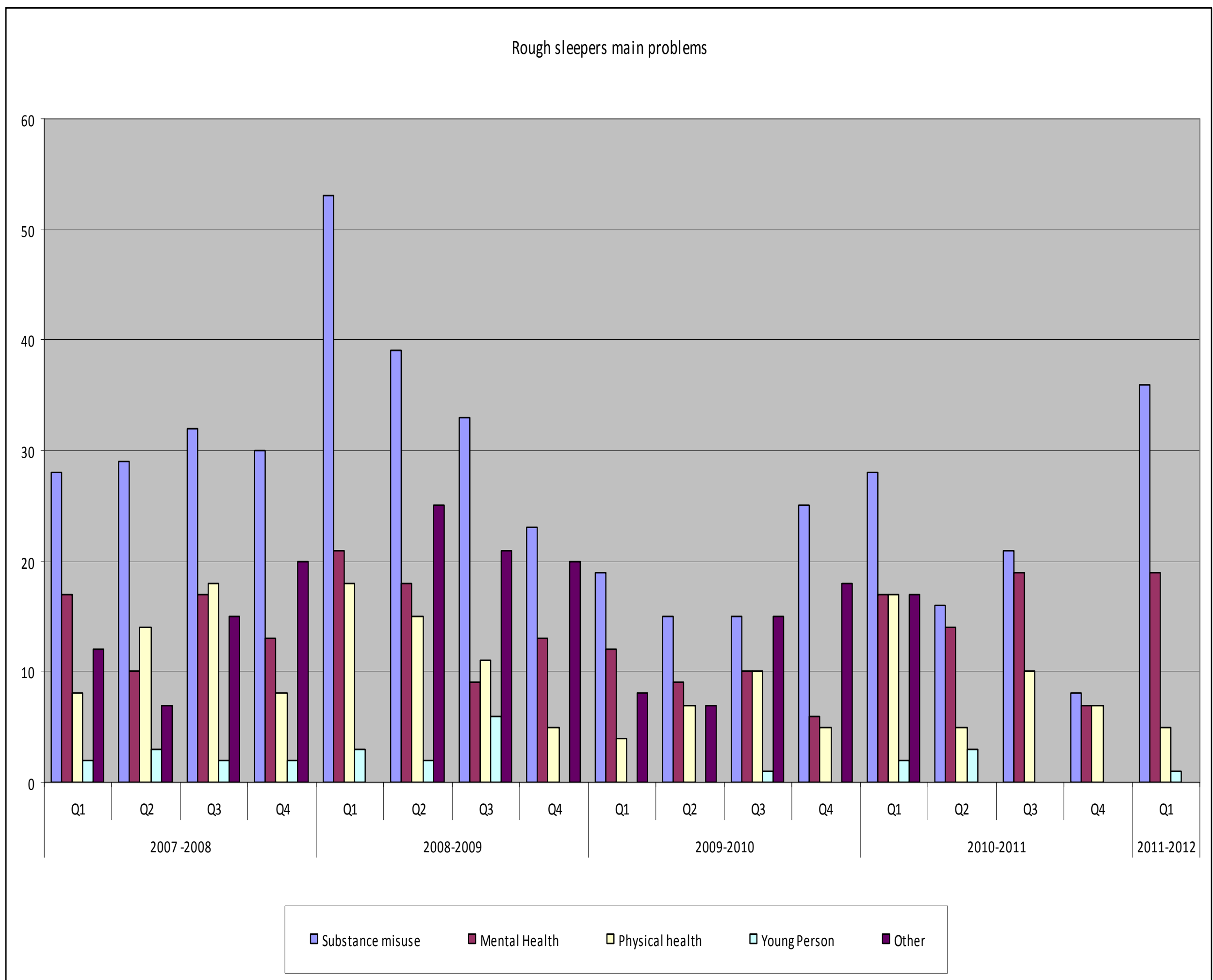
	% of homeless people	% General population
Mental health difficulty	70	30
Chronic respiratory illness	36	5
Illegal drugs or on a methadone programme	34	
Musculoskeletal problems	27	10
Eye problems	16	1

The Office of the Chief Analyst [5] noted that homeless people's hospital admissions are most commonly for mental health conditions and general medicine. Compared to the general population, homeless people experience far fewer hospital admissions for ENT, general surgery, oncology, ophthalmology or urology. The report also notes the "tri morbidity" experienced by homeless people of physical health problems, mental health needs and substance misuse. Wright[12] also found remarkably similar health problems featuring mental health and substance misuse.

Health Problems commonly found in homeless patients: description and examples from NMJ Wright, 2006[12]

Mental ill-health	Schizophrenia, depression and other affective disorder, psychosis, anxiety states, personality disorder, earlier onset of drug misuse and severity of alcohol use.
Physical Trauma	Injury, foot trauma and dental caries due to self neglect.
Skin Problems	Inflammatory conditions e.g. erythromelagia, infestations e.g. scabies or body lice, infections e.g. cutaneous diphtheria impetigo.
Respiratory illness	Pneumonia, influenza, tuberculosis (often latent)
Infections	Blood-borne viruses e.g. Hepatitis B, C and HIV. Hepatitis A. Secondary to louse infestations e.g. typhus, trench fever, relapsing fever.

Drug/alcohol dependence	Heroin-related death secondary to respiratory coma. Cocaine –case reports of toxic inhalation leading to pulmonary inflammation and oedema ('crack lung'), agitation and paranoia due to acute toxicity and thromboemobolic events. Cardiological –cardiomyopathy. Neurological – peripheral neuropathy, erectile dysfunctional,Wernicke's encephalopathy, Korsakoff's psychosis, Amnesic syndrome, cerebellar degeneration, alcohol withdrawal seizures. Gastrointestinal and hepatobiliary – hepatitis, liver cirrhosis, Pancreatitis, gastritis, peptic ulceration, oedophageal varices, carcinoma of the oesophagus and oropharynx, cardiomyopathy. Metabolic –vitamin deficiency (particularly thiamine), obesity.Psychological ill health – including depression and suicide, sexual dysfunction, alcoholic hallucinations, marital, family or employment breakdown.



The graph above shows overwhelmingly that physical health needs, substance misuse and mental health problems are strongly associated with rough sleeping in Stoke-on Trent and in Newcastle-under-Lyme. In the first quarter of 2011 -2012, fifty-three rough sleepers reported sixty one instances of these conditions. Records going back to 2007 show a consistently high incidence of these conditions amongst rough sleepers.

Chapter THREE:

How Homeless People Use Health Services

It is clear that there is a high incidence of particular health conditions amongst people sleeping rough and homeless people in hostels. These seem to persist in spite of new investments in "mainstream" health services. For example there has been considerable change in substance misuse services in the City over the last four years. We have a new provider of extended drug services and a significant expansion in the availability of alcohol services. The establishment of the Healthy Minds Network has made psychological treatments and talking therapies more widely available and yet the problems that homeless people and rough sleepers experience seem to have persisted.

The experience locally

Hospital

Recent work on the use of Accident and Emergency (A&E) services at the University Hospital North Staffs, (UHNS)[9] revealed that homeless people make greater use of A&E and the ambulance service than the general population. When they are admitted to hospital they tend to stay for longer, are more likely to self discharge, or to be discharged without having had their health and social care needs assessed.

People from socially excluded groups have a much higher morbidity rate than the general population and therefore we would expect a higher rate of presentation at A&E. The data shows that around 50% of attendances were for serious injury. Just under 50% were discharged to home (sic) or self care. This clearly supports the evidence that homeless people who presented at A&E were in need of treatment. Just under a third were admitted to hospital. This represented 554 admissions to wards from A&E for the 28 month period 2009 – 2011. The subsequent average length of stay was 5.95 days. The Chief Analyst at the DOH noted in his/her study that the emergency to elective treatment rate was 11.3: 1 in the homeless population compared to 0.71 : 1[5] in the general population.

Local data

247 ambulance call outs were made for people staying in hostels in Stoke between April 2010 and April 2011. 139 people were subsequently transferred to A&E.[9] What is not clear is how many people:

- Received treatment that meant they did not need to attend A&E.
- Had had an ambulance called out when they did not need it.
- Needed A&E treatment but refused to go.

25% of homeless people who took part in the study reported having been to A&E in the last 6 months.[11]

Locally homeless people were three times more likely to have had an in patient stay in any six month period than the general population were in a year.[11]

National data

Compared to the general population, homeless people are:

Five times more likely to use A&E.

Twice as likely to be admitted to hospital via A&E.

Four times more likely to need acute services: 89% of admissions are emergencies (16 – 64 y olds).[5]

Eight times more likely to need in patient care than a person of a similar age.[6]

Have a length of stay on average three times as long.[5]

Commonly admitted for conditions relating to toxicity, drugs and alcohol or mental health.[5]

Less likely to attend outpatient services or follow up appointments.[5]

In national research[13] Bunce found 57% of visits to A&E could have been dealt with by GPs at one third of the cost. Local research indicates that a significant number of A&E attendances are not necessary and could be dealt with in primary care settings. This figure could increase significantly if people were better engaged with primary care and their health needs were addressed before their condition became more acute.

Self or early discharge

Homeless people are also more likely to seek an early discharge or self discharge from hospital. Despite clear guidelines from the DOH[14], nearly one third of homeless people reported that they were discharged from hospital without any check on their accomoodation.[11]

Primary Care

Inclusion Health nationally found that homeless people are 40 times less likely to be registered with a GP than the general population. It is reported that of 1553 people attending A&E only 201 people did not have a GP. However when GP discharge letters were sent, many GPs denied having the patient on their current record and it is therefore likely that many more than 201 people did not have a GP. This may be because the homeless people in Stoke are more likely to have been born and bought up in Stoke than homeless people in other areas. It may be that the GP whose name is given at A&E may date back a considerable period of time, possibly to childhood. This supports the national research which indicates that many homeless people, despite their poor health, are not in contact with primary care services, or when they are, they do not make full use of the services available. "The Health Needs of Homeless People in Stoke on Trent"[11], found that, 80% of people reported they had accessed a GP or doctor in the last 6 months and 45% had attended a walk in centre. There might be a question here as to whether people included doctors at A&E and walk in centres.

Gaps in knowledge

There are significant gaps in national and local research around maternity and neo-natal services and how they are used by homeless women. There is an assumption that because pregnant women have a statutory right to housing that they cannot be pregnant and homeless. There are, however, instances of pregnant women sleeping rough, living in hostels or being actively engaged in street sex work.

We know of women who do not attend ante-natal checks and avoid admissions to labour wards for as long as possible. This is particularly true of women who are addicted to heroin. We would recommend that more work is done to look at local maternity services and at how they work with homeless women. Homeless women or street sex workers who regularly use opiates are particularly at risk of extremely serious health issues both for themselves and their babies if they do not engage with these services.

Chapter FOUR:

What is causing the problems? Why are these things happening?

The most cost effective way to provide health services is to ensure that health needs are met as soon as they arise. The longer a condition is left untreated the greater the risk of a poor outcome and the more costly the intervention. Short term savings are realised at the risk of far greater costs in the long term. For example, effective alcohol treatment and counselling services are cheap compared to the longer term costs of liver transplants, family breakdown, homelessness, domestic violence, crime and anti social behaviour which are associated with alcoholism.

When homeless people do engage with primary care they tend not to comply with treatment regimes which are designed for patients with more settled lifestyles. This means that they make ineffective use of primary care services. They "miss out" on screening and vaccination programmes, fail to return for follow up tests or repeat prescriptions and fail to take medication reliably. Clear evidence shows that secondary care services struggle without good links to primary care and patients in treatment fall through the gaps between services. This leads to delays in hospital discharge and a reduction in the effectiveness of hospital treatment. Discharge from hospital to primary care breaks down.[13].

Why don't homeless people make better use of primary health care?

"The Royal College of General Practitioners (RCGP) issued a statement on homelessness and primary care which said that homeless people may experience difficulty accessing health care. For them health may be a secondary priority, meaning health problems only get addressed when they become acute. It suggests several reasons for homeless people not registering or visiting a GP such as depression, low self esteem, low health priorities, or that they might find it hard to locate a GP who will register them. It highlights the complex needs of homeless people who may have mental health or literacy problems, chaotic lifestyles or a lack of social skills that impinge heavily on their ability to cope with the registration forms, appointment systems, busy waiting rooms and long waits. Others do not recognise the severity or seriousness of their ill health, or mistrust doctors. Some report being embarrassed about seeking help because they are dirty and unkempt, and fear being stigmatised by staff or other patients. [13]

These factors highlight the impossibility of ever producing a "one size fits all" NHS. Homeless people do not conform to societal norms of eating, sleeping, communicating, relating or anything else. It is unrealistic to expect them to conform to an NHS system which was designed around lifestyles completely different from theirs. In addition to the points made by the RCGP the evidence indicates that homeless people need to feel more confident and reassured about the services they will receive. In order to use primary healthcare effectively, homeless people need:

1. <u>To be motivated to have their health needs met.</u>

Many people, particularly those addicted to drugs and alcohol or who are sleeping rough do not give their health as high a priority as finding a safe place to sleep or to acquiring drugs or alcohol. Studies have found that people may only seek help when their health needs become critical and when those health needs are not surpassed by more immediate needs.[5]

When they are admitted to hospital their need to satisfy their addictions, fear or restlessness may lead them to self discharge before their treatment is completed. People who are addicted to alcohol or drugs will prioritise satisfying this need above all else, even to the point of death. If their drug or alcohol use is not properly assessed, or is ignored in hospital, and there is no methadone or detox support offered to them, many will discharge themselves to get drugs or alcohol.[13]

2. <u>To have an expectation that the service will be accessible and effective in their case.</u>

When asked about their treatment in the health service a common response from homeless people is that they feel invisible or excluded and that they are not respected or treated with dignity. In a survey by the Queen's Nursing Institute 71% of non homeless health specialist reported they were not confident in their ability to care for homeless people.

Many people have experience of poor treatment outcomes from drug, alcohol and mental health services. The Making Every Adult Matter Coalition argued that these poor outcomes are due to services focussing on the physiological aspects of illness rather than the cause or the "root" of the problem.[10]

Homeless people often present with multiple and complex needs but health services tend to focus on the presenting need rather than deal with a person's health in a holistic way. This means that people are not supported fully in their recovery and in sustaining behavioural change.

Particular services may be organised and delivered in ways that mean homeless people cannot make use of them. They may have problems when their "home" environment is not conducive to the treatment offered, as illustrated by these two examples.

- A hostel may not be able to provide the necessarily level of care someone that needs and a hospital admission may be deemed inappropriate. This can lead to people either staying in hospital too long or people being discharged requiring, but not receiving, on-going treatment.

- A community alcohol detox requires a carer to stay overnight with the patient to monitor their health. The outcome of long term alcohol abuse is often the breakdown of social and family relationships. Many people with alcohol problems do not have anyone willing to monitor them and are therefore unable to get a community alcohol detox, without which they cannot stop drinking.

3. To know that the service they need is available.

At the moment there is no diagnosis and treatment service for people with personality disorders unless they have already been diagnosed as having a treatable mental health condition. Research estimates that up to 60% of people in hostels and supported housing have some form of personality disorder.[6] It is also extremely difficult to get treatment and access to services for people who have a dual diagnosis of either a drug or alcohol addiction and a mental health problem.

Stigma, personal safety, mental ill health cross cutting theme

Specific social groups who are stigmatised can change over time and can vary between cultures. Social norms can be influenced and are subject to change even over a relatively short period of time. We are able to challenge and discontinue behaviours that no longer serve an effective social function.

Stigma is very powerful. Research has found that children as young as ten years old can identify stigmatised groups. Children from stigmatised groups are aware of their status at an even younger age. It is hardly surprising then that Phelan and Link[4] noted that:

“healthcare workers mirrored the stigma and prejudice in wider society”

Phelan and Link described stigma as being a four stage process in which:

1. People identify and label human difference.
2. Stereotyping takes place where the individual person is linked to undesirable characteristics.
3. The group doing the labelling then separates the stigmatized “them” from “us”.
4. Stigmatized people experience discrimination and loss of status.

In a world where lip service is usually paid to anti oppressive practice, it may be difficult for the professional worker to admit to stigmatising or oppressive tendencies. Our experience tells us that even well intentioned professionals can hold the belief that someone else is of a lower social value so deeply that they may not readily recognize it even though it strongly influences their attitudes and behaviours towards patients or service users.

Blame is a very powerful component of oppression and may suffice, in the mind of the oppressor, to justify inappropriate actions or words. An intravenous drug user’s needs may command less respect and attention than those of a premature baby, because, “they chose to take drugs so they are to blame”. Obese people may be denied surgery, because they are at greater risk from anaesthetics, but this decision may be readily supported by those who hold obese people responsible for their situation, because they are “lazy and stupid and its their fault they eat too much”.

Services which work closely with stigmatized groups may in turn carry the stigma. In everyday language we talk about some services being “more sexy” than others. Gerontology and genito-urinary medicine can be seen at the bottom of a hierarchy that reaches up towards cardiac or brain surgery at its top. Denigrating certain professionals creates the real risk that their patients are less well served than others. If medicine for the homeless is seen as a “Cinderella service” it is no surprise that the health of homeless people is poor.

Cost

The Chief Analyst identified significant costs associated with the healthcare of homeless people which was calculated amongst the participating study areas as

Number of episodes	Venue	Total cost
45,000	Outpatient appointments	£4.4 million
53,000	Attendances at A+E	£5 million

The work of the Adults with Chronic Exclusion pilot noted that effective interventions designed to meet the needs of this group of adults effectively reduced health costs and the costs associated with the criminal justice system and crime.

It also noted that the voluntary and community sector interventions at an average cost of £16 per hour were extremely cost effective when compared to the average cost of a social worker at £32 per hour.[7]

In all the published work little attention has been given to the cost of poor health, although the cost of health inequalities is reported to be in the region of £58 billion a year in terms of lost tax, benefit payments and healthcare costs.

We should also consider the waste of unsuccessful healthcare interventions and the cost of treating acute conditions as opposed to early interventions or health promotions. We could also consider the waste of talent and skill to our community of people who are excluded and unable to contribute socially or economically because of their poor health.

Chapter 5: **What can we do?**

Rather than start by describing the development of specific services we recommend starting by identifying the values and principles we should work to and the broad outcomes we wish to achieve with the aim of getting better health outcomes for homeless people in the City, and developing the plans by which we will pursue them.

Our values and principles

The Office of the Chief Analyst was very clear when they wrote in their report:

"What is needed is a new way of thinking whereby mainstream services adapt to provide responses tailored to meet the needs of homeless people…….Joined up, integrated, de-stigmatised, reflect the inter connectedness of problems and issues in an individuals life…..that re engineers them from the bottom up and ensures they look first at the whole needs of the individual and then that the services deliver a tailored, personalised package of support that truly responds to the homeless persons circumstances and sets out to empower them and not administer another short term fix"

This means we must recognise the need for cultural change within our health service. The fact that some people are excluded and stigmatised because they have certain illnesses or are members of certain groups, and as a result do not get their health needs met is no longer acceptable. If we genuinely seek to address health inequalities then we have to accept that the thinking that has developed our health services to date, in which there is an implicit acceptance of inequalities of outcomes, has to change.

In working with homeless people we have to start from a position that genuinely believes in equality and that recognises the potential for change in everyone. We should create environments which are purposefully designed to address people's psychological and emotional needs. Rules, regimes and the physical environment should be designed in terms of the needs of users not logistics or convenience of the service provider[6]. If services are to be appropriate to patients, funders, or the community at large, then one size will most definitely not fit all.

The National Institute for Mental Health in England developed its "Guiding Statement on Recovery" in January 2005. These principles were written to guide services which were supporting people in the recovery of their mental health. The principles recognised that recovery is not about what services do for people but what people experience themselves as they become empowered to manage their lives, achieve fulfilment, live meaningful lives and contribute a positive sense of belonging to their communities. These principles could form the basis of developing more equal specialist or mainstream services. In brief a system based on recovery will:

1. Focus on people rather than services.
2. Monitor outcomes rather than performance.
3. Emphasise strengths rather than deficits or dysfunction.
4. Educate people who provide services, schools, employers, the media and the public to combat stigma.
5. Foster collaboration between those who need support and those who support them as an alternative to coercion.
6. Through enabling and supporting self-management, promote autonomy and, as a result, decrease the need for people to rely on formal services and professional supports.

Principles for accessing healthcare [15]

These were the principles developed by Crisis in it's report "Lost voices the invisibility of homeless people with multiple needs". They argue that an accessible healthcare system is characterised by:

- Availability.
- Flexibility.
- Provision of appropriate care.
- Non prejudicial treatment.
- Support and advocacy.
- Information.
- Structural hurdles lack of resources and resistance to change.

The overall outcome we should pursue is to ensure that homeless people get better health outcomes from the services that they use. In order to do that we should pursue five specific outcomes each of which will need a clear plan of action.

Getting Better Health Outcomes

1. Promote recovery and self care.
2. Better take up of screening and vaccinations.
3. Reduce A&E attendances.
4. Reduce emergency admissions.
5. Reduce early and inappropriate discharge.

Redesigning healthcare to meet the needs of homeless people requires us to be clear as to whether we should provide more specialised services for homeless people or whether we should focus our efforts on the mainstream of health provision. I propose a pragmatic approach which would take whichever actions we consider will best deliver our overall aim and outcomes in the short, medium and long term. This may mean investing more money in a specialist service for homeless people in the short term. However, alongside this, we should apply the lessons learned in this interim work to improving the design and delivery of the mainstream services to make them more accessible to homeless people in the medium and long term.

In order to check our progress towards our targets we should carefully monitor our progress. The things we monitor should include keeping track of where people are going for their health interventions and whether they are completing treatment programmes.

I suggest that the health promotion priorities for homeless people are different from others. We should prioritise, for example, harm reductions from substance misuse, mental health and screening and vaccination programmes over smoking, diet, and breastfeeding. We should monitor the take up of vaccination and screening for HIV, TB, Hepatitis B, Hep C, flu, and cancer. We should also monitor the impact of harm reduction and improvements in mental health.

We should raise the expectations of homeless people around their health by offering stigma free services and by carefully collecting feedback from people on their experience. We suggest that front line health staff and homeless people work together on the redesign of services.

We also need to ensure a more seamless service between hospital, A&E and primary care. Working with homeless people, we could look to provide support workers, skilled and experienced in working with homeless people and rough sleepers, to support their use of A&E, advocate for them in services and help them in the transfer to community and primary care services.

We should develop hospital discharge protocols in line with the government's recommendations. Hospital based support workers could support hospital discharge by helping people who are admitted to hospital maintain their accommodation to ensure that they have somewhere to live before they are discharged. Support workers could also help to ensure that the needs of drug and alcohol users are assessed in hospital and could help support health staff to reduce early and self discharge. A project on self discharge should be undertaken to establish what could be done to reduce it.

We should continue to monitor A&E attendances for non emergencies, emergencies and those leading to an admission.

In order to ensure that homeless people get their health needs met in the short to medium term we should consider reconfiguring the current specialist services. This may involve bringing together the community matron and homelessness mental health nurse and considering which of the models of specialist health care that exist would best deliver our outcomes. The five models that are currently being operated are :[5]

1. Drop in session at a GP. This model assumes that the problem is GP availability; we have recognised that the problem is far more complex than this.
2. Outreach nurse – advocacy support, wound dressing, refers to others including GPs. We have this model at the moment but there are significant shortcomings in terms of capacity and governance issues between primary and secondary care. It is often found that a lone health worker can become isolated and over time risks burn out and reduced effectiveness.
3. Full primary care specialist homeless team GP, nurses, CPNs, podiatry, substance misuse, dedicated and specialist co-located with hostel/drop in.
4. Fully co-ordinate primary and secondary care outreach, in reach, intermediate beds. This is a kind of cottage hospital for the homeless that has been tried in Boston USA.[5.] It has been

Whichever model we choose should include integrated health provision that covers substance misuse services, talking and psychological therapies, GP, physical and mental health nurse practitioners. The approach must be to treat the whole person and not just the presenting symptoms. The mental health practitioners should be able to work with personality disorder, complex trauma and dual diagnosis. GP support is needed because the matron has noted medical governance issues, especially when she is working at the boundaries between primary and secondary care.

Specialist services designed to meet the needs of specific groups of people, led by dedicated staff, have proved successful in reaching excluded groups. Research, however, shows that the service they offer may be limited because of their isolation as lone practitioners within the health system and their lack of access to appropriate resources for their patients.

In Stoke, the Community Matron Service is extremely effective in providing physical health care to homeless people. This is a service highly valued by patients[1], who are able to establish an effective relationship with her and get their needs met. The Community Matron is diverting people from A&E, treating conditions before they escalate, providing vaccinations and facilitating hospital discharge. Brighter Futures currently funds a Homeless Mental Health Nurse two days a week. She is employed by Combined Healthcare and provides support to local hostels.

The Royal Liverpool Hospital has developed a successful model which involves nurses trained to work with homeless people. They form a multi-disciplinary team which ensures needs are recognised and they have helped colleagues to reassess their care ethic to provide non judgemental services. They also teach at the university medical school and in community agencies. They won a Nursing Times best practice award 2010.

Lack of intermediate care beds accessible to homeless people is an issue. We need a service that would work with people who are addicted to alcohol or drugs and would need to drink or access to

[1] Jane Morton has been nominated by one of her patients for The Sentinel "Local Heroes" Award.

methadone. We also need a service that can cope with the more chaotic of people with mental health needs to ensure they get their physical health needs met. There are a number of existing models that we could consider using, including skilled support workers, who would help some of the more complex and restless people to maintain their stay. To this end we should consider adopting the fully co-ordinated primary and secondary care model that was trialled in Boston USA. We should include health promotion which would best be provided by training homeless people to be "barefoot health workers" ready to support their peers.

We should also conduct an investigation into how homeless women and street sex workers use ante-natal and neo-natal services. We should also consider research which looks at the attitudes of homeless people towards health services and health service staff.

If we can develop mainstream services which work for and address the needs of some of the most excluded people in our community, what might these services deliver across the whole health inequalities agenda?

Endnotes

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