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Homelessness, health, and inclusion

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Sexually abused at 14 years old by an alcoholic father. Left home for the streets. Alcohol dependent by 15. Sex work. Intravenous drug dependent by 17. Hepatitis C by 19. Epilepsy and anxiety disorder. In and out of hostels, hospital, and prison (for violence, theft, drugs) in 20s and 30s. Not registered with a general practitioner. Rough sleeping at times, hostels at others. Tuberculosis at 35. Discharged from hospital in pyjamas without shoes back to under the railway bridge. Chronic leg ulcers. Violent, aggressive behaviour. Four children, no contact with them. Died at 40 of haematemesis. Two of his children now homeless, addicted, depressed.

This man, his father, and his children, have been failed by their health system and society. Look around the streets and see the people on the benches, in the bus shelters, under the bridges, by the canals, and in the hostels. How can they best be helped?

Government leadership is crucial, especially in times of economic hardship. Employment, housing, and welfare policies, and a legal framework to iron out inequalities in health, are fundamental. But health-care workers can do more to ensure that excluded groups, such as the homeless, sex workers, prisoners, migrants, and gypsies and travellers, receive the health care they need.

Inclusion health, also defined as health care for excluded groups, was the subject of the inaugural conference of the UK Faculty for Homeless and Inclusion Health, held in London last week. Passionate and inspirational leaders in inclusion health shared their experiences of providing specialist health care for the homeless in primary care centres in London and Oxford. Street medicinepractitioners in Boston, Pittsburgh, and Dublin were praised by service users attending and speaking at the conference, for their commitment in founding services in their cities. Rapid access to integrated services—health, housing, social care—is needed. Training of students is crucial. Never give up on anyone was the resounding message. We agree. To encourage research and best practice, *The Lancet* commits to a Series on inclusion health, which we hope will promote research and continuing debate, and ultimately make a difference to those currently excluded.

It is, therefore, a profound shame that so many medical graduates still acquire a reductionist view of the doctors' role. Many appear to learn from their teachers that it is enough to write: 'medically fit for discharge' across the bottom of the hospital notes and walk away. The fact that the patient is a recent amputee, and can't get a wheelchair or a district nurse without a GP, can't get a GP without an address, hasn't really got the hang of his insulin injections, can't afford to eat properly because he has no benefits, and can't raise the strength to raise these problems because he is profoundly depressed by his situation – all this can all be ignored if his biochemical markers are temporarily restored to something approaching normal.

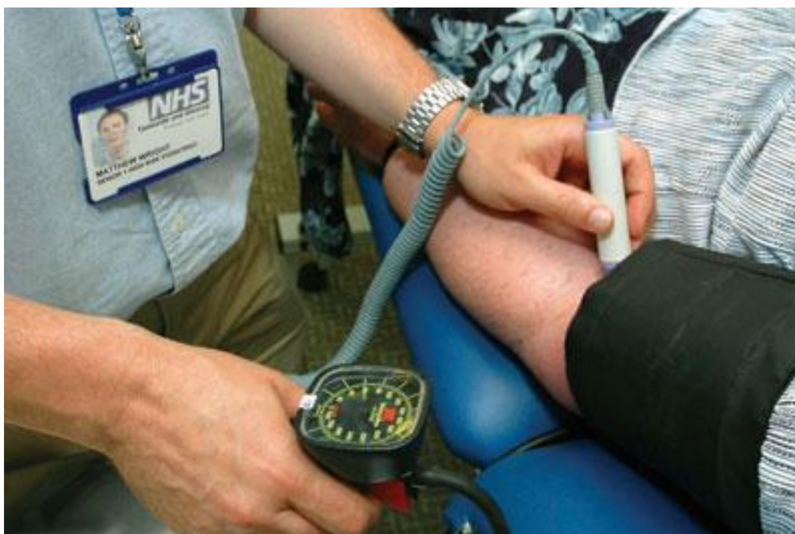
As this example shows, homeless patients can provide the ideal test for a narrow medical model of health, and highlight deficiencies in our current health care systems.

Chronic homelessness is characterised by tri-morbidity: physical illness with mental illness and drug or alcohol misuse. This combination challenges narrow specialisations and requires an holistic response.

There are many examples of excellent and dedicated health services for homeless people. However, these have usually been developed by local champions working with voluntary sector groups. The NHS as an organisation has tended to have a poor understanding of the issue of homelessness and health. It is too often dismissed as simply a social care and housing problem, whereas we believe it that should be seen as a "red flag" symptom of significantly raised health risks. The evidence to support this view is gathered together in a recently published and pivotal paper from the Office of the Chief Analyst at the Department of Health [1]. In this context, homelessness is defined as those who are sleeping rough, or in a hostel, a squat or on friends' floors. This group do not have the same rights under homeless legislation as families with children, and often experience particular difficulties in accessing primary care.

There are estimated to be 40,500 people in England in the hostel system at any one time, and approximately 100,000 individuals cycle in and out of it in the course of a year. Although a relatively small group in national terms, they experience such high health care needs that they represent a significant cluster of increased health care expenditure. Acute hospital services for this group cost at least £85 million per year – eight times the equivalent cost for the population aged 16-64. The increased costs don't just result from more frequent admissions. The average length of stay for this group is almost three times that of the general population. This is due to the severity of their health conditions rather than delays in discharge. That is, homeless patients stay longer in hospital because they are more unwell than the average patient.

Despite this huge expenditure, the average age of death for homeless patients is between 40 and 44 years. At a time of significant and prolonged cuts in public expenditure, this raises the prospect of reducing secondary care costs by improving community health care provision for homeless people.



Primary care services for homeless patients commonly integrate complementary medicine into daily practice.

Often the most powerful interventions can be the simplest. Many years ago, watching a nurse wash a rough sleeper's feet in aromatherapy scented water demonstrated the potential of this approach. The patient, relaxed and respected, spoke for the first time of his childhood, and took the first step towards rebuilding his self-respect.

At the Dawn Centre in Leicester, the Local Authority recently organised a questionnaire asking homeless service users how they would like their health care to be improved. The most popular request was for complementary health care provision. As a consequence, the Local Authority funded twice weekly reflexology and aromatherapy sessions hosted by the homeless primary health care service. Patients are referred by a doctor or nurse, ensuring that conditions are fully diagnosed and a range of treatment options discussed.

The principle benefit of complementary therapy in this context probably arises from therapeutic touch. Physical interactions for homeless patients are all too commonly confined to the experience of violent assault. To relax in clean and calm surroundings while experiencing empathic touch can have a transformative effect on a person who feels isolated and excluded from human interactions.

Complementary therapies are also frequently offered in the context of addiction, which can be a particular problem for homeless people. Addiction can often arise as a result of the trauma of homelessness, as well as being a cause of homelessness. Auricular acupuncture is probably the most widely deployed intervention and many nurses in addiction are trained to provide this intervention.

The latest innovation in homeless health care is being piloted at University College Hospital. Called the London Pathway2, this approach involves encouraging primary care teams and people with an experience of homelessness into hospitals, to coordinate and re-focus the care of homeless patients. A GP-led ward round of all the homeless patients in the hospital supports a specialist nurse 'homeless health practitioner' and 'care navigators' – people with an experience of homelessness - to provide patient centred care specifically for homeless patients.

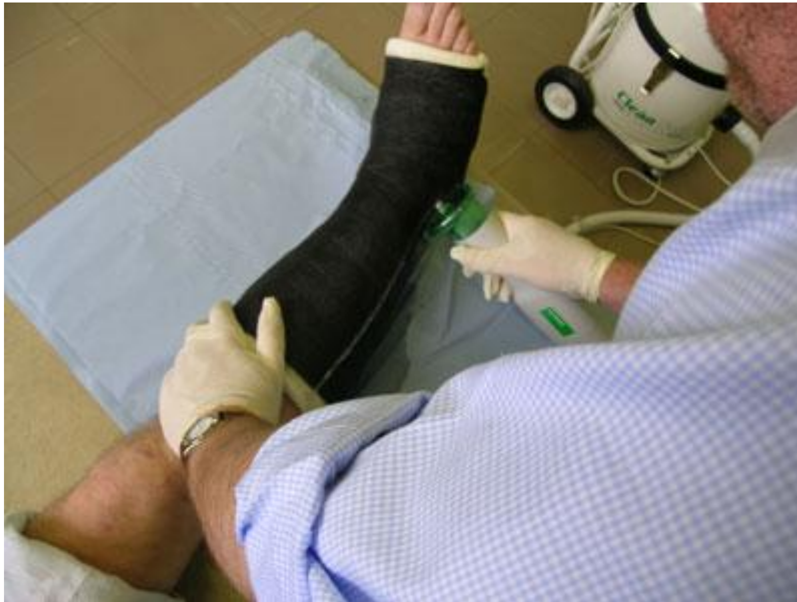
The University College London Hospital Trust is top of the Dr Foster league table for Hospital Trusts in England and was named 'Trust of the Year 2009'. This achievement is attributed to a process of 'super-specialisation' in which surgical and medical teams concentrate on achieving excellence in increasingly narrow areas of medical care. Yet UCLH is close to King's Cross and surrounded by patches of profound poverty and deprivation, with significant numbers of rough sleepers. The busy casualty department results in regular admissions of messy and complex reminders of the challenges of real life on the chaotic edges of our affluent society.

These welcome reminders that humanity demands an holistic response to its health care needs are a daily challenge to the hospital and vital breaches in the walls of its ivory tower. Hospital clinicians aspire to do the best for their patients, even under difficult circumstances. But in common with the rest of society, doctors and nurses in hospital have a number of pre-conceptions about homeless people. These prejudices can be reinforced by interactions with patients whose serious physical health problems are complicated by drug and alcohol withdrawal, psychiatric symptoms, or patterns of behaviour established in traumatic childhood experiences. Deeply ingrained 19th Century concepts of deserving and undeserving poor meet NHS targets and strained staffing levels in an invitation to conflict that too often results in the patient leaving the ward.

A visit from an empathic team, dedicated to the care of homeless patients in the hospital can transform this interaction. 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.

Sometimes this care can be simple and direct. It costs £5 a day to watch bedside TV in hospital, this is clearly beyond the reach of a homeless patient. The provision of a TV card (funded by a sponsored cycle ride from Lands End to John O'Groats) can be the small gesture that encourages a patient to stay and complete a course of treatment. The offer of donated clothing in preparation for discharge provides immediate and practical support, while restoring dignity.

With a relationship established, the hard work of planning community support and negotiating with housing, social care, health care providers and the voluntary sector can begin.



(In order to preserve confidentiality this case is a composite of several patients' experiences.)

John is 47 years old. His parents separated when he was a baby and his mother had drug and alcohol problems. He grew up in a variety of foster homes and local authority care homes and lost touch with his sister. He was often excluded from school and spent time in young offenders' institutions and prison. For many years he struggled with injecting heroin dependency. This led to hepatitis C infection and damaged all of his peripheral veins.

After prolonged methadone treatment from a community drugs team and a couple more periods of relative abstinence in prison he managed to stop using heroin but slipped into alcohol dependency. For the 2 years prior to his admission he had stopped claiming benefits and was living in a squat without plumbing or heating. He survived by begging and keeping his alcohol withdrawal symptoms under control by drinking 3 litres of strong cider a day.

One day he collapsed in the street with abdominal pain and was brought to UCH. Abnormal blood tests were found and he was admitted to hospital where further tests revealed that he had Lymphoma – a cancer of the immune system.

Within 24 hours John went into alcohol withdrawal requiring detoxification treatment to control his symptoms. Feeling alone and desperate John was talking of taking his own discharge from hospital and returning to the streets. At this point the ward staff realised that the address he had given was a squat, and he was effectively homeless. The homeless team came to visit him the same morning.

Non-judgemental befriending transformed John's experience of hospital and improved his relationship with the ward staff. A TV card and the purchase of some chocolate was the first step. A full history was taken, including specific housing, benefits and social history. Details of past and current substance misuse and plans for discharge were explored with offers of help. It became clear that severe alcohol

withdrawal was causing some paranoid thoughts that were affecting his behaviour. The medical team were approached to temporarily increase the dose of his detoxification medication and control his symptoms.

John was then discussed at the weekly multi-agency team meeting. The alcohol team in-reach worker agreed to see him and offer support with continuing abstinence. The local street outreach team gave some background history, visited him on the ward for support and agreed to try and re-establish contact with his sister. The Local Authority housing options manager gave advice on a homelessness declaration and the GP homeless team lead wrote a detailed medical report to support his housing request.

Over subsequent days John was helped to re-establish a benefits claim and supported through the first round of chemotherapy. Regular attention from a Reiki Healer on the ward helped with the side effects of treatment. After three weeks he was well enough to leave hospital. After a short period in temporary accommodation he moved into his own studio flat. During each admission for repeat chemotherapy he is visited by the homeless team who are also available for telephone support when he is outside the hospital. John remains abstinent from alcohol. He has re-established contact with his sister who has proved to be a good match for a bone marrow transplant, offering a good prospect of cure for his lymphoma.

Building a trusting relationship between the patient and the homeless team is fundamental to the therapeutic alliance, which is particularly necessary with patients who will be returning to a chaotic hand-to-mouth existence.

Therapeutic alliances are also necessary across all the different professional groups working with homeless patients in the hospital and the community. To encourage this approach a weekly 'paper ward round' meeting has been developed. This draws together the homeless team, hospital discharge team, social services, liaison psychiatry, hospital in-reach drug and alcohol workers, community housing options managers, and community homeless support workers to develop multi-agency care plans for the most challenging cases.

The real benefit of these meetings does not lie in the plans, but in the relationships built across professional barriers as we all gradually remember that we are there to help the patient who is central to our discussions. With time and trust, the adversarial, budget defending systems in which we all work can be challenged, subverted or side-stepped with the shared goal of helping the real person we re-discover in the suffering homeless patient.

As well as a trained nurse 'Homeless Health Practitioner' within the hospital, supported by General Practitioner ward rounds, this approach includes people with an experience of homeless in health care provision. Known as 'Care Navigators', they are developing a role that will move from providing peer mentoring and support, into direct advocacy and continuing support in the community. The fourth element is the development of a dedicated Sanctuary for homeless people. This is intended for those patients who are well enough to leave hospital, but not well enough to cope back on the streets, or in a hostel. Combining funding streams from housing, health and the voluntary sector, this unit will provide hands on care as well as support, and offer access to a range of CAM therapies as well as psychological therapies and help with medical care.

We plan to roll out this collaborative approach to other major London teaching hospitals and to other cities with significant deprivation and homelessness.

We anticipate that the benefits of re-discovering patient centred, generalist, holistic health care in a highly specialised acute hospital setting may have applications and benefits for other patients with complex needs and long term conditions.

Perhaps we may even help some doctors to remember why they entered the profession, to discover the importance of walking alongside those many patients we cannot cure, to learn from them in empathy and share their journey.

1. Healthcare for Single Homeless People. Office of the Chief Analyst. Department of Health. March 2010.

2. Hewett N Evaluation of the London Pathway for Homeless Patients. UCH January 2010.