Homelessness: it makes you sick

Information on St Mungo's Action Week report covering:

- New research into the health problems faced by homeless people
- Our solution – a synopsis of St Mungo's first comprehensive health strategy
- Some recent innovations and our call for partners

September 2008

ST MUNGO'S
ACTION WEEK
7-11 SEPT'08

P.H.A.S.T.

St Mungo's
Opening doors for London's homeless

The Problem

It is perhaps well known that homeless people are not healthy. However we continue to be shocked by the levels of ill health our residents endure. In our hostels last year, we found that: 32% of our residents had an alcohol dependency; 63% had a drugs problem; 49% had a mental health problem; and 43% had a physical illness. The great majority of rough sleepers – over two-thirds – have multiple needs, often a combination of a mental health problem with (poly) substance misuse, usually involving multiple physical health problems, and sometimes accompanied by a non-compliant attitude falling into the 'challenging behaviour' category.

Our recent research* highlights the real health problems of homeless people and the struggles they face in accessing basic healthcare.

Health and homeless

Homelessness exacerbates existing conditions, and may give rise to new ones. The most common illnesses to affect residents in our hostels include:

- Circulatory disease
- Cardio-vascular problems
- Epilepsy and neurological problems
- Gastro-intestinal disorders
- Liver disease
- Inflammation of the joints
- Pulmonary disease

We have also identified clients suffering from TB, renal failure, abscesses, deep vein thrombosis, and blood-borne viruses, especially Hepatitis C. Perhaps the most telling detail is that, in the middle of London in the 21st century, we are seeing cases of trenchfoot. Over half of interviewees in our research had a long-term condition.

Health care services failing the homeless

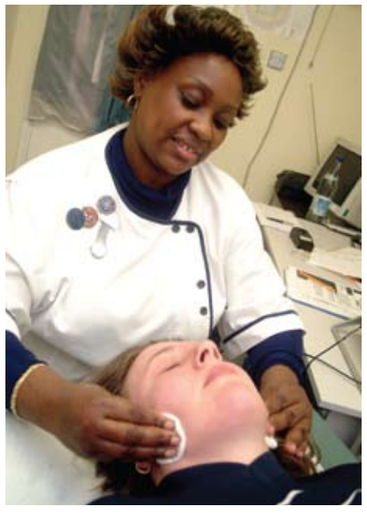
Despite these illnesses, one in three interviewees had a condition for which they were not being treated; and over half of this group was estimated to have conditions which could deteriorate to the point where they would require urgent medical attention. It is not then surprising that ambulances were called to St Mungo's on average twice a week.

More tellingly, 85% of all ambulance calls were for illness or overdose, and our data show that most call-outs were for pre-existing conditions (asthma; diabetes; heart and circulation problems; epilepsy; respiratory difficulties; stomach or liver complaints; substance use crises) which had reached emergency status. Although we cannot quantify it precisely, it is undoubtedly the case that enhanced primary care could have prevented some of this usage of crisis services.

Our research showed that:

- At least two-thirds of call-outs result in a trip to hospital, of which the majority (two thirds) are visits to A&E. 42% of all ambulance call-outs end up in A&E. 24% result in hospitalisation.
- Only a very small number overall (17%) came away with a treatment plan. Even after hospitalisation only 30% come away with a treatment plan.
- 49% of interviewed clients have experienced a negative contact with A&E or hospital.
- A third of interviewees (33%) reported experiencing difficulties accessing health services.
- 18% of clients don't use a GP at all and 41% use a GP 'as necessary' which, given the high incidence of medical conditions, could indicate they are not making good decisions about their own healthcare (i.e. most of them probably ought to be attending regularly).
- One in three interviewees has a condition for which they are not receiving treatment at all.
- The death rate in St Mungo's hostels is 1 per month and clients are, on average, only 41 when they die and 50% are under 40 when they die.

Clients interviewed as part of our research were quick to suggest potential solutions to the inequalities experienced by homeless people within the health service. These included:



- 47% of interviewees, when asked to suggest ideas, said the most important medical services a project should have are general primary health services (Doctor/ Nurse).
- 75% of interviewees rated as 'High' importance the proposal that a full package of primary healthcare provisions be provided in every project.
- Health Support Workers and Hospital Discharge Workers were also considered to be highly important by a significant majority of clients (64% and 56% respectively). These workers provide a link between homeless people and NHS services and ensure that homeless people always leave hospital with a treatment plan in place if one is needed.

Developing a solution

St Mungo's is committed to tackling these inequalities in access to health, and it is this commitment which has led to the launch of our Health Strategy for Homeless People 2008-2011. We intend our full strategy document as a kind of blueprint of how Our Health, Our Care, Our Say could deliver significant improvements in healthcare to one of the most disadvantaged community groups in Britain.

"We see the chronic – and acute – ill-health of most of our residents daily, and know it is crucial to tackle homeless people's poor health if their prospects are to improve. But organisations like us - for people who fall so far through the gaps in services they have ending up sleeping rough – are also falling through service gaps. The health hole is far too big – and we aim to work alongside health services to challenge and change that."

Charles Fraser CBE, St Mungo's Chief Executive

**For a full copy of the research report 'St Mungo's research into interactions between clients and primary health services', by Helen Bilton, go to www.mungos.org/campaigns/homelessness_it_makes_you_sick*

St Mungo's Solutions:

A Summary of St Mungo's health strategy* and solutions for homeless people

The following pages outline St Mungo's response to inequalities around homelessness and health

1. Make rough sleepers a priority group

It is sometimes said that rough sleepers with multiple and complex problems are 'hard-to-reach'. We do not find them so – that is the group we mostly house in our hostels. It is arguable that in fact it is the services which are 'hard-to-reach'. The NHS has a system of separate clinics for physical illness, substance misuse and mental illness, each with a different philosophy and funding stream – but very few of these clinics are well-suited to guiding and treating patients with multiple needs, dysfunctional lives and poor engagement skills.

Premature mortality, and extreme ill health, is high among rough sleepers. We firmly believe rough sleepers need to be identified as a key sub-group within public health and primary care strategies and annual plans, as well as being a policy priority for Health Inequalities.

We also wish to see rough sleeping identified as a needs category, in much the same way as is dual diagnosis, where it is recognised that one condition impacts negatively on the other, and that the combination is more severe than either condition independently. We wish to ensure that St Mungo's residents (and, eventually, rough sleepers everywhere) gain access to high quality NHS healthcare in order to obtain treatment for their illnesses.

2. Develop and pilot service-models

Our full strategy (available online at www.mungos.org) gives considerable thought into what services residents of a homeless hostel need to receive on-site to ensure quality healthcare. We are piloting as many as we can. Many are outlined in this report.

We are not just suggesting solutions - we are also putting our own money where our mouth is:

Innovation one: St Mungo's £250K pilot – investing in homeless people's health

This pilot will integrate core elements of physical health screening and treatment, and support for mental health, drug and alcohol problems as well as progressing well-being amongst our clients. Our intention is to create a healthcare pathway for homeless people.

We have identified three hostels (Cedars Rd (120 beds), Cromwell Road (56 beds), Endell Street (56 beds) – total 232 beds) in which to test a pilot for up to 15 months. The pilot will enable us to put in place the comprehensive service we believe should be in ***every*** rough sleeper hostel – mixing and matching to existing services as we need. We will spend £250K of our charity income on this pilot. This includes an amount of £40k for evaluating the pilot. The cost equates to £106 per person per week.

"We want to raise the importance of health in the minds of all our residents (and staff). Key to this is to introduce a comprehensive, nurse-led health-check for everyone shortly after their arrival." **Charles Fraser**

For a full copy of the strategy, developed with PHAST, please go to: www.mungos.org/campaigns/homelessness_it_makes_you_sick

2.1 Physical health

Some hostels have good on-site GP coverage: others have none at all. We want to see a uniform and consistent level of service across all our hostels. Our aim is for a basic service of a consistent standard available on-site in each of our hostels, wherever they are located in London, and that this basic service is supplemented by other services which meet any specific needs prevalent in an individual hostel; it is likely to necessitate the co-ordination of locally - and regionally - commissioned services. The totality will constitute a healthcare pathway for rough sleepers, which will be ground-breaking in concept and practice.

> *"The totality will constitute a healthcare pathway for rough sleepers, which will be ground-breaking in concept and practice."*

St Mungo's new health strategy – physical health

1. Ensure that hostels offer primary care on-site which is (a) accessible to all residents, and (b) used by them;
2. Improve preventative care, and reduce the usage of emergency services;
3. Improve mutual understanding, and the transfer of information between, St Mungo's hostels and the NHS;
4. Promote the integration of healthcare so that people receive treatment for all their illnesses – physical and mental – and dependencies;
5. Promote healthy lifestyles and well-being;
6. Identify the best vehicle for delivering this basic primary care to a niche and marginal population

Physical health service model: All rough sleeper hostels require a health-check for all clients within 14 days of admission; on-site surgeries run by nurse practitioners, or nurses from Personal Medical Services (PMS) settings, with visiting GPs; onsite TB and sexual health screening where required; health support staff in each hostel.

Innovations in healthcare at St Mungo's

Hospital at Home: We are introducing an intermediate care scheme at our Cedars Road hostel alongside Lambeth PCT, which includes on-site provision of a nurse and an intermediate care worker to support very ill residents whom might otherwise be in hospital.

Palliative Care: We are introducing a palliative care scheme, which has been developed in partnership with Marie Curie, providing terminally ill clients with access to a nurse, allowing them to die with dignity at home, thanks to the Department of Health Section 64.

2.2 Mental health

The proportion of people sleeping on the streets with a diagnosed mental illness has remained fairly static at about 35%. A significant minority of rough sleepers suffer from the "severe and enduring mental illnesses" such as schizophrenia and bipolar disorder. It is increasingly evident that people with: undiagnosed mental health problems, emotional and psychological disorders and 'lower level' mental illnesses also require significant help. A recent survey in one of our hostels by a clinical psychologist from Southampton University found levels of up to 85% of clients with personality disorders; around 40% with anxiety disorder; around 25% each with depressive disorder and/or PTSD. All also had substance use problems, and were characterised by 'avoidant' engagement patterns – in other words, they were actively help-shunning, not help-seeking, as part of their mental health condition.

A vicious circle operates whereby this group avoids services, and the services avoid this group.

Treatment for psychological disorders remains scarce, and hard to access. There are almost no services for people with personality disorders who continue to use drugs and alcohol, for example – but such individuals make up the majority of the intake to many of our rough sleeper hostels.

Innovations in homeless mental health at St Mungo's

For many years, our largest specialism has been mental health. We continue to manage specialist accommodation at all levels (hostels; temporary and permanent housing; and Registered Care Homes).

In 2007 we committed to using the **Recovery Approach** to shape our provision of client-centred services. It now constitutes our unifying theory for service-delivery.

We have piloted the London Development Centre's training in **Essential Shared Capabilities**, and we have decided to make this training a requirement for all staff working in our specialist mental health projects.

We have devised an **e-training tool** ("Frontline" http://www.frontline-training.org/about.aspx), in partnership with SW London & St George's Mental Health Trust, for working with people with personality disorders.

We have developed **two new dual diagnosis projects in Brent**; directly employing a psychotherapist; and have developed a **relationship-counselling service** in partnership with 'Relate'.

We have also been successful in winning funding for one of the Cabinet Office-funded ACE (Adults facing Chronic Exclusion) national pilot projects, to develop a **pilot psychotherapeutic intervention** for rough sleepers with complex needs and avoidant engagement patterns. Our **Lifeworks** project is currently being rolled out across St Mungo's.

Overall Strategy – mental health

1. Reduce the proportion of people sleeping rough who have a mental illness;
2. Enable rough sleepers to receive appropriate treatment for psychiatric illnesses or emotional disorders;
3. Challenge any disqualification from services due to overlaps between mental illness and other problems (e.g. substance dependency);
4. Promote independence through a choice of onward housing, and occupational opportunities; increase the competency of St Mungo's staff in assisting and supporting residents with a mental illness.

Mental Health Service Model: All rough sleeper hostels require initial mental health screening, as part of health-check; On-site specialist staff; access to talking therapies; occupational service for people with a mental illness or disorder; accompaniment; advocacy; specialist move on.

2.3 Alcohol

Alcohol-related kidney and liver failure remains one of the most common causes of death amongst rough sleepers. Alcohol dependency is a key trigger of homelessness. It keeps people on the streets for longer, makes resettlement more difficult, and increases the risk of tenancy loss and a return to street-life after resettlement. Always housing large numbers of heavy drinkers, over the years we have evolved from being merely containing to providing services intended to either reduce consumption, or at least reduce harm. Two of our Registered Care Homes cater specifically for drinkers, and we have a variety of projects working to help street-drinkers. We also focus our efforts on tackling drinking at the harmful end of the alcohol-dependency spectrum.

Our recent innovations in alcohol

We developed the first **alcohol arrest-referral** service in London.

Our street population services target **street-drinkers** to bring them into treatment and other support networks.

We have opened an **Alcohol Reduction Unit** which aims to reduce the harmful effects of alcohol use on individuals and the wider community.

A potential homeless detox and rehab pilot – partners wanted!

Harmful usage is compounded by both too narrow a range of treatment options and a shortage of treatment providers with the skills and experience to work with our client group. ***In effect long term drinkers and/or drug users are often asked to resolve the problems that led them to substance abuse before entering rehab.*** We currently run a successful reduction unit which takes account of this; and we would like to develop, in partnership with the NHS or another specialised provider, more accessible detox and rehab projects which can successfully work with challenging behaviour and complex needs.

Overall strategy – alcohol

1. Ensure that all dependent drinkers can access the services they need to contain and reduce their consumption, so as to mitigate the harmful effects of alcohol;
2. Explore how to develop an in-house range of services spanning reduction, treatment, detox, rehab and post-rehab support;
3. Help drinkers improve their overall health, and to obtain work and permanent housing;
4. Promote an understanding of the special problems which rough sleeping adds to harmful alcohol use, and which St Mungo's is particularly well-placed to address.

Alcohol Service Model: Our hostel residents require initial screening for hazardous drinking as part of health-check; on-site specialist staff (DANOS standard); dry areas; AA on-site, or locally accessible; easy access to reduction units, detox and rehab, and to detox/rehab projects which can cope with complex needs; occupational service for dependent drinkers; and development of support networks.

"We would like to develop, in partnership with the NHS or another specialised provider, more accessible detox and rehab projects which can successfully work with our client group."

2.4 Drugs

Drug use per se may not cause homelessness, but problematic drug use is around 40 times more prevalent than in the general population. Between 50% to 75% of rough sleepers have drug problems. In some areas over 80% of new admissions to our hostels have problematic drug use, alone, or alongside mental illness and/or harmful alcohol usage. We were one of the first homelessness agencies to work coherently with drugs users, and in 1993 developed a legal and practical policy to guide our work. Unlike many landlord agencies, we want to engage, not evict. As with alcohol, the funding streams favour those on a fast-track to abstinence, rather than the problematic and chaotic end of the spectrum, which is where St Mungo's focuses.

Our innovations for drug users

We have achieved some remarkable successes with this client group, bringing just over 500 individuals into treatment last year (2006/2007).

Where we have **needle exchanges**, we achieve more than 100% recovery, i.e. we receive more than we distribute, helping in a practical way to eliminate dangerous syringes from the community. We have also set up **in-hostel substitute prescribing** services for rough sleepers, bringing into treatment a group of users who had never previously been reached. This service won the runners-up Andy Ludlow Award for "Innovation in Homelessness Services", and an NHS "Innovations in Care" prize. We now have three services, in different PCT areas. We have run a **'Substance Reduction Unit'** in one of our central London hostels, successfully supporting chronic users to begin the process of change.

We also work with **specific populations** where drug use is tied up with other problems, e.g. sex workers. We run a culturally-specific service for Portuguese drug users in our Lambeth hostel because of the large population in Brixton of Portuguese poly-users with English as a second language, often no ID, and living on the streets or in squats.

We make **'low-level' treatments** easily available, and all members of St Mungo's Substance Use Team are trained in assessment, auricular acupuncture, motivational interviewing, relapse management, cycle of change, and safer injecting practices. All meet the DANOS requirements of the NTA. Many are also trained in solution-focused short-term interventions, group facilitation, and interventions such as social work or addictions counselling. These interventions are available to clients across St Mungo's.

Overall strategy – drugs

1. Ensure that all problematic drug users can access the services they need to contain and reduce their usage;
2. Develop an in-house range of services spanning reduction, treatment, detox, rehab and post-rehab support;
3. Help drug users improve their overall health, and obtain work and permanent housing;
4. Promote an understanding of the special problems which rough sleeping adds to problematic drug use, and which St Mungo's is particularly well-placed to address;
5. Reduce the harmful effects of drug misuse on communities.

Service Model for Drugs: Our hostel residents require assessment for problematic drug usage as part of the health-check; on-site specialist staff, prescribing services and needle exchanges; easy access to reduction units, detox and rehab, which can cope with complex needs; occupational service for problematic drug users.

2.5 Well-being

The DH's Choosing Health paper promotes healthy lifestyles. This needs to be contextualised for homeless people, and we are in a strong position to carry out this work for the DH as part of its efforts to address health inequalities. We shall focus on three areas of **well-being**.

Firstly, the **physical** well-being which is promoted by developing help-seeking, self-caring attitudes that lead to healthy options, such as a healthy diet and physical exercise.

Secondly, the **economic** well-being which derives from financial independence and proceeds from our on-site Pathways To Employment model of occupation, training and job search in our hostels.

Thirdly, the **emotional** well-being which flows from our pilot projects with on-site counsellors and psychotherapists, rebuilding self-esteem and the ability to form healthy relationships. We expect that increased levels of well-being will flow from our client involvement work, including 'Outside In'.

Overall strategy – well-being

1. Promote opportunities for residents to undertake physical exercise;
2. Ensure that dietary advice is available;
3. Secure access to relationship-counselling;
4. Embed in every hostel the Pathways to Employment programme (ranging from an activities programme run by hostel staff, through basic & key skills training, to job-search);
5. Extend client involvement opportunities.

Well-being in our hostels: We aim to develop the Recovery Approach in all services; we want to see access to relationship counselling; our Pathways to Employment programme on-site; healthy eating and exercise; plus "Choosing Healthy Options" service for each hostel, delivered in partnership with local PCT's.

3. Develop world-class commissioning

To ensure top-notch commissioning, we need to ensure the decision to commission locally or regionally derives from the needs of rough sleepers rather than from convention.

Hospital discharge is still a fraught area, with some very poor practice in London. Firstly, we will press for every resident discharged from hospital to have an appropriate treatment plan with follow up. Secondly, we have particular concerns about the small number of people who are discharged each year for whom there is absolutely no suitable destination in the community, and many of whom die without dignity as a result. Thirdly, we wish to pilot a 'hospital at home' project which can offer both sufficient medical care to make hospitalisation unnecessary, and act as a 'soft landing' for residents being discharged from hospital. St Mungo's would like to support initiatives to establish a **London-wide forum** to share and address health policy as it impacts on homelessness.

Many **gaps in care** can be best addressed through pilots in the first instance. We have identified 4 key current gaps, where we either invite, or are undertaking, pilots:

i) Psychotherapy for people who have had relationship breakdowns, traumatic childhoods, histories of abuse and violence, and substance dependency;
ii) Tier 4 rehabilitation services for people with complex needs and challenging behaviours, and who may lack stability and motivation; (Residential specialised alcohol and drugs treatments (e.g. detox and rehab) which are care-planned to ensure continuity of care and after-care);
iii) Post-discharge 'step-down' facilities for homeless people who, whilst no longer needing hospital treatment, do need continuing care at a level which exceeds what can be provided by hostels or other existing services;
iv) Terminal care for those who die / wish to die in hostels, and support for hostel staff to enable this.

4. Improve the effectiveness of health interventions

Leaving aside the question of whether or not the right services are in place and accessible, the effectiveness of interventions is diminished by various factors including, for example, inadequate knowledge of available health services in the case of our staff, and of the specific needs of homeless people in the case of NHS staff, and poor communication between our staff, NHS staff, and our residents.

A better mutual understanding and respect between St Mungo's and the NHS is essential. We believe that two-way training can go a long way towards achieving this, as can the joint development of protocols and Service Level Agreements, and joint service-delivery ventures. We will also agree competency levels for all hostel staff and develop the capacity of residents to identify their own health-care needs.

St Mungo's recent innovations – championing health

We have introduced a role of **'health champion'** within our hostels, which is essentially an additional link-worker duty undertaken by existing staff. They will ensure that information about locally-available health services is disseminated within the hostel, and is easily accessible to residents. Our medium-term goal is to have a **Health Support Worker** in each hostel: we are currently trialling this through two posts with charitable funds. These workers will assist keyworkers to fulfil their duties of brokerage between an individual resident and available health services, and take overall responsibility for the relationship between the hostel and the NHS locally.

September will see the launch of the first **St Mungo's Action Week** and the focus this year is health. There will be many activities during the week, one of which will be the launch of a **training scheme for NHS staff**, which aims to bring to the forefront the needs of homeless people in their day-to-day work.

5. Strengthen the evidence base

We know we need to invest in strengthening our evidence base – our data collection, and also the evaluation of our pilots and other interventions. We will develop clear Performance Indicators against which to measure our progress, and which will be incorporated into our performance management systems, including our organisational Key Success Indicators. As part of our organisational KSIs, performance against health targets will be reported to the Board.

Innovation

As part of our St Mungo's Action Week we have called together an **expert panel** to review our strategy and develop the ideas within it.

We shall lead on establishing a **new London Health and Homeless forum** of homeless colleagues and health delivery agencies to create a partnership that shares best practice and tries to influence policy.

Working with PCTs – partners wanted!

PCTs are the main vehicle through which the NHS assesses local needs, plans services and commissions providers to meet those needs. As part of the fieldwork for this strategy, PHAST sought to identify who within key PCTs had the lead responsibility for homelessness and the degree of importance attached to the topic.

The result was a mixed picture. The prioritisation of homelessness was variable, and in practice further diluted by changes in key personnel, by the conflicting pressures of other priorities, and by uneven levels of knowledge and capacity. It is worth emphasising, though, how horrified PHAST were at the great difficulties they experienced in making any sort of contact with many PCTs.

Whilst we do not underestimate the difficulties in having our message heard by PCTs, this simply emphasises the extreme importance of finding a way in which we can work in close partnership with them to implement and evolve this strategy. We welcome support from all levels within PCT and will be in touch with as many potential partners as we can.

We are London's largest charity for homeless people and people whose complex needs mean they are at real risk of street homelessness. We provide over 100 accommodation and support services day in and day out.

We run **emergency** services – including street outreach and emergency shelter. We support homeless people in their **recovery** – opening the door to safe housing, health care and work. We help more homeless people into lasting new homes, training and employment than any other charity.

We also **prevent** homelessness through our complex needs housing and support teams for people at real risk.

By opening our doors, and our support services, we enable 1000s of homeless and vulnerable people to change their lives for good every year.

For more information please contact:
Peter Cockersell, Director of Programmes
St Mungo's, Griffin House,
161 Hammersmith Road, London W6 8BS

Tel: 020 8762 5500 **Fax:** 020 8762 5501
Email: peterc@mungos.org
www.mungos.org

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