

Practitioner's blog

The inequality of homelessness

Mary Dawood RN BSc (Hons) MSc

Nurse Consultant, Emergency Medicine Directorate, Imperial College NHS Trust, London, UK

No society can legitimately call itself civilised if a sick person is denied medical aid because of lack of means.

(Aneurin Bevan, 1952)

Equity and equality in healthcare, which are seen as markers of a civilised society, have in the UK been the moral aspirations of the NHS since its inception in 1948. Despite this laudable objective, some of society's weakest and most vulnerable, namely the homeless population, suffer the poorest health and frequently face discrimination when trying to access healthcare, usually when they are in greatest need.

Homelessness is a major public health issue which predisposes people to ill health, and it is a growing global problem, affecting both the industrialised and developing world. A high percentage of people who are living on the streets suffer from some type of mental illness, with bipolar disorder and schizophrenia being the most common. They may have become homeless because of their illness, or vice versa. Drug and alcohol abuse may be additional factors. People with serious mental illness are often unable to keep a job or are refused housing even if they have the money to pay for it, so they end up becoming homeless as an indirect consequence of the incapacity of the system to care for them.

Although it is not so surprising to find homelessness in war-torn countries, it is shameful to find people living on the streets in wealthy industrialised nations. Helping people who have become homeless is not always easy, as some are resistant to receiving help, having lost their trust in society in general. Sometimes, because of their mental fragility, homeless people can be aggressive and hostile towards healthcare staff, who do not always appreciate their predicament. Even when they accept help it is often difficult for homeless people to adhere to treatment plans and keep hospital appointments, which compounds their already precarious state. Typically, a long-term rough sleeper experiences tri-morbidity, consisting of mental health, substance misuse and physical health problems (St Mungo's, 2008). The most common reasons for admission to hospital include alcohol toxicity, alcohol or drugs misuse and mental health problems, all of which usually present as emergencies due to lack of access to other sources of help. The severity of their illness means

that the average length of stay for homeless people is almost three times that for the general population aged 16–64 years. According to Hospital Episode Statistics, this patient group consumes around four times more acute hospital services than the general population, costing at least £85 million in total per year. Secondary care costs are estimated to be around £3000 per homeless person per year, compared with around £400 in the general population (NHS Information Centre for Health and Social Care, 2011).

Much of the evidence to date suggests that there are four key challenges in providing homeless people with effective healthcare, namely the limited accessibility of treatment agencies (Brindis and Theidon, 1997), high dropout and low completion rates (Sindelar and Fiellin, 2001), frequent and multiple service utilisation (Cox *et al*, 1998; Thornquist *et al*, 2002), and long treatment careers (Hser *et al*, 1997). Most healthcare professionals feel a mixture of sympathy for and exasperation with homeless patients. It is likely that this exasperation stems from a perceived inability to address their multiple health problems in an effective way. We only seem to offer homeless people immediate palliation, rather than engaging with them more effectively in a genuine effort to bring them in from the periphery, thereby empowering them to access primary healthcare.

In the past year an innovative project in London has sought to improve the health of homeless people by increasing their capacity and confidence to access services and adhere to treatment with the support of peer advocates who themselves have experienced homelessness. This Peer Advocacy Homeless Health Project has been developed jointly between Groundswell, a self-help network for the homeless, and NHS Westminster and Imperial College NHS Trust. The project provides training for up to ten peer advocates to support homeless people to access healthcare more effectively. Training is provided by emergency care staff. It is based on a flexible and responsive model that draws on participants' previous experiences, which provide practical insight into the challenges that homeless people experience and form a basis for enabling the advocates to build the capacity and confidence of currently homeless people to access health services and adhere to treatment. Traditional methods of promoting health

services to the most excluded have proved unsuccessful. In this project, peer advocates work directly with excluded people to provide health information, accompany them to consultations, help them to navigate their way through the healthcare system, and ensure that their health needs are met. It is hoped that these advocates will also create a legacy of understanding health systems, increased confidence and skills that enables homeless people to address their health needs, access services, and work with healthcare professionals in the future. Early scoping exercises by the project team have highlighted the wide disparity in mutual understanding between homeless people and healthcare professionals. There is a great need to inform and promote a more positive perspective on both sides of the divide. Comments made by homeless patients included the following:

'When you say you are homeless they look at you differently.'

'Healthcare staff just do the bare minimum. If you're homeless they don't really care.'

Healthcare staff made the following comments:

'Homeless people stay in the department as long as possible to stay warm.'

'Homeless patients on the whole aren't abusive.'

'I sympathise with the patient's overwhelming need to seek drugs to maintain their addiction.'

This project, which is being funded by the Innovation Fund, offers an opportunity to forge excellent partnerships and links between agencies with real user ownership and control. The team has supported 65 clients so far, over 150 meetings, with 12 successfully closed, one or two lost to follow-up (evicted), and sadly one who died. Advocates have supported homeless people to attend dentist appointments, opticians, blood tests, scans, injections, fracture clinics and physiotherapy. Feedback from clients and staff has been very positive, with a number of people keeping appointments that they would otherwise not have attended, and particular successes with engaging some hard-to-reach clients and completing courses of treatment. The project leads have also been successful in securing a second round of funding to support dissemination to another borough and to establish links with another emergency department. Furthermore, three of the advo-

cates have also now secured themselves permanent jobs (one of these with a homeless charity).

It is further anticipated that, once the systems for training and supporting the peer advocates have been fully evaluated, the model will be replicable, and extendable to other marginalised and vulnerable groups. This project has demonstrated that the solution to what is thought to be an intractable problem is often right in front of us, if we open our eyes and minds to the possibilities and consider the valuable contribution that all our citizens can make when treated with respect and afforded dignity, irrespective of their home status.

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ADDRESS FOR CORRESPONDENCE

Mary Dawood, St Mary's Hospital, Praed Street, Paddington, London W2 1NY, UK. Email: mary.dawood@imperial.nhs.uk