

Debate & Analysis

The challenge of providing medical care to homeless men

HOMELESSNESS AND HEALTH

The average age of death for a homeless man is 47 years, 30 years before the national average of 77.¹ This is clear evidence of the impact of homelessness on a person's wellbeing. It highlights the need within this population for the best possible medical care to try and address these health needs. Here we explore what homelessness means today and how it affects health, and reflect on the experience of our practice in providing medical care to a hostel for homeless men. Using this experience we formulate some general ideas on providing medical care to the homeless, and how this service could be improved.

Homelessness in the UK is rising.² Total numbers of homeless people are difficult to estimate due to the transient nature of the population. The legal definition of homelessness is used by local councils to decide whether they are obligated to provide assistance. A person is considered legally homeless if they have no home in the UK or anywhere else in the world or if they are being evicted or their property repossessed. A person can be considered legally homeless despite having accommodation if, for example, the home is too small for the person and their immediate family, if they are in temporary accommodation such as a hostel or refuge, if they don't have permission to live where they are living, or if they can not afford to stay where they are.³

Multiple issues make the homeless population a unique community. Common health problems include drug dependence, alcohol use, mental health issues, and infectious diseases.⁴ Barriers to accessing health care include chaotic lifestyles due to substance abuse or mental health problems, difficulty registering with a practice, challenging behaviours, and previous experience of prejudice within health care.

SERVICES ON OFFER

The White House Surgery in Sheffield has provided medical care to a hostel for homeless men for the past 20 years. Over the years there have been many changes in the local homeless population and in the provision of medical care to this group. Initially the hostel was known as a resettlement unit and was managed by the Department of Social Security. Under Thatcher's government the state provision

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of accommodation for homeless men was stopped and the resettlement units were sold off. This offended our socialist consciences and we were worried about the future; but we were wrong. The hostel was taken over by a housing charity, Saint Anne's. The place was transformed. Long corridors with rows of beds separated only by curtains were replaced with individual rooms. The hostel now provides temporary accommodation for up to 66 homeless men over 18 years of age. It exists to provide immediate accommodation, education, and support to help people to find their own accommodation. Medical rooms were provided. Flats were built in the grounds to provide a place to adapt to the transition to independent living. Real attempts at resettlement are made.

The surgery has always offered an outreach clinic one afternoon per week at the hostel. The residents can access appointments at the surgery at other times. The outreach clinic is run by a partner and a doctor in training. It offers open access to accommodate the lifestyle of some homeless men. The surgery is also responsible for out-of-hours care at the hostel. In the early years this often meant visits at night to the men in their communal bedrooms with little privacy. This is now being provided by the local GP collaborative.

One of the strengths of the service is that it is visited by a range of agencies. Sheffield has a Homeless Health and Support Team (HAST). A community psychiatric nurse from the team visits weekly and has support from the professor of psychiatry. The psychiatric care is excellent but spread very thinly across the city, meaning some clients have to access the local community mental health team instead. This can mean a longer wait, which can create difficulties in a transient homeless population. The HAST team has limited access to a social worker. A nurse visits weekly to offer screening and vaccinations which is a vital part of the health promotion work. A substance misuse worker does individual and group work and acts as a link with the

community substance misuse team. Hostel staff provide essential key working support.

CHANGES IN THE RESIDENT POPULATION

The clientele have changed over time. Twenty years ago the hostel housed a large number of street drinkers with a few young drug addicts. Slowly this ratio has reversed. Recently the hostel has housed increasing numbers of people who have moved to the UK from abroad. They can become trapped in homeless accommodation while being unable to work due to their legal status or due to limited employment opportunities. This has brought different challenges. They may be dismissive of primary care if they have come from a country where health care is mainly provided in hospitals. They have often had traumatic experiences and may come from cultures where men find it difficult to accept psychological illness and are more likely to somatise their problems.⁵ They may have difficulties integrating into a local community which may not welcome their arrival. Combining these factors with limited English language skills can make it difficult to provide good medical care. None of these issues are mutually exclusive and all the men can have a variety of problems including alcohol or drug addiction, mental health issues, and the myriad of physical health problems associated with homelessness.

THE IMPORTANCE OF FUNDING

Funding is always a driver of care and has changed over the years. When the surgery took on the job it was paid a retainer fee, and Saint Anne's have continued to pay this. Although small, without this the extra work involved in the care we give would not be viable. In the early years this fee was supplemented with temporary resident fees. The transient nature of the population meant that the work involved in finding the notes and summarising them in order to fully register the patient at the practice was not worth the effort when the men would often move quickly on. A local

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enhanced service (LES) payment has been available since 2012. The funding from this has allowed us to make the improvements we have wanted to for many years. We have computerised the notes with remote connection to the surgery database and we aim to register all patients who wish to be registered.

THE CHALLENGE OF HEALTH PROMOTION

The LES has challenged us to look at our patterns of work. The work has been reactive and patient-led; seeing patients when they present rather than reviewing all patients at regular intervals. It has been very challenging at times, but also very interesting. Health promotion work is sadly not as interesting. In order to provide the best medical care and improve the health of this group we need to focus on health promotion. We need to try and address the many risk factors for physical and mental health problems within the homeless population. The LES guidelines are heavily focused on preventative and proactive management, for example, offering screening to all patients and reviewing chronic problems. This is challenging as it is time-consuming and is not as immediately obvious as the ‘fire fighting’ approach to their problems that we have developed over the years. The Royal College of General Practitioners statement on homelessness in 2002 discussed this and concluded that:

*‘Homeless people should be integrated into all health prevention and promotion activity’.*⁶

The chaotic lifestyle that often accompanies homelessness can be a barrier to accessing health care. The time that a person spends at the hostel could be a period of stability where they have the opportunity to address mental and physical health problems. This may be their first chance to easily access health care on a weekly basis, making it important to use this opportunity fully and to encourage health promotion activities such as screening and vaccinations. This would be in line with the World Health Organization definition of Health in 1948 that:

*‘Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.’*⁷

To begin to move towards a change in our approach we have developed an electronic template to help direct our work and enable us to audit our progress. This prompts the doctors to cover certain aspects of the consultation; such as, mental health review, chronic disease review, substance misuse, and childcare responsibilities. This aims to improve the record keeping and therefore the management of the patients at the hostel. We are also working to improve communication between the different team members at the hostel.

We feel that looking after homeless men is important as they have significant health needs and great health inequalities when compared with the general population. This work is interesting and satisfying as well as challenging. Idealistic motivation is important but adequate funding is essential to ensure good and continuing care. The challenge is to focus on preventative and proactive management as well as dealing with immediate presenting problems.

Richard Watton,
GP Partner, White House Surgery, Sheffield.

Ceri Gallivan,
Former GP Registrar, White House Surgery, Sheffield.

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ADDRESS FOR CORRESPONDENCE

Richard Watton
Whitehouse Surgery, General Practice, 1 Fairfax Rise,
Sheffield, S2 1SL.

E-mail: rjwatton@gmail.com

REFERENCES

1. Thomas B. *Homelessness kills: An analysis of the mortality of homeless people in early twenty-first century England*. University of Sheffield, Crisis. 2012. http://sasi.group.shef.ac.uk/publications/reports/Crisis_2012.pdf [accessed 21 Oct 2013].
2. Wilson W. *Homelessness in England*. 2013. <http://www.parliament.uk/briefing-papers/sn01164.pdf>. London, House of Commons Briefing Paper. [accessed 21 Oct 2013].
3. Shelter. *Legal Definition of Homelessness*. Shelter: London, 2013. http://england.shelter.org.uk/get_advice/homelessness/legal_definition_of_homelessness. [accessed 21 Oct 2013].
4. Hwang S. Homelessness and health. *CMAJ* 2001; **164**(2): 229–33.
5. Perron N, Hudelson P. Somatisation: illness perspectives of asylum seeker and refugee patients from the former country of Yugoslavia. *BMC Fam Pract* 2006, **7**: 10.
6. Royal College of General Practitioners. *2002 RCGP statement on homelessness and primary care*. <http://www.rcgp.org.uk/policy/rcgp-policy-areas/homelessness.aspx> [accessed 21 Oct 2013].
7. World Health Organization. *WHO definition of Health*. <http://www.who.int/about/definition/en/print.html> [accessed 21 Oct 2013].