Hauora mo nga Kainga Kore: Health and homelessness

Improving health and social outcomes for a central Auckland high needs population

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Introduction

During August and September 2018, I visited the United Kingdom and Ireland as a Churchill Fellow. The purpose of my visit was to understand how primary healthcare could better be provided to homeless people, in particular what can be done for homeless people in Auckland, where I work. I undertook to bring back practical ideas to improve our parctice at Auckland City Mission's Calder Medical Centre.

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Background to the fellowship

I have been a GP at Auckland City Mission's Calder Medical Centre for the past five years. About 10% of our patients are rough sleepers, many of whom suffer from mental illness, addiction, and poorly managed chronic illness. They often struggle to access primary care due to poverty, difficult social circumstances including recent imprisonment, deportation and chaotic lifestyles. Rough sleepers (sleeping on the streets) have a life expectancy or about 20-30 years less than average. The mean age of death for Mission clients who are rough sleepers, is 55 years. Many

of our other patients (about a quarter) are vulnerably housed in hostels and boarding houses, couch surfing sleeping in cars, and in short term emergency accommodation.

There are significant challenges to providing quality primary care services to this population but Auckland City Mission aims to provide , the same high quality service to rough sleepers and other vulnerable groups that other NZ citizens and residents expect.

Many rough sleepers are 'tri-morbid', that is they have mental illness, physical illness, and addiction. They often behave badly, may turn up late or intoxicated, and are prone to outbursts of anger. This alienates those trying to help, confirming their prejudices, and can be further traumatising for the patient. It is well documented that many, if not most, long term rough sleepers, have suffered childhood abuse and trauma. This should moderate any judgemental attitudes towards this marginalised group.

There is evidence of institutional indifference and ignorance of their needs. Busy hospitals may not have the resource to ensure all discharges of homeless patients are safe. Without an address, it is hard for patients to receive out-patient appointments or to apply for the public assistance that they need to pay for somewhere to live. If they are in emergency accommodation they may be moved from one DHB to another, losing their place in the queue for appointments. It is hard to keep wounds clean, eat a healthy diet, or store insulin and other drugs safely when sleeping on the street. Life is hand to mouth and looking after your ischaemic heart disease or diabetes, is not seen as a high priority.

We see with not only complex and multiple health needs, but the underlying social determinants which precipitate or perpetuate these, including homelessness, social inequity, racism and judgements about lifestyle, and exploitation.

Ireland and the UK have similar health services to New Zealand, and increasing rates of homelessness. The Fellowship afforded me a chance to see how the issues are being tackled there, and understand how we might better approach these challenges and advocate for this population. It also provided me an opportunity to be stimulated and re-energized. A number of issues were identified from my Fellowship:

- The nature of the most effective types of clinic including booked appointments, open access services, outreach services
- How to improve hospital outpatient attendance rates
- How to improve and make more equitable, access to services such as mental health, addiction, psychotherapy and counseling, dentistry, and similar
- Improve co-ordination of our service with the District Health Board to ensure our patients more equitable access to secondary care, and to minimize 'unsafe' discharges from hospital
- Improve management of chronic diseases and compliance
- Funding of other related services. I contend that providing high quality primary care and overcoming inequities in this population is hindered by the business model for New Zealand general practice

Itinerary

Over a period of four weeks I visited a wide range of services in Dublin, Oxford, Bradford and London. These visits included primary care services, street outreach services, hostels, Detox and Rehabilitation Centres, Hepatitis C services, and homeless teams in hospitals. I meet with clinical and service leads during the visits. There were also opportunities to meet with multi-disciplinary teams working with rough. I will briefly outline my itinerary before looking at specific areas and issues in more depth.

Dublin: Merchants' Quay Drugs & Homeless Service and SafetyNet

Merchant's Quay Riverbank Centre (MQI) in the centre of Dublin provides a similar range of services to the Auckland City Mission. The drop-in service provides breakfast and lunch as well as help accessing benefits, accommodation and health and addiction services. At night it becomes a night shelter with 61 'sit up' beds with yoga mats.

Dublin has a significant issue with homelessness and rough sleepers are very obvious. Begging and drug use are common on the streets. The rough sleeper count in March 2018 was 110 people. However, there are a number of night shelters offering single night shelter. I saw Bru Aimsir hostel (100 beds), Ellis Quay (60), and 61 beds at MQI drop-in. We do not have comparable night shelters in Auckland.

MQI runs a small health centre on the Riverbank site in Dublin. They have a full-time practice nurse and GP clinics are provided by Safetynet - a medical charity which aims to provide primary health care to those who struggle to access mainstream services, particularly migrants and homeless. There is a full-time dental service funded by donors, offering a drop in clinic in the morning and booked clinics for more complex work in the afternoons. There is a mental health nurse and a needle exchange. Having this in the primary care setting provides an opportunity to engage with clients who might not otherwise attend primary care. They do a fairly comprehensive initial assessment with an emphasis on harm reduction. Services include screening for infection, OST, hepatitis B vaccination, naloxone training, and injecting workshops, needle and pipe exchange and supply of tourniquets.

Safetynet[1] offers GP services to people who are not enrolled with a practice – their aim is to get people to a point where they can 'maintain' enrolment with a mainstream practice. Although people on lower incomes have free access to GPs via a community card, this does not apply to undocumented migrants, EU cicizens who have not met residency criteria, returned citizens who cannot prove entitlement, etc.

Their 'In-reach' primary care team bring health services to homeless people by offering GP/nurse clinics in several emergency hostels around Dublin. They work closely with the Inclusion Health team at St. James Hospital to facilitate admission and discharge planning.

[1] See their work on https://www.irishtimes.com/news/social-affairs/safety-net-providing-primary-healthcare-for-the-homeless-1.2535347

I visited the Tuesday morning clinic at Bru Aimsir, a 100 bed hostel (80 men and 20 women). This is a single night hostel which provides an evening meal and breakfast. Beds are in 2-3 bed rooms and 2 can be locked. These beds are used for particularly vulnerable rough sleepers. Room and toilets are checked every 15-60 minutes (depending on time of night) for overdoses. The clinic takes place in two small rooms provided by the hostel, for a doctor and a nurse. The hostel manager acted as an informal receptionist. Patients could self refer or be invited by the manager. The clinical team also had a list of people they were looking out for, to follow up.

They also operate an 'Out-reach' mobile health unit from a custom fitted Mercedes van which parks at St Stephen's Green 3 evenings a week. It is staffed by GP registrars and Safetynet nurses, as well as outreach workers from the Simon Community or Housing First. Typical patients might be sleeping in tents or cars.

On Wednesday 15 August I drove around two hours to MQI's detox and rehab centre at St Francis Farm, Tullow. Annette O'Dwyer, the manager, kindly showed me around the facility. St Francis Farm is a working farm in lovely countryside with 10 detox and 13 rehab beds. Detox is medically supervised and individually tailored. Most clients are detoxing from methadone and/or benzodiazepines and programmes typically run for 4-8 weeks, significantly longer than alcohol or methamphetamine. Clients on methadone are nevertheless detoxed fairly quickly. Anticonvulsant cover may be needed for benzodiazepine withdrawal. Clients move on to a 14 week rehab programme. They are kept busy with one to one counselling, group therapy, health education workshops, gym. Working on the farm is also part of therapy. Many clients have abusive backgrounds. Feeding lambs, seeing seedlings grow may be the first opportunity they have had to learn to nurture and care. 'Aftercare' – helping clients into housing and work – is an important part of the programme.

Oxford: Luther Street Medical Centre

After Dublin, I spent a week in Oxford hosted by Luther street medical centre (LMSC). They kindly organised a very full and interesting week for me in Oxford. I was able to sit in on clinics at Luther Street, and the John Radcliffe hospital, at Turning Point (drug and alcohol services), to meet a wide range of people, see team meetings and education sessions, and go on street outreach.

Luther Street Medical Centre is a specialist GP surgery providing primary care to homeless people in Oxford. It opened in 1985 in a portakabin, and a purpose built surgery was opened in 1998. It is part of the NHS (unlike 'mainstream' practices in the UK) and staff are salaried. They have approx. 500 patients registered. They are homeless or vulnerably housed. When they achieve more stability they are encouraged to register with a mainstream practice. As in all the specialist homeless clinic I visited there is a high number of GPs to patients (2 FTE GPs in this case), illustrating the high level of clinical input these patients need.

They are open 8.30 – 6pm daily Monday to Friday with no out of hours cover. There are 2 GPs on each day, one covering 8.30 – 4.30 and the other 10 - 6pm. There is a brief morning meeting for all staff on site to check who is on duty, and assess the coming day, in addition daily team meeting for clinical staff over lunch at 1.30pm. There are also regular training sessions. In

addition to GP and nurse clinics there is a mental health nurse, social worker, dentist (1 day a week) and a monthly psychiatric clinic.

The building is clearly built with security and safety in mind. Patients can usually enter the waiting room freely, but may need to be 'buzzed into' if there is an incident occurring. From the waiting room, they are 'buzzed' through to the clinical areas when called by doctor or nurse. The reception desk is open plan with only a 30cm barrier of safety glass above it, but there have not been any incidents. In spite of the security measures the space feels light and airy. Clinic rooms all have two doors to improve safety. (because there is always a second exit)

In addition to sitting in on some clinics I attended some of their practice meetings and teaching sessions. They have a very active programme of teaching for students and health professionals on health and homelessness. In the week I was at LSMC, they also had a clinical education meeting with Dr Ian Coffey from Turning Point (drug and alcohol service) and a meeting with the visiting psychiatrist, to discuss referrals. These regular meetings re-enforce team working, help with education, and the morning meeting contributes to safety as concerns can be discussed as well as confirming who is in the building.

About 10% of our patients at the Calder Centre have hepatitis C, and since treatment (direct acting antivirals or DAAs) have been available to GPs, we have run a clinic in conjunction with Auckland District Health Board (ADHB). I was interested to see how the epidemic is managed in the UK. While in Oxford I also visited the hepatology (liver) clinic at the John Radcliffe Hospital (JRH) and attended one of their multidisciplinary meetings. This clinic sees mostly patients with hepatitis B and C, mostly complex cases (co-morbidities, previous treatment, etc.) The prevalence of hepatitis c in the UK is around 0.1% (about a tenth of NZ) but 11-15% in IVDU and maybe up to 60% in some subgroups (crack cocaine users). Like us the commonest genotype is 1, but there is a high prevalence of G3 in immigrant populations, who are poorly screened.

Direct acting antivirals are not available in primary care, and not even all District General Hospitals prescribe them. This appears to be due to the high cost and the liability of the prescriber. Drugs can only be dispensed by a hospital pharmacy and then are couriered to the patient. This causes challenges in reaching and following up some patients. However there is an active community nursing team and I sat in on one of their clinics at 'Turning Point' – which is similar to a Community Alcohol and Drug team. In Oxford, drugs for homeless patients can also be delivered to Luther Street Medical Centre.

Pangenotypic treatment regimes are not funded due to cost, and when I was there three different regimes were being used for different genotypes (strains) of hepatitis c. These treatment regimes change from time to time depending on cost. This contrasts with New Zealand where a pangenotypic treatment (Maviret) can now be prescribed by GPs, giving us a real chance of eradicating hepatitis c from New Zealand.

I also spent an afternoon with Jane Phillips, a hepatitis community nurse who was doing an outreach clinic at Turning Point, a community drug and alcohol service (similar to CADS). In Oxfordshire they use finger prick testing fairly widely for screening for hepatitis C and other

blood borne viruses[2]. There is also a testing bus that goes round to GP surgeries, Turning Point Hubs, festivals. The hepatitis nurses who go out to the community use these. Many people who inject drugs have very bad venous access because the commonest drug, heroin (in contrast to methamphetamine which is injected in New Zealand) is a biological material, often contaminated and needs strong solvents. Many people are reluctant to have blood tests for screening but are more willing if they have tested positive on finger prick. A positive finger prick test may provoke a strong emotional reaction, possibly because the client may have little time to prepare mentally for a result, as compared to blood test which is sent to a laboratory. This is something to consider if testing at events like concerts. This service have developed a checklist they complete when point of care testing.

The JRH hepatology department has a close relationship with Luther Street Medical Centre but there is no hospital team with a focus on homeless patients. However, I believe the John Radcliffe Hospital is currently looking into funding a hospital based homeless ('Pathway team') which I will discuss below.

On my final day in Oxford I went on a street outreach with Dr Kate Smith, Martin and Holly, outreach workers employed by Oxford City Council. Martin and Holly do an outreach walk round 6.30-9am every weekday. Since 2016 a GP has accompanied them once a month. The main aim of this is to engage with rough sleepers and invite them to LSMC, but it is also an opportunity to give advice to patients and outreach workers. Patients may be reluctant to give details or seek medical care for a number of reasons. Lack of documentation, warrant out for their arrest for example. An annual street count is done on a set route. Last year the count was 44. This is in a city with population of about 150,000 so is comparatively high compared to Dublin. However it is difficult to compare figures from city to city as street counts are done in different ways. They may confine the count to a specific route, and numbers vary with the time of day or season. In Dublin (inner Dublin population approx. 550,000) the March count was 110, but this does not take account of those in single night hostels, who are on the street in the day. The figure of 1367 families with 2894 children in homeless accommodation (Greater Dublin July 2018) is probably more reflective of the scale of the problem in Dublin.[3]

There is an outreach team in most cities and coastal towns in the UK. These are usually funded by the council. Rough sleepers have to be 'verified' as such to access council services. This involves a brief assessment, recording personal details. If they are to access services for more than 2 weeks, or to be eligible for council housing they must be able to prove a local connection. This adds an extra level of complexity to housing homeless people. I later saw this particularly starkly in London where the Pathway teams often have negotiate with several boroughs before someone is accepted as being their responsibility.

Bradford: Bevan Healthcare

I next travelled to Bradford, where Bevan Healthcare provides primary health care to rough sleepers and other vulnerable groups such as migrants and refugees. They have 2 clinics in Leeds and Bradford with about 6,500 enrolled patients. In contrast to the clinics I visited in Oxford and

[2] The test is made by Alere and tests Hep C, Hep Bs Hep Bc and HIV

[3] Dublin Region Families who are homeless' Dublin Region Homeless Executive. July 2018

Dublin many of the patients are housed – although vulnerable in other ways, and it felt more like the Calder Centre. Bevan have a philosophy of delivering healthcare to the patient, and have a street medicine team delivering health care both on foot and using a customised mobile van. Bevan also provide the hospital homeless team (Pathway), and in partnership with a housing provider they provide 14 respite beds for homeless people discharged from hospital (Bradford Respite and Intermediate Care Support Services).

I was able to attend a morning briefing for street outreach workers and then accompany one of the teams, who stopped to talk to some of the rough sleepers, giving advice about healthcare and other services, some basic medical advice, and encouraging attendance at the clinic. As well as meeting people on the street they also made contact with other clients at a church hall where meals were provided. I sat in on a drop in clinic with a GP providing approximately 20 minute appointments, backed up by a practice nurse and attended the weekly multidisciplinary meeting of practice staff.

In the last week of my Fellowship went to London to visit the homeless charity Pathway, and two of the hospital Pathway teams. These are multidisciplinary hospital based teams providing support to homeless patients and the clinicians looking after them.

University College London Hospital (UCLH) Pathway team

The University College London Hospital (UCLH) Pathway team comprises a GP (0.4 FTE), a full time nurse practitioner, an alcohol and drugs worker, and three health care navigators / support workers with lived experience of being homeless. UCLH has approximately 660 beds. The homeless (Pathway) team work office hours. There are limited benefits to being available at weekends as organisations dealing with housing are not available. The team share one small office near the hospital reception area.. They can access (paper) hospital records, and EMIS (a GP software programme similar to MedTech) is used as a database. Staff cannot access other GP's records. They also have read-only access to CHAIN[4], a database maintained by St Mungo's, of homeless people within the M25. This is comparable to ACM's database of clients.

Staff are alerted to all admissions and A+E attendances of homeless patients. Identifying patients as homeless is important but not always straightforward as people may be ashamed to admit they are sleeping rough, and may give a relatives address as a contact. Reception and clinical staff need to have a high index of suspicion and be ready to ask sensitively about

[4] *'CHAIN is a multi-agency database recording information about people sleeping rough and the wider street population in London. The system, which is commissioned and funded by the Mayor of London and managed by St Mungo's, represents the UK's most detailed and comprehensive source of information about rough sleeping. CHAIN allows users to share information about work done with rough sleepers and about their needs, ensuring that they receive the most appropriate support and that efforts are not duplicated. Reports from the system are used at an operational level by commissioning bodies to monitor the effectiveness of their services, and at a more strategic level by policy makers to gather intelligence about trends within the rough sleeping population and to identify emerging needs.'* (www.mungos.org)

homelessness. Ward staff and A+E staff may additionally ask the Pathway team to review patients about issues such as drug use, rehabilitation, detox and methadone initiation. The team can help patients with food and clothes, transport (e.g. on discharge to a housing provider, or to be 'repatriated' to another city such as Birmingham). They help arrange for housing, including support letters to councils which need to provide evidence of homelessness, of individual entitlement, and high health needs in order to prioritise them. They can also assist clients with registering with a GP and have a good relationship with two local 'CHIP' (Camden Health Improvement Practice) practices[5]. These practices focus on vulnerable and homeless patients. Some GPs may be reluctant to register homeless patients, who are seen as disruptive and demanding of time and resource. The team has access to two respite ('step down') beds at Ollalo Hostel, comparable to those in Bradford, which can be used for patients being discharged.

I visited two ward patients with the team; a young woman with complications from alcohol abuse and a history of trauma, to discuss rehab options, and a woman who was not fit for discharge but the ward could not manage her behaviour and needed the bed. She was given an oyster (travel) card to get to the local council offices and it was arranged for one of the health navigators to meet her there and support her.

East London Hospital Pathway Team

This team comprises a GP (0.4 FTE), an administrator (0.5 FTE), Senior sister, Occupational Therapist, Care Navigator and Social worker who comprise the rest of the team. The GP also works in a homeless general practice. These staff work out of a slightly bigger office than UCLH, but a long desk with four terminals but is still very cramped. East London Hospital has electronic records which the team have access to. They can also access EMIS (PMS) records for several local general practices, on a read only basis. They also access CHAIN.

While in London I met Alex Bax, CEO of the Pathway charity which has its office close to UCLH and Trudi Boyce, who was involved in setting up the first Pathway Team in 2009. The Pathway hospital teams are independent from the charity which helps set them up, engages in research and hosts the Faculty of Inclusion Medicine and annual conference. Membership of the Faculty of Inclusion medicine is free to all those involved in working with homeless people.

I was able to attend multidisciplinary meetings held by the UCLH and ELH Pathway teams. These are attended by the Pathway team members, housing providers, council representatives, and hospital clinicians. This meeting focused on patients coming up for discharge, who had complex medical, social and financial issues, the aim being safe discharge to appropriate housing.

Finally, I was invited to attend a reflective Practice meeting with members of East London and UCLH Pathway teams, facilitated by Dr. Nick Maguire, Clinical Psychologist.
This is a monthly meeting for the two Pathway teams where staff can bring difficult cases and concerns. In some ways it performs a similar role to individual supervision. Each meeting also has a specific focus – in this case we discussed 'How do we show effectiveness?

[5] https://gps.camdenccg.nhs.uk/service/chip-camden-health-improvement-practice

After returning to New Zealand, I attended a round table on homelessness at Brisbane Common Ground, where I met Dr. Jim O'Connell, Boston Healthcare for the Homeless Programme[6] (Boston, USA). This was a further opportunity to hear about and discuss approaches to providing healthcare.

Discussion

'the life of man is solitary, poor, nasty, brutish, and short'

Thomas Hobbes' description of the conditions of life when society has broken down describes the lives those who sleep on the streets in modern developed societies. Often solitary, little or no income, scarred by trauma and abuse, at high risk of assault and further trauma, and short – they die 20 or 30 years younger than the rest of us. They too deserve the right to live and die in dignity with access to high quality primary care and a supportive health available to them.

The Churchill Fellowship provided me a unique opportunity to reflect on how this might be achieved better in New Zealand by understanding how these patients are dealt with in the United Kingdom and Ireland. While there are differences in services and nature of the addictions, there are significant similarities that do allow for comparable responses.

While this discussion is primarily aimed at Auckland City Mission and the Calder Medical Centre, I hope it will be of interest to other clinicians.

I have divided my discussion into three particular themes, with a few miscellaneous points at the end:

i) Coordination of primary and secondary care
ii) Engaging better with patients
iii) Messages for clinicians – improving care of homeless people

Coordinating care: Homeless team

'Barts NHS Trust believes that chaotic homeless patients provide an ideal stress test for our systems, revealing gaps in services and breakdowns in communication. This offers the opportunity that by improving the care of homeless patients we may improve systems that benefit all patients' (terms of reference for Pathway MDT meeting).

Homeless people attend ED more often, have more hospital admissions, longer hospital stays and more re-admissions[7]. Discharges back to the street may lead to re-admission, or death. This is in part due to their complex health issues but is also due to a lack of a coordinated approach to their care. Homeless people, like people who are dying, or people with diabetes, or schizophrenia, have special health needs and priorities. We recognize this in secondary care by

[6] https://www.bhchp.org/

[7] Eg: In the UK, people who are homeless attend A&E six times as often as people with a home, are admitted four times as often and stay three times as long. (Department of Health 2010: Inclusion health: improving primary care for socially excluded people)

having palliative care teams and liaison psychiatry, and through support staff who manage special groups.

To improve outcomes for homeless people, close co-ordination of primary care, secondary care and social services is essential. I saw two approaches which have addressed this successfully.

In Dublin, Dr Clíona Ní Cheallaigh, a consultant in General Medicine, started the Department of Inclusion Health[8] at St James's Hospital. This Department are notified of all admissions of homeless patients and visit them on the wards, supporting their care. They also attend MDT meetings at Merchant's Quay, so linking with primary care. They have successfully reduced re-admission rates and length of stay.

In the UK, the Pathway model was first developed by Professor Adrian Halligan and Dr. Nigel Hewitt in London in 2009, prompted by the death of a homeless man on the front steps of the University College Hospital in London, shortly after discharge from their ED to the street. There are now 11 Pathway teams in the UK, and one in Perth, WA. In contrast to the Irish model they tend to be GP led, but the emphasis is on co-ordination of primary and secondary care.

Pathway recommends that hospitals with more than 200 contacts per year (ED attendances as well as admissions) should consider setting up such a team[9].

Pathway teams typically comprise a part time GP, an experienced hospital nurse, a social worker and care navigators/support workers. They are independent of hospital specialties and GP led, in contrast to the Department of Inclusion Medicine in Dublin. They provide patients with:

- *'Housing and benefits advice*
- *'Help to recover important documents such as birth certificates, passports etc*
- *'Links to community services*
- *'Support and collaboration with other clinicians e.g. advice on drug interactions*
- *'Complex care planning and discharge liaison*
- *'Referral for addictions support*
- *'Help with GP registration*
- *'Fresh clothes, shoes and other basics (for example where these have been destroyed because of infection/infestation)*
- *'Help to reconnect with loved ones'*
  (www.pathway.org.uk)

The team is notified when a patient is identified as being homeless. Initial contact is made by the nurse and health navigator. There is a weekly GP led ward round. Weekly multidisciplinary meetings involve outside agencies such as housing providers and focus on safe discharges and follow up. An integral part of the Pathway approach is access to respite beds for selected patients on discharge.

[8] https://www.hse.ie/eng/about/our-health-service/making-it-better/inclusion-health-service-at-st-james-hospital.html

[9] https://www.pathway.org.uk/wp-content/uploads/Pathway-Annual-Report-2017-18.pdf

A well as providing a more humane approach there are financial benefits to this approach. The Pathway approach has been shown to reduce ED attendance, length of stay and re-admission rates for homeless people [10] [11] . Patient satisfaction is improved and it is of interest that although overall length of stay in hospital is decreased, short says increase in length slightly – suggesting that with better support, homeless patients stay in hospital to complete treatment, rather than discharging themselves prematurely.

Coordinating care: respite beds

Respite beds are available for homeless patients fit for discharge from hospital, but need further time for recovery and have no home to go to. Pathway estimates that about 1 in 5 homeless patients admitted as emergencies will benefit from a period of respite care. This supports convalescence, nutrition and recovery, in a psychologically informed environment equipped to manage substance misuse and personality disorder issues. There has been funding for a number of pilot studies in the UK and a number of models have been trialed, with more or less clinical input, and which may be GP or consultant led.

UCLH Pathway team has access to two respite ('step down') beds at Ollalo House which is a local hostel[12]. Patients discharged to respite remain under the care of a hospital consultant and receive nursing care (up to three visits per day). This is funded by the NHS. Once fit for discharge they may be able to remain in the hostel but alternative funding is required. This eases the transition from hospital to 'home' for particularly sick/vulnerable homeless patients. It frees up acute hospital beds and saved over 500 bed days in the first year pilot.

In Bradford, there is a 14 bed respite unit called, 'Bradford Respite Intermediate Care Support Service' (BRICCS), which is supported by a GP, mental health/addictions nurse, and a physical nurse. It has been shown to reduce secondary care costs, improve patient experience and reduce re-admission rate. In this case a GP rather than consultant is responsible for their clinical care.

In some cases respite beds may be available for GP admissions to avoid hospital admission ('step up' beds), or for the palliative care of homeless patients.

As with Bevan Healthcare in Bradford and Leeds, Auckland City Mission and Auckland City Hospital have all the skills which would be required to start a hospital homeless team and look after respite beds in Auckland. I have seen at first hand some of the difficulties our homeless patients experience on discharge and there is no doubt that we could do this better in Auckland.

Coordinating care: improving attendance at specialist out-patient clinics

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[10] Watt L 'Positive outcomes for homeless patients in UCLH Pathway programme'. British Journal of Healthcare Management 2017 Vol 23 No 8

[11] Hewitt N. et al 'A general practitioner and nurse led approach to improving hospital care for homeless people'. BMJ 2012;345

[12] Pathway: 'Piloting a Medical Respite Service for Homeless Patients at University College London Hospitals' Summary Report November 2016

Homeless patients have a high 'did not attend' (DNA or FTA) rate at hospital clinics. This is partly because of poor experiences of health care, but also for a number of practical reasons. They may not have a reliable mailing address, or a functioning phone with credit with which to receive their appointments. If living in emergency accommodation, they may be moved from one DHB to another with very little notice. If they do receive their appointment they may not have money for the bus fare, petrol, or parking. This was an issue at all the places I visited, and there are no simple solutions. This is something we probably do as well at Auckland City Mission as anywhere else I visited. Bringing the clinic nearer the patient helps – the specialist comes to the primary care centre, or to and AOD hub. This works better for some specialties than others. Providing rough sleepers with a reliable mailing address, and lending HOP cards, also helps. At the Calder Centre we often ask the hospital to copy outpatient appointment details to us so we can help the patient attend. Some patients need someone to go with them, and we regularly help with this. We need to continue to work with the hospital to ensure our patients receive communications in a way that works for them, and to make hospital clinics welcoming and trauma-informed environments.

Engaging with patients: Outreach / Street Medicine

"*A physician is obligated to consider more than a diseased organ, more even than the whole man – he must view the man in his world.*" *(Harvey Cushing)*

There are a wide number of ways in which we can take primary care out of the medical centre to homeless people. Rough sleepers are often reluctant to attend traditional clinics where they may be viewed with a judgmental attitude. Homeless patients are often chaotic, and poor at keeping appointments, and may be badly behaved and demanding. This may be met with irritation and a lack of understanding by practice staff.[13] Both sides have their pre-conceptions re-enforced. The medical centre is seen as hostile and judgmental and the patient is seen as a drug-seeking ingrate. Such interactions can further traumatise the patient - the opposite of what we should be seeking to achieve. Unhappy experiences of interaction with health services may make homeless people reluctant to attend GP and hospital clinics. The shame of being unwashed, or having an unpaid bill at the GP may be a further disincentive.

It is clearly important to make our GP clinics welcoming and accessible to all our patients. Another approach is to take healthcare out of the clinic to where the patient lives – the street, in our case. I saw several examples of 'street medicine' during my Churchill Fellowship.

At one end of the spectrum a doctor or nurse may accompany outreach workers out on the streets to engage with rough sleepers, provide information about the medical centre and offer advice about health issues. I saw this in Oxford. At the Calder Medical Centre we have done it on an occasional basis to see a particular person of concern who is reluctant to attend the clinic.

In Dublin and Bradford I saw well equipped vans which go out with a multidisciplinary team, where many of the services of a traditional medical centre can be provided. I also saw this in Dublin and Bradford. Usually they park up at a particular place and time.

[13] See guidance for receptionists on pathway website - https://www.pathway.org.uk/wp-content/uploads/2017/02/GP-reception-standards-for-primary-care-v10.pdf

Another model is for a primary care team to offer clinics in hostels, as SafetyNet do in Dublin.

At the other end of the spectrum Dr. Jim O'Connell describes a team of 2 physicians, a psychiatrist, a nurse practitioner and a case manager who work on the streets in Boston, USA[14]. They also run a hospital based clinic once a week. He estimates that about 80% of primary care is possible on the street, and they can deal with a caseload of around 800 patients. They find that many of their patients are reluctant to attend traditional clinics. These are often hospital based with a strong business model, and it is probably difficult to make them as unthreatening as many GP clinics in New Zealand.
A mobile clinic is an expensive asset to buy, maintain and staff. This would be a major commitment for the Calder Centre at the Auckland City Mission.

I suggest we should focus on;

- Having the flexibility to go out and see specific patients when needed.
- Consider a doctor or nurse going out with an outreach team on a regular basis (once a month, or once a week) as in Oxford. This is instructive for clinician and outreach worker, and offers the opportunity to engage with patients and invite them into the medical centre
- If possible, sharing the costs of a mobile clinic with another organization might mean that a pilot mobile clinic could be provided. We need some measure of how much unmet need there is on the streets, and to consider what geographical area might be served.

Engaging with patients – what type of clinic should we offer?

GP clinics vary in terms of how they are booked, how long appointments are, and how provision is made to fit in urgent cases. In a mainstream general practice, appointments are typically 10-15 minutes long and booked in advance. Our experience at the Calder Centre is that this does not work well for our patients. I was able to see a variety of GP clinics for homeless people in Dublin, Oxford and Bradford. Luther Street in Oxford have evolved an approach not dissimilar to ours, with 20 minute drop in appointments in the morning (but not triaged by nurses) and booked appointments in the afternoon. Like us, they offer walk in rather than booked clinics, with long or flexible appointment times to try and address all the presenting issues. Doctors need to recognize that non-medical issues, such as Work and Income certificates may be just as urgent to sort out as the strictly medical ones. Drop in clinics seem to work well for some patients but they often involve a long wait to be seen. Many people who have slept outdoors for a long time find it quite claustrophobic being inside and would prefer to be able to book an appointment time in advance.

In the end there is no perfect solution and compromises have to be made between convenience, flexibility, running to time, and so on. Clinics vary in the skill mix and experience of staff with some nurse led clinics, specialist medical clinics offered in primary care or outreach. In my view the mixture of drop in and booked clinics offered by Calder Medical Centre, Luther Street Medical Centre, and Bevan Healthcare, works well.

[14] Boston Healthcare for the homeless website: www.bhchp.org

Healthcare is an important way to build trust among the rough sleepers. They have many years of distrust of many professions and struggle to accept 'help' and reject the social ostracising they commonly experience.

Engaging with patients: continuity of care/carer

A number of studies [15] have shown that people value continuity of care in general practice, and prefer to see a doctor with whom they have built a relationship of trust. This is no different for people who are homeless. Dr. Jim O'Connell from Boston Healthcare for the homeless discovered [16] that this was highly valued by his homeless patients and this informed their approach to building teams with a long-term commitment to the service. While there is a place for people who can only offer a short term commitment, we should aim to staff our medical centres with people who can offer a long term commitment, so our patients get continuity of care, and the clinicians can develop some expertise in the specialist needs of homeless people.

Improving care: Trauma Informed Care

It is widely recognized that a high proportion of rough sleepers, particularly those who became homeless at a young age or have been homeless for a long time, suffered trauma as children. Childhood trauma may be due to abuse but can also stem from living in a household with adults with mental health or substance misuse problems, or domestic violence. Trauma early in life affects the 'hard wiring' of the brain,[17] and is associated with depression, anxiety, substance abuse, impaired social skills and personality disorders. It disrupts biological systems and damages the ability to form normal attachments and healthy relationships. The earlier it occurs, the more damaging it is.[18] A study in Sydney[19] showed a lifetime prevalence of 79% in a sample of 70 homeless adults. Usually trauma and PTSD preceded homelessness, but re-victimisation is common. Domestic violence is a common trigger for homelessness in women.[20]

It is important to recognize that many if not most of our homeless patients have suffered significant trauma in their lives because we need to be careful not to compound the damage, and people may come to a point where they want to address their trauma through psychotherapy.

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[15] See for example Turner et al 2007 J Health research and policy – Do patients value continuity of care in general practice.

[16] Dr. Jim O'Connell Personal communication

[17] Herman, J: Trauma and Recovery: The Aftermath of Violence—From Domestic Abuse to Political Terror. Ingram, 2015

[18] European Federation of National Organisations Working with the Homeless. Recognising the Link Between Trauma and Homelessness. 2017

[19] Taylor K.M, Sharpe L. Trauma ad post-traumatic stress disorder among homeless adults in Sydney 2007

[20] National Law Center on Homelessness and Poverty. Some facts on homelessness, housing, and violence against women. https://www.nlchp.org/documents/DV_Fact_Sheet 2006.

Trauma informed care is a relatively new term which describes care that recognises how common trauma is, and approaches patients with the knowledge that they may have experienced this. [21]. It promotes safety, empowerment and healing and avoids responses which may cause further damage. Peoples coping reactions after trauma are poorly understood and victims may not always react in ways that we might expect. Failure to understand this may lead to judgmental attitudes, lack of empathy, inappropriate responses and re-victimisation. For example there is a tendency to blame a woman who 'chooses' to stay in an abusive relationship. 'Drug seeking' patients may irritate us; but substance abuse may arise from the use of alcohol or drugs as a survival strategy. Angry patients may be met with further anger or defensiveness, or be trespassed so they cannot receive the care they need.

A medical history may be probing or intrusive, and the examination and tests are often invasive and may trigger anxiety, hostility and flashbacks. It is important to explain why you need to ask probing questions, or ask a patient to remove their clothing. Privacy is important and patients should be empowered to refuse or postpone.

Type 1 trauma is a specific event, out of the ordinary in terms of shock and terror, such as an assault, rape, accident, or the witnessing of such. Type 2 trauma is repetitive prolonged trauma occurring in childhood and often with in the family, from neglect or harm by caregivers (or witnessing of such). The earlier, nature of the abuse and sustained nature of the abuse makes it damaging. Trauma informed care is not about getting a disclosure, but about empathy, compassion and understanding.

As people achieve some stability in their lives, often once they have been housed, they may wish to address their abuse. PTSD and borderline personality disorder can be treated. This involves specialist psychotherapy / counseling which may not be easy for us to access on behalf of our patients. Survivors of childhood sexual abuse can access effective and appropriate counseling through ACC sensitive claims. However, if abuse has been physical and emotional, it is more difficult to make an ACC claim. WINZ will fund some counseling but some counseling services do not take WINZ clients, and the funding is limited both amount and duration. It is important that if and when our patients are ready, we are able to support them to tackle the challenging and daunting task of engaging in psychotherapy: Currently I believe this is an unmet need which we at Auckland City Mission need to consider.

Improving care: Harm reduction in primary care

I was impressed with the needle exchange in the primary care centre at Merchant's Quay. In addition to the benefits of harm reduction, they offer the opportunity for the practice team to engage with people who would not usually visit a health centre. The trust built by the needle exchange team may lead to a consultation with GP or practice nurse to address other health issues.

[21] Hopper EK, Bassuk EL, Olivet J. Shelter from the Storm: Trauma-informed care in Homelessness Service Settings, Open Health Services and Policy Journal 2010, 3:80-100

New Zealand has a very successful needle exchange programme funded by the Ministry of Health, and I do not think we need one in Auckland City Mission. However, we should be ready to ask people about injecting, if they ever have, and if they still do. Most practices may not see many patients who inject drugs – or may not be aware that some of their patients do. Patients who inject drugs should be offered advice on harm reduction and sexual health, information about CADS, NA, needle exchange, screening for blood borne viruses, and so on.

Improving care: Teaching and learning

the trouble is that intelligent, cultivated people, the very people who might be expected to have liberal opinions, never do mix with the poor. For what do the majority of educated people know about poverty?"

(George Orwell in Down and Out in Paris and London)

I saw a real commitment to teaching, sharing experience and disseminating knowledge on my visits. Luther street medical centre in Oxford provides placements and education for health professionals, medical, nursing and social work students, and GP trainees. Edinburgh University has recently established a Centre for Homeless and Inclusion Health. In addition to research they run a master's programme and offer teaching to medical, law, and social science students. Pathway is very active in research and dissemination of knowledge around homelessness.

Most GPs will look after homeless and marginalised patients, and Emergency Departments will see them regularly. Nevertheless few doctors and nurses in New Zealand (or elsewhere) have had much formal teaching about homelessness, its causes and social determinants, its effects on health and life, and the particular needs of those who are homeless. There is a growing literature, and the Pathway website is a good source for recent papers and evidence. All practice staff need to know how to interact sensitively to achieve better outcomes. There is for example a good factsheet[22] for receptionists published by Pathway.

Homeless people often lead chaotic lives and have difficulty in their interactions with medical services. They turn up late for GP clinics, they fail to attend outpatient appointments, they use ED 'inappropriately', they discharge themselves prematurely from hospital, and they often behave badly. On their part, they feel judged by clinical staff, and that their needs are not met.

Better understanding of homelessness will help us manage them more effectively.

A good starting point for those working with the homeless who want to learn more is the Faculty for Homeless and Inclusion Health[23]. Their aim is to improve healthcare for the homeless and other excluded groups. Membership is free to all working in the area, medical, nursing, social work professionals, researchers, outreach and housing workers, those with experience of homelessness. They are hosted by Pathway and the two organisations organize an annual conference.

[22] https://www.pathway.org.uk/wp-content/uploads/2017/02/GP-reception-standards-for-primary-care-v10.pdf
[23] https://www.pathway.org.uk/faculty/

Improving care : identifying at risk individuals and families

Not only do we look after homeless patients but we look after those who are at risk of homelessness and from other social harms (including dealing with poverty, violence and lifelong trauma). Ideally these would be identified and helped before the crisis. In Manchester Focussed care practitioners[24] work alongside practice teams to identify and help individuals and families who are struggling. ('failing to thrive households'). They may use social interventions such as help with benefits, debts or housing, or clinical interventions. Such patients are often 'invisible' and only come to our attention when there is a crisis. In New Zealand a promising way to identify such households or individuals would be those who have bad debts[25]. Not only is this a marker for financial difficulties, but it may be a disincentive to seeking medical attention.

Community engagement team

Merchant's Quay Riverbank Centre is in the heart of Dublin, with business and tourist destinations in the surrounding streets. Businesses may be concerned that organisations such as Merchant's Quay (or Auckland City Mission), attract 'undesirables' who commit crime, leave drug paraphernalia around and generally lower the tone of the neighbourhood. Merchants Quay have a community engagement team who go round the surrounding streets each morning, engaging with businesses, listening to concerns, picking up litter, and also engaging with rough sleepers and beggars.

Funding primary care services for the homeless

It is difficult to provide high quality primary care to homeless people on a business model. Many rough sleepers are 'tri-morbid' (physical health + mental health + addiction issues) and thus require a high level of care. Ideally this means a high GP:patient ratio. Luther Street Medical Centre has 500 enrolled patients and nearly 2 full time equivalent GPs. The mean number of patients for a GP in England is 1,734[26]. Calder Medical Centre also has a relatively low ratio of patients per GP. At the same time our homeless patients are often the least able to pay for care. Both the specialist homeless practices I visited in the UK were funded by the NHS (this would be comparable to having District Health Board funding in New Zealand. SafetyNet, the provider of primary care to many homeless people in Dublin, is a charity. The Calder Medical Centre also relies heavily on donors for support.

A note on street counts

I have quoted some figures for numbers of homeless people living in the cities I visited. These are difficult to compare as they are done in different ways. In Oxford a count is done on set route each year. This makes year-to-year trends in Oxford more reliable, but is difficult to

[24] http://focusedcare.org.uk/
[25] Joanna Easingwood, personal communication
[26] https://inews.co.uk/news/health/more-than-3000-patients-per-doctor/

compare, say with the recent more thorough count in Auckland[27], which was then given a weighting to adjust for people who were missed. In Dublin, the fact that several hundred people can sleep in overnight shelters means fewer on the streets, but this hides the extent of the problem.

The Future

It is an encouraging time to be working with homeless people in New Zealand. Auckland City Mission and Lifewise have housed over 70 long-term rough sleepers through the Housing First initiative. Political initiatives are starting to make more affordable homes available to middle and low income New Zealanders. It is tempting to see a real possibility that homelessness could be eradicated, for all intents and purposes, in New Zealand. There is evidence that as well as being a humane response, helping people into housing will save the taxpayer in the long run.[28] When people are housed it is essential to ensure the 'wrap around' services are delivered to get them out of the 'revolving door' of hostels, prison, hospitals and the streets.[29]

But we should not forget that inadequate numbers of homes is not the only determinant underlying homelessness. There is a core of people who have been seriously harmed by their experience of trauma, who will continue to find it very difficult to find and maintain a home. In New Zealand this trauma was often experienced as children, at the hands of their carers.

To prevent homelessness we must not only ensure enough houses, but also tackle the risk factors for such abuse by tackling child poverty and domestic violence, and ensuring children in New Zealand are safe. For those who have already suffered trauma, we need to advocate for generous support to help heal the scars. Until we do that they will never truly find homes.

Richard Davies
February 2018

[27] www.aucklandhomelesscount.org.nz

[28] The Economist 18 August 2018 'No end in sight for the homeless' – for every 1 pound spent on housing first in the first 5 years, the taxpayer will save over £ 2.50

[29] 'Homelessness and mental health: Adding clinical mental health interventions to existing social ones can greatly enhance positive outcomes' Cockersell, P Journal of Public Mental Health. Vol. 10 No. 2 2011