Historical perspectives – health care for homeless people

Charles Fraser

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Black Death

Poor Law Act 1388 sought to restrict the movement of labourers

Migrant labour + poverty = homelessness

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Alms and discrimination

Indiscriminate giving came to be seen as a problem

How to distinguish between the deserving and undeserving poor?

Juan Vives *On Assistance to the Poor (*1526) enumerated 13 categories of beggar, which could be differentiated visually

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3 categories of the poor

1. The able-bodied
2. The elderly and infirm
3. The persistent idler (rogues & vagabonds)

Henry Mayhew *London Labour & the London Poor* (1851)

1. Will work
2. Can't work
3. Won't work

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Poor relief & the “principle of less eligibility”

Outdoor relief – food, money or goods sufficient to prevent admission to an institution

Indoor relief – House of Correction (work for the able-bodied poor / punishment for rogues & vagabonds) or Workhouse (accommodation & employment for the destitute)

The “principle of less eligibility” = the condition of the pauper in the workhouse should not be as attractive as that of the poorest labourer outside

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The risks of indiscriminate provision

The Poor Law Commissioners complained that the old workhouses were not more than

... a large almshouse, in which the young are trained in idleness, ignorance and vice; the able-bodied maintained in sluggish sensual indolence; the aged and more respectable exposed to all the misery that is incident to dwelling in such a society"

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National Assistance Act 1948

Abolished the Poor Laws

Established a social safety net:

1. Re-establishment Centres, to help the unemployed receive training so they could find work

2. Reception Centres, to influence “those without a settled way of living” to settle

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Rough Sleepers Initiative (RSI)

- Set up in 1990 for 3 years "*to make it unnecessary for people to have to sleep on the streets of central London*"

- Main components:
  - Intensive outreach
  - Cold weather shelters
  - Increased resettlement
  - Move-on (private sector leasing)

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RSI 2 1993 - 1996

- Sharper focus on those actually sleeping rough
- Should support agencies with a proven track-record
- Regular street counts introduced

- Evaluation of RSI 1 recommended more specialised hostels for "*those still on the streets who have mental health problems, often associated with alcohol / drug abuse*"

- DoE rejected the initiative becoming "a special needs housing programme"

- It reckoned the high care needs of rough sleepers should be addressed by HMII and Community Care

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Government claim 1995

Many of those who remain sleeping rough in central London have problems beyond a lack of accommodation, such as alcohol or drug misuse, or mental ill health, and have often been sleeping out for some considerable time. The key development over the life of the RSI has been the evolution of a co-ordinated multi-agency approach to focus attention on these people to ensure that all the help they need is available. The Initiative is involving not only organisations concerned with accommodation, but also those concerned with health care, training and employment

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RSI 3 1996 – 1999 / Social Exclusion Unit report 1998 / RSU

RSI 3 – extend the initiative outside London

SEU target – *to reduce rough sleeping to as close to zero as possible* and by at least two-thirds by 2002

Rough Sleepers Unit established 1999 – 2002

Integrated government funding streams

Achieved the two-thirds target (or nearly)

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Post-Rough Sleepers Unit

Homelessness Directorate (DETR)

- *Supporting People*
- Hostel Capital Improvement Programme

GLA (2010)

- Target of eliminating rough sleeping by 2012
- Established London Delivery Board, with a health sub-group

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Homeless Mentally Ill Initiative

Set up in 1990 to address concerns about the growing numbers of people on the streets with visible and obvious mental disorders

For 88% of homeless people with a mental illness, their illness had preceded their homelessness

There were hardly any community projects which could cope with the level of disability or disruption displayed by many ex-patients with "*chronic, treatment-resistant psychoses*"

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How HMII worked

Multi-disciplinary medical and social care outreach teams

Specialist high care hostels, move-on and resettlement

4 teams in London with different structures, priorities and accountability arrangements

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HMII evaluation

"... the fact remains that homelessness among those with a mental illness is a preventable adverse outcome that ought to be addressed by mainstream services"

Professor Tom Craig

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DHSS Resettlement Units transfer programme

215 Reception Centres nationally in 1948

The largest was Camberwell, with 985 beds. It was decided in 1981 to close this

The Camberwell Replacement Scheme provided capital and revenue funding to provide 108 direct access beds, and a mix of smaller low-care, medium-care and high-care projects, mainly run by the voluntary sector

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Some examples of homeless health

Homeless people stayed in hostel twice as long as the housed population because they were twice as ill

People admitted to hospital in Glasgow with drug problems were 7x more likely to die within 5 years as housed people admitted with the same drug problems

60% of homeless people suffer from some form of mental illness

Average age of death is 47

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Exemplar projects

Great Chapel Street

- Walk-in medical service set up in 1977
- Offers multi-disciplinary primary care covering general practice, psychiatric services, dentistry, substance use support, podiatry, counselling and social advocacy & advice
- Describes its approach as *accessible, non-judgmental, opportunistic, inclusive and multi-disciplinary*
- It aims to:
    1. reduce social exclusion
    2. reduce health inequality
    3. Provide continuity of care

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Great Chapel Street (cont'd)

- Housing status of patients:
  1. sleeping rough 57%
  2. shelters / hostels / other temp 30%
  3. permanent housing 9%

- Major presenting problems:
  1. respiratory 27%
  2. drugs 25%
  3. skin 22%
  4. trauma 21%

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Lancefield Street

Integrated outreach / drop-in / hostel / resettlement for elderly rough sleepers

- All aged 50 + (49% > 60)
- 57% homeless > 5 yrs (incl 42% > 10 yrs)
- On admission 55% had physical health problems
- 39% had mental health conditions
- 58% were heavy drinkers
- 27% perceived their future as hopeless and expected to be dead within 6 months
- 60% had not seen a GP for 5 yrs

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Lancefield Street (cont'd)

- 40% required assistance with personal hygiene & bathing
- Many had to be reminded to take medication, encouraged to have dressings replaced, and have doctors' appointments arranged for them
- 50 residents were admitted to hospital on 107 occasions
- The health authority funded a local practice to run a drop-in clinic where people could be seen without appointments

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Three Boroughs Homeless Team

Was set up in 1992 and runs open access, nurse-led health clinics in homeless hostels and day centres in Lambeth, Southwark and Lewisham

Consists of senior community nurses backed up by a GP with a long-standing commitment to homeless health, and a chiropodist and a dentist

Services include: health screening (incl TB & sexual health); minor illness / injury assessment; provision of “immediately necessary” medications; wound care; proactive vaccinations; chronic disease management; needle exchange; smoking cessation support

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TB Find & Treat

- A multi-disciplinary specialist team to detect TB early amongst at-risk groups through mobile screening
- Covers 84 hostels / 56 day centres / 83 community drug & alcohol projects
- Has screened 10,000 people through active case finding
- Recognised as “best practice” by NICE & Inclusion Health, and in the Mayor’s health inequalities strategy
- Can easily be extended to screen for other illnesses with a higher prevalence – Hep B, Hep C, latent TB, HIV
- Multi-drug resistant TB is a time bomb in our hostels

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St Mungo's Intermediate Care

Specific conditions which led to people's admission:

- Renal failure
- Osteomyelitis of the spine
- Acute bacterial endocarditis with septicaemia
- Necrotising fasciitis
- Right jugular vein thrombosis
- End-stage live failure
- MRSA infection
- Acute syphilis
- Pulmonary TB
- Wernicke's encephalopathy

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Intermediate Care (cont'd)

The overall background morbidity of the client group was:

- Mental health condition 88%
- Hepatitis C 84%
- Significant drug use (crack, heroin) 83%
- Alcoholism 74%
- At least one suicide attempt 71%
- HIV 24%
- Current episode of TB 12%
- Current episode of syphilis 11%

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Intermediate Care (cont'd)

- Outpatients: appointments fell by 20%, attendances rose by 7%
- In-patient admissions fell by 69%
- 1 death during the year of the pilot, compared to 7 the year before
- Comparison with other hostels not offering intermediate care:
  1. In-patient episodes - 77% (other hostels + 15%)
  2. Ambulance call outs - 68% (other hostels n/a)
  3. A&E attendances - 52% (other hostels + 52%)

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Case study

She was

- 45 years old
- A long-term rough sleeper
- IV drug dependent (heroin & crack)
- Alcohol dependent
- Occasionally incontinent

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Case study (cont'd)

She had:

- Bleeding duodenal ulcers
- Chronic bilateral leg ulcers and deep vein thrombosis
- Poor mobility, even with crutches
- Problems with her balance, leading to falls
- Hepatitis C
- Asthma
- A methadone script
- No spleen
- A history of challenging and aggressive behaviour
- Served custodial sentences for violence, theft & drugs
- 6 children

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