

St Mungo's

Health Report

Homelessness:
it makes you sick



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St Mungo's 
Opening doors for London's homeless

St Mungo's research into interactions between clients and primary health services

This research project looks at the scale and nature of healthcare needs in St Mungo's hostel clients.

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1. Key findings

The overall picture revealed by this research is that St Mungo's hostel clients have a substantial need for high quality healthcare services. Hostel clients have a history of rough sleeping and are highly likely to have medical conditions that need treatment and yet a large number of them do not get that treatment, or do not get proper treatment. There are many reasons why they do not receive treatment but difficulties in accessing healthcare services are common. Many conditions are treated by a hospital in the first instance rather than a GP. Of particular concern is the number of occasions on which clients come into contact with healthcare services (typically hospital) and come away with no ongoing treatment plan.

Ambulances

- Ambulances are called to St Mungo's hostels on average twice a week. Another way to look at it is that, extrapolated over a year, it is one call per year for every 6 bedspaces
- 56% of ambulance calls take place in daytime hours (between 8-6) and the rest in traditional 'out of hours' times. 21% occur when night shift is on.
- 69% of ambulances are called for clients being taken ill. Ambulances are called for acute medical emergencies and in most cases are being called for pre-existing conditions which have worsened.
- 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. Only four clients (11%) who went to A&E came away with a treatment plan.

Clients' health and experiences with medical services

- 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.
- The vast majority (90%) of interviewees were able to give details of at least one significant medical condition they had suffered or were still suffering.
- 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).
- 22% of interviewees reported blood, heart or circulation problems, 19% injuries and 18% sleep problems. There is wide range of other conditions experienced; these are the most common.
- Just over half of all interviewees had a long-term (1 year +) condition
- One in three interviewees has a condition for which they are not receiving treatment at all.
- Sleep problems are the most likely health issue to be untreated (38% of sleep problems go unreported).
- A high percentage (over half) of 'untreated' clients have conditions which could potentially escalate into a situation requiring urgent medical attention.
- In 60% of cases the client sought treatment at either A&E or hospital and not, as you might expect in most cases, from their GP. This corroborates the findings from the ambulance section that conditions worsen until they become acute before healthcare is sought.

Deaths

- The death rate in St Mungo's hostels is 11 per year. Clients are, on average, only 41 when they die and 50% are under 40 when they die.

Clients' opinions on in-house medical services

- 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.

2. Background and methods

This research project looks at the scale and nature of healthcare needs in St Mungo's hostel clients and the treatment and support clients receive for them. In particular, its objective is to investigate the need for a higher level of health support within hostels.

The research focus was on hostel clients. Data from St Mungo's client database shows that 88% of clients in this research have a known history of rough sleeping and hostels provide support and accommodation for this particular client group. Clients are typically highly vulnerable and often have complex multiple needs around mental health, substance use and/or their ability to look after themselves. Physical health problems in rough sleepers are very common and often hard to address due to clients' chaotic lifestyles and the barriers they face in accessing healthcare services.

St Mungo's collected data from two sources

- **Ambulance call-outs.** 13 hostel projects and two complex needs projects (623 bedspaces) completed a special form whenever an ambulance was called for a client. This form was then logged and flagged for follow-up by the information team. Data collected on ambulance call-outs covered the period July 06– April 2007 (10 months).
- **In-depth health questionnaires.** The second source of data was 146 health interviews carried out by independent peer researchers from Groundswell. The questionnaire asked for information on the client's experiences of healthcare services, their own health conditions and treatments, and their views on proposed healthcare services.

The research also reviewed the forms completed on the death of a client over the same period as the ambulance call-outs. Whilst this did not provide any statistical data or conclusive evidence there are two case studies which serve to illustrate very well the nature of the problem St Mungo's is dealing with.

This report was written by an independent researcher.

3. Ambulance call-outs

The basics of the research are as follows:

- 83 call-outs recorded
- Period July-06 – April 07 (43 weeks)
- 13 hostels and 2 complex needs projects (projects that are closely associated with partner hostel projects) were involved covering 623 bedspaces.
- The data has been checked against the demographics of St Mungo's hostel population as a whole and it would seem that there are no particular signifying characteristics of those for whom ambulances are called.
- Data capture relied on project staff filling in forms to initiate the process and it is likely that this may not have occurred on every relevant occasion. Any results therefore are likely to be an *underestimate* of the true situation.

3.1 Frequency of ambulance call outs

This part of the research shows that ambulances are called to St Mungo's hostels on average twice a week. Another way to look at it is that, extrapolated over a year, it is one call per year for every 6 bedspaces.

3.2 Multiple calls to the same individual

Multiple call-outs to the same individual are common. Of the 57 clients for whom ambulances were called in the 10 month period of research, 12 (21%) had an ambulance called more than once. The following case studies illustrate common scenarios.

Client A is a 50 year old man. An ambulance was called one evening (21.30) because he was feeling dizzy and vomiting blood. He was admitted to hospital and stayed for nine days before being discharged by the hospital without a treatment plan. Nine days after discharge the hostel nurse, following a consultation, called an ambulance 'as a precaution' because of the client's inability to eat and suspected pancreatitis. The client was hospitalised for over a month and then again discharged without a treatment plan. Five days later he was again bringing up blood so a third ambulance was called, this time he was discharged with a treatment plan.

Client B is a 34 year old man. He had five ambulances called for overdoses over a period of seven months, plus another prior to that called for severe stomach pains and collapse. Three times he refused to go with the ambulance to hospital, although two of those times he did get treatment from the ambulance crew at the scene. On a further two occasions he went to A&E and was discharged with no treatment plan both times.

Client C is a 38 year old male who had three ambulances called in one week for seizures. Twice he refused to go and the other time went to A&E and discharged himself with no treatment plan. A very similar pattern occurs with client D, a 36 year old woman, who had a seizure and refused to go to hospital, followed by another seizure five days later after which she went to A&E and discharged herself with no treatment plan.

3.3 Timing of ambulance call outs

56% of calls take place in daytime hours (between 8-6) and the rest in traditional 'out of hours' times.

Of importance for service planning purposes is to note that 21% of calls take place between 22.30 and 08.30 when night staff are on shift.

3.4 What are ambulances called for?

Mostly, ambulances are called for clients who have been taken ill rather than accidents or other causes.

Illness	69%
Overdose	16%
Accident	6%
Alcohol Excess	4%
Self Harm	4%
Suicide Attempt	2%

Looking more closely at the ambulances called for 'Illness' we get a picture of St Mungo's staff regularly dealing with a variety of acute medical emergencies including clients having seizures or collapsing, coughing up or vomiting blood, having difficulty breathing or in severe pain.

There are indications on a just a few reports that perhaps the incidents could have been handled differently, without calling an ambulance, but the research shows that St Mungo's frontline staff are regularly faced with the stressful situation of handling acute medical emergencies. For example, 1 in 5 calls for 'Illness' involves a client having seizures.

What is clear from the data is that most of the ambulances were called for pre-existing conditions which had reached the point of needing urgent attention (asthma, diabetes, heart/circulation problems, epilepsy, respiratory conditions, stomach or liver conditions, substance use problems) rather than, for example, accidents or sudden illnesses. It is undoubtedly likely that with enhanced care and management of these conditions some of the ambulance calls could be avoided, saving the cost to the health service. In addition, frontline staff would be spared the stress of dealing with medical emergencies and most importantly of all, the client would benefit.

3.5 What happens when the ambulance is called?

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.

A quarter of all ambulance call-outs result in the client *not* being taken to hospital – in most cases this is because the client refuses treatment but sometimes the client is treated on the spot with no need for a hospital trip.

3.6 What happens when leaving the hospital?

Of the 60 who went to hospital with the ambulance crew, one in five discharged themselves and the rest were discharged by the hospital.

Only a very small number overall (17%) came away with a treatment plan. Even after hospitalisation only 30% come away with a treatment plan. Only four clients (11%) who went to A&E came away with a treatment plan.

4. Interviews about individual clients' health

The basics of the research are as follows:

- 146 clients from four hostels (Cedars Road, Pound Lane, Endsleigh Gardens, Birkenhead Street) gave information about their experiences via an interview style format recorded on a questionnaire. Interviews were conducted by independent peer researchers from Groundswell.
- The demographics have been checked against St Mungo's hostel population as a whole and the interviewees represent a good sample of the whole. It is worthy of note that only one in ten of the clients discussed here are over 50.

4.1 Experiences of accessing A&E/ hospitalisation

Clients were asked to tell the interviewers about any negative or positive experiences they had had of A&E or hospitalisation. Every single interviewee was able to recount at least one encounter with A&E or hospital and many gave details of more than one contact.

Two-thirds were able to recount a positive experience attending A&E or hospital. However, just under half (49%) had suffered a negative experience with A&E or hospital. Types of negative experiences include rude or unpleasant staff, discrimination, unacceptable waiting times or poor quality treatment.

Typical examples of negative experiences:

Refused transport back to hostel. Had to walk home in the cold without proper clothing after discharge

Experienced a very judgemental attitude.

Reception staff were rude but thereafter medical staff were respectful.

3 hr wait. Staff told him hes a recovering drug addict so it must be withdrawal symptoms. Not much interest from staff.

Client was very badly treated and felt this was because she is a 'working girl'. Staff did not talk to client or tell her what they were doing.

They just stitched him up and tried to get him out of there as fast as possible and told him to find a GP to remove the sutures, though he told them he did not have one- had to go to a place in King's Cross to get them out.

4.2 Barriers to accessing treatment within the health service

A third of interviewees (33%) reported experiencing difficulties accessing health services. There were many positive comments about services received too.

11% of clients report a particular problem accessing dentists (can't find one or waiting times too long). Other common barriers include difficulties in finding a GP to register with, getting appointments once registered and dealing with discrimination or poor treatment.

4.3 How often do clients visit the GP?

The first group to be concerned with here are the 18% of clients who never use a GP. Reasons vary, or were not given, but the most often quoted are 'don't need treatment' or 'don't want treatment'.

Then there are the 41% of interviewees said they go to the GP 'as necessary'. Given the extremely high incidence of medical conditions this could indicate these clients are not making good decisions about their own healthcare (i.e. most of them probably ought to be attending regularly).

The 59% of clients in these two groups are highly likely to have conditions which could worsen without regular monitoring and could well end up with an ambulance call-out.

A further 41% of clients said they go at least once a month, with 1 in 10 clients visiting the GP 3-4 times a month.

St Mungo's Client Needs Survey 2007¹ showed that 94% of hostel clients are registered with a GP.

4.4 What sort of health conditions are clients experiencing?

From other research by St Mungo's² we know that 47% of hostel residents are known to have at least one physical health need at a given point in time and 1 in 4 (27%) have concurrent multiple physical health needs.

This new research goes deeper into the types of conditions clients experience and any treatment that they may or may not have received for them. Firstly it is of note that of the 146 interviewees, 131 (90%) gave information about health conditions they have suffered in the

¹ Client Needs Survey 2007. Data provided by St Mungo's Information Team

² Client Needs Survey 2007. Data provided by St Mungo's Information Team

past or are still suffering. Of those, half (50%) reported on multiple health conditions. There were no restrictions on the types of conditions interviewees were asked to talk about but the conditions discussed are generally not what would be considered minor complaints or everyday illnesses, they are significant medical conditions which would affect day-to-day living.

The table below breaks down the conditions by type:

Blood, heart and circulation problems	22%	of which 20% is Deep Vein Thrombosis
Injuries and wounds	21%	
<i>Mental Health problems</i>	19%	<i>80% mentioned depression</i>
Sleep problems	18%	
<i>Substance use</i>	14%	
Infections	14%	of which 75% were abscesses
Liver problems	12%	
Bones, joints and muscles	12%	
Respiratory problems	10%	of which over half were asthma and a third TB

These figures are very similar to the condition-by-condition breakdown assessed by the Client Needs Survey 2007 for physical health needs. For mental health and substance use we know that considerably higher numbers experience these issues (57% have mental health problems and 76% some form of substance use issue) but for the purposes of this research, only 19% and 14% respectively brought them up.

Just over half (51%) of all conditions have been present for over one year. Of those conditions which were more recent (0-3 months) the most prevalent types were injuries/wounds and infections.

4.5 Are clients getting treatment for their conditions?

Overall one third of the interviewees reported either having a condition for which they had not sought treatment or had an ongoing condition for which they had sought treatment but were currently not receiving treatment. Eight interviewees had both.

Sleep problems are the most likely health issue to be untreated; 38% of clients with sleep problems go untreated.

4.5.1 No treatment sought

22 interviewees (16%) reported having conditions for which they had not sought treatment at all. Two-thirds of these said they had had their condition for over a year.

One in three of this group reported having conditions which could potentially escalate into needing emergency medical attention; for example liver conditions, respiratory or heart problems, joint problems and stomach pains.

The most commonly mentioned single issue for this group overall, however, was sleep problems (36%) and all of them had had this problem for over a year.

When asked why treatment was not sought, typical answers include 'Don't want treatment', 'Never thought to ask', 'Never asked', 'Will recover without treatment'.

4.5.2 No current treatment

Of particular interest for this research are the 34 interviewed clients (almost a quarter of all those interviewed) who reported having ongoing conditions for which they were not currently receiving treatment despite having sought treatment in the past. 9 of these clients had multiple untreated conditions.

Well over half (59%) of this group of clients have the kind of conditions which could potentially escalate into the acute medical emergencies seen so frequently in the ambulance research. For example, eight of the 34 have currently untreated liver complaints. In most of these cases this is because there is no treatment available for the condition but in some cases it is because the client continues to drink.

Other untreated conditions are heart problems, epilepsy and alcoholic seizures, high blood pressure and kidney problems. Examples of reasons given for not receiving treatment for these conditions include not liking hospitals, uncertainty about the medication offered, no treatment offered by the doctor or being on a waiting list.

Again, sleep problems feature prominently with 7 of the 34 (20%) having untreated sleep problems, mostly for 1 year +. The most common reason for the lack of treatment is that the doctor won't give the client pills.

Six of the 34 have currently untreated depression. Two clients say the doctor won't prescribe pills, one says they don't want to take pills, one is on the waiting list for a counsellor and one has no current GP. This range illustrates perfectly the need for varied and client-centred approaches to healthcare situations St Mungo's needs to be able to offer.

The following case studies illustrate examples of situations in which clients find themselves without treatment:

A 45 year old male has had two bouts of fits within the previous 3 months. He has been to hospital both times but 'Does not know what caused condition' and 'Plans to see GP soon'. Clearly there was no treatment plan on discharge from hospital.

A 25 year old woman has had sleep problems for over a year. She has sought help but the doctor wouldn't prescribe pills. No counselling was offered. This is a highly typical case – there are a further 5 similar examples in the data.

4.7 Where did clients seek treatment for these conditions?

In 60% of cases the client sought treatment at either A&E or hospital. This would seem to indicate the same findings as the ambulance call-out section; that typically conditions worsen to the point that they become acute before medical attention is sought. Looking a little closer at these clients' GP usage shows that 40% use a GP 'as necessary' and 14% never use a GP at all. The remainder generally visit their GP once or twice a month. If we assume that many clients do not realise the need to see a GP nor understand their condition is worsening we can conclude that earlier intervention at hostel-based services would undoubtedly reduce the number of conditions ending up with hospital attention.

In a further third of cases, the client sought treatment via the GP (or dentist where appropriate) or a clinic, the rest were unknown.

5. Deaths

Information from St Mungo's client database shows that on average there are 11 deaths per year in St Mungo's hostel projects (27 per year across the whole organisation). Another way of looking at it is to say that there is roughly one death per year for every 60 hostel bedspaces.

The average age of death for hostel clients is only 41 and in fact 50% of them were under 40 when they died. A third of them had been homeless for less than a year and a third of them had been in their current hostel for less than 6 months. This illustrates the need for fast action when clients come into hostels.

The case studies below provide further illustration of clients' contact with health services.

Client A, a 46 year old man, died in his hostel room on 20/12/06. He had lived in a St Mungo's hostel for almost five months. He was a long-term heavy drinker and occasional crack cocaine user. He was due to go into detox followed by rehab within a few weeks and had been seeing the hostel GP weekly. His physical health was poor, but his death was sudden and unexpected.

Client B, a 50 year old man died on 16/4/07 having lived in a St Mungo's hostel for 18 months. He had multiple health conditions, mostly to do with his liver, and had been a heavy drinker. The hostel had been working very hard to address his health needs but had come up against many of the issues and barriers outlined in this report. He had multiple ambulance call-outs and many visits to the GP but was repeatedly left without a treatment plan, despite hostel staff's best efforts. The client had been making good progress to control his drinking with hostel support, and was engaged with specialist services. Nevertheless he was still unable to access treatment for his liver complaints and could not get into a detox facility which he very much wanted. He died while hostel staff were still battling to get him the services he needed.

6. Clients' opinions on health services in projects

Clients in the health interviews were asked their opinions about what medical services projects need.

6.1 What do clients see as the most important medical services at a project

This was an open-ended question and the top five answers were

1. Doctor [29%]. See also 'General' below
2. Dentist [22%]
3. Substance use support (drugs or alcohol and included mentions of rehabilitation and needle exchanges) [16%]
4. General medical services (These clients were not specific about what particular services they wanted, just that it was important to have some services onsite. It could probably be taken to mean doctor and or nurse) [11%]
5. Counselling services [10%]

It is possible to add (1) and (4) together and add the 5% who said 'Nurse' and 2% who said 'First Aid' to reach the overall conclusion that 47% of clients think the most important services a project should have is general primary healthcare (Doctor/ Nurse).

6.2 Evaluation of proposed services

Clients were asked to evaluate the following options as High, Medium or Low importance.

	Proposed option	% rating it as 'High' importance
1	A full package of primary health care provisions in every project comparable with a GP medical centre. (e.g. GP, visiting Nurse, Counsellor, Podiatrist etc.)	75%
2	Health Support Workers to help homeless people to use hospitals and GP's efficiently, and to help hospitals and GP's to treat homeless people effectively	64%
3	Hospital Discharge Workers and CPA-style Discharge Plans to ensure no homeless person leaves hospital needing treatment and without a treatment support package	56%