Street doctor on the streets of London and other solutions

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Dr Angela Jones MA BM BCh MRCGP
Independent primary care physician

angela.jones@inclusivehealth.co.uk

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Addressing the health needs of entrenched rough sleepers as a route to ending their rough sleeping via a primary care approach

Homelessness – what is it?

- Sleeping on street
- Sleeping in tent
- Sleeping in caravan or car
- ‘sofa-surfing’
- Sleeping in hostel
- Sleeping in temporary shelter

Many causes, many effect, many solutions

- Relationship breakdown
- Mental illness
- Physical illness
- Leaving institutional care
  - Young people care for by the state
  - Prison
  - Mental hospitals / institutions
  - Military
- Addiction
  - Drugs
  - Alcohol
  - Gambling
- Financial
  - Unemployment
  - Redundancy
  - Debt

Outreach ‘social’ services for rough sleepers

- NGOs
- Rely on state funding
- Offer a range of services of variable quality
  - Accommodation
  - Support
    - Work and training
    - Benefit claims
    - Finding accommodation
    - Health

The National Health Service

- ‘Universal’ health service
- Free at the point of need
- BUT
- Not free of stigmatising attitudes and behaviours
- Not good at treating people with complex and multiple needs

Homeless primary care services

- Developed in last 25 years
- Especially since 1997
- Primary care physicians or nurses
- Office based
- Offer a range of services for physical health
- Some have good relations with psychiatric services
- Some offer addiction services as well
- Unstable funding

Oxford

- University city
- Largest number outside London
- Homeless primary care for 25 years
- Few entrenched
- Outreach?

Oxford Model

- One stop shop
- Mainstream but tailored
- Primary care to equivalent or better standard
- 0800-1830 Monday to Friday
- Good liaison with out of hours service
- Easy access to drug, alcohol, mental health and physical health care
- Also dentist and podiatry on site
- Social work trained person on site
- OXFORD HOMELESS NETWORK

THREE HOMELESS MEN IN OXFORD

WITH LUTHER STREET MEDICAL CENTRE IN THE BACKGROUND

Entrenched rough sleeping

- ‘Trench’
- ‘Rough sleeping’
- Entrenched rough sleeping
- Street homeless for many years
- Strongly associated with severe mental illness
  - As a primary cause
  - As a secondary effect

Street doctor project

- Primary care physician working on the streets
- April to August 2010
- Referrals from outreach teams across capital
- Limit of 15
- Phone, rucksack with medical equipment, notebook, access to computer at medical base

Why primary care?

- More generalist
- Less threatening for patients
- Able to engage via a physical issue such as feet, or skin, or cough initially
- Able to engage over a longer period
- Able to diagnose and treat physical illness
- In UK, primary care doctors treat and manage majority of mental illness and can participate in compulsory treatment orders

Demographics

- From around the edge of Greater London
- Average age 56 years (35 -72)
- Average time on street 16 years (2 – 34)

Outcomes

- No contact 7
- In without input 1
- In via mental health section 3
- Nearly in with physical health input 1
- In negotiation 1
- Assessed but remaining out 4

No contact

- No attempt made 3
  - Unable to make night time visits

- Repeated attempts to contact failed
  - Reasons for failure
    - Moved on repeatedly in no drink zone 1
    - No stable pitch 2
    - Died 1

In via mental health section (1)

- Elderly gentleman, severe leg ulceration, cognitive loss
- Local mental health team unwilling to visit on street
- After street doctor assessment, contact with local EMI team
- Smooth progression to section
- Still in and doing well
- Key success factors: obviously in need with physical health issues, excellent outreach worker with understanding of MH and MH structures and willingness and confidence to work flexibly, good ASW

In via mental health section (2)

- Female approx 40, name unknown
- Sleeping rough in and around Lewisham for several years, refusal to communicate
- Local mental health team not willing to assess on street
- Local police not willing to intervene as not a risk to others
- Multiple early morning contacts with street doctor
- MHA arranged after case conference
- Released by inpatient psychiatrist
- Further MHA, on second occasion gave name and found that previously a patient of SLAM
- Key success factors: helpful council official, involvement of specialist homeless psychiatrist

In via mental health section (3)

- Male in 50s, no known home for 30 + years
- Local mental health team and local homeless health team refuse to engage on street
- On engagement with street doctor, clearly psychotic
- Local council offical called case conference
- MHA and taken to Maudsley
- Released by judge at tribunal
- Despite further case conference, no further outreach being offered locally
- Back on streets

Nearly in with physical health input

- Male in 50s
- Dropped out for no clear reason
- No obvious sign of mental illness
- At meeting with street doctor, gave history of severe headaches, no help from medical profession, worse indoors, probable cluster headaches
- Referred to City of London Migraine Clinic (charitable) for help with headaches
- Agreed to personal budget and to look for accommodation with balcony

In negotiation

- 50s
- Homeless since parents died
- Distrust issues relating to ‘the system’
- Suspicious beliefs relating to Masons etc
- After repeated joint contacts with experienced outreach worker, has agreed to view properties but still not wishing to make a benefit claim

Assessed but no action (1)

- Elderly lady
- Long term urban survivalist
- Has support from local community
- Visits by street doctor ended in loud swearing and no wish to engage
- MHA last year, split team, released by Clinical Director
- Same clinical director co-visited with me – no change
- Not suitable for compulsory treatment, therefore no further section
- Planned case conference to agree contingency plans, has not happened…

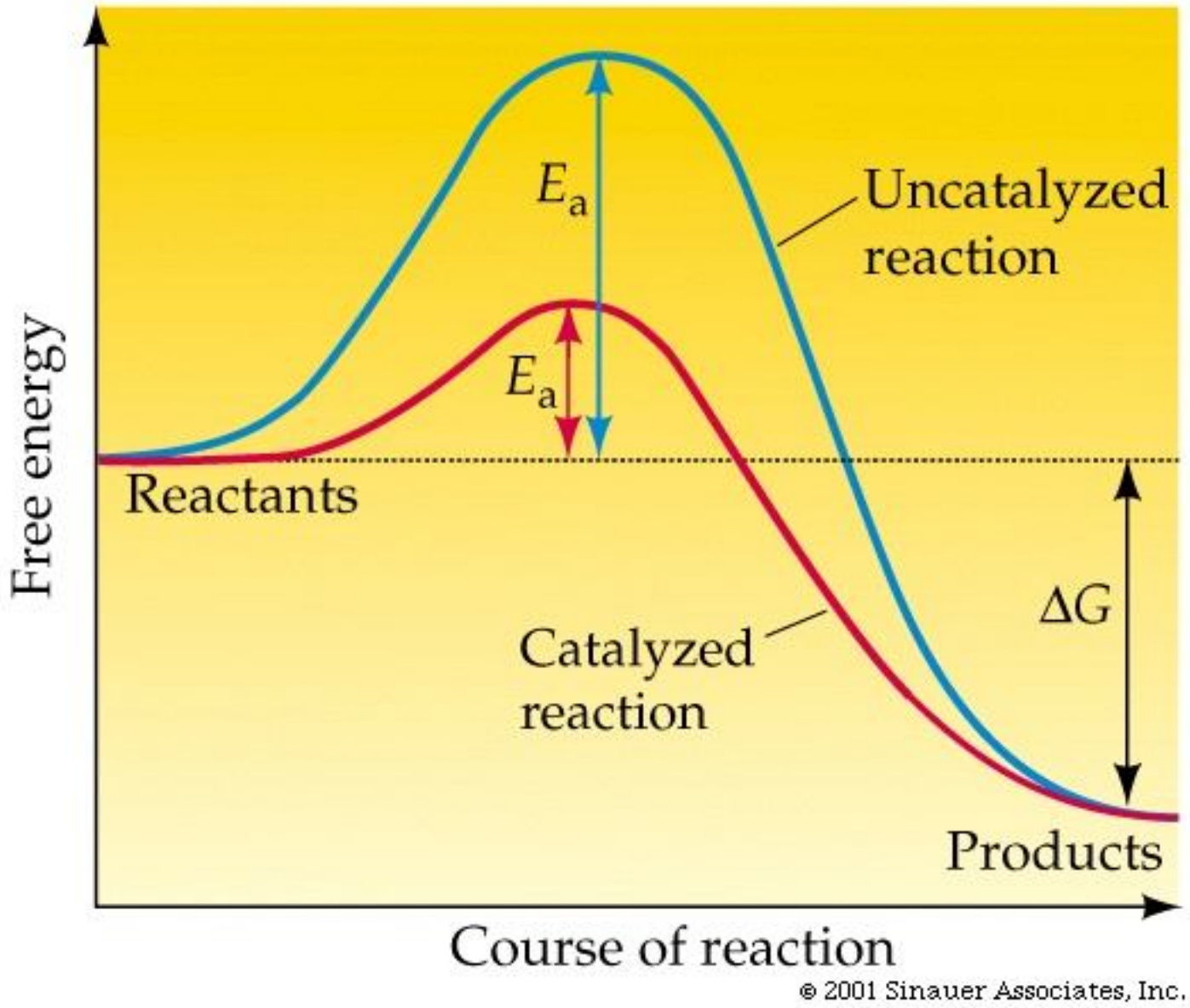
Assessed but no action (2 and 3)

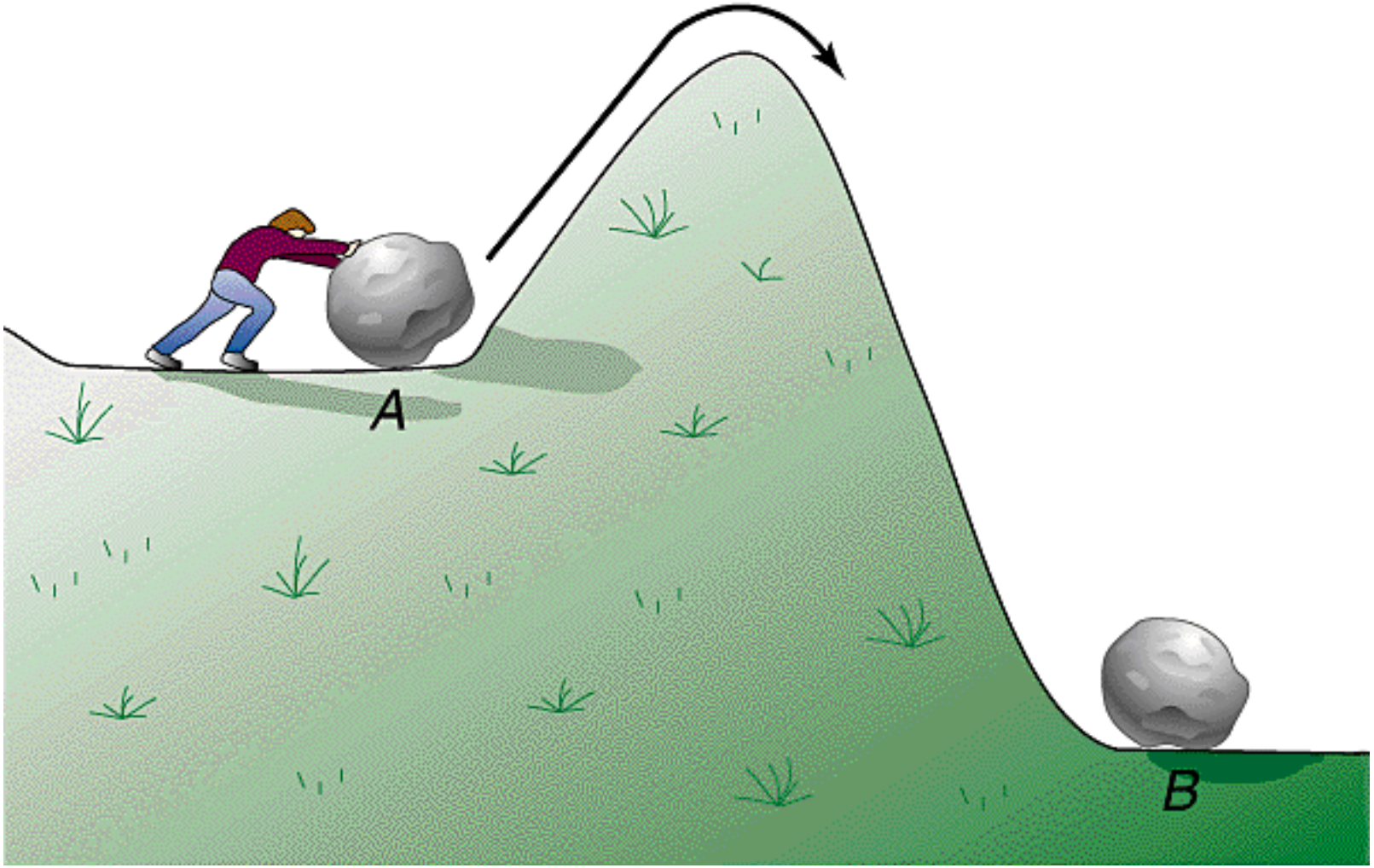
- Mother and daughter 70s and 40s
- Rough sleeping around Tooting for 20+ years
- Religious calling of mother
- Local parish priest feels it is beyond ‘normal’
- Local psychiatrist inclined to feel the same
- Mental health team overruled section as did not feel clear ongoing plan
- V complex, needs ongoing intervention and observation

Assessed but no action (4)

- Dutch national late 50s
- Probable psychotic illness
- Binge drinker (not dependent)
- Refuses help on grounds that has not contributed to UK system
- No information available from Netherlands
- Local mental health assessment is that not suitable for section (too stable)

Getting a change needs energy

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Challenges to street doctoring

- Difficult liminal mental health issues: severe but chronic
- Staff stress: both because genuinely challenging technically and also emotionally
- Structural issues:
  - Timing of outreach
  - Borough and health boundaries
  - Organisation and purchasing of care
  - Interprofessional and interorganisationalunderstanding (interorganisational governance)

Why does nothing happen?

- Difficult cases
- Many are chronic schizophrenic with extensive delusional systems but who do not communicate this
- Only a danger to themselves, not to others
- Homelessness is not viewed as a harm in itself
- ‘Wallpaper’

Discriminatory practice?

- If a *housed* person is at risk of losing their home because of mental illness emergency

- If a *homeless* person has been unable to obtain or maintain any accommodation because of their mental illness not a problem

  lifestyle choice

Deprivation of liberty

- Difficult issue
- Necessary in order to assess and treat
- Emotional toll
- Strong reactions
  - Patient
  - Advocates
  - Staff

After detention, then what?

Aftercare

- Essential
- In Oxford, provided by homeless primary care team
- Halfway house which would be a clear onward pathway from acute mental health ward
- Appropriate long term care including protected floating support for ex-entrenched rough sleepers

“The street is my home”

- Visiting someone who is unwell AT HOME is generally recognised to be a sign of good quality care
- For the street homeless person, that place is on the street
- We should ensure that primary health care is available on the street to people who are homeless
- This can help to address their mental health

Top tips

- Do not do this on your own
- Make sure you can work late evenings and early mornings
- Joint working
- Good communication
- Comfortable boots and rucksack
- Take a folding chair

Every city needs a street doctor

or 2

or 3...

Thank you

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