



The Queen's
Nursing Institute

groundswell
inclusive solutions to homelessness



LOTTERY FUNDED

The Queen's Nursing Institute Homeless Health Initiative Service User Consultation Report

February 2008

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Groundswell's Core Beliefs

- Homeless people are not the problem - they must be part of the solution.
- Homeless people hold the key to solutions in their experience and knowledge
- Homeless people have a right to information to make choices about their own lives.

Groundswell's Key Aims

- Enable homeless people to set up and run their own projects
- Increase homeless people's influence in policy and decision making
- Increase homeless people's meaningful involvement in the services they use.

1. Introduction

Groundswell UK is a registered charity that believes that homeless people are not the problem, but must be part of the solution to homelessness. Groundswell is the leading user involvement and self-help organisation working in the field of homelessness in the UK. It provides training in service user involvement, conducts research to ensure homeless people's opinions can help shape policy and gives out small grants to groups of people with experience of homelessness who want to start up their own projects. See www.groundswell.org.uk for more information.

The Queen's Nursing Institute Homeless Health Initiative, funded by the Big Lottery Fund, provides support for nurses working in the field of homeless health. The HHI acts as a forum for peer networking and the promotion of best practice as well as providing opportunities for information sharing and support. It also provides professional training opportunities and resources tailored specifically to the needs of homeless people.

The QNI Homeless Health Initiative approached Groundswell to assist them in ensuring that homeless people themselves could influence the way that nurses work with this client group. It was agreed that Groundswell would facilitate three focus groups in different geographical regions in the UK to find out about homeless people's experiences and opinions of the health care they receive.

The first two focus groups were hosted by projects offering a broad range of services to local homeless people: Open Door Care in Grimsby, "more than just health", and The Vaughan Centre in Gloucester, 'One Stop Shop for homeless and vulnerably housed people'. The third was held at St Pancras Hospital in London, where homeless people from a range of projects were invited.

In general participants indicated that when it was received, medical care was good, with the main areas of concern being accessing care and receiving follow up care. The theme which most homeless people wanted to discuss was the issue of staff attitude and a lack of understanding of the homeless experience. Second to this was an insistence that lack of access to shelters and day centres continues to create health issues and make it difficult to recover from them.

Participants' solutions to improving health care for people experiencing homelessness were many and varied. The most common solutions offered related to changing staff attitudes through training and guidance, and greater investment in shelters and permanent accommodation to prevent the health complications which many of the people involved in this research were experiencing.

What Makes a Great Health Service? Largely the people! Participants were asked what makes health services great - top of the list, across the groups, were people skills: "respect, good people, tolerance, care, compassion, friendly, no general rudeness". The next most important elements for participants were

related to skills and speed of service: “efficient, professional, correct diagnosis, right reference for specialists, up to date equipment, training for staff, faster service, more services”. Finally there was recognition that improvements related to staff and services were related to funding! Every group indicated that lack of funding would be a barrier to making the improvements they suggested.

2. Findings

2.1 Important aspects of health

Individuals were asked what **aspect of their health** was most important.

Responses largely depended on the situation people were in. For the many people who were sleeping rough, cleanliness, safety and foot care were the most important issues – for drug users, access to treatment options and scripts were most important. Across the board Mental Health was mentioned – as was dental care and nutrition.

As well as discussing their specific illnesses participants thought there were some illnesses that were specific to, or exacerbated by, their homelessness.

‘Cause when you’re on the street you don’t eat.

Diabetic. That’s to do with too much sugar, too much alcohol and that’s what caused the blood sugar – It can happen anytime.

My body. The whole thing. Everything. Life, bread. Stuff like that.

Interestingly, many related their drinking and/ or drug use to their mental health and their street lifestyle, recognising that there can be a negative dynamic between them and access to appropriate medical assistance.

For me it’s mental health. If I get pissed off, I will self destruct and drink myself half to death, by which time I will be so ill that I will get battered by some little bastard that’s half my size

I think it’s a shame – you need a bit more care, know what I mean, for homeless people ‘cause they’re on the streets, they get attacked and this and that... know what I mean, they get robbed and stabbed and shooting(?)

Just ‘cause you’re living on the street you can’t have a good nights sleep ‘cause you’ve gotta keep your one eye open all the time.

These thoughts are backed by the literature. In her 1996 report *Still dying for a home*, Grenier reported that alcohol and drugs were used by rough sleepers as a form of self-medication to deal with physical and mental pain. As well as rough sleepers being 35 times more likely to kill themselves than the general population, they are four times more likely to die from unnatural causes, such as accidents, assaults, murder, drug or alcohol poisoning related to their lifestyle and the precariousness of a street existence.

2.2 Barriers to accessing health care

- **Waiting Time**
- **Lack of Time**
- **Opening Times**
- **Lack of Information**

Participants were invited to list the health services they had accessed or tried to access. Following this exercise they were asked to list the barriers they had experienced accessing or trying to access each service. Among the most significant barriers was waiting time – the groups acknowledged themselves that this wasn't always particular to people experiencing homelessness.

Just waiting time, ain't it.

Well waiting time, and sometimes you might need a sick note but you can't get an appointment to see one for two weeks.

Like if a doctor's only got ten minutes per patient. He's always rushed off his feet

Second to waiting time, people felt in general staff were not spending enough time with them – this pertained to all health services accessed. There was some indication that as a result staff dealt with the presenting problem and not with all the other issues. Related to this there was some indication that individuals wanted more holistic care; one individual, believing that his underlying issues are mental health related, has received very good services in regards to treatment for drug addiction but no one wants to assist him with mental health issues.

in and out as quick as possible

Well, mine I'd say is... being in gear now for 15 years, it's my mental health... I'm lucky I've got my flat now.

Opening times were seen as a barrier; across the board people indicated that there was a need for more weekend and evening services.

Finally, it was apparent that among the most significant barriers was a lack of consistent, reliable information in regards to health in general. To begin with, many people - or perhaps many GPs - were not aware they could access GPs if

they don't have an address. In addition, there was confusion around who could access their Health Records. Also, around the issue of discharge from hospital it was apparent that there is sporadic good practice, especially in London, but in general sign posting did not occur. On discharge from hospital in Grimsby some individuals were given a '24 hour support number', that, when called, routed them to an answering service.

they put you back on the streets again, knowing that you ain't got a phone, you ain't got an house, so how can you phone them up if you ain't got an house and no money and no phone?

Most of these barriers are concurrent with other research. Thomson (2003) found waiting times, the inflexibility of services, staff attitudes and lack of information on the availability of services to be factors. Staff attitudes were reported to be the biggest deterrent, with 54% of people citing this as a problem.

2.3 Staff attitudes

I was homeless and he didn't want me around. He (the GP) perceived me as to be a problem... I mean, he's a lot better now I've got a stable address and all that, he treats me with respect.

This attitude was encountered in GPs. This seemed particularly so in London. Many saw this as a prejudice that people gained through stereotypes or through previous bad encounters with other homeless people, and felt that these prejudices could be overcome.

Yeah. When I was homeless he didn't really want me at the surgery. He thought I was just making trouble all the time. But since I've settled down and got an address and all that he treats me a lot differently. He's even turned round and said that I'm quite knowledgeable about the problems I've got, so his attitude has changed.

Others saw it as more a case of the attitude that you needed to have as a patient.

I mean, I go to the doctor's or something, I go with the attitude they're there to help me. As long as I'm polite and I don't swear and all that and I don't give them a nasty attitude and all that, you basically get something back

I haven't given them swearing and attitude and all that so they haven't treated me nastily.

However for some this did have some limitations, which they again put down to the pressures of the surgery, but also to what professionals' previous experiences of homeless people had been.

nurses too can also have bad attitudes - sometimes they prevent you from seeing the doctor. You're forced to see the duty nurse and she now has got the case history sometimes they're trying to prescribe solutions for you which are not suitable

Yeah. As long as you respect them I find that they usually respect you back. But he's right, there is times when you come in after someone who's been causing hassle and all that, and 'cause they're still angry about what happened before -

if they're having one of those days where... maybe a couple of my kind have come in earlier on and (unclear) made the place a bit rowdy. If you go in after that you could run into an attitude where... very unhelpful. It's rude. And you're like... are you having a bad day or what, or did I say something, or is it because of my colour

As indicated in the introduction, although it seems that many people are accessing 'one stop' health provision and GPs, much of the discussion in relation to staff attitudes was related to Accident and Emergency; in particular a feeling that security and triage were gatekeepers.

healthcare professionals, they're like - gatekeepers, so to speak.

Once you get to see the doctors, they generally are interested in your case as medical professionals and will try and give you some service, but frontline staff are another matter

Others thought that there was an active discrimination on the part of some health care professionals because of the need to save costs. Such a phenomenon has been noted by Bevan (2002) with regard to homeless people with multiple health needs. They are often given, at least as a first option, cheaper medication.

I've been diagnosed with something completely different just so they don't have to put you down as mental health - because if they diagnose me as a certain thing, like, it means they would have to spend more money on my care.

Throughout discussion around staff attitudes there was a prevailing underlying feeling that health professionals didn't take individuals' conditions seriously, and didn't always give individuals credit for their own understanding of their own physical conditions.

We're in, out, very quickly 'cause they're actually having a laugh at people. You can't get the necessary referrals or as smoothly. It took me a while to actually get them treating me as someone with a genuine case rather than someone trying to get some pills or whatever.

An individual from the Grimsby group relays their experience:

The bad ones is that when you go in and you've got the same problem and you've already been admitted somewhere before with that same problem, they just say, "Oh well, you had an investigation and there was nothing – blah blah blah, there's nothing wrong with you". There's all sorts of things it can be. There is something wrong... and they just ignore you

2.4 Accident and Emergency

We were surprised to discover that only 25% of the people we spoke with accessed A&E as their first port of call when unwell – when looking more closely at the statistics it is clear that in Grimsby, where 64% of the participants indicated that they were sleeping rough, a much higher percentage - 54% of people - accessed A&E in the first place. Overall 38% stated that one-stop shops – specifically Open Door in Grimsby and the Vaughan Centre in Gloucester – would be their first port of call, and 33% would go to their GP. One person would go to a family member as a first port of call and another declined to answer the question. Across the three groups A&E was accessed in an emergency by 56% - just under half of the people in Gloucester would instead call 999.

People's experiences of A&E were problematic across the board. The first barrier was the security staff, whom many participants did not feel they could get past.

when you go in and it's obvious you're a homeless person, you've got your bag with you and you're sitting around waiting and you might have something badly wrong with you. They're straight over, embarrassing you – 'cause they think you're just there to doss, you know? And their attitude stinks, usually, security guards. They're just bully boys mostly, the ones in hospital.

Frontline staff – whether it's from the security guard to the desk clerk, can be a real problem if they realise or suss that you're homeless.

Many felt that even beyond this they were discriminated against by health care staff. For some it was just being homeless, but there seemed to be particular discrimination if people had been drinking, even if they had a genuine medical concern that was not related. In Grimsby the A&E practices zero tolerance on alcohol.

If you've got a drug or alcohol problem they can be prejudiced.

I couldn't walk and they just looked at me, this little bloke... he just says, (unclear - coughing) "on your way"... He says it weren't infected and there was, like, green pus on feet 'n' that. And even one of the nurses looked at it and said it were serious, and he said it weren't, didn't he?

No all good(?), I mean there are times when you feel you've been penalised for your lifestyle.

And it is - A&E's the same thing, if you smell of drink, "Ugh, you've been drinking again, what are you doing falling over?" It's a load of bull(?).

One participant recognised that the conditions he was going in with are not really designed for A&E and consequently would not be prioritised. He needed to be both patient and pick the times he went.

Um, depends on the time you go to A&E because if you go in a particularly busy period you could end up with a four hour wait because they're going to prioritise other illnesses or situations. But normally you do get a chance to see a doctor eventually

What seemed to compound the situation is the long waits that can be associated with A&E, which could lead to frustration on the part of the homeless person who only goes there when the situation is acute, who then fulfils people's expectations of their behaviour which leads to them being excluded.

They've got no patience.

I went to hospital, right... just 'cause I was a bit pissed 'n' that, yeah right... like you said, they made me wait about three or four hours, d'you know what I mean? I was not happy. And when I said something can you get something sorted 'cause I was in serious pain there, he started having a go at me, but if we have a go at them back, you raise your voice once, and they can say, "Right - we saw this and that - out."

Positively this kind of experience was not universal, below is a comment from one of the participants in the London group.

All I ever hear from other people is “It’s terrible, it’s terrible”. My own experience – absolutely fine, no problem at all. I’ve always gone in and got the treatment I was expecting on time. And me, I’ve never had a problem at A&E, like. They’ve always dealt with me fair and square and gave me the right treatment and all that.

2.5 Hospital stays

If a homeless person was admitted, they found that the discrimination continued, particularly on the part of the nurses, making them feel that their condition was not deserving. Positively, doctors did not seem to discriminate. These experiences were again across the board.

Like everyone’s saying, once they realise that you’re homeless, got a drink or drug problem, a few of the nurses have got an issue about you being like that and they feel you’re taking up their time and their beds. But as for the doctors on the whole, they are quite reasonably understanding. It’s only like, um.. 10% percent of them who aren’t

Two participants from the Gloucester group felt that their drug use made the medical staff not want to give them drugs, one as ‘punishment’ and another because the nurse felt the person was only in there to access drugs and so denied them. Positively in the former case the doctors did not allow this to continue.

Yeah, whereas I went into hospital and I was in severe agony and because I had a drug problem the nurse said she’d not give me anything because I was a drug user and the doctor came out and said, “I don’t want to see any patient of mine in pain around me” so he gave me the dosage to help me, whereas the nurse didn’t want to do it.

The following are examples of the negative experiences participants had, taken from across the groups.

Just the same really, I went to hospital last week with a proper gouge, it was like that and it was still bleeding... and I was homeless, there’s nowhere to go, d’you know what I mean? No, like, washing, they just left me

I got robbed, and er, basically had fractured ribs. They took me in there and had to treat me. Er...gave me some tablets and sent me on my way.

And just to show balance there were positive accounts such as this one from Grimsby, although they were very much in the minority and the individual's account was preceded by one bad account he had had. His final statement about the amount of medication he received was significant.

I was travelling and I was in the middle of – no, Warrington, sorry – and I'd been waiting about two years to get an endoscopy – you know, to check if I had ulcers and stuff like that. I was in there and because she knew I was homeless she kept me in for five days... and she tried to sedate me to do it and then I ended up breaking a nurse's thumb, you know when you I was medicated but I didn't know I did it. So then she said, "Right, we're going to put you to sleep now", so she did that and then she sent me home with two weeks of all me medication and that was all on the house(?), and that was with me asleep and everything.

2.6 Hospital discharges

Experiences of hospital discharge were almost universally negative. The following example being what seems an extreme of negligence.

I was beaten up and had stitches. 2'o' clock in the morning they're throwing me out. The following day I was vomiting blood. I lost seven pints of blood ...

While not as extreme, this was the experience of many. Many felt they had received little help at all.

In the hospital they throw you out on the streets anyway, with no accommodation they just throw you out like a doll, really. (unclear) a couple of days and tablets 'n' that, but they don't give you the right stuff half the time.

Others felt that they had been promised something they had not received. Whether this was through negligence or hospital staff being naive about the situation out there is unclear. We would recommend that all trusts are made aware of the DOH guidelines for hospital discharge procedures (DOH, Homeless Link: 2006), and that relevant PCT(s) audit them on their use of them.

they didn't find me anywhere to live even though they said they would if I've been discharged on the streets.

They put me back on the streets, there's no social care, even though they said they wouldn't put me back on the streets, like.

One participant felt that that it was a lottery whether they got good treatment, but that the deciding factor was not the knowledge of the workers, but, again, their attitudes.

Once I was discharged with a list of places I could go to get temporary accommodation... in the other one I was just straight back into the night hostel? (laughs), so... it depends on the hospital, some of them have good social workers, while others tend to be... "we need to free this bed, bugger off".

An important factor here was the medication – that people were discharged with a week's medication, rather than just a few days. A factor seemed to be the longer time it took to recover on the street, and also the hand to mouth existence that might preclude following up after care.

I wasn't just discharged with, like – a day's worth of medication. I got discharged with a good week's worth. 'Cause they know it's gonna take time because of my circumstances. I was impressed with that.

Yeah, I had exactly the same as (name) – I left with enough medication for a week, I didn't have any problems with it.

People in general reported good treatment in hospital – but that the lack of understanding around homelessness meant that discharge was haphazard. One individual was admitted in Grimsby and transferred to Hull – he was discharged and the hospital would not take responsibility for taking him back to Grimsby because he was NFA.

2.7 Health rights

Clients' views on their health rights very much focused on the equality that people should have, and that there should be a right to free accessible healthcare. This view went across all the groups.

I think our rights to healthcare should be same as any other man in England where they normally go.

we're all entitled to treatment. And anyone else is entitled to treatment.

Yeah, and even though it does happen I don't expect to be treated like a piece of dirt and all that lot, but it does happen.

We have the rights to the same treatment as anyone else regardless of whether you've got alcohol problems, drug problems... anything like that. You've got the same rights as anyone.

One participant from London was explicit in describing how he felt that homeless people, while given primary care services, were actively denied other forms of treatment.

Um... there are times when... if you're homeless, it's almost as if you have no rights through the eyes of the system - you cannot get the full range of treatments available to all people. So I'd say people have open access to normal healthcare.

2.8 Health records

There was almost universal support for the idea of health records. Many saw it as a solution to their transientness and that they often did not have a GP. Others valued it, recognising that they were often not in a position to give consent when they needed medical treatment.

I think health professionals should routinely be allowed access to your records.

at least you can pass that information on to whoever's treating you.

It's important because if you come and you're knocked out how are they gonna know what's going on with you? What if you're in a coma? And don't wake up for 10 years?

I mean, it should be all there in one file on the computer so they know everything about you... like, if you have fits or sommat, yeah? It should all be in that file. If you're moving around, like... sometimes it takes about five, six weeks to come through - I mean, they don't know what medication to give you so they have to wait while your papers come through so you can get your medication ain't it?

It should be like the American - it should be a certain password that everyone should have but there should also be an override thing that they can do just in case you are, like, gone - unconscious or whatever.

not all your records, but one main page - everything they need to know just on one page, right, and they can go "oh right, OK", this and that and that.

However, others were clear that while there should be health records, access to people's full records should be restricted to medical staff and/or doctors and consultants. This was to counteract some of the gatekeeping tendencies mentioned previously.

I think it should be anyone that's in the medical services. But I don't think it should be open to... anyone who's interested in your care, i.e. a normal GP or a consultant who's actually helping you in a medical emergency or a medical issue, they should have access to your records. But apart from that no one else should have access.

Yeah, any health professional. But not – you know, secretaries, temps, receptionists.

Others were more cynical, particularly the London group, seeing medical professionals citing not having records as just an excuse to not give them a service. Some again related this to gatekeeping and denying homeless people more expensive forms of treatment.

I've been to institutions in the past where they couldn't find my past records. That's what they told me... but you realise after a couple of times they were just playing you.

Actually they know your past records if they dug out your past records they'd have allowed you access to the next stage of treatment which they object to because of my homelessness.

Some had experienced that it took too long for Health Records to follow them.

it takes a long time for your records to catch up with you

it takes too long to get records when you move – this is a bigger issue if you are dependent on medication

There was a general lack of understanding about who could access health records. In addition there was confusion around what individuals could access on their own health record and how they could access this information. In Gloucester, one individual thought they weren't able to access their own record and a staff member indicated that they could but would have to pay about £50 to do so.

2.9 What's missing locally?

Participants in each group were asked to list what is missing locally, then, depending on the size of the group, people were given a number of votes to indicate which of the gaps was most pressing in their particular circumstance. There was a strong indication in Grimsby and Gloucester that people felt that the biggest difference to their health would be the provision of shelter/housing. In Grimsby most people indicated that what was missing locally in health provision was Night Shelters – closely followed by more GPs and out of hours services. In Gloucester the number one provision in health services that was missing was a

day centre followed by women's accommodation, soup kitchens and faster access to script. In London the clear favourite was 'specialist training for staff on homelessness'.

Lack of accommodation compounded health in a number of ways; firstly some people were finding it hard as many GP surgeries still would not register people who did not have an address. This seemed to be a particular issue for the group in London.

The problem I had was twofold, erm... no address, can't register at the surgery. So I was forced back to Great Chapel Street

I tried to go back to my local area where I was, GP wouldn't have me 'cause I didn't have a proper address, which is a bit tricky.

For others it was a lack of an address that meant people did not prioritise their health as they were living a day-to-day existence. Those in Gloucester particularly mentioned these views.

If all boils down, I think to if you've got a good roof over your head then you're halfway there. It's all about accommodation.

unless they're settled, they're never gonna be able to sort their life

If you've got nowhere to live you can't possibly evolve 'cause you've got nowhere to feel comfortable. Then you can think, "I've had a lot of problems in the past, but now I've got this roof over my head, I'm safe, then I can look into all these things", But you can't do that while you're living on the streets, living in a night shelter.

This meant that they did not access health services until they were in an acute state. Daly (1996) and Grenier (1996) note that this also has the effect of people accessing health care services on a primary care basis to be patched up. This was a theme that ran through all the focus groups; secondary and tertiary care was rarely a priority for people. Some found that this meant that health services professionals were cynical about them taking up secondary care, probably based on experience, and this resulted in them being discriminated against.

Erm... sometimes, erm... when I've been into Grimsby and seen the triage it doesn't get prioritised in the same way that other patients do.

Finally the drug users in the groups felt that unless they had an address to go to when coming out of detox, their success would be in jeopardy. They thought

that their drug use compounded their homelessness making their health a small priority beyond where it related to their drug use.

it's all very well getting your detox in place, but if you haven't got accommodation when they come out...So then the detox is completely wasted...

Sometimes people don't always get a choice, they're not able to go and look before their treatment. You have to take what comes up. And there are lots of different treatments so one way isn't necessarily the best –Yeah, one rehab it's all about God – it the same with detox, you know – the problem we mentioned about not having an address – that is the same with rehab.

2.10 Solutions

Training and Protocols

Participants thought that training was needed for health care staff. In particular there was a need to develop understanding in nurses and ancillary staff about the nature of homelessness and its relation to health issues. This could include the specific health problems they faced, why homeless people present at A&E in the way they do, the difficulties of secondary care and the importance of hospital discharge procedures. More generally they thought that all staff could benefit from some reminders about the importance of customer care.

not to have an attitude to someone being homeless. Um... you're not causing trouble, you're ill. You know... just like anyone else.

I would say, like, being more open... You know, people have got mental health problems, not just... drug using problems or – they need to be more open

They need an attitude change. Basic people management, they need to be taught, rather than just go through the medical stuff. They need proper training to deal with all the different kinds of people they're going to be dealing with. One set(?) of people freaks them out, until they're taught that they're people as well.

Polite, you know, treating people with respect. All people.

So look at the whole picture, not just the drug or mental health problem. Become more human. really.

Along with this some protocols recognising that while a person may be drunk, intoxicated, or displaying signs of mental illness, they should still be seen in terms of other illnesses they have. This may include, as a short-term measure, some recognition of

the difficulties homeless people have in accessing primary care, such that presentations at A&E with inappropriate presentations are not automatically de-prioritised. In the longer term protocols should be developed for GP registration of homeless people.

This later recommendation could include GPs prescribing methadone. While, as we shall shortly see, homeless people welcomed some walk in and dedicated health services, they still thought they had a right to access the full range of possible GP services.

a normal doctor to prescribe me that? Why have I got to go through a drug agency and wait months? In the two or three months you're waiting you've gotta pay for your gear so you could get into trouble in that time.

The primary concern here was the speed with which people are scripted for methadone. While there are debates about whether people should have

Well, like (name) said, SREC seem to have got the right solution. It's been proven with them they can have you on script within a week. They had me on in three days. I came out of prison with a habit on the Friday, I picked up my first script on the Monday.

speedy scripting (reference), participants felt that they could discern when it was appropriate to be scripted, and to be made to wait for some time, particularly when living a homeless lifestyle, is problematic.

if you go to the Hungerford project, you can get registered there and within a week or so you're on a methadone script and they're quite good, like.

Temporary registration

One participant from London was very much in favour of temporary registration, in recognition that many homeless people were initially concerned with their primary care needs. He had a very novel solution worth repeating!

I think they do something like they do with the voter's list. There's two kinds of voters lists – there's an open voters list and a permanent(?) voter's list. Open voter's list allows people to get registered as an electoral, er... person would only be able to vote at a particular level, whereas the permanent one means you can vote at all levels. They should allow GPs to do what you call temporary registrations, 'cause if somebody's in (unclear), chances are they'll be sorted within three to four months

Walk in services

However, while most called for greater GP registration, many from across the groups thought that dedicated walk in clinics were the solution. Some recognised that such provision should mirror A&E, but with less waiting times and more appropriate health priorities. A particular desire was that staff should spend more time with them.

They should have a special 24-hour healthcare for homeless people. I mean, A&E's just like a special, like, walk-in(?) centre.

They should have more walk-in centres too. Things happen quickly in there. That really works.

So that would be a kind of solution then – to get in and out as quickly as possible and more places like that where people can actually spend a bit more time with you. And dedicated doctors who don't like(?) to rush.

However some thought that such centres should have more access to secondary care, akin to the power of doctors.

And the last one – get a prescription and go – they should look at us like a normal GP would do. You complain about the symptom, the solution's not readily available, so your GP will say, "OK, take this or "go and give some blood" or "go and do some tests" to ascertain the problem.

Yeah, proper follow-up in terms of tests, um... and er, the usual specialist advice, you know? Like, the chiropodist or whoever you need to see.

Perhaps this calls also for some interaction and intervention with homeless people to challenge their own prioritising of primary care issues and only presenting at moments of crisis. Such interventions may be carried out by non-medical staff, and could indeed be placed in both doctors' surgeries and in walk in centres.

Shelters

A recurring theme, relating to the previous statements, was the primacy of accommodation. Interestingly people saw it as both a primary need but also as a starting point to address their health needs. In Grimsby and Gloucester, participants related this to the lack of Shelters.

I reckon you need more day centres and night shelters because there's a lot of people round here sleeping in squats and all that-

There should be a port of call for everyone because even if you're a drug addict, er, an alcoholic or anyone there should be... in Aberdeen there's a place – all it is is it's like a little lay house(?). Every night you get to go there, you get soup...and there's like, not a mattress but there's something to lay on. That's all I need to do when you're homeless, know what I mean

Because if you have accommodation your health would be better. It's all about accommodation.

I'll just say this – all it needs to be is an empty warehouse or an empty room. A room like this, you'd get 20 – you'd get 10 people in this, you know? But it's "health and safety".

Again, this would seem to call for greater integration, communication and possible joint planning between housing departments, health authorities and the voluntary sector. Services for women seemed to be a particular issue in Gloucester, as mentioned by one of the participants.

Because there's four women's beds in the whole bloody shire, there's four women's beds for homeless people in the whole of Gloucestershire. Four women's beds.

3. Recommendations

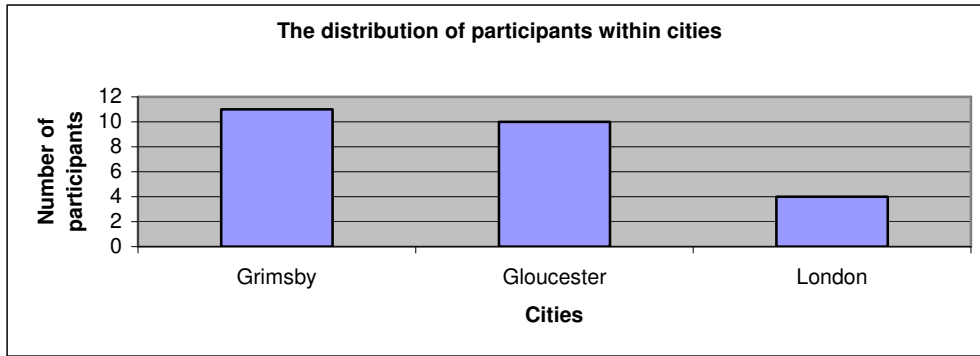
Groundswell recommends that:

- 3.1. Training for Staff.** Training should be developed on the particular health care issues faced by homeless people, particularly their mental health needs. This should be made available for health care professionals, particularly for frontline staff in A&E, nurses, GPs and A&E receptionists. This training should be developed with people experiencing homelessness and health professionals.
- 3.2. Training for Homeless People.** Training should be developed for homeless people about the range of health services on offer to them and on how to approach services. This training should be developed with people experiencing homelessness and health professionals.
- 3.3. Hospital Discharge.** That all Primary Care Trusts are made aware of the Department of Health (DOH) guidelines for hospital discharge procedures (DOH, Homeless Link: 2006), and that there is a formal audit of their use.
- 3.4. A&E Signposting.** Good practice relating to how homeless people can be signposted to other more appropriate support services when departing A&E, developed by Health Link (health-link.org.uk), should be adopted and disseminated.
- 3.5. Intoxication.** Protocols should be adopted recognising that while a person may be drunk, intoxicated, or displaying signs of mental illness, they should still be able to be treated for their other physical health needs.
- 3.6. GPs & Walk in centres.** Walk in centres offer a good access point for homeless people to reach health care and these should be supported. However they are not a substitute for GP registration and homeless people should be encouraged and supported to register with GPs. Clear protocols should be developed for GPs for registration of homeless people.
- 3.7. Health Records.** Clear protocols need to be developed on access to health records: who should have access (eg medical professionals), who should not (eg. ancillary staff), and in what circumstances they can be accessed without the client's consent. Clear information on this protocol and on how individuals can access their own records should be produced and disseminated to homeless people.

Appendix 1: Demographics

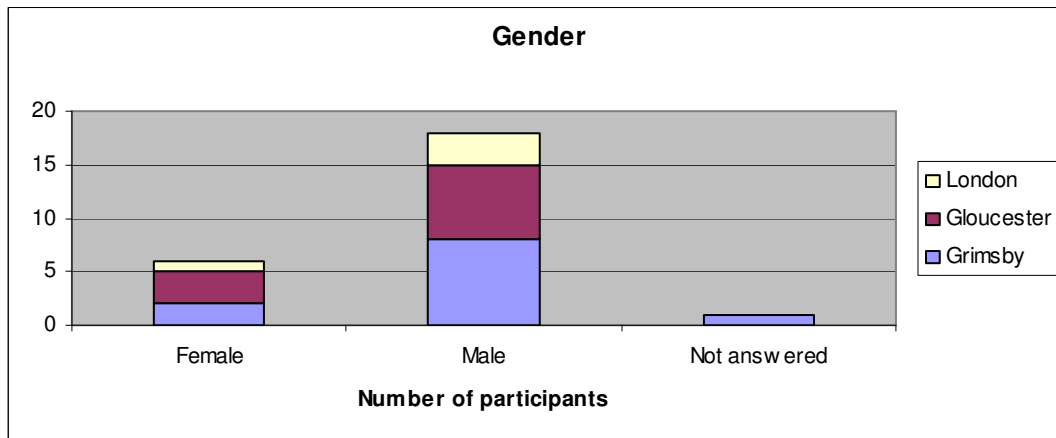
25 people participated in the research. Figure 1 shows that 44% of the respondents came from Grimsby, while 40% came from Gloucester and only 16% from London.

Figure 1



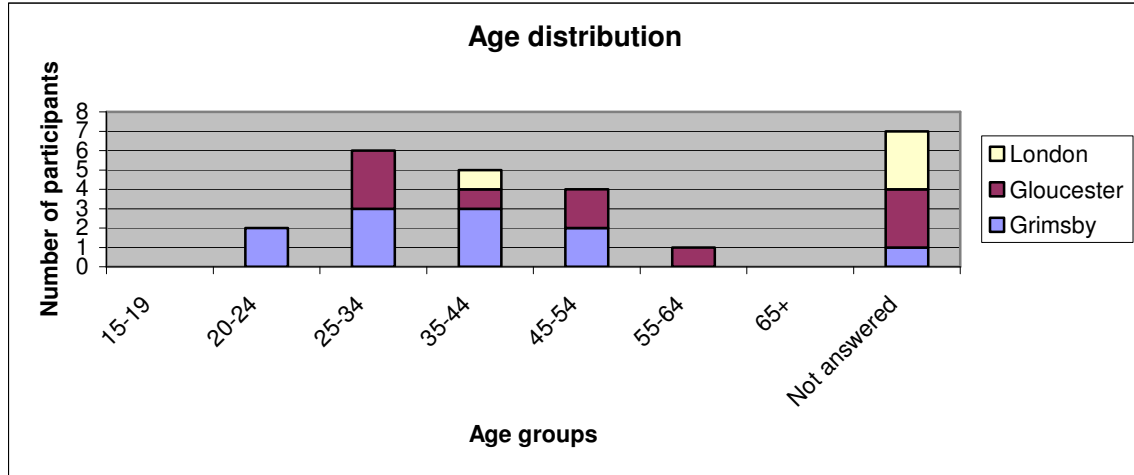
The survey population comprised 6 women (24%) and 18 men (72%) aged 20 to 64 years old. This distribution of men and women is almost equal within the 3 cities. The gender balance reflects the wider homeless population, as Crisis’s 2003 study shows that between 80-88% of single homeless people in the UK are male.

Figure 2



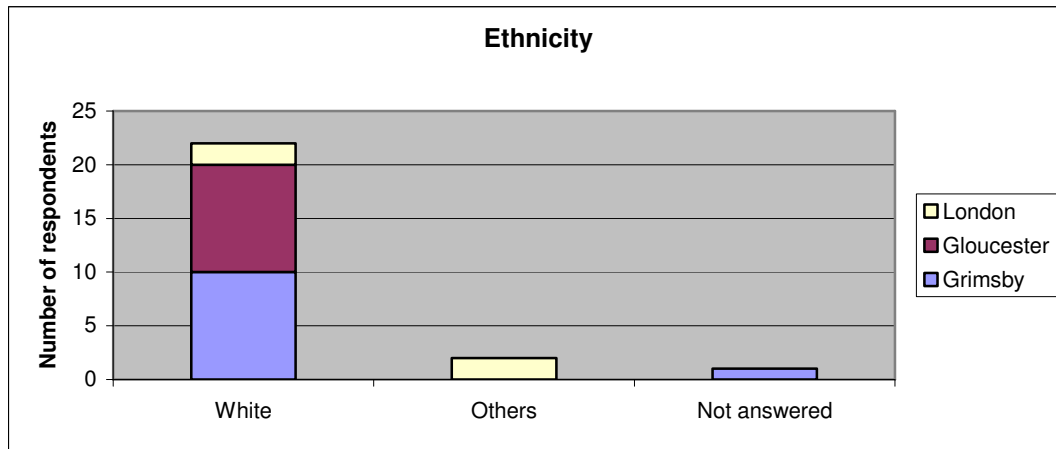
In terms of the age distribution of the respondents, the breakdown among those who mentioned their age was 11% aged 20-24, 33% aged 25-34, 28% aged 35-44, 22% aged 45-54 and 6% aged 55-64. In other words the majority of the respondents (83%) had an age between 25 and 54 years old (Figure 3). Furthermore the figure indicates that the respondents from Grimsby were younger than those from Gloucester.

Figure 3



In terms of the ethnicity of the respondents, 88% classified themselves as “white”, while 8% classified their ethnicity as other than white and the remaining 4% didn’t answer the question (figure 4). Of the residents with a different ethnic origin than “white”, black Caribbean (4%) and Indian (4%) was mentioned.

Figure 4



The length of time people have been experiencing homelessness is represented in figure 5. Among those who answered 5% stated that they had been homeless for less than 2 months, 20% that they had been homeless for between 2 months and 1 year, while another 20% had been homeless for 1-3 years and 55% stated that they had been homeless for more than 3 years.

Figure 5

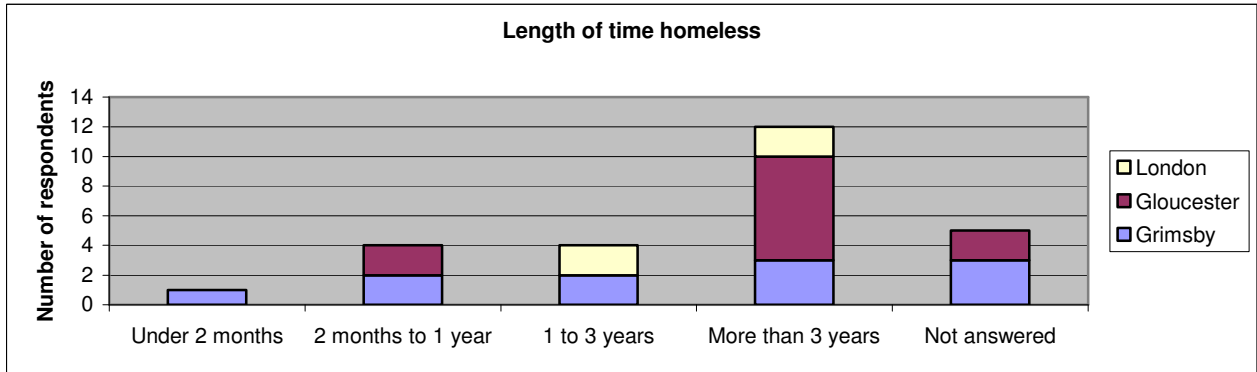
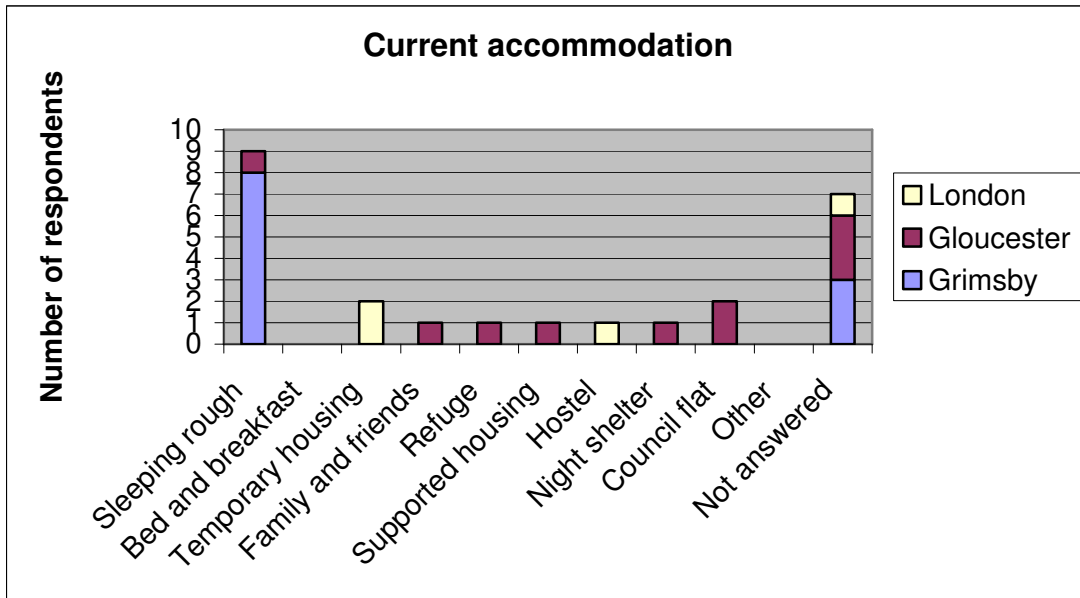


Figure 6 shows the distribution of the respondents within different kinds of accommodation. Most of the respondents stated they were sleeping rough (50%) and 8 out of 9 of the rough sleepers came from Grimsby.

Figure 6



Appendix 2: Bibliography

- Daly G** (1996) *Homelessness Policies, strategies and lives on the street*
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- Grenier, P** (1996) *Still Dying for a Home* Crisis: London
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Acknowledgements

Groundswell would like to thank the following for their invaluable assistance:

- Angela Faulding, Sarah Cook, Debbie Woodfine and everyone else in Grimsby and Gloucester who hosted the focus groups, supporting and encouraging clients to participate and making us feel so welcome.
- Groundswell researchers Mark Flynn and Corine Davidson.
- Jimmy Carlson, who has worked for years highlighting health issues for people experiencing homelessness.
- Mike Seal, who assisted Groundswell in the analysis of the results from the focus groups and imbedded them in a broader context of health and homelessness research.