

# **SJR(2)-15-06(p.4)**

## **Social Justice and Regeneration Committee**

**Date: Wednesday 8 November 2006**

**Time: 9.30am – 12.30pm**

**Venue: Senedd, National Assembly for Wales**

**Policy Review: Youth Homelessness**

**Good practice in health care for homeless people**

**Kay Saunders MA(Cantab) BM BCh MRCGP**

In this paper I hope to give an idea of the medical problems commonly occurring in people who are homeless, and how we address this in our practice.

### **Background.**

I am a GP in Butetown, Cardiff. I have worked in Cardiff since 1995, and established my single handed practice in 1997. This is an ordinary GMS practice, ie there are patients of all socio-economic groups, not only homeless people. Since 1995, due to the choice of practice area, I have looked after people who are homeless. This is challenging, complex, work. I discovered that I am good at this work, and valued the chance to make a big difference to people who are generally unattractive to practices, and who have high needs. Since April 2004, this work had been resourced via the National Enhanced Service for the Homeless, part of the new GMS contract, commissioned by Cardiff LHB.

- This provides good value for money.
- I am writing from my experience, I do not know of other GPs providing a similar service in Wales.

### **Dr Kay Saunders' Practice**

I could not do this work alone. I am lucky in having gathered an exceptional team of people together to work in the practice, my practice manager, nurses, receptionists and counsellor. I also work closely with the nurse attached to the hostels, and provide her medical cover.

Outside the practice, we cooperate closely with the Hostels for the single homeless, Cardiff Social Services City Centre Team, Cardiff CAU (Community Addictions Unit) and Sealock CMHT (Community Mental Health Team). The hostel staff, who often bring people to see me, do a hugely important job.

On 1/10/2006 my list size was 1718, and 249 (14.5%) were single homeless. Of the homeless, 46 were 25 years and under. This count does not include those who stay on my list when they move on,

often to accommodation owned by the hostels. Their extra needs continue. I do not have hostels for under 18s or families in my practice area.

## **Good Practice**

I believe it is important, if possible, to look after people who are homeless in a mainstream, but tolerant and flexible, practice. These patients are used to being unwanted by most of society, sadly including many GP practices. Many homeless people access all their care via Accident and Emergency Departments, so have no continuity, and their needs are not properly met.

They can be loud, intoxicated, threatening or intimidating, messy, smelly and demanding (often for inappropriate medication such as diazepam and dihydrocodeine). For these reasons many healthcare staff are apprehensive, lacking the confidence to deal with such behaviour. They do not fit into neat appointment systems. They can be used to rejection and many have few skills to negotiate the complexities of some practices' systems, which can cause conflict. Our practice has very little trouble with behaviour. This is because the staff are welcoming (in fact at the moment we are only able to accept homeless people on to the list due to the premises constraints – a reverse of the common attitudes).

They soon come to trust us, and I have had many who come back to Cardiff to see me if they are in medical trouble. The staff are confident in managing the many and varied behaviours exhibited, they are sensitive to the often poor reading and writing skills.

We have found the only way to work is to have an open GP surgery every morning; this also suits many of the other patients. We try to prepare the patients so that they will be able to fit in to ordinary surgeries' ways of working when they move elsewhere. Our boundaries regarding behaviour are very clear, and we very rarely need to remove patients from the list.

People often move around the hostels, or are rough sleepers. This causes problems if they need referrals. We can have appointments sent to the surgery, and then find the patient, this is time intensive. We often use the City Centre Team's e-roof database system (a database updated by the hostels for all movements in and out). We also use the soup/breakfast run workers and the pharmacist if the patient is on methadone. Partial booking systems can cause huge problems, especially due to the inflexible time limits.

## **Workload**

In 2005, I did a snapshot of the work involved.

Firstly, I took a period in 2004 when I was accepting all approaches for registration and looked at 20 consecutive registrations for each of homeless and housed patients. A year later, 9 of the homeless (compared to 18 of the housed) were still registered. This shows the high turnover of homeless patients. The average number of consultations had been 9 (compared to 4). Substance and alcohol were problems for 7 (including 3 with both), and mental health problems in 6 (1 also with substance problems). None of the housed had any substance or mental health issues during the year.

Secondly, just before I restricted registrations to homeless patients again, I looked at the previous 10 registrations. Of the homeless, I had seen 8, the length of the first consultation was from 12 to 35 minutes (average 20, NB most GPs allow 10 minutes per appointment). 5 had mental health issues (2 serious), 1 had opiate dependency, 2 alcohol problems. None of the 10 regular patients had needed to see me.

This demonstrates the level of mental health and substance dependency problems suffered within this sector of society. It also shows the extra workload.

My current impression is of more of those registering having opiate dependency problems. Some people become homeless because of health problems, especially mental health. I see many people with fractured personalities, dreadful life histories, and multiple problems. Often mainstream psychiatry, and medication, has little to offer. Personality disorder is regarded by many as untreatable. People use substances to drown their psychological pain. Remove the haze of the substance, and the memories and life can again become intolerable. Self harm (including overdose) is common and provides a brief relief. Sadly the average age of death of homeless people is in their early 40s.

Recent deaths among my patients include several accidental opiate overdoses.

## **Skills**

I did 6 months standard psychiatry as a GP trainee. I was in the first cohort in Wales to do the Assembly funded RCGP Certificate in Substance Misuse, though had gained experience with the help of Inroads (street drugs project) and the CAU before that.

Homeless people present with many problems, so need time to sort out. I need to use all my long experience and skills as a GP. The substance dependency work is outside many GPs' experience and training.

## **Attitudes**

I have a reputation in the hostels for being firm, but fair. I may not give the medication they want, but give the care they need. Some reject my advice, but often come back when they are ready, and after they talk to others in the hostels whom I have helped. I talk honestly and in a straightforward way with all my patients, I try gently to coax the chaotic patients in a better direction. People have to be ready to change, develop ways to cope with the past, and look to the future.

Many people are given medications elsewhere, such as diazepam, that cause serious problems, for example disinhibition, especially when combined with alcohol, and can lead to aggression and assaults to others or to the subject. Some people register and immediately ask for diazepam. I take the history first, and then at the end of the consultation have the robust discussion about the diazepam! We ring previous practices and pharmacies to check medication history. We ring the prison and psychiatric hospitals. Clinical information is vital, but often very hard to obtain for such mobile

patients.

The person who can prescribe is the one most at risk of assault.

I register people as permanent patients, thus standing a chance of getting their previous GP notes, or part of them. We often register them as care of the surgery, and this is acceptable to the registration system.

## **Resources**

Working with people who are homeless needs a lot of time, a valuable resource. In the new GMS contract there are mechanisms called "Enhanced Services" to resource work that is over and above normal GMS (General Medical Services) workload. I am commissioned by Cardiff LHB to provide the National Enhanced Service (NES) – enhanced care of the homeless, for single homeless people in hostels and rough sleepers. This is to resource not only GP time, but that of the nurses and all practice staff. I also provide the NES for patients suffering from drug misuse. However I cannot take on as many as I could because of the current premises (and therefore manpower) limitations. This NES also has limitations in that it does not resource the time needed for initiation of opiate replacement, for prescription of opiate blocker therapy, or other services unless the patient is being prescribed opiate substitute. There are many patients with alcohol problems, but the LHB does not commission this service, so I am only able to provide a limited service.

This commissioning of NES work is not secure.

Two of the CPNs from the addictions unit see patients at my practice regularly. There used to be a general CPN attached to the hostels, but this post was lost years ago. To have this post re-established would be one of my good practice wishes.

I work very closely with Geraldine Jones, a district nurse who has worked in the hostels and with rough sleepers since 2001. She is a sole worker who is about to go on maternity leave for a year, and cover for her absence is in doubt. I hope to have more news by 8<sup>th</sup> November. Her job has been commissioned from Cardiff and Vale NHS Trust by Cardiff LHB.

The first nurse to work in the hostels was Mary Cooksley, from late 1995 to mid 2000, when contractual complexities became insurmountable

## **Future Practice Development**

I have mentioned constraints several times. Despite the huge expansion of housing in Cardiff Bay there has been no increase in primary care provision, placing huge strain upon local practices. If our application for additional temporary premises in Mermaid Quay, Cardiff Bay is approved by the WAG premises forum on 2/11/06, I will be joined by two other GPs, Sion Edwards and Penny Owen, allowing expansion of the practice list for all the population, and an increase particularly in the substance dependency work.

If the practice expansion plans happen, we could be in a position, if appropriately resourced, to provide attachments and experience for GPs who would like to gain confidence in working with homeless people.

## **A Personal Wish List**

- Premises expansion and establishment of a partnership. This will allow capacity to serve the wider socioeconomic population, and establish a succession to the specialist homeless service. This also could allow training of GPs from other areas in homeless work.
- Maternity leave cover for the sole nurse working in the hostels and outreach
- A second nurse to work in the hostels and outreach
- Dedicated CPN to work in the hostels and outreach
- Availability of Dialectical Behaviour Therapy (DBT) for personality disorder
- Efficient Housing Benefit system. Housing benefit is a very slow bureaucratic process, and especially if changing between incapacity and job seekers' benefits, can take many weeks to be processed, and can cause eviction

## **General comments about good practice**

In summary, working with homeless people needs a solid practice team, confidence, tolerance, trust, setting of clear boundaries, time, patience, communication skills, common sense, specialist knowledge (especially of psychiatry in the widest sense, substance dependencies and dual diagnosis), co-morbidities, networking with many agencies, administrative tasks outside the normal, and a solidity of personality and outlook to cope with work that can be distressing.

Not all GPs and their staff can be expected to have such qualities.

## **Invitation**

If any of the committee would like to come for a morning and sit in when I am doing surgery, please contact my surgery: 02920 483126

Ask for Christine Read, my practice manager.

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24<sup>th</sup> October 2006