

My Memorable Elective Experience: Working with Homeless People and Project LIGHT.

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Introduction

There are many reasons why I decided to pursue an elective working with homeless people and Project LIGHT. During my acute care placement last year I met and took histories from patients who were homeless. I realised that I knew little about the circumstances that can lead someone to become homeless or the health problems experienced by this particular cohort of patients. I got in contact with the Project LIGHT team here in Leicester who were kind enough to put together an elective experience that gave me wide exposure to various aspects of healthcare targeted at the homeless population. The broad range of experiences that I have been lucky enough to take part in have been eye opening and overall have provided a fantastic learning experience. I decided to write a series of reflections on topics that struck me during this elective placement. Each paragraph aims to highlight some of the key problems facing marginalised groups.

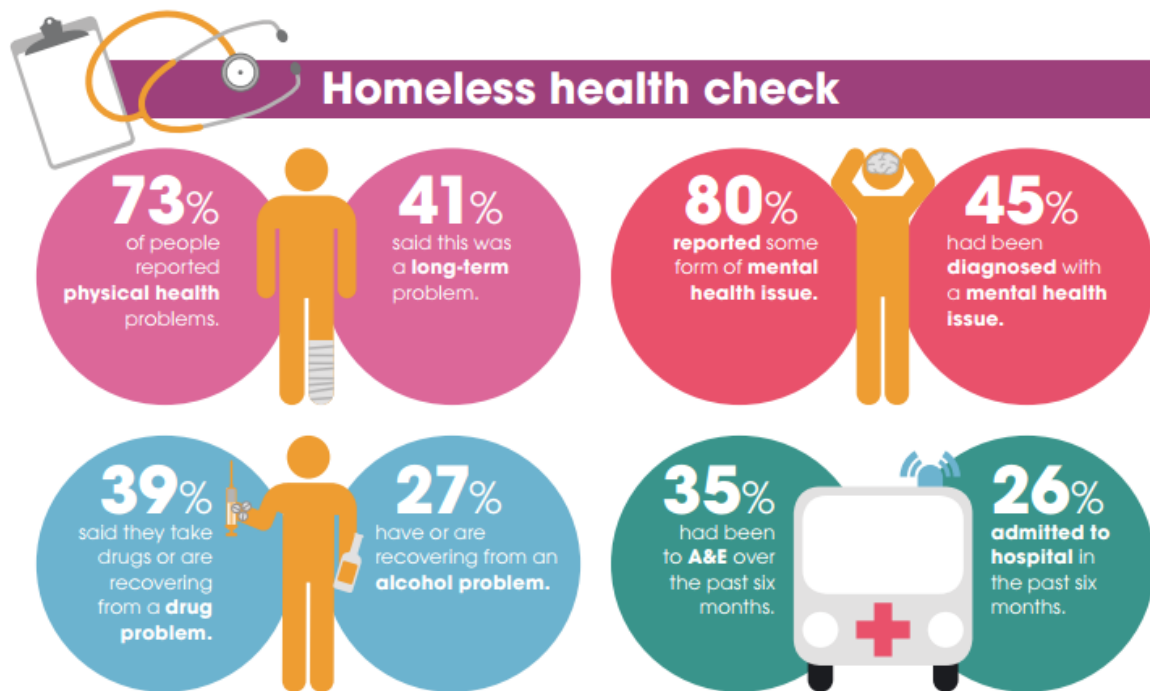
Inclusion Healthcare

Over the course of my elective I spent several days with the 'Substance Misuse Nurse and Director of Specialist Services' at Inclusion Healthcare here in Leicester. Inclusion Healthcare is a successful not-for-profit social enterprise which provides healthcare services for the homeless and other vulnerable groups. In what is effectively a nurse led clinic for homeless patients I saw a variety of presentations – topics covered included mental health problems and suicide, drug use, malingering, abscesses due to intravenous drug use, rashes, foot problems and other chronic medical conditions in homeless patients.

The experience I gained with Inclusion Healthcare was invaluable and gave me insight into the health problems facing the homeless. We discussed how difficult it can be ascertaining a patient's suicide risk and the need to ask very specific questions to judge the level of risk a patient is to themselves or others. I also learnt about techniques to manage a difficult patient with drug seeking behaviour, something that I have not had exposure to during my medical degree. I learnt about the various health services available to homeless patients in Leicester and how Inclusion Healthcare has grown over the years from what was effectively a one man mobile clinic where a single GP would take any available equipment and 'set up shop' in various places in the city for homeless patients to drop in and be seen. What shocked me

was the large number of charitable and third party healthcare services currently available in Leicester, I suspect they are more numerous than the general public realises.

It is known that homeless patients are more likely to have unhealthy lifestyles. Data from the Homeless Link 2014 audit which looked at 2,590 responses from people using services in 19 areas across England demonstrated that 77% of homeless people smoke, 35% do not eat at least two meals a day and two-thirds consume more than the recommended amount of alcohol each time they drink (1). Part of the executive summary from this 2014 audit is shown below, outlining some figures regarding the health problems facing homeless people (1).



Worse than the general public	Health issue	Homeless population	General population
Physical, mental and substance misuse issues remain prevalent among the homeless population and at levels that are much higher than those experienced by the general population.	Long term physical health problems	41%	28%
	Diagnosed mental health problem	45%	25%
	Taken drugs in the past month	36%	5%

‘Legal Highs’

Substance misuse is a significant problem facing the homeless population. During my elective I spoke to various healthcare practitioners about the advent of ‘legal highs’ and the burden they seem to be placing on services. Coming into this elective I knew very little about these so-called legal highs (also commonly referred to as ‘mamba’ and ‘spice’), this soon changed as I realised the huge proportion of homeless patients using legal highs and how

dangerous they can be. I remember being in A&E last year and seeing a patient come through Resus who was reported to have smoked a legal high and who quickly became unwell and lost consciousness. At the time I did not lend much of my time to learning about legal highs, however following this elective I have realised how relevant knowledge of the effects of legal highs is to my future practice. What is really terrifying is that these substances are so variable, they are generally a mixture of several compounds and it becomes extremely difficult to predict how one particular individual will react to such a drug. Moreover treating these patient is very challenging due to the fact that one can't be sure what chemicals are contained in 'legal high' packet; there are no antidotes, all clinicians can really do is provide supportive care and hope that the patient recovers with time.

I also learnt about the strain that legal highs seem to be putting on various services in Leicester including the police and acute medical services (due to reasons stated above). It is very difficult to police them as they are usually a mix of substances, although they are now being brought under the bracket of 'New Psychoactive Substances' (NPS) and under that guise policy is being implemented to make the sale of such substances illegal. The way retailers have, up to this point, circumvented policy is by writing 'Not for Human Consumption' on the packet of these newer 'designer drugs' (of course knowing that this will be ignored). This labelling means the vendor cannot be prosecuted as they are seen not to have control over the customer after the point of sale. This legal loophole has caused significant problems in terms of policing these substances. Hopefully, the updated 'Psychoactive Substances Act 2016' will have an impact on the amount of these substances available on the streets (2).

Charity vs Philanthropy

During my elective I attended a meeting with various public service personnel including police, fire-fighters, council and healthcare professionals. A topic that interested me was that of giving to people on the streets. A recent campaign was orchestrated by Leicester City Council to discourage people from giving money to people 'begging' on the streets. Police worked with De Montfort University and Leicester College students to produce a video to explain the campaign (3). The argument behind this was formed following research by Leicester City Council's homelessness outreach team which found that the majority of those who are seen regularly 'begging' on the street have roofs over their heads, alcohol or drug addictions and are receiving benefits. The argument appeared to be that giving to homeless people on the street may have low long term impact and may actually perpetuate people being homeless. Rather, it appears that donating to one of the many supporting organisations which help the homeless and those with substance addictions is a more

effective way to provide real support to these people and instigate real positive change. Predictably this experienced a sort of backlash from the public. As I stated earlier, I was surprised to learn about the level of support available to the homeless via third party organisations. I wonder if people realised this was the case they might be more inclined to give to these organisations. However I suspect that there are two main factors limiting this: 1. People are often not keen to give to charities for fear of their money being spent on administrative costs and wages meaning that little of it reaches the intended recipient, 2. There is an instant social reward intrinsic to giving directly to a person in front of you, this is not felt when giving to a charity. This really surprised me and I have to say that had I not seen with my own eyes the services provided here in Leicester I may have been inclined to share some of that apprehension associated with giving to charity rather than giving to people on the streets. It is a challenging idea and one which will continue to cause controversy in the eyes of the general public.

Substance Misuse – Clinics & MDT meeting

During one of my placements I observed a request to perform a medical review on a lady who was complaining of being 'off her feet' and dizzy. Before visiting this lady I was informed that she had been known to services for a long time and that she was showing physical signs of long term substance misuse. When we saw her she was emaciated and looked very unwell. What shocked me was that I felt she looked 20 years older than her actual age. She was a long term drug user and although she was receiving methadone she had not been to the pharmacist for the last few days to pick this up; she had instead been using heroin. Seeing this lady prompted me to learn about the long term health effects associated with heroin use which, aside from malnutrition which was clearly a factor in this lady's case, include: insomnia, constipation, various types of pneumonia, tuberculosis, sexual dysfunction, irregular menstrual cycles, addiction, infectious disease (e.g., HIV, hepatitis B and C), collapsed veins, abscesses, endocarditis, arthritis and other rheumatologic problems and liver and kidney disease (4).

I subsequently attended a substance misuse clinic which mainly comprised of patients who attended for reviews of their methadone prescriptions. I was surprised to learn how effective methadone can be and I met several patients who were very stable on a set dose of methadone. I also found it interesting learning about the different ways of testing for substance use and the length of time drugs stay in your system for. For example 6-MAM (a breakdown product of heroin) is an indicator of heroin use within the last day. Attending clinics and particularly an MDT meeting where we covered many patients with various

different types of substance misuse problems made me realise how substance misuse can be a problem for anyone, from all walks of life.

Attitudes towards Substance Misuse

Something that really captured my interest over the course of my elective was the differences in attitudes that people feel towards certain 'mind altering' substances. For example, I have many friends and colleagues who are heavily prejudiced against tobacco smokers, yet they will themselves go out on a Friday or Saturday night and drink over the recommended weekly limit in one sitting. I understand that these two behaviours are different in some respects but they are also very similar in others. The reasons for participating in these behaviours are often similar; to relax, wind down, relieve stress etc... I find it a little odd how one can be perceived to be morally superior to the other, particularly because we know that bingeing on alcohol can have dramatic health consequences and has a far greater social and economic impact compared to many other 'illicit' substances (5, 6). There is clearly some hypocrisy here. These clear biases towards certain substances were also present in the young male prison population that I spoke to during my visit to HM prison Glen Parva. Young offenders (18-25 years old) seemed to generally feel a strong dislike towards people who used opiates such as heroin and crack, so much so that they would use very derogatory language to describe these people. Despite this they would happily use many other substances such as cannabis and other NPS. This inconsistency of attitudes towards different substances is interesting and, judging by my discussions with colleagues, probably very common. Ultimately I think that we should aim to be more consistent in our attitudes towards substance misuse. Clearly some substances are more dangerous than others and this should be taken into account but we should be wary of being hypocritical when it comes to forming opinions based on someone's use of a particular substance.

Addiction & Free Will

I have for a long time struggled with the idea of free will. Believing or not believing in free will has important implications for one's attitude towards health related behaviours. This is of course central to the debate surrounding addiction; in one camp you may have someone who views a substance user as wholly responsible for their situation, having made the 'decision' to start using substances in the first place. However I suspect that the majority of the medical profession does not see substance use/misuse in this very black and white context, rather most I have spoken to realise that there is often a complex set of bio-psycho-social circumstances that can lead to someone engaging in potentially health damaging substance use. However if you take the view that one does not really have free will at all, rather every decision we make is a consequence of an infinitely complex set of

circumstances and prior environmental and genetic pre-conditions that lead to that decision, you cannot really accept that someone's substance use is their choice at all. In other words you cannot lay any blame at the foot of someone with a substance misuse 'problem' or even someone who participates in any health damaging behaviour (e.g. overeating, smoking, binge drinking etc...) in general. This 'complete lack of responsibility for lifestyle choices and health related behaviours' viewpoint is an extreme one and is something I will no doubt continue to reflect on during my future practice when I am looking after patients who's health related behaviours have contributed to their medical problems.

Outreach, Engagement and Entitlement to Support

During my time with Inclusion Healthcare I was able to go out with the early morning outreach team to speak to and engage rough sleepers in the city. It was great to see that this service was provided and how effective the team was. I was surprised to learn that there were only around 25-30 rough sleepers estimated to be present in the city currently. The figure for homeless people overall is likely to be much higher but this is more difficult to estimate. The key principle behind the outreach team is engagement. The outreach team can encourage homeless people to engage with healthcare services, provide help with benefits, work and housing, signpost to voluntary and charitable organisations who provide clothing and food parcels. I also learnt about how to be entitled to certain forms of housing support from the local council you need to have a 'local connection'. For example you need to have lived in the area for six months out of the past twelve, or three years out of the past five or you must have close family who have lived in the area for at least five years to be defined as having a 'local connection'.

I also got the chance to spend some time with the 'Revolving Doors' service who talked to me about how they help to house people who have been evicted from tenancies multiple times due to various reasons with the ultimate goal being to keep people in a stable tenancy. I also learnt about the many social problems associated with being homeless which other than lacking personal shelter, warmth and safety include difficulties with:

- personal security, quiet, and privacy, especially for sleeping
- safekeeping of bedding, clothing and possessions
- hygiene and shaving facilities, cleaning and drying clothes
- keeping contacts, without a permanent location or mailing address
- access to education, health care and dental services
- risk of suffering from violence and abuse
- rejection or discrimination from other people
- not being seen as suitable for employment

- access to banking services or communications technology

The factors listed above highlight the importance of housing and the need to support people as much as possible in maintaining tenancies. I learnt about how difficult this can be for some, particularly in the context of mental health problems and/or substance misuse problems. I spent a few days with the Action Homeless team who let me sit in on support sessions and help serve food and talk to residents. All of which provided me with useful insight into the services provided and the various forms of support available to residents. I was interested to hear about the 'no second night out' initiative that was being run which seeks to ensure that no one spends a second night sleeping on the streets of Leicester (7). To do this the project aims to provide a more efficient service for rough sleepers by ensuring that they are linked with accommodation and support services as quickly as possible.

Police & Mental Health Street Triage Car

My time with the 'Police and Mental Health Street Triage Car' service has been very interesting. The service is collaboration between Leicestershire police, Leicestershire Partnership NHS trust and Leicester probation service. A mental health practitioner works together with a police officer to provide on the spot advice to other police officers who are dealing with people with possible mental health problems. The aim is, where possible, to help police officers make appropriate decisions, based on a clear understanding of the background to these situations in order to provide appropriate care more quickly, leading to better outcomes and a reduction in the use of section 136 of the Mental Health Act. The service has been very successful here in Leicester and other police forces have developed similar services as a result (9, 10).

Project LIGHT Health Promotion Sessions

Over the course of my elective I delivered two Project LIGHT health promotion sessions at a facility based at Action Homeless. My first session was titled 'Healthy Eating on a Budget' and the second was 'Art and mental health'. I really enjoyed delivering these sessions as it gave me creative license to do what I wanted in terms of structuring the sessions and the content. I was slightly nervous in the lead up to the sessions as I didn't know quite what to expect however both went well overall and I received positive feedback from the attendees. I realised that simplicity was key in terms of talking about healthy eating and positive reinforcement was useful throughout the sessions. Both sessions had two attendees which was nice in the sense that it meant I could focus my attention and tailor the session more closely to the attendees which wouldn't have been possible with a larger group. I particularly

enjoyed exploring the relationship between art and mental health, a topic I will continue to explore over time.

Final Remarks

Overall I really enjoyed my elective experience, there are so many learning points that I will take forward in both my future practice as a doctor and in life in general. The placement has given me a great insight into the complex bio-psycho-social factors that both contribute to and result from homelessness. I have developed a greater understanding of the impact of mental health illness on this population and the interplay between substance misuse and mental health. Hopefully, these experiences will enable me to better support patients with mental health problems, substance misuse problems and other chronic medical problems commonly seen in this patient cohort in the future.

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