HIV and Homelessness
The double whammy of exclusion

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Outline

- Context I work in – London and Great Chapel Street
- The Picture at our Practice
- Key points for clinical practice
- Case study discussion Q+A
London Homeless Statistics

- 64% increase in rough sleeping (2010/2011 – 2013/2014)
- 54% of rough sleepers not UK born (2013/2014)
- 90% projects report clients being benefit sanctioned (2015)
- 6% reduction in hostel bed spaces (2013 – 2014)
- 54% of attendees to a specialist GP clinic turned away by mainstream GPs (2012)
- 75% of pregnant women attending project London had passed 10 weeks without referral to antenatal care (2013)

- Westminster has highest number of rough sleepers in Europe based on CHAIN data.
Support need of rough sleepers CHAIN 2014 data

Support needs of people seen rough sleeping by outreach services.

<table>
<thead>
<tr>
<th>Support Needs</th>
<th>No. people</th>
<th>% of people seen rough sleeping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol only</td>
<td>59</td>
<td>7%</td>
</tr>
<tr>
<td>Drugs only</td>
<td>33</td>
<td>4%</td>
</tr>
<tr>
<td>Mental health only</td>
<td>114</td>
<td>13%</td>
</tr>
<tr>
<td>Alcohol and drugs</td>
<td>31</td>
<td>4%</td>
</tr>
<tr>
<td>Alcohol and mental health</td>
<td>59</td>
<td>7%</td>
</tr>
<tr>
<td>Drugs and mental health</td>
<td>39</td>
<td>4%</td>
</tr>
<tr>
<td>Alcohol, drugs and mental health</td>
<td>66</td>
<td>7%</td>
</tr>
<tr>
<td>All three</td>
<td>158</td>
<td>18%</td>
</tr>
<tr>
<td>All three not known or not assessed</td>
<td>292</td>
<td>33%</td>
</tr>
<tr>
<td>All three no, not known or not assessed</td>
<td>34</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>885</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Base: 593. Note that the base figure for this chart excludes clients where all three support needs are not known or not recorded (292)
Great Chapel Street History/ Model

- Longest running homeless GP service in Europe
- Founded in 1978
- One stop shop model plus assertive outreach and case management.
- Weekly MDT every Tues am with invited partner organisations eg St Martins/St Mungos/JHT/ Turning Point/ social services etc to discuss patients.
What services are available as walk in at the practice?  (clinic hours for patients Mon –Fri 10-5)

- GP and Practice Nurse/Nurse Practitioner every day
- CNS Mental health/substance misuse every day
- Benefits/legal/debt/housing NRPF advice and support from our in house lawyer every day
- Psychiatrist all day Tues 2 sessions – appointment based referral via CNS
- Drop in Counselling 4 sessions per week
- Dentist Tues and Thurs appointment based but will do emergencies
- Podiatry Fri AM
- Hep C Rx bi monthly clinic with CNS
- 56 Dean St HIV/Hepatology Consultant Screening monthly – last Fri of the month pm
GCS Clinical Services provided beyond practice premises

- *Twice weekly* (more in winter) Nurse led Targetted Outreach: work with third sector/mental health outreach/focus on engagement. Visits on streets, nightshelters various
- *Weekly* Women’s Outreach Clinic in Women only day Centre
- *Ongoing* Nurse led Case Management supported by peer advocacy and third sector support
- Training: when requested: A+E teams, outreach teams etc
Who do we see?

- Commissioned for Homeless (hostel/rough sleeping) in Westminster.
- Rough Patient Demographics
- 20% New asylum seekers/NRPF Sub-saharan Africa. Many have left detention/arrival accommodation where care was poor (they access Notre Dame refugee centre and are directed here or Medicins du Monde/Red Cross refer)
- 80% Entrenched Rough Sleepers/Hostel Population with ETOH/IVDU and/or Mental Health Problems
- Estimate 70% Practice population have ‘Complex Personalities’
HIV in Central London and homelessness

London has the highest HIV infection rates in Europe according to the literature; an estimated 1-in-8 gay men in London have HIV [5].

It should, however, be acknowledged that surveillance and testing here is more freely available than in much of the rest of Europe, so it may be that there is a more accurate picture of the problem. In Dublin, a sexual health screen typically costs at least 80 euro, and in Athens it’s unlikely to be available other than privately at a similar cost, if available at all at present.

Public Health England (2014) [5] estimates that 24% of people infected with HIV are unaware of their infection.
HIV at Great Chapel Street

Our practice prevalence of HIV is much higher than the national prevalence of 2.8 per 1000 [5]; given we have 32 known of 900 permanent registrants, which would scale up to nearly 36 per 1000 or 3.6% of the practice population. Put another way 12x the national prevalence!

Distinct demographic groups and behaviour patterns which reflect the wider demographic profile of HIV infection in the UK (PHE 2014)
Mortality; risk and demographics

### Table 1: Homeless mortality data

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
<th>Both sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean age of death</td>
<td>Median age of death</td>
<td>Mean age of death</td>
</tr>
<tr>
<td>General population</td>
<td>74</td>
<td>77</td>
<td>80</td>
</tr>
<tr>
<td>Homeless population [3]</td>
<td>48</td>
<td>47</td>
<td>43</td>
</tr>
</tbody>
</table>

### Table 2: HIV infection, risk behaviour and demographics

<table>
<thead>
<tr>
<th></th>
<th>Gender</th>
<th>Migrant from sub-Saharan Africa</th>
<th>Engaged in Rx</th>
<th>IVDU</th>
<th>MSM</th>
<th>Sex working</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>27</td>
<td>0</td>
<td>17</td>
<td>9</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td>Female</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td></td>
<td>5</td>
</tr>
</tbody>
</table>

MSM: men who have sex with men; Engaged in Rx: engaged with HIV team (from clinician’s perspective); Sex working: exchanging sex for money or other things, e.g., drugs or bed for the night; IVDU: intravenous drug use.
Data sources and reliability/validity

- Brief retrospective analysis of electronic case notes at the practice.
- Diagnosis based on mixture of self report/BBV test; likely underestimate
- Necessarily limited in terms of the wider conclusions that can be drawn; given known documentation variance between clinicians; multiplicity of Read codes
Demographics and behaviours

- MSM $n = 13/15$ or 86.7% sex working, wide variety of backgrounds, mainly UK
- S.S African women $4/5$ or 80% of women, all engaged in treatment,
- All women sex working, all have history of sexual assault and trauma
- Non engagers in treatment $n=11$ of sample IVDU $n=10$: 90% non engagers are IVDU
Substance Misuse

- IVDU usually a mixture of crack/heroin  \( n=10/32 \) of sample but **not whole picture of drug use**
- **Club drugs and Chemsex issue for all MSM in sample**
- **Chemsex** parties can last for days, may involve strangers and multiple partners, and can include higher risk sexual practices. It is not usual for injecting equipment to be shared as part of the experience. Unprotected sex is common and deliberate risk-taking is part of the experience
Clinical Approaches to Resolving Chaos

**Case management** bedrock of providing care; facilitates case finding and planning. Early case conferences!

**Caseload** focus on complex needs and high demand on services. Provide management overview and liaise with all services involved.

**Networking** – get to know local HIV teams, work together.
**Case Management**

*Figure 1: Typical teams with whom I liaise during case management of a single patient.*

A&E, Accident and Emergency; CSTM, Connection at St Martin’s; JHT, Joint Homelessness Team; LAS, London Ambulance Service; SFTS, Shelter from the Storm; WLDC, West London Day Centre.
Meet people where they are, not where you want them to be

- Patients priorities often radically different than from a clinician’s perspective
- Focus on their priority and then work towards clinical goals

**Often high levels of risk** that you may have to accept/get advice about – importance of MDT

For example

- Impulsive self harm,
- Self neglect of significant physical health problem
- Harm from others
Rules of Engagement

- Meet someone where they are at
- Address current needs
- Focus on the relationship, not treatment.
- Keep showing up
- Share some of self
- Extend traditional boundaries
- Accept hospitality
- Stay humble

- View client as person not patient
- Instil hope
- Let client educate you: they are the expert
- Focus on persons strengths
- Compromise
- Remember engagement is not a linear process
- Seek supervision/consultation
- Don’t give up on anyone

Taken from my notes at ISMS10 workshop Dublin 2014 multiple contributors
Case 1: Mr JB

- Presented to us September 2012. Previously known in 2006
- On methadone
- IVDU incl large veins, crack, benzos
- Alcohol dependence
- HIV diagnosed via A+E in 2013, HCV +ve also
- History of drug-induced psychosis
- DVT, anaemia, peripheral oedema
- Loud, demanding, rude, abusive. Banned from local chemists.
- Multiple A&E attendances
Case 1: Mr JB

- Challenges
  - Addressing physical health concerns
    - Blood Borne Virus – too chaotic for ART, low CD4 sharing sharps HIV and HCV co-infection
    - Concordance with medications
    - Leg ulceration and worsening oedema
    - Concerns over mental state / capacity / memory
    - Needed Admission but was more focused on getting next giro.
    - Conflicts of agendas between healthcare practitioners and patient
What we did

- Multiple MDT’s from early stages.
- Chose our treatment goals together
- Harmonised ART, methadone and other drugs into one supervised collection from pharmacy (challenging 3 different prescribers (HIV, Drugs Service, GP))
- Hung in there…
Case 1: Mr JB

- **Outcome**

- Prolonged admission to hospital
- Improvement in physical health
- Stabilisation of substance and alcohol use
- Care Package
- Placement in residential nursing care in Somerset
Questions?
References


References 2


