

Expert testimony to inform NICE guideline development

Section A: Public Health and Social Care team to complete	
Name:	Dr Mary Hickey
Role:	GP
Institution:	The Dr Hickey Surgery for the Homeless
Contact information:	
Guidance title:	Severe mental illness and substance misuse (dual diagnosis) - community health and social care services
Committee:	Public Health Advisory Committee- B
Subject of expert testimony:	<i>Dual Diagnosis among Homeless people- primary care perspective.</i>
Evidence gaps or uncertainties:	[Research questions or evidence uncertainties that the testimony should address are summarised below]
	Physical health needs of people with dual diagnosis

Section B: Expert to complete

Summary testimony: [Please use the space below to summarise your testimony in 250–1000 words. Continue over page if necessary]

In 1987 I opened the surgery in central London to offer full Primary Care medical services to the adult homeless population in Westminster. It is estimated that between 2011 and 2014 the numbers of rough sleepers alone ,in London ,rose by 64% to around 4000 – 6500 , (1) of which the highest number are in Westminster. Also Westminster was rated as the 10th highest area for mental health need in the country.(2)

ARGUABLY in terms of health, wealth ,employment and life-span ,if the homeless were a country rather than an underclass, they would be one of the poorest nations on earth, living between the palaces of Buckingham and Westminster.

The surgery team consists of a partner plus 2 other doctors, 3 nurses ,receptionists and data-base clerks .We have a mental health team of a psychiatrist, psychologist, a general counsellor ,a drug and alcohol counsellor , a psychiatric liason nurse and a homeopath.

A very comprehensive history is taken by the nurse with basic tests of blood pressure , weight BMI , general urine screening and ,if appropriate, for illicit drugs . Blood tests are offered as part of a general health check and we have low tolerance for requesting chest Xrays .

NUMBER of PATIENTS:

Male 1474 83% Female 309 17% Total 1783

The demographics change every few years with latest influxes from war-torn African countries and EU nationals .Many do not speak English, have no access to benefits .

ACCOMMODATION

Hostel 20%

No fixed abode 60%

Other 20.% (sofa-surfing, in squat , B&B)

ETHNICITY

White British/Irish 50%

White European 30% (EU countries)

African 12% (Mainly from Somalia, Eritrea, Ethiopia)

Afro-caribbean 5%

Asian 3%

Chinese 0.2%

INCIDENCE of Mental Health

Drug misuse 16%.

Alcoholism 40%

Schizophrenia 11%

Severe depression/ anxiety 22%

Bipolar Disorder 9%

Personality Disorder – estimated to be in the region of 70 -80%.

Dual Diagnosis- estimated at 40%

In addition there are a few with Gambling problems, Eating disorder, Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder and Obsessive Compulsive disorder.

We have 283 addicts on a methadone or buprenorphine programme, always with a view to reduction/detoxification, mostly as an outpatient due to difficulties accessing inpatient facilities. Most have used category A drugs, heroin and crack cocaine, as well as cannabis, and more recently Legal Highs. There is now a street demand for Pregabalin as it is getting harder to access diazepam. Many have turned to crime to fund their habits or beg which is illegal in Westminster.

There is a high incidence of violence, self-harm, overdose, suicidal attempts and deaths especially in dual diagnosis. Also in this category there are high rates of relapse, hospitalisation, imprisonment, unemployment and poor compliance with medication.

It is important to try to get the correct diagnosis of a primary mental health illness as this and substance misuse is separate illnesses each needing its own treatment plan. But this can be challenging as drug and alcohol abuse itself can induce psychotic symptoms. Because of this we have no definitive figures for dual diagnosis but would suggest it is about 40% .Some are reluctant to admit psychotic symptoms or that they have a mental health problem. Many refuse to see the psychiatrist or the Psychiatric Liaison Nurse.

MEDICATION :

If we cannot fully identify the problem then we have been advised to treat the symptoms. We try to prescribe from a set group of medicines. We do not prescribe diazepam or sleeping tablets.

Schizophrenia – Olanzapine , Aripiprazole , Quetiapine, Risperidone

Depression – Sertraline / Citalopram.

Anxiety – Propranolol .Very rarely Pregabalin if suggested by the psychiatrist.

Mood stabiliser – Carbamazepine / Lamotrigine

Insomnia – Mirtazapine / Promethazine

Pain – Paracetamol / NDAIDS / Nefopam/ Gabapentin/Pregabalin

Methadone or Buprenorphine – daily pick up and supervised consumption.

Alcohol detoxification – Chlordiazepoxide.

Food supplements - for those with a BMI of under 18

PHYSICAL HEALTH NEEDS: (3)

- Undernourishment, obesity, low vitamin D.
- Diabetes
- Abscesses, cellulitis.
- Leg ulcers which can take months of treatment and dressings.
- Infection and gangrene from injecting drugs resulting in amputation.
- Deep vein thrombosis, pulmonary embolism.
- Respiratory infections, Chronic Obstructive Pulmonary Disease relating to smoking and crack abuse. Tuberculosis.
- Septicaemia & multi-organ failure.
- Endocarditis .Circulatory disease.
- HIV.
- Hepatitis C. (There are very few cases of Hepatitis B due to the good immunisation programme).
- Alcoholic gastritis, hepatitis, cirrhosis, liver failure.
- Acute & chronic pancreatitis.
- Cancer, especially lung and liver.
- Prenatal effects- especially foetal defects, still birth.
- Premature death – in 2015 there were 13 deaths of which 10 had dual diagnosis. Average age of death was 47 years.
- Poor attention to their physical and mental health needs as their main agenda upon registering is to obtain scripting for substance misuse and/or a medical certificate to claim benefits.

LINKS TO OTHER COMMUNITY SERVICES:

- We can refer into the Drug and Alcohol Dependency Unit (Turning Point) if a patient requires inpatient referral for detoxification and/or rehabilitation.
- Single Point of Access run by CNWL offers a phone triage which can be accessed for acute and chronic mental health problems and an appropriate referral pathway arranged.
- The local mental health teams provide an assessment and brief intervention service as well as assessment for the elderly,
- Memory loss and dementia. They are cautious about seeing those with dual diagnosis.
- Those with learning disability are referred to the Westminster Team.
- Community services are provided for anticoagulation, cardiology, dentistry, dermatology, diabetes, hepatitis C, physiotherapy, phlebotomy, podiatry and radiology.
- The Joint Homelessness Team offers assessment and treatment for those with mental health problems but will rarely accept those with severe dual diagnosis.
- The Waterview Centre provides counselling for personality disorder.
- Refugees can be referred to the Forced Migration Trauma Service and there is a local Migrant Resource Centre.
- There is an assessment service next door which provides housing, immigration and legal advice.
- For those with a language barrier we can access Google Translate,

interpretation by telephone or a face-to-face booked interpreter.

HOW IS THE SERVICE CONFIGURED TO MEET THE LOCAL NEEDS?

- We do not have an appointment system .Patients have immediate access to general medical services, 99% being seen by the nurse & practitioner on the day they attend.
- Addicts have immediate access to address their substance misuse needs as we provide 16 clinics a week run by a doctor trained in substance misuse and a drug counsellor.
- Because we have so many clinics we can see patients often especially when titrating or detoxing.
- After careful assessment we provide some alcoholics with a community detoxification using chlordiazepoxide. We exclude those who are chaotic, drinking very heavily or have a history of withdrawal fits. They are required to attend the surgery daily for medication and breathalysing and must be in hostel accommodation so there is some supervision by the staff.
- They can be seen by the same doctor or counsellor who can get to know them.
- We use a group of local pharmacists who also get to know the patients and will contact us if they miss pickups of medication .
- We have rapid access to a hepatologist. We have 157 patients (9%)who have active infection with Hepatitis C. There are now excellent drugs to treat Hepatitis C and the take up and compliance for treatment is good.
- We have easy access to HIV clinics and 27 patients (1.5%) who are on treatment . There would be more cases but many patients refuse blood tests.
- Patients can self-refer to podiatrists and dentists in 4 homeless centres in Westminster.
- Long-term patients are visited in hospital.
- One doctor visits 2 prisons and a high dependency hostel weekly.
- A doctor and the Practice Administrator do monthly outreach at night to connect with the homeless and encourage them to attend for medical care. They liaise closely with other homeless services that can assist with accommodation, benefit and legal problems.
- Our outreach nurse visits the high dependency hostel 4 times weekly and arranges dosset boxes for medication. She does dressings and heath checks, reminds them of appointments and may take them there. She also visits other hostels as necessary.
- We have access to 10 intermediate beds in 4 local hostels. These are for homeless patients ready for hospital discharge but still need some care which cannot be provided while roofless. They are allowed to stay for 6 weeks. There is no requirement for benefits or recourse to public funds.
- We provide free tea and sandwiches which can have a marked calming effect on those with mental health problems and homeless who are often starving and dehydrated. We also keep a stock of clothing and bedding.
- We have 3 staff members who can offer interpretation in French, Spanish and Phillipino.
- Groundswell (a charity with peer advocacy) will accompany patients to the surgery, appointments at hospitals or courts and pay the fares.

- Patients have access to Out of Hours services.

WHAT WORKS WELL :

- We believe our availability and flexibility are essential in helping the homeless to access medical services rapidly & effectively.
- We have medical & counselling staff trained in substance misuse allowing rapid access to addicts to address their needs.
- Long serving staff and pharmacists who get to know the patients and can alert us if behaviour or compliance is deteriorating.
- The mental health team, doctors and nurse meet every month. Sometimes it includes staff from other agencies regarding eg accommodation or refugee status, whose input could be helpful.
- We are increasingly using electronic prescribing to reduce lost and stolen prescriptions and frequently issue medications on a weekly basis to reduce overdoses.
- The Integrated Care Network providing the intermediate beds with cross sector multi agency working has been a great success.
- There is close cooperation with hostels, outreach workers and other homeless centres. The Homeless Health Team frequently refer patients to us and there are proposals regarding providing GP services at their centres.
- The Patient Participation Group was formed in 2015 .
- The Care Quality Commission rated us as OUTSTANDING.

WHAT COULD BE BETTER :

- One of the greatest needs in Westminster is for more hostel beds and housing accommodation. In recent years two hostels closed losing over 150 beds. Charities providing night shelter and NSNO (No Second Night Out) are very helpful but are insufficient to cope with increasing numbers.

- More effort should be made by mental health teams and homeless services to engage, diagnosis, prescribe and support those with dual diagnosis. There is a dearth of psychiatrists and general practitioners who are fully trained in substance misuse. Our in-house psychiatrist is able to see only a small percentage of patients due to restrictions on time and space.

-It would be very helpful to have referral rights into detox and rehabilitation centres as it can take many months for patients to access these services.

-The Drug Dependency Unit and some of the homeless centres will not accept those who have no verified connections with Westminster .Many also have no access to benefits but are living on the streets in Westminster. As a result they turn to crime. More communication and cooperation from these services and the Council would be appreciated.

- Making or keeping hospital appointments can be very difficult for those with mental health / substance misuse problems who have no address, no phone, no computer and little money for fares. Making use of Choose & Book has enabled better compliance.

Self-discharge from hospital is not uncommon and hospitals will evict those who are persistently abusive, uncooperative or abusing drugs. Expansion of peer advocacy programme which focuses on patients in hospital may improve relationship,

understanding and co-operation.

We allow patients to use the surgery address for mail which can offer some help with non-attendances.

- Could we make more use of prison doctors and psychiatrists who see patients - a captive audience, but we never get reports? Also time in prison could be made more useful by detoxing the inmate.
- Quite often prisoners are released from prison on a Friday, some as far away as Scotland. They are given methadone for that day only. They may need antipsychotic or antidepressant medication as well as methadone for the weekend. By the time they arrive in the capital and cross London the surgery is closed forcing them into crime to buy drugs. This is not uncommon.
- Prison communications could be improved. One letter omitted the dose of methadone and to say they had prescribed clonazepam and pregabalin while in prison. It was impossible to get through to the prison health team by phone and my fax was replied to after 3 days.
- Despite a letter to the prison Governor, our request to release a patient a day earlier to let him attend 2 urgent hospital appointments, one for possible cancer, was refused.
- While we make every effort to reduce methadone and buprenorphine and try to aim for patients being free of drugs, some, especially long term and older users, may need lifelong maintenance to sustain stability and should not be forced or stigmatised.

OTHER VULNERABLE GROUPS:

-The elderly – we have 29 people over the age of 65 ,the eldest 80 years old .One has dual diagnosis (bipolar + alcohol) , 7 have alcohol problems and 6 have severe mental health problems. Two have advanced cancer. The elderly are given priority for accommodation. Alcohol counsellors and mental health workers visit the hostels or homes of those who are housed. Trinity Hospice provides excellent care and staff support for those wishing to die in a hostel.

-Sex Workers – we have three female patients, all drug addicts and one an alcoholic who attends erratically. Two have dual diagnosis due to schizophrenia and personality disorder .All are roofless and there is very little suitable accommodation available for women in Westminster. One is vulnerable with possible learning difficulties but unwilling to attend for assessment. A safeguarding application has been made.

There is a women's organisation in another borough that provides support and accommodation for sex workers but they declined to see them because of their mental health problems and chaotic state.

We have offered counselling at the surgery and stressed the need for a health check especially for sexually transmitted diseases.

-SEXUAL ABUSE – all are offered counselling at the surgery with a female counsellor and referred to our in-house advice centre if they wish to have legal aid. Known paedophiles are monitored by Jigsaw and we may be invited to meetings.

-PEOPLE TRAFFICKING – In line with NRM (National Referral Mechanism) as a first responder we have an allocated number available which we have found very helpful.

References to other work or publications to support your testimony (if

applicable):

- 1) Homeless Monitor-England Feb 2015 Fitzpatrick,Pawson,Bramley,Wilcox and Watts.
- 2) Understanding Social needs in Westminster.Findlay, Yeowart and Kail 2012.
- 3) Medical Consequences of Drug Abuse National Institute of Drug Abuse USA

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