Supporting an elderly homeless population:
Palliative care and Frailty
Erasmus project April 2023

Dr Caroline Shulman

Clinician and researcher in inclusion health

Honorary Senior Lecturer UCL, Pathway Clinical Research Fellow

Caroline.Shulman1@nhs.net @carolineshulman

OAK FOUNDATION

pathway Healthcare for homeless people

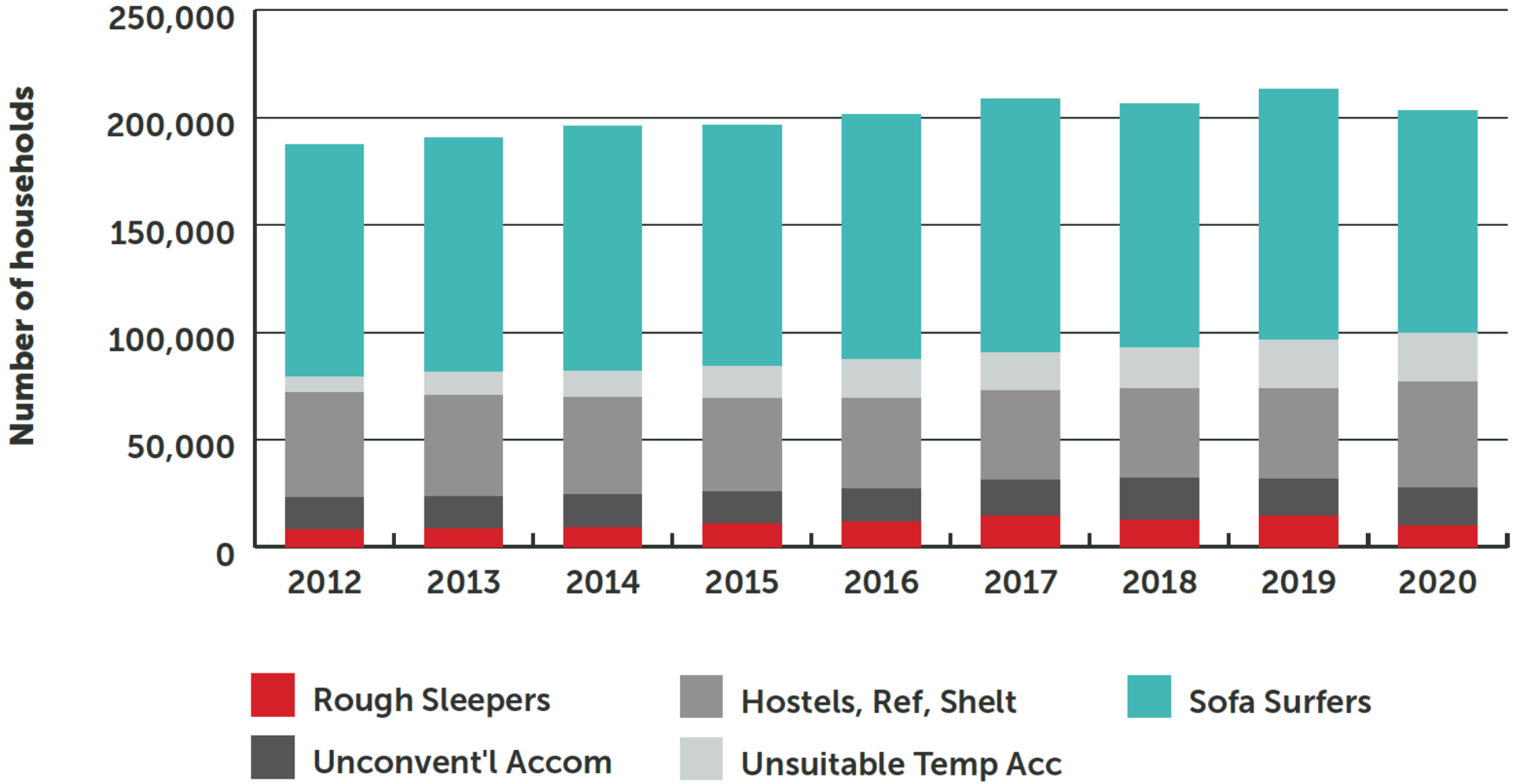
Marie Curie Care and support through terminal illness

UCL

Today's Talk

- Homelessness and health background
  - Complex trauma / adverse childhood experiences
  - Trimorbidity
  - Long term conditions
  - Barriers to health care
  - Premature mortality
- Frailty
- Palliative care
- What's needed
  - Trauma informed inclusive services
  - Recognition of frailty and palliative care needs
    - re framing approaches
  - Multiagency support
- Tools that can help

Homelessness estimates by category – England 2012-2020



The homelessness monitor: England 2022, Crisis

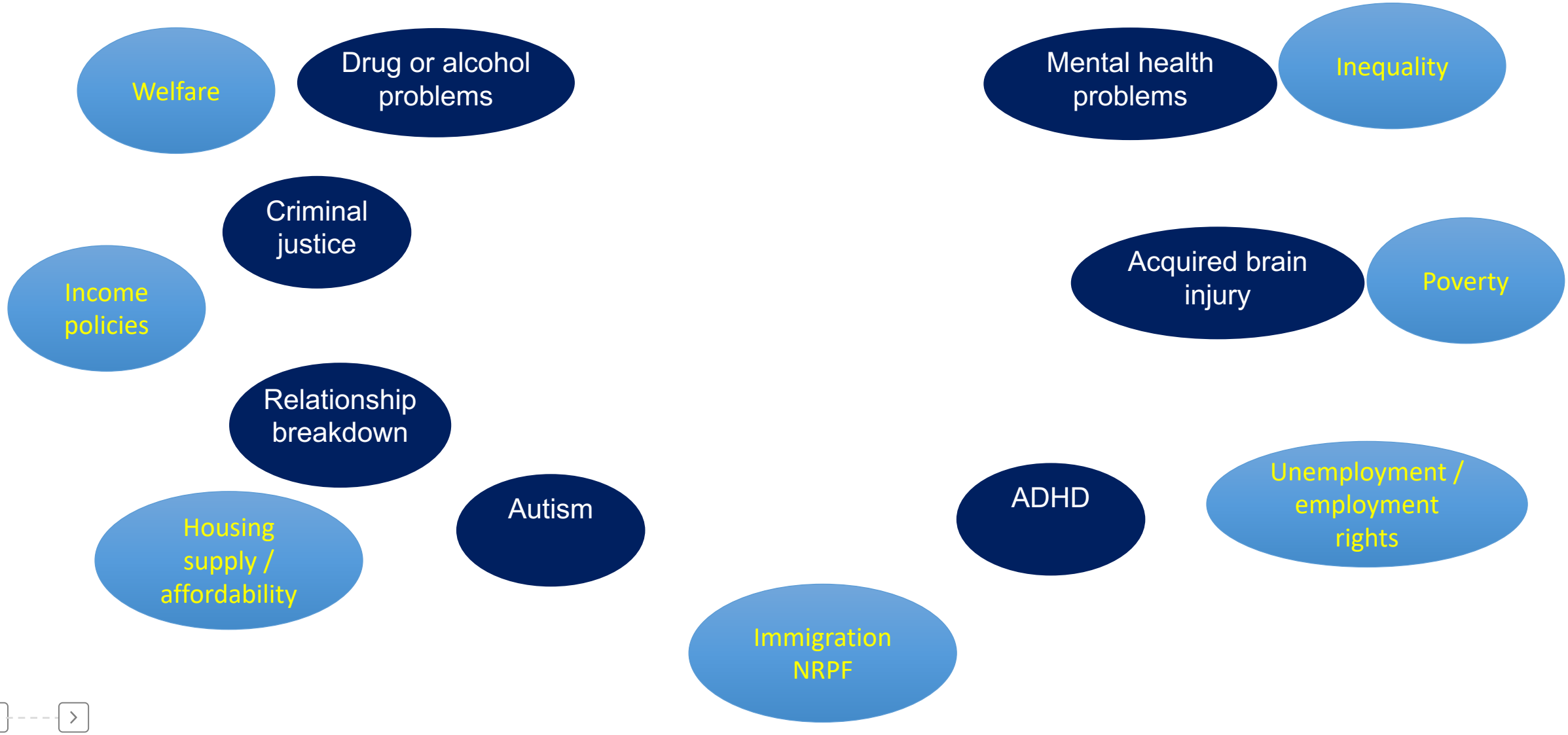
Beth Watt's, Glen Bramley, Hal Pawson, Gillian Young, Suzanne Fitzpatrick & Lynne McMordie

Risk factors for homelessness

Many routes to homelessness – Structural and social causes

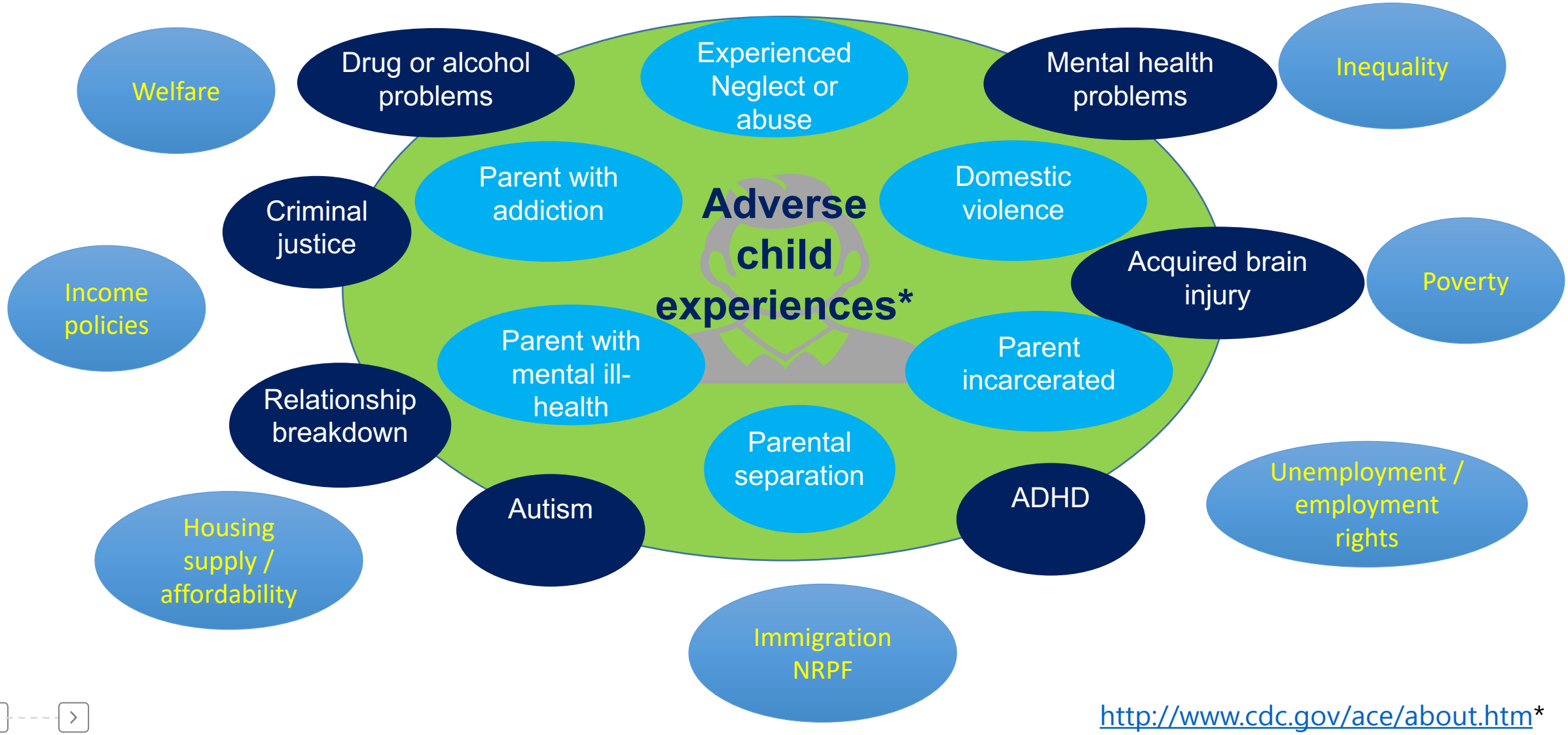
Risk factors for homelessness

Many routes to homelessness – Structural, social, life events and individual vulnerabilities



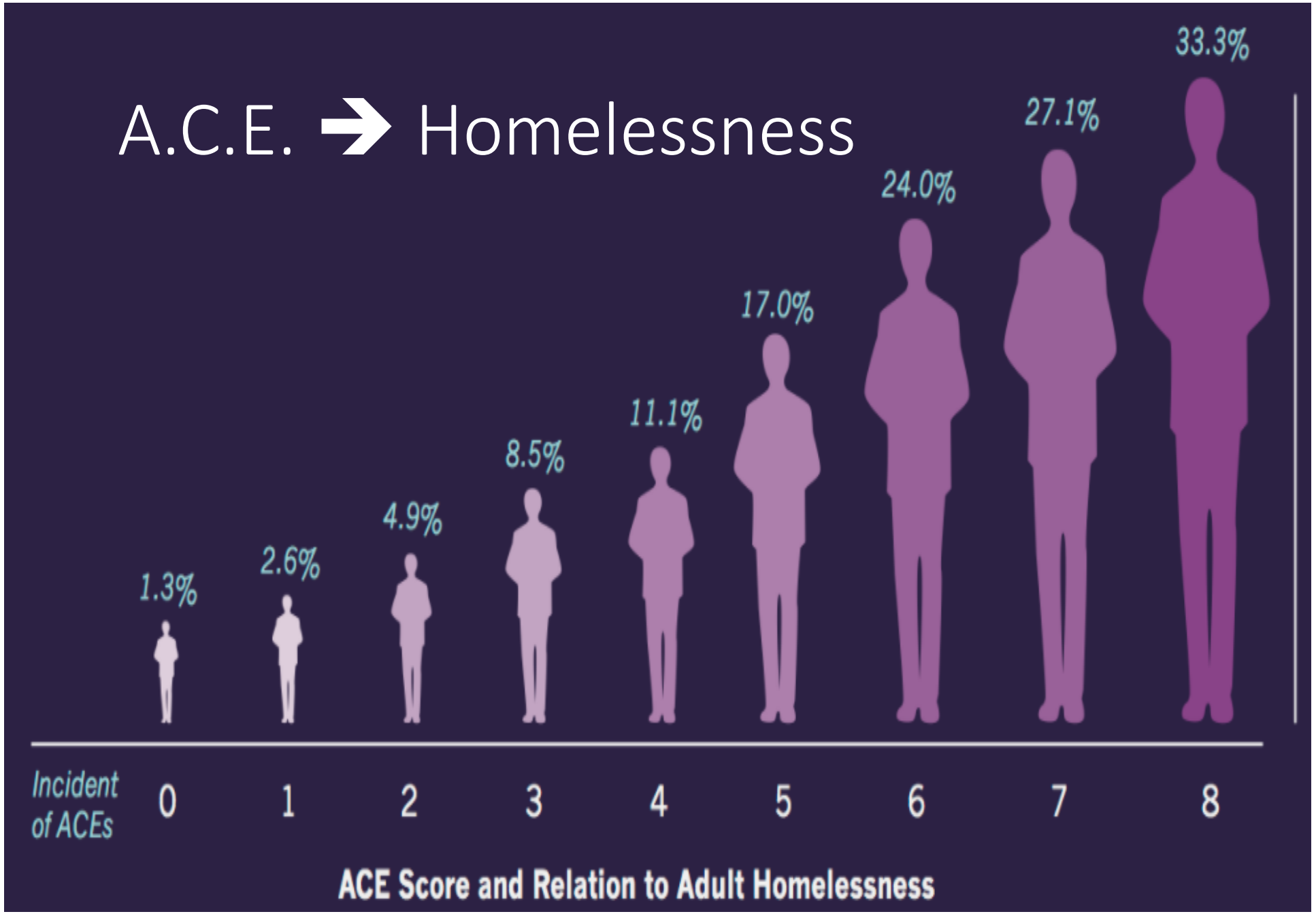
Risk factors for homelessness

Many routes to homelessness – Structural, social, life events and Individual vulnerabilities



http://www.cdc.gov/ace/about.htm*

A.C.E. ➔ Homelessness



Multiple exclusion homelessness

Definition of multiple exclusion homelessness:

- Homeless in addition to *one or more* of the following domains of 'deep social exclusion':
  - institutional care (prison, local authority care, mental health hospitals);
  - substance misuse
  - participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work).

Fitzpatrick, S., Johnsen, S., & White, M. (2011). Multiple Exclusion Homelessness in the UK: Key Patterns and Intersections. *Social Policy and Society, 10*(4), 501-512. doi:10.1017/S147474641100025X

Complex Trauma and Multiple exclusion homelessness

85% of people with experience of homelessness + substance use + contact with criminal justice had experienced childhood trauma.

http://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf

Pictured: Young man experiencing street homelessness, taken from 'Less?' film.

Childhood trauma / Adverse Child Experiences / Social exclusion

Adverse child experiences my impair the development of stable attachments which can have profound long lasting effects

Our attachment relationships are thought to be crucial for:

- Developing **knowledge** – an understanding of ourselves, other people, the world around us
- Developing **skills** – how to self-soothe, what are the appropriate behavioural responses to various situations etc
- **Protecting** us from everyday stresses

FEANTSA: European Federation of National Organisations Working with the Homeless, 2017. Recognising The Link Between Trauma And Homelessness, Brussels: FEANTSA
Herman, D. B., Susser, E. S., Struening, et. al 1997: Adverse childhood experiences: Are they risk factors for adult homelessness? American Journal of Public Health, 87(2), 249-255.

pathway
Healthcare for homeless people

Childhood trauma / Adverse Child Experiences / Social exclusion : Impact on adults

Following trauma, body may react as though it's threatened or in danger, even if initial threats have gone

- People may view the world as fundamentally unsafe or others as untrustworthy.
- They may struggle to understand others' perspectives, or their own emotions.
- Emotional arousal can escalate quickly and lead to conflict with others and 'challenging behaviour'
- Without effective self-soothing skills, self-directed harm or self-medicating with substances are often a means of coping.

pathway
Healthcare for homeless people

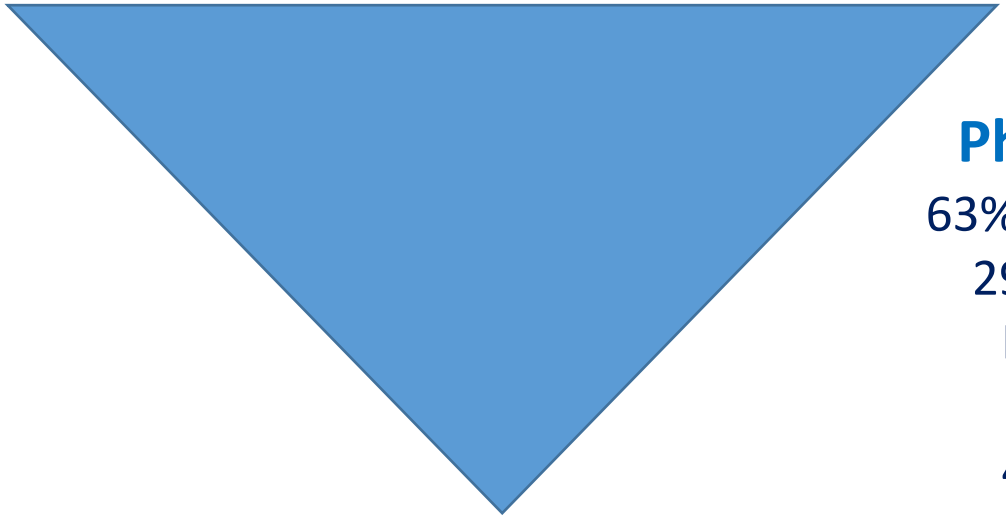
Homelessness is a health issue

Complex needs & Tri-morbidity

Mental health problems: 82% MH diagnosis

Of those: 81% at least 2 conditions, 72% depression,
60% anxiety, 25% PTSD, 25% dual diagnosis, 20% psychosis

Trauma is a risk factor for homelessness and homelessness puts people at risk of trauma



Substances use 54%

38% drug problem
29% alcohol problem

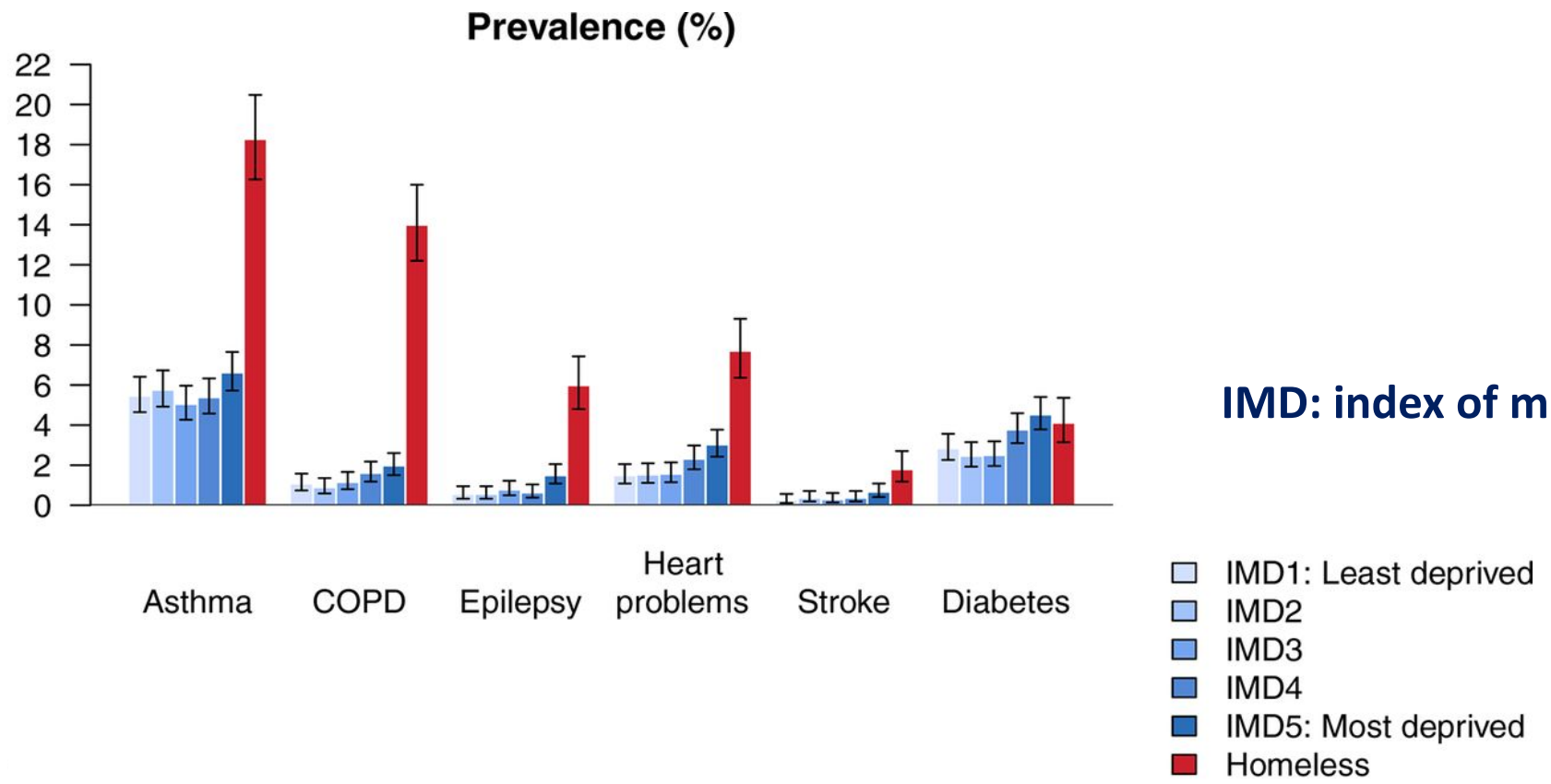
Physical health problems

63% long term illness or disability
29% between 5-10 diagnoses
Hepatitis C 50x more likely
TB 34x more likely
45% traumatic brain injury

Homeless Link: The Unhealthy State of Homelessness, Health audit 2022
Beijer, U et al (2012) Prevalence of tuberculosis, hepatitis C virus, and HIV in homeless people: a systematic review and meta-analysis. The Lancet Infectious Diseases; 12:11, 859–870
Topolovec-Vranic J, et al Traumatic brain injury among men in an urban homeless shelter. CMAJ Open. 2014 Apr 25;2(2):E69-76.

pathway
Healthcare for homeless people

Prevalence of long term conditions



IMD: index of multiple deprivation.

BMJ Open

Dan Lewer et al. BMJ Open 2019;9:e025192

Complex needs and Access to Health Care
Inverse Care Law

Barriers to accessing health care services can include:

https://www.healthylondon.org/homeless/healthcare-cards

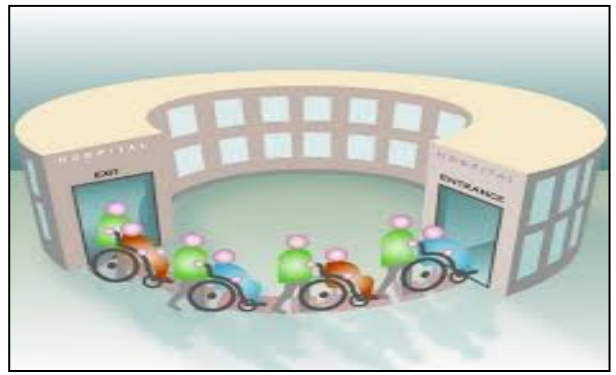
- Health not a priority
- Fear of being judged, distrust, feel unwelcome
- Difficulty registering with GP
- Inflexibility in appointments – discharged for non-attendance
- Lack of trauma informed services
- Digital exclusion/complicated systems
- Fear of withdrawing

pathway
Healthcare for homeless people

Complex needs and Access to Health Care
Inverse Care Law

Impact of these barriers:

- People seek treatment when problems reach advanced stage
- High A&E attendance
- High rate of self discharge
- High rate of unsafe discharge
- Revolving Door



pathway
Healthcare for homeless people

Museum of Homelessness Dying homelessness project:

1286 people experiencing homelessness died in 2021

Mean age at death 2020 (ONS):

men- 46

women - 42

NEWS

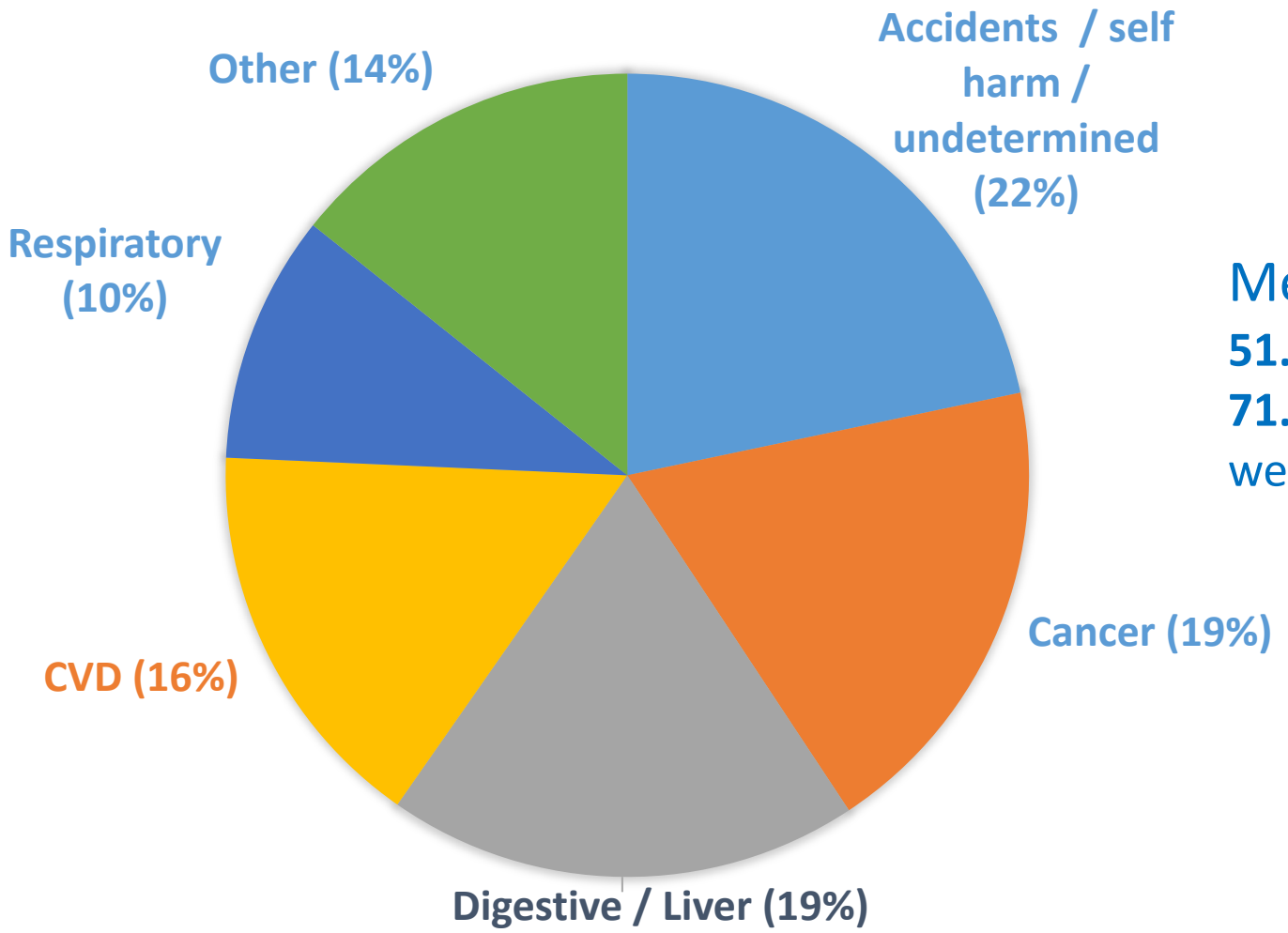
A person died while homeless every seven hours in the UK in 2021

The Museum of Homelessness's Dying Homeless Project recorded 1,286 deaths across the UK – the rise of a third in just one year is a 'hammer blow', the campaigners said.

LIAM GERAGHTY | 31 Mar 2022

Carla Ecola, the director of the LGBTQ+ homeless shelter The Outside Project, was among the campaigners laying candles on the landmark in memory of homeless deaths. Credit: Anthony Luvera

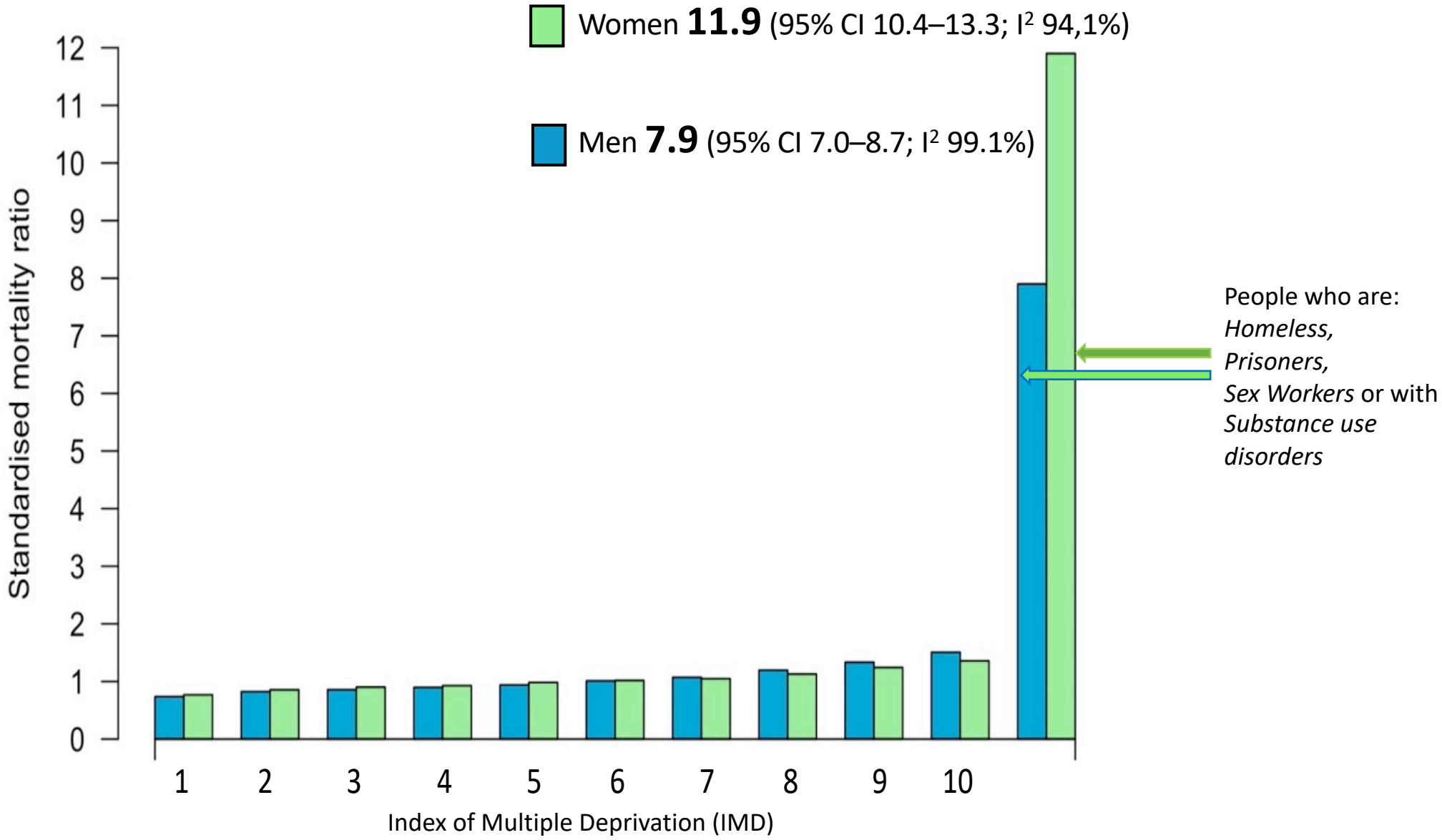
CAUSE OF DEATH AMONG PEOPLE EXPERIENCING HOMELESSNESS (PEH)



Mean age of death:
51.6 PEH
71.5 for people who were IMD 5

Aldridge, R. W., Menezes, D., Lewer, D., Cornes, M., Evans, H., Blackburn, R. M., ... & Hewett, N. (2019). Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England. *Wellcome open research*, *4*.

Homeless people are dying young



Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: systematic review and meta-analysis. R Aldridge, A Story, S Hwang et al, The Lancet Nov 2017

Understanding ageing in this population

Looking at this population through an older age lens

Ageing and homelessness

Number of older people experiencing homelessness is increasing and has doubled between 2010 and 2015.*

People working in homelessness services often refer to their clients as appearing old before their time - referred to as “young olds”

48% of hostel residents were assessed as having memory problems with a further 19% having borderline memory problems. Median age was 60 years**

*https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/equality-and-human-rights/rb_may16_cpa_rapid_review_diversity_in_older_age_older_homeless_people.pdf
**https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr07090#/full-report

Frailty: Looking at the population through an older age lens

What is frailty?

- Health state related to the ageing process in which multiple body systems gradually lose their inbuilt reserves and resilience. It is not defined by age
- Makes someone less able to recover quickly from health problems so relatively minor infections, injuries, can result in:
  - Dramatic change in physical, mental, functional health
  - Higher risk of hospitalisation and institutionalisation
  - Death: An older person with severe frailty has 4.5 times high mortality than a fit older person
- Frailty is not a long-term condition and is not static – it can be reversed and varies in severity
- People with frailty benefit from multi-disciplinary care in the community, prioritising the issues that are important to them. This holistic approach can reverse frailty and reduce hospital admissions.

Fauja Singh: aged 112 ran first marathon aged 8 marathons between aged 89 and 100

Frailty Measurements: 2 examples

Fried:

- Unintentional weight loss
- Reduced strength
- Reduced gait speed
- Self-reported exhaustion
- Low physical activity

3 or more: frail , 1 or 2 pre-frail

Edmonton Frailty scores derived from:

- Cognition
- General health status
- Functional independence
- Social support
- Medication use
- Nutrition
- Mood
- Continence
- Functional performance

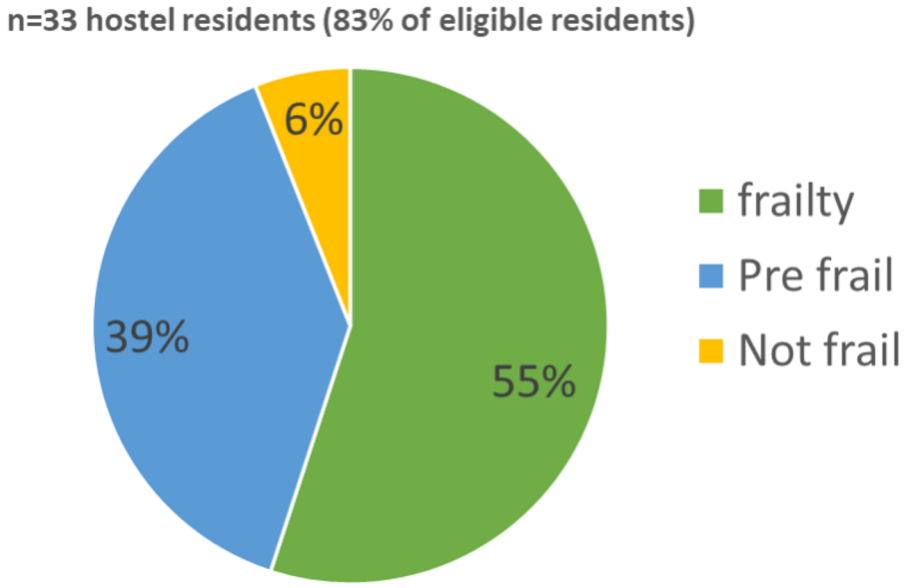
Study 1: Establish rates of frailty in a London hostel

Methods: Comprehensive geriatric and frailty assessment undertaken by geriatrician in London hostel, in addition to key worker and resident questionnaire.

Frailty: *Reduced strength; Reduced walking speed (gait speed); Fatigue (self-reported exhaustion); Low physical activity; Unintentional weight loss:* ***(3 or more = frail, 1 or 2 = pre-frail)***

Findings

- Average age: 55
- Frailty scores equivalent to 89 year olds in general population
- **Geriatric conditions:**
  - > 50% : Falls, Mobility problems, Low grip strength & Visual problems
  - Cognitive impairment 45%, Malnutrition 39% and Urinary Incontinence in 30%
- **Multimorbidity:**
  - Everyone had 2 or more long term conditions
  - Average number of long-term conditions per person > 7
- Only 9% had any form of package of care



Rogans-Watson, R., Shulman, C., Lewer, D., Armstrong, M., & Hudson, B. (2020). Premature frailty, geriatric conditions and multimorbidity among people experiencing homelessness: a cross-sectional observational study in a London hostel. *Housing, Care and Support*.

Study 2: Aims

To develop and pilot a tool that non health care staff could use in hostels to:

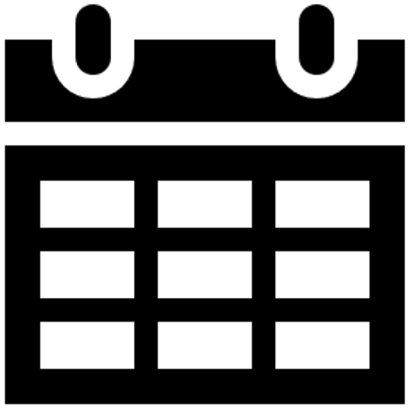
- Aid recognition of frailty and other care needs
- Help staff to advocate for support from health and social care providers
- Evidence level of need in hostels for local and national advocacy & planning and equitable funding

Development of comprehensive frailty and health needs assessment

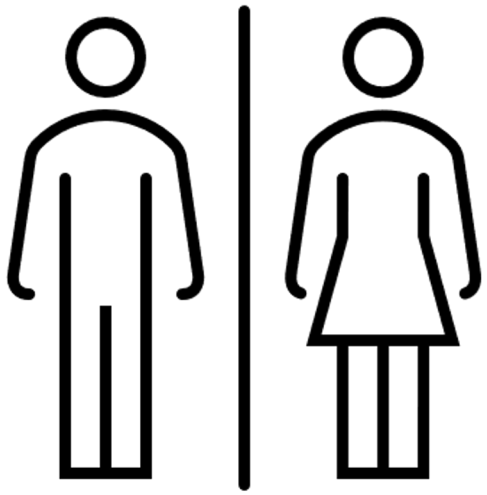
- with inclusion health and frontline staff (using Edmonton frailty scale)
- 2 part questionnaire (key worker and client part)

Survey results

Total number of hostel residents: **74**
2 hostels in one borough



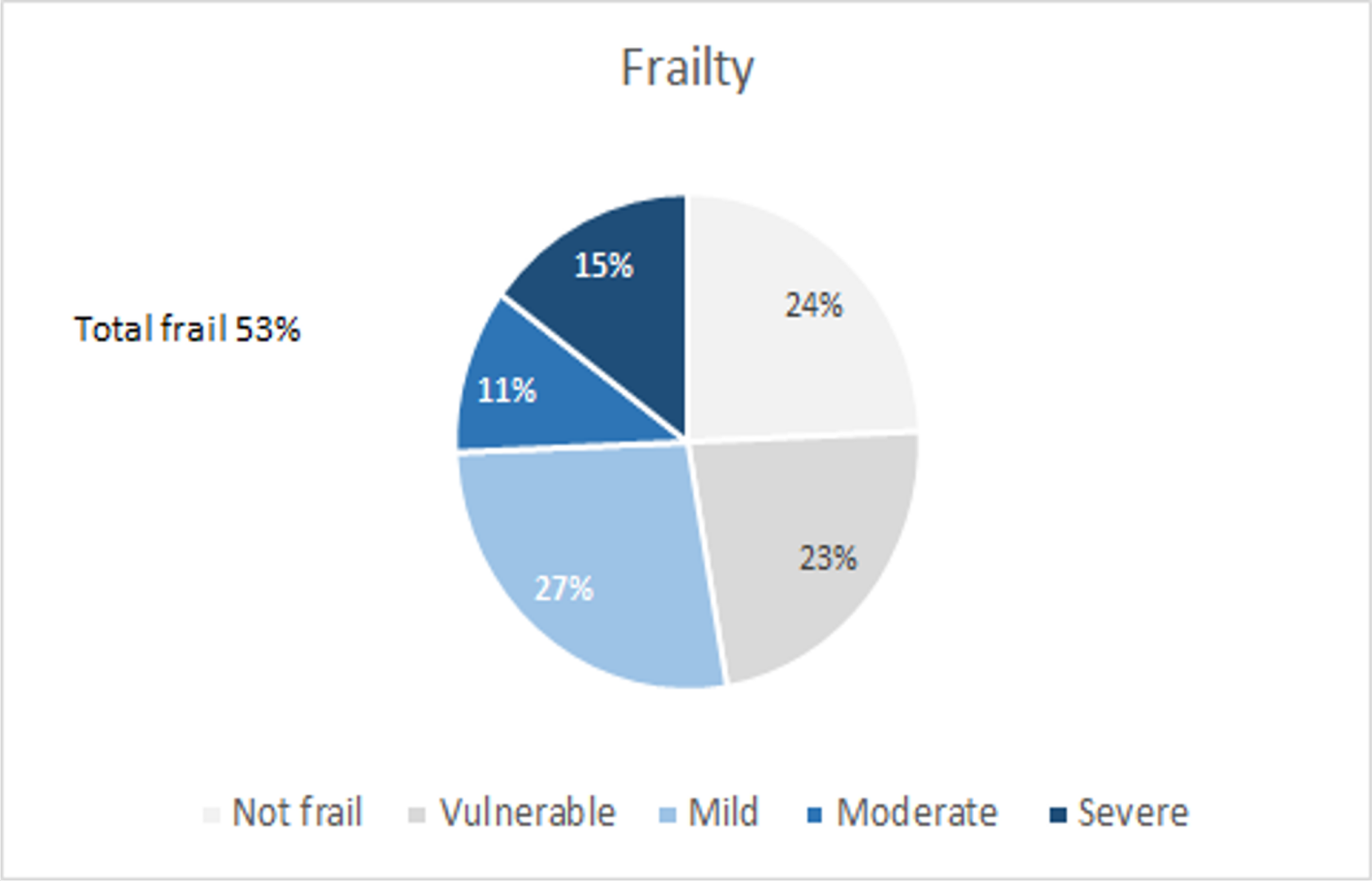
Average Age 48yrs
Range 22-82yr



Gender
M 73%
F 27%

74/120 residents completed (62%)

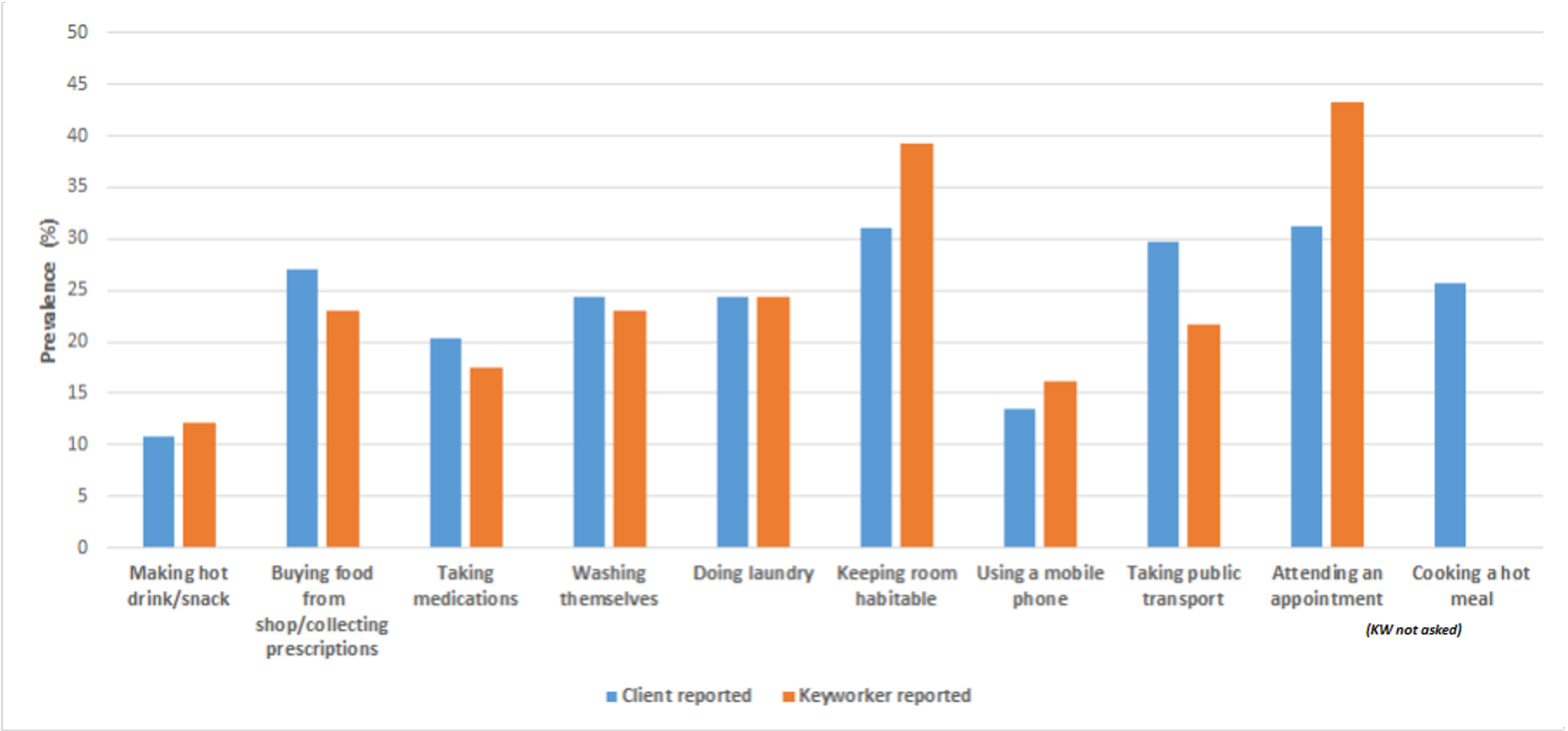
Frailty



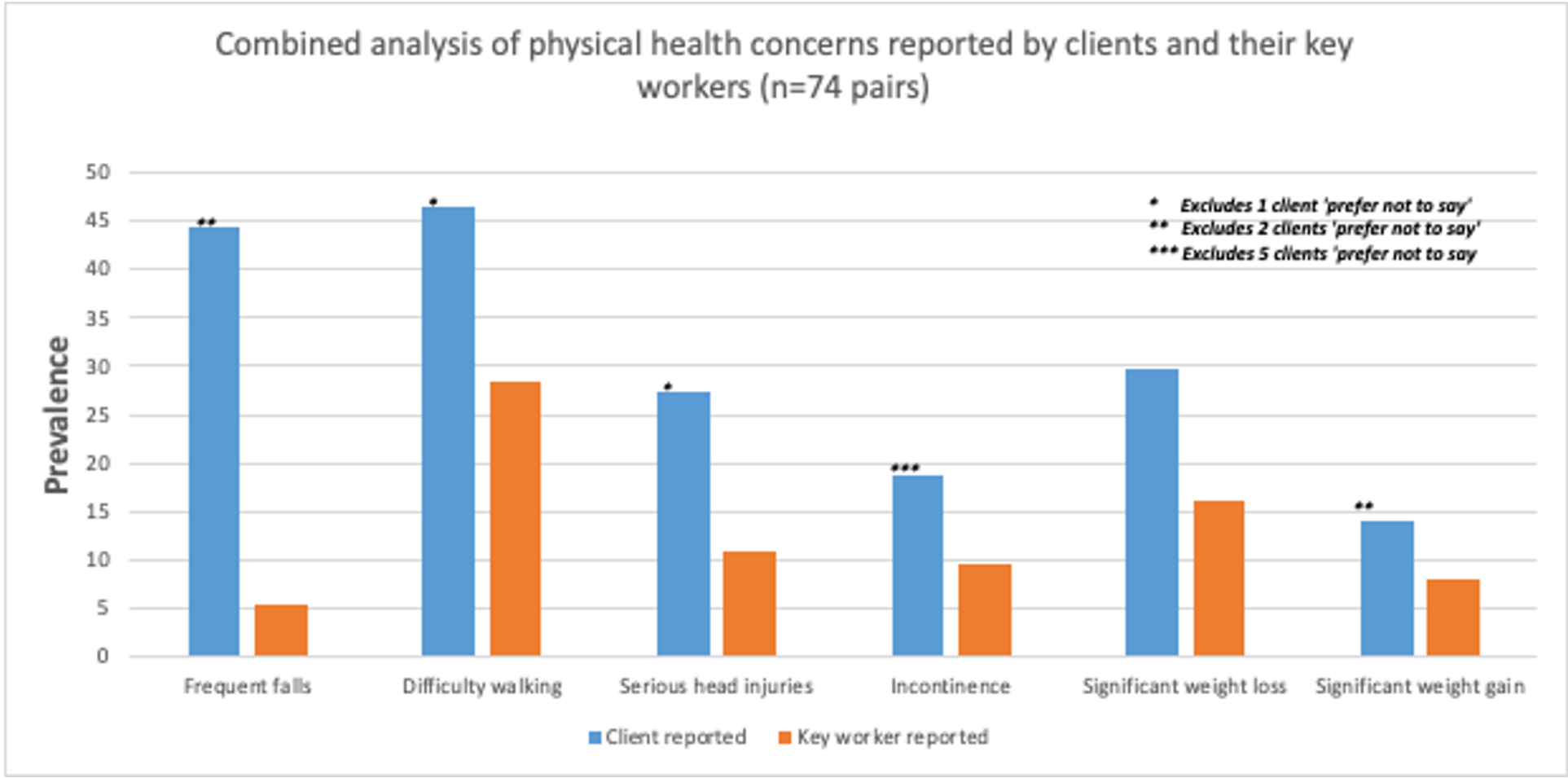
Frailty scores derived from:

Difficulties with activities of daily living
Cognition
Unplanned hospital admissions
Continence
Mood
General health perception
Medication
Needing support with medication
Need for social support
Mobility/strength sit up to stand test
Nutritional status

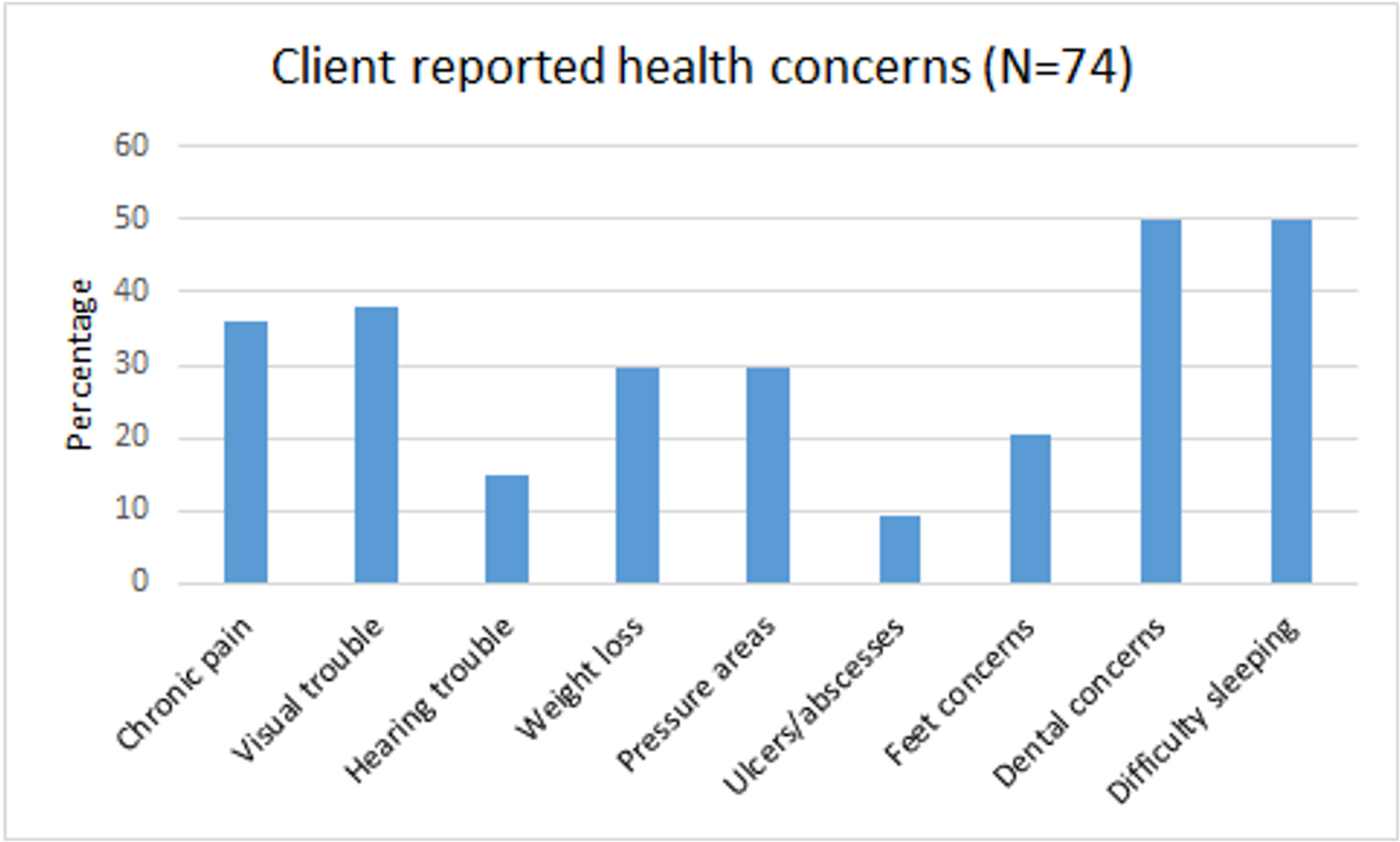
Difficulty with activities of daily living (functional support needs)



Physical health concerns



Other health concerns



Qualitative findings from focus groups

Benefits of undertaking assessment

1. Highlights often overlooked functional needs & health concerns
2. Can open up conversations between clients and their support workers
3. Produces a quantifiable measure to help advocate for support using common language
4. Did not take long to fill in

Discussion

- Do these findings surprise you or are they similar to what you see in your area of work?
- How are health and social care needs managed? ***Needs based or age based?***
- How might these findings change our approach?

We can make the holistic frailty and health needs assessment and / or a hostel survey to be completed by managers, available in due course if helpful. Please email me if interested at caroline.shulman1@nhs.net

3. Pan London hostel survey

Aim: to quantify the level of health and social care needs amongst residents in homeless hostels across London within:

- First stage hostels
- Semi-independent accommodation
- Assessment hubs (with accommodation)

Hostels specifically for young people and outreach services were excluded.

Methodology:

- A cross-sectional survey completed by hostels managers

- The surveys contained a combination of quantitative closed questions and opportunity for free text (open questions).

Coverage:

Total **58 hostels, 9 providers, total clients 2355**

Transformation Partners in Health and Care

St Mungo's
Ending homelessness
Rebuilding lives

shp
Single Homeless Project
Preventing homelessness
Transforming lives

Evolve Housing + Support

Look Ahead
CARE SUPPORT AND HOUSING

Thames Reach

Findings

THE SALVATION ARMY

Riverside

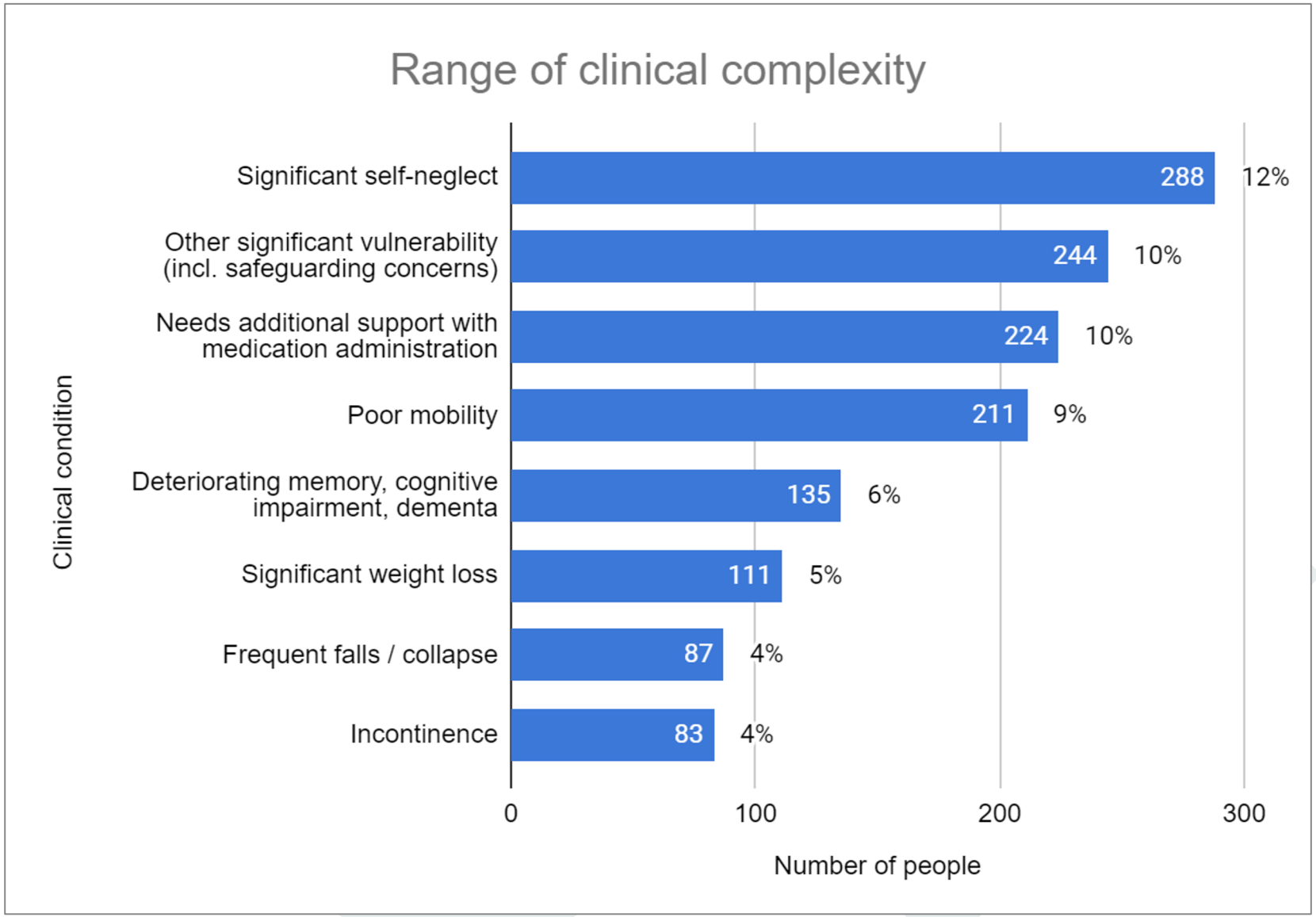
DEPAUL
Homelessness has no place

Prha
PROVIDENCE ROW
HOUSING ASSOCIATION

Complexity & vulnerability

- Many long-term conditions similar to the elderly
  - 609 (26%) had > one of these
  - 209 (13%) had ≥ three
- 603 (26%) clients deemed to have generally poor or deteriorating health

Total number of clients with 58 services surveyed = 2,355



Findings: lack of support for people with care needs

- 133 Care Act assessments were made by hostel staff in the past year
  - 72 (54%) responses received were believed to be adequate
- Managers felt 110 (5%) clients needed a Personal Care Package but did not have one
  - Hostel staff felt support needed around:
    - ➢ Medication management, self care, keeping room clean, supporting nutrition, addressing isolation
- Challenges
  - **Lengthy and complicated process**
  - Assessments in hospitals **often not reflecting realities of life in the community**
  - **Cases closed too quickly** if resident was not contactable or refused to see the assessor
  - Assessment often relied on what the person said without listening to staff who knew them
  - Substance use and self-neglect seen as **'lifestyle choices'**

Findings: Move-On Options

- 30 (52%) managers said they had no options or rarely had access to move-on options. Only one manager reported having adequate move on options
  - Waiting lists were long and thresholds for eligibility were high
  - Particular problem for those with substance use issues and high care needs

- 25 out of 32 (78%) service managers had one or more individual(s) they believed needed high-support accommodation*
  - A total of 102 clients (9%) were identified as having needs that were too high for the service they were in*
- Managers felt that there was a need for more:
  - Specialist care homes
  - Women-only accommodation
  - Smaller units for people with mental health issues
  - Abstinence based accommodation
  - Housing First options with floating support
  - Sheltered accommodation

*Second phase survey only (32 services; 1184 clients)

Hostel survey: Deaths

- In the last 12 months, within 32 services, managers recalled 28 deaths (approx 2% of clients)
  - 10 (36%) deaths were believed to *not* be related to an overdose, accident or suicide
    - Causes include multi-organ failure, brain haemorrhage, cancer, heart attack, heart failure, infection, liver disease or unknown
- Location of deaths:
  - 15 (54%) in the hostel
  - 8 (29%) in a hospital
  - 2 (7%) in a hospice
  - 3 (11%) not stated

Managers felt that for approximately 10% of their clients they would **not be surprised if they were to die in the next year** from a health condition

Dying as a homeless person

Deaths are often sudden, untimely and undignified, with access to palliative care being very unusual
(Crisis report 2012)

Nick (52)

Gemma (28)

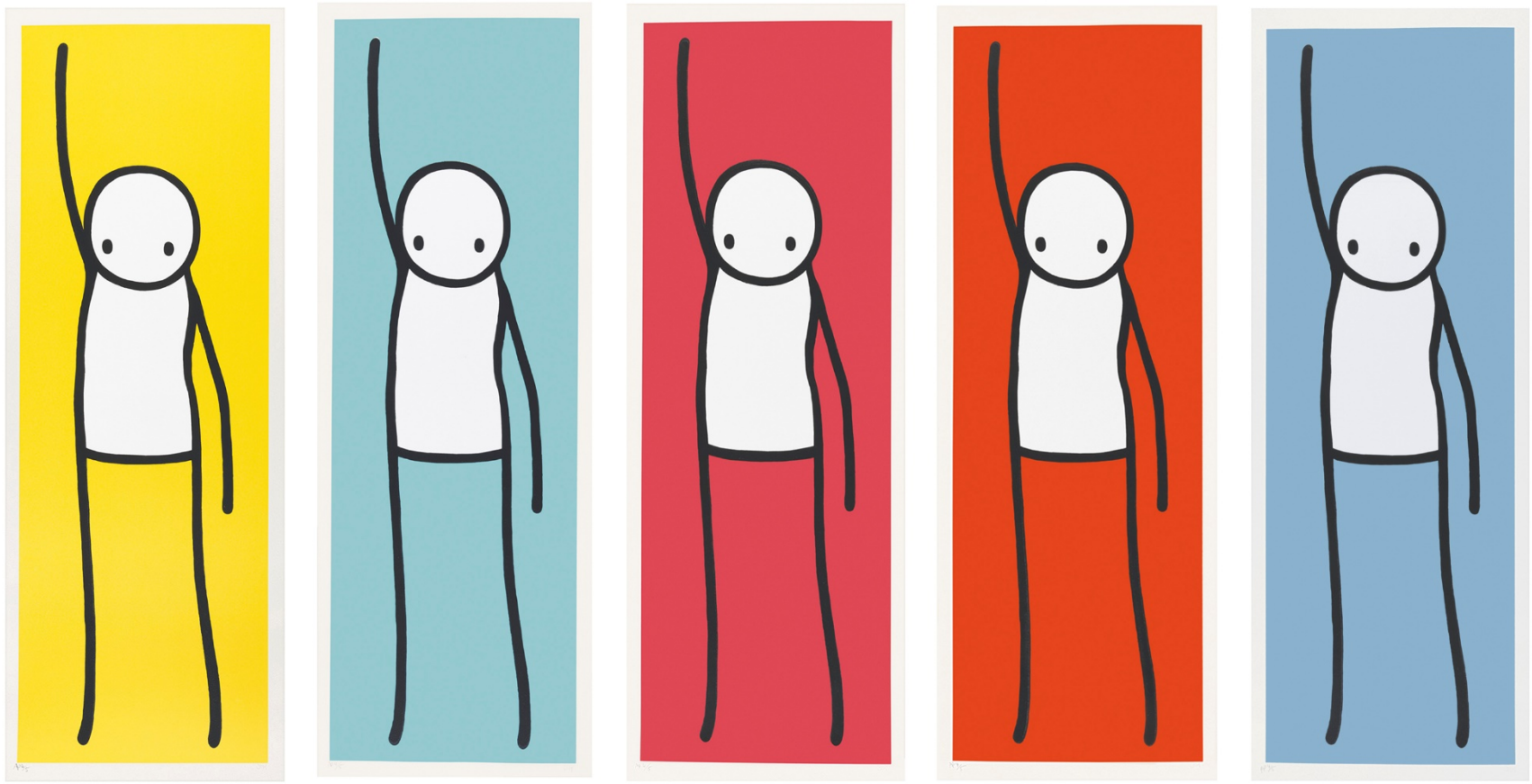
How can we improve palliative care for people who are homeless?

What is Palliative Care?

Palliative care

- is a holistic multidisciplinary approach in the care and support of people with a life limiting condition and advanced ill health
- aims to help people have a good quality of life
- can occur alongside active treatment

What we know from research



Shulman C, Hudson B F, Low J, Hewett N et al (2018). Palliative Medicine 32(1): 36-45 https://doi.org/10.1177/0269216317717101
Hudson BF, Shulman C, Low J, et al (2017). BMJ Open 2017;7:e017502. doi:10.1136/ bmjopen-2017-017502
Shulman C, Nadicksbernd, Nguyen T, et al People living in homeless hostels health and care needs (in press)

Why people are not accessing palliative care:
Lack of identification: Young age

"I think that people are just resistant to the concept of them [people who are homeless] being palliative patients. You are dealing with people who are still relatively young…it's difficult".

Specialist GP

Why people are not accessing palliative care:
Lack of identification: Uncertainty and complexity

Disease trajectory

Substance misuse & complex behaviour

Lack of access to and utilisation of mainstream services

Many deaths are sudden, but not unexpected

They sort of…could be classed as palliative but they are also reversibly palliative. So if you don't stop drinking, if you don't stop doing these things, then you are probably going to die in 6 months. And it's a little bit difficult sometimes to class them as palliative, when you have a reversible cause to it. **Healthcare professional**

The often young age and uncertainty results in people not being considered for referral to palliative care

Gaps in current systems

lack of options in place of care

Many people with very complex needs, at risk of dying, are in hostels or temporary accommodation

Gaps in current systems:

People with complex needs often remain in hostels and lack support

…we're trained to do recovery…. our hostel is commissioned to engage people with support and recovery… getting better, moving into jobs, whatever..

"At least three times a shift we check she's okay. It's hard… particularly on weekends and nights when we only have two staff… it's a big hostel [60 residents]… this isn't an appropriate environment, but it's the best we have" **Hostel staff**

- Homelessness services role is to support people into recovery
- Hostels are designed to provide temporary accommodation
- Staff left to support people with increasing complexity
- Staff go way over and above their role
- Often struggle to get adequate medical support or support from social services
- High rates of staff burnout

Gaps in Current systems:
Lack of options for place of care

Most care homes are for people with dementia who are older; it's just, it's our patients just don't fit any of these like rigid things....the care homes themselves are like 'what?! 'We don't want this 29 year old"…? **Specialist nurse**

Gaps in Current systems

- Lack of alternative places of care due to:
  - Young age
  - Mental health difficulties
  - Substance misuse

Findings: Lack of Advance Care Planning

Lack of confidence

Denial - from all sides

Concern about fragility & removing hope

Uncertainty of prognosis

Lack of options to offer

Overcoming the challenges

©STIK

What's can help / what's needed?

- Being trauma informed
- Recognise what is happening: Better identification of those that might benefit from palliative care or need other health and care input
- Multidisciplinary support (including adult social care) taken to where people are
- Shared understanding and training for all professional groups

Being trauma informed

- Compassionate response, recognition and understanding that some behaviour or mental distress is a result of past trauma
- Recognition that for healing, there is a need for continuity and time to develop trust
- Recognise risk of re-traumatisation if not understood
- Shifts focus
  - Help people recognise that their substance use is their coping mechanism to deal with what has happened to them,
  - ie shift from *“there is something wrong with me”* to *“I am suffering and reacting to what happened to me”*
- Recognition that staff can experience vicarious trauma

©STIK

pathway
Healthcare for homeless people

How understanding impact of trauma can help

- When with a client, it's helpful to consider 'how is trauma operating here?'
- Consider the impact trauma may be having on behaviour – anger is often a result of fear and distress
- Acknowledgement that they are attempting to deal with something awful or shameful is a huge relief: giving a sense of not being judged, having their experiences validated can be transformational

You're already doing this by letting someone tell their story and validating their experience and acknowledging how they feel, and that the behaviour is a way of coping

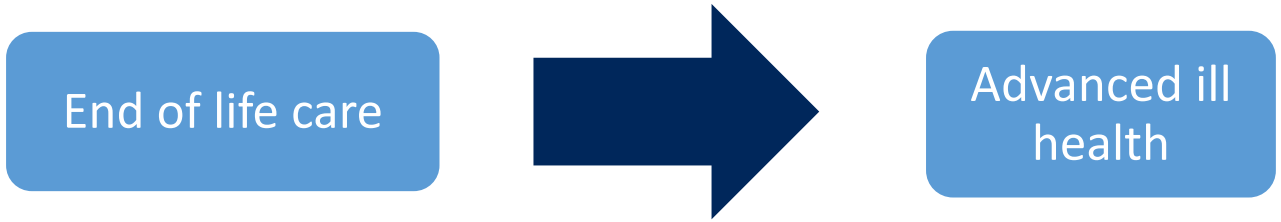
Listening, bearing witness and developing a trusting relationship has huge potential for helping people turn their lives around.

©STIK

pathway
Healthcare for homeless people

Better identification and earlier recognition of people who might benefit from palliative care support: how to work with uncertainty

A Shift in Approach:



Supporting engagement and conversations, keeping options open

- Person-centred exploration of insights into illness, wishes and choices around living well
- Not centred around giving warnings
- Early & repeated conversations
- Shared understanding of palliative care and what it can offer: not giving up on someone, active treatment can continue
- Recognise that not everyone can recover, we cannot ‘fix’ people
- *Where possible respect and explore choices even if we feel they are unwise*

Taking support to where people are

A Shift in Focus:

End of life care → Advanced ill health

Choice in *Place* of Care and *Care* in *Place* of Choice

- **Multiagency support taken to where people are, eg hostels / own home:**
  - In-reach into hostels by health and social care professionals with regular meetings to discuss clients of concern, and provide support to both staff and residents
  - Help support decision making in complex situations: safeguarding / autonomy
    - Help advocate for appropriate care and support eg around care act assessments
    - Support staff with training
- **Collectively advocate for more alternative places of care such as high support need facilities**
- **Training for all professional groups**

Training and Support:

Developing a shared understanding

©STIK

Homeless palliative care toolkit

- Identifying Clients
- Assessing Needs
- Sharing Care
- Communication
- Bereavement
- Practicalities after a death
- Self Care

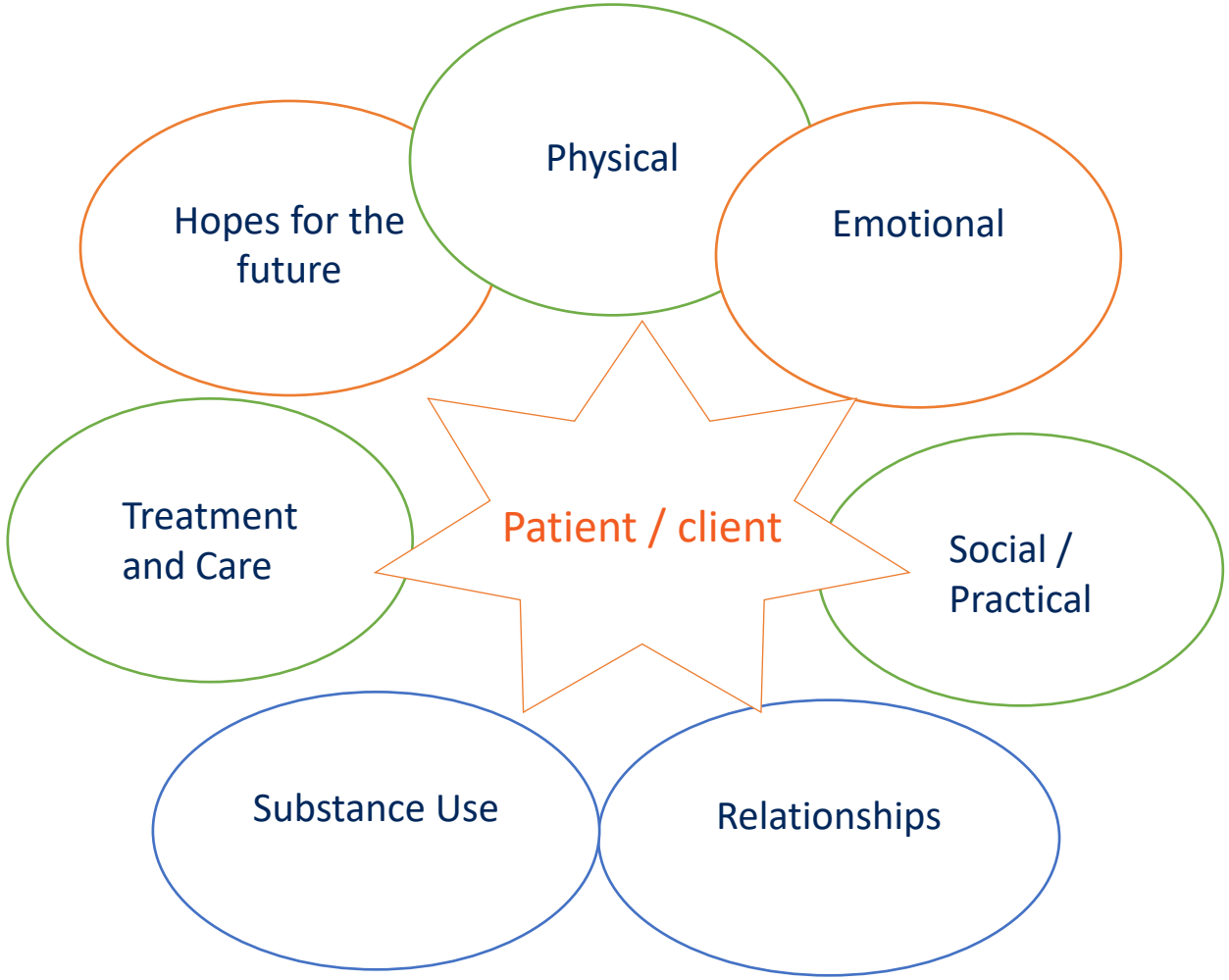
www.homelesspalliativecare.com

pathway Healthcare for homeless people | UCL | St Mungo's Ending homelessness Rebuilding lives | Marie Curie Care and support through terminal illness | OAK FOUNDATION

Person centred care - support and concerns mapping

start from where client is and work alongside them

- Place patient in centre
- Locate important issues to address
- Colour lines according to priority



pathway Healthcare for homeless people | UCL | St Mungo's Ending homelessness Rebuilding lives | Marie Curie Care and support through terminal illness | OAK FOUNDATION

Questions to consider

PHYSICAL

- Do you have thoughts about where things are going with your illness?
- What do you understand about your current health situation?
- What are your main concerns?
- What would you like to see happen next?

SUBSTANCE USE

- Do you wish to reduce your drinking/substance use?
- Say you struggled to stop drinking, what do you think might happen in the next 3/6/9 months?
- Would you like to go to detox/rehab?
- Can we make a plan to meet again in a few days/weeks/months, and see where you're at with everything then?

TREATMENT AND CARE

- Do you feel you need any extra support with your care (nursing or personal care)?
- Are you having any difficulties getting around?
- If you became very ill, where would you want to be cared for? Here at the hostel, in a hospital or a hospice?
- Would you like to talk to your GP/doctor about what treatments you want/do not want?

EMOTIONAL

- How are you feeling about your recent diagnosis/hospital admission/poor health?
- I've noticed you seem a bit withdrawn lately, can I help with anything?
- Would you like to tell me about your concerns/worries?
- What do you feel would help right now?

HOPES FOR FUTURE

- What is most important to you at the moment?
- Are there things you have always wanted to do?
- Would you like support to reconnect with family?

SOCIAL / PRACTICAL ISSUES

- Have you been having trouble attending appointments, could we help with this?
- Have you thought about making a will or letter of wishes?
- What do you want to see happen with your possessions/pets after you die?
- Have you ever thought about how you'd like to be remembered?

RELATIONSHIPS

- Who are the people you trust the most?
- Who would you like to be there if you got ill (again)?
- Who would you NOT want to be there if you got ill?
- Would you like to get in touch with family?

pathway Healthcare for homeless people · UCL · St Mungo's Ending homelessness Rebuilding lives · Marie Curie Care and support through terminal illness · OAK FOUNDATION

Activity worksheet:

Identifying clients of concern

- Are there current clients you are concerned about (e.g. a notable deterioration in health), or an **no** to the surprise question *('Would I be surprised if they were to die in the next 6 to 12 months')* ?
- Use this activity sheet to help you **gather your thoughts** when you have identified clients of concern, using a separate one for each client. Once completed, consider any **actions** you can take.
- Actions can take the form of people you need to talk to, (including the client), practical tasks, (e.g. proposing a multi-agency meeting), fact-finding (e.g. gathering more medical information).
- Consider whether each action is 1-to-1, a team action, or one jointly shared with members of the multi-agency team.
- This sheet can be completed at different times to reflect changing needs, (e.g. a further deterioration in their health), and to help explore concerns with clients and other professionals.
- How might the SPICT4-All tool, liver map, and shared care section of the main toolkit help you? Who else can help you to explore clients' concerns with them?

What are your concerns? *e.g. presenting physical signs and symptoms, notable changes in physical/ mental health, more admissions to hospital, place of care issues at the project.* Remember, many concerns may not have a known medical diagnosis/prognosis, and this is ok. You are simply recording your concerns, many of which may be a gut feeling.	**Thoughts and actions**
What is their current health status? *e.g. known medical diagnosis/prognosis, presenting physical signs and symptoms. Do you need more medical information?*	**Thoughts and actions**
What does the client think? *e.g. about their poor health?, how well they are managing?, if not managing, how open are they to talking to you and others?, coping strategies, and any worries you may have about how they are managing.*	**Thoughts and actions**
Multi-agency response *e.g. who already is involved? Who else needs to be involved? Have recent multi-agency meetings addressed concerns, or is there enough concern for you to set up a multi-agency meeting now?*	**Thoughts and actions**

Multi-agency prompt tool

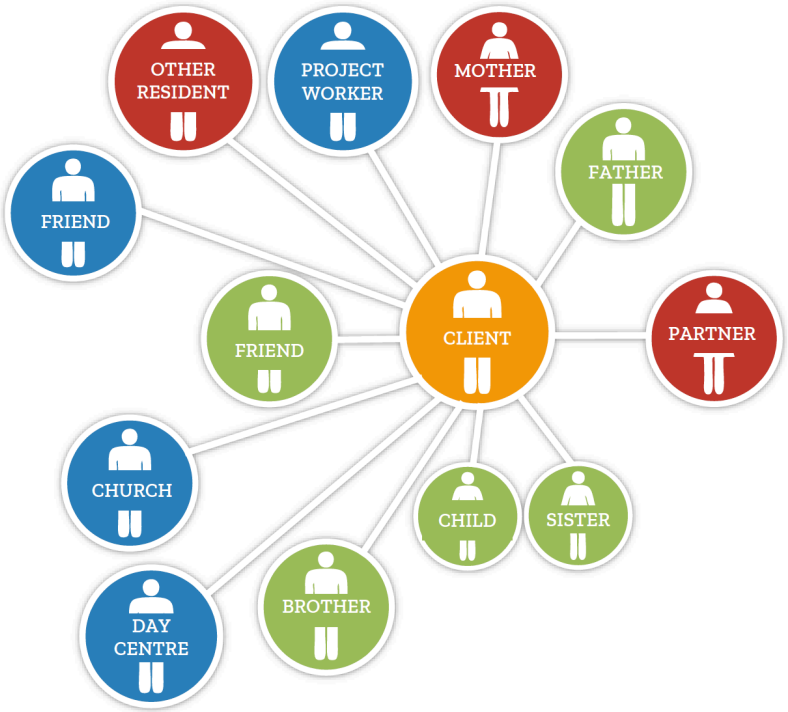
Use this tool to prepare for a multi-agency meeting and to list any actions from the meeting.
For each client whose health you are concerned about, complete a new sheet

	Client – concerns / wishes / desired outcomes (if discussed)	**Project** – concerns / needs / desired outcomes	**Actions** – outcomes from the case review
Physical health • Current health status • Notable changes (if any) • Current / Future health needs • Engagement with health services			
Mental / Emotional well-being • Current mental health issues • Psychological difficulties • Insight / Impact of illness • Ability to express feelings			
Substance Use • Current usage (if any) • Notable changes • Engagement with addiction services • Current / Future support needs			
Place of residence • Medical / nursing concerns • Personal care issues • Place of care issues • Concerns about mobility / access • Health and safety concerns • Impact on staff and other residents			
Supportive networks • Relationships / significant others *(family / friends / peers / staff / other professionals).* See *ecomap* in the end of life care section of the toolkit • Those most/least significant and supportive • Reconnecting with family			

Eco-map tool

Benefits

- Useful when exploring with clients the people and organisations most important to them, and the kind of support, if any, they can provide
- Can support opening up conversations about what really matters to clients i.e. people they may wish to reconnect with (or not)
- Helps us to consider the needs of those people and organisations important to the client, including after the client dies
- Enables us to revisit the significance of the people and organisations in a client's life as needs change (i.e. notable changes in health, approaching end of life)



- A **strong** connection suggests a good level of emotional and practical support
- A **weak** connection suggests little or no emotional and practical support
- A **stressful** connection implies someone significant to the client who may bring additional stress or distress to them. Though a stressful connection, they remain important to the client, which needs to be acknowledged when planning physical and emotional supports

Opportunities to get involved

©STIK

Inspired to get involved?

1. Join a national ECHO **network** on palliative care and homelessness:
   - 1 hour monthly online meetings with opportunity to learn, share and connect.
   - For more information and to register for the network email homelesspalliativecare@mariecurie.org.uk
2. Programme to help you develop and facilitate a **multi-professional community of practice in your area** (UK)
   - to support each other and provide care for people experiencing homelessness with advanced ill health.
   - For more information email: homelesspalliativecare@mariecurie.org.uk

Funded & developed by

OAK FOUNDATION

pathway

UCL

Marie Curie

LESS?

A film of personal stories and journeys to health from people who have experienced and overcome homelessness

> While the tone of the film is optimistic, it does contain references to depression and suicide. If you need help please contact 111, or speak to Samaritans on 116 123.

https://journeystohealth.co.uk/

Short film that you can use to stimulate discussion and support culture change within your organisation.

Equitable treatment does not mean the same treatment!

Provide reasonable adjustments…

…or remove the barriers (the source of the inequity)

With thanks to

The amazing commitment of hostel staff and the palliative care teams from St Christopher's and St Joseph's hospices

The Oak Foundation

Pathway: Dr Nigel Hewett & Julian Daley

St Mungo's: Niamh Brophy & Peter Kennedy

Marie Curie Palliative Care Research Department, UCL: Dr Briony Hudson, Dr Megan Armstrong, Professor Patrick Stone

Useful Resources

Queen's Nursing Institute for a range of resources & guidance
https://www.qni.org.uk/nursing-in-the-community/homeless-health-programme/homeless-health-resources/

Faculty of Homeless and inclusion health: Join for free – Standards for providers and commissioners, publications, network, local meetings: http://www.pathway.org.uk/faculty/

Homeless Palliative care toolkit: www.homelesspalliativecare.com

Report: reducing health inequalities for people living with frailty https://www.gypsy-traveller.org/wp-content/uploads/2020/10/health_ineq_final.pdf

Homeless link, Hospice UK and Marie Curie report – Care Committed to me (2018).

Publications and Further resources

How to use legal powers to safeguarding highly vulnerable dependant drinkers: alcohol change UK
https://alcoholchange.org.uk/publication/how-to-use-legal-powers-to-safeguard-highly-vulnerable-dependent-drinkers

Palliative care for people with substance use disorders
https://endoflifecaresubstanceuse.com/wp-content/uploads/2019/02/eolc-final-overview-report.pdf
https://endoflifecaresubstanceuse.com/wp-content/uploads/2022/03/Practice-pointers-1-6.pdf

Complex trauma:
John Conolly: link to presentation on trauma enhanced communication skills https://vimeo.com/325173923
Childhood trauma and the brain – short video from UK trauma council
https://www.youtube.com/watch?v=xYBUY1kZpf8
FEANTSA: European Federation of National Organisations Working with the Homeless, 2017. Recognising The Link Between Trauma And Homelessness, Brussels: FEANTSA

Film on palliative care and homelessness made by St Ann's Hospice with partners:
https://www.sah.org.uk/2021/12/01/homelessness-and-palliative-care-new-film-from-st-anns-hospice/

Publications and Further resources

- Rogans-Watson, R., Shulman, C., Lewer, D., Armstrong, M., & Hudson, B. (2020). Premature frailty, geriatric conditions and multimorbidity among people experiencing homelessness: a cross-sectional observational study in a London hostel. *Housing, Care and Support*.
- Hudson BF, Flemming K, Shulman C, Candy B. Challenges to access and provision of palliative care for people who are homeless: a systematic review of qualitative research. *BMC Palliative Care*. 2016;15(1):96.
- Shulman C, Hudson BF, Low J, Hewett N, Daley J, Kennedy P, et al. End-of-life care for homeless people: A qualitative analysis exploring the challenges to access and provision of palliative care. *Palliative Medicine*. 2017;0(0):0269216317717101.
- Hudson BF, Shulman C, Low J, Hewett N, Daley J, Kennedy P, et al. (2017) Challenges to discussing palliative care with people experiencing homelessness: a qualitative study. *BMJ Open* 2017;7:e017502. doi: 10.1136/bmjopen-2017-017502
- Shulman, C., Hudson, B.F, Brophy, N., Kennedy, N., & Stone, P (2018). Evaluation of training on palliative care for staff working within a homeless. Nurse Education Today Sep 29;71:135-144. doi: 10.1016/j.nedt.2018.09.022.
- *CQC & Faculty of Homeless and Inclusion Health* (2017). A Second Class Ending. Exploring the barriers and championing outstanding end of life care for people who are homeless
- Cornes M, Rice B, Shulman C, Hudson B. Morbidity and Mortality amongst people with experience of rough sleeping https://thamesreach.org.uk/wp-content/uploads/2020/01/TST-Executive-Summary.pdf
- Klop, H.T., de Veer, A.J., van Dongen, S.I. *et al.* Palliative care for homeless people: a systematic review of the concerns, care needs and preferences, and the barriers and facilitators for providing palliative care. *BMC Palliat Care* **17**, 67 (2018). https://doi.org/10.1186/s12904-018-0320-6
- James R, Flemming K, Hodson M*, et al* Palliative care for homeless and vulnerably housed people: scoping review and thematic synthesis *BMJ Supportive & Palliative Care* Published Online First: 03 May 2021. doi: 10.1136/bmjspcare-2021-003020