

Premature ageing and frailty among people living in a homeless hostel in London

Dr Rafi Rogans-Watson

Elderly Care Specialist Registrar, Pathway Fellow

Dr Caroline Shulman

GP in Homeless and Inclusion Health

Honorary Senior Lecturer UCL, Pathway Research Fellow



Nick's story (age 52)

File on 4: Dying on the streets



Ann's story (age 87)

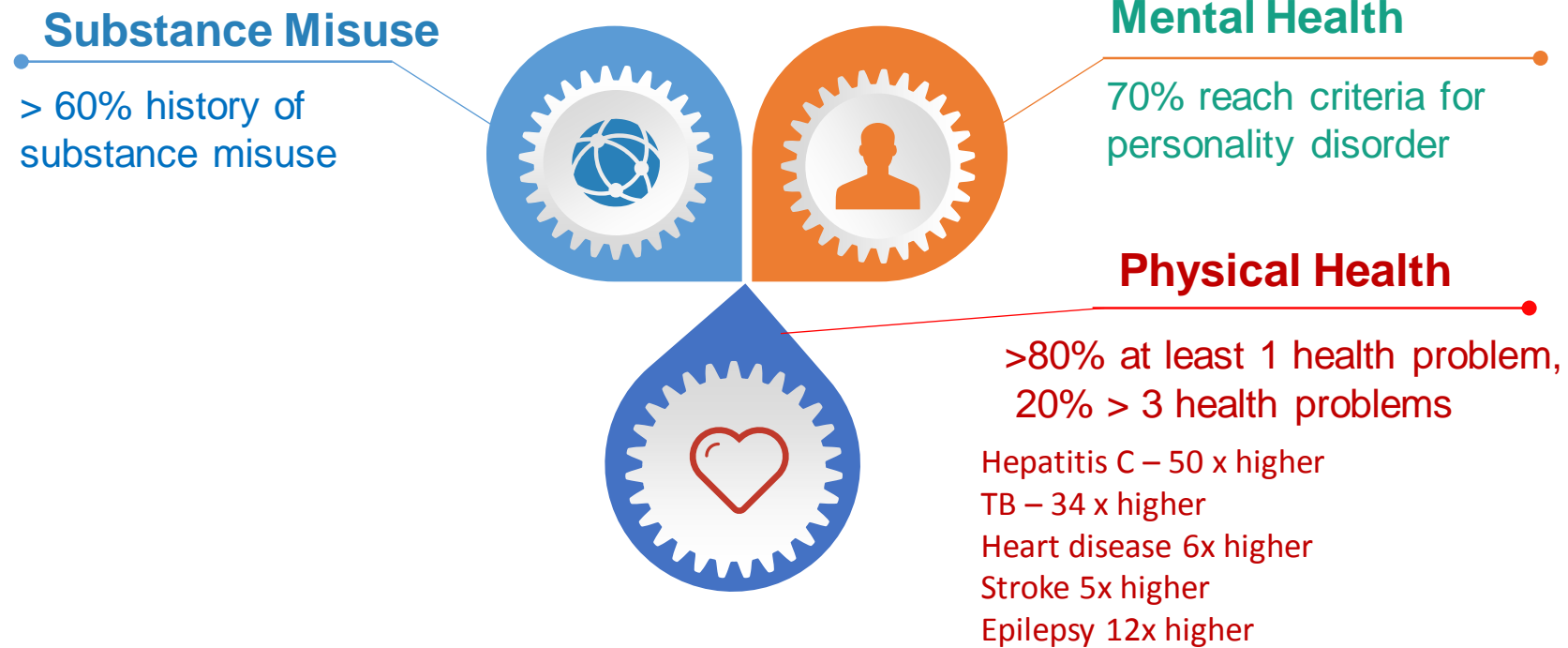


Today's Talk

- Homelessness & health in the current system
 - Multimorbidity / young olds and gaps in provision
- Elderly care concepts:
 - Frailty
 - Comprehensive Geriatric Assessment (CGA)
- Our study: frailty & geriatric conditions in people experiencing homelessness in a hostel
- Recommendations
- Discussion

Homelessness is a Health Issue

Complex needs & Tri-morbidity



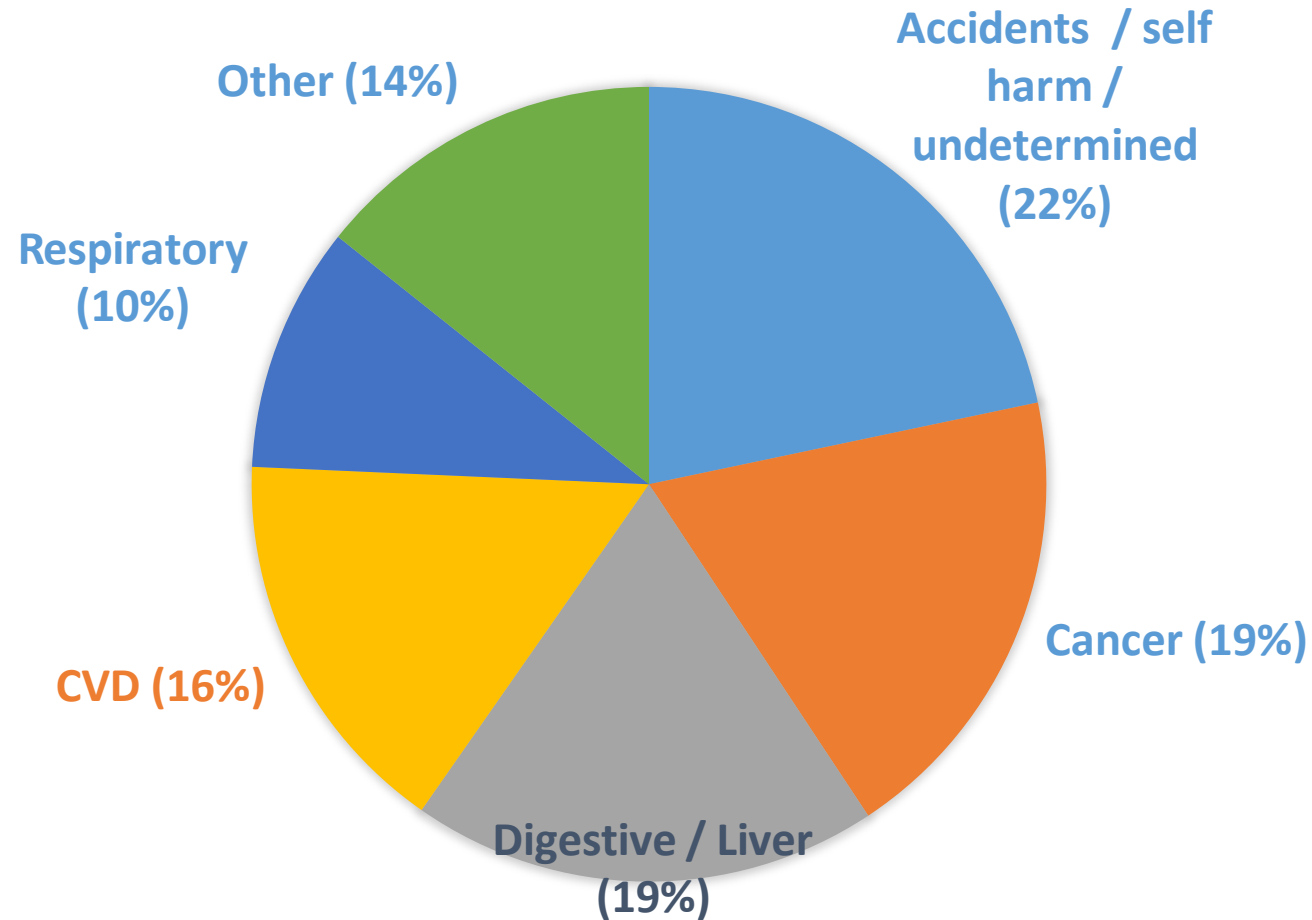
St Mungos (2010), Homelessness, it makes you sick, Homeless Link Research (n = 700)

Suzanne Fitzpatrick et al (2010) Census survey multiple exclusion homelessness in the UK (n= 1268)

Story, A. (2013) Slopes and cliffs: comparative morbidity of housed and homeless people. The Lancet. Nov 29. Volume 382. Special issue. S1-S105

High rates of multimorbidity

CAUSE OF DEATH AMONG PEOPLE EXPERIENCING HOMELESSNESS

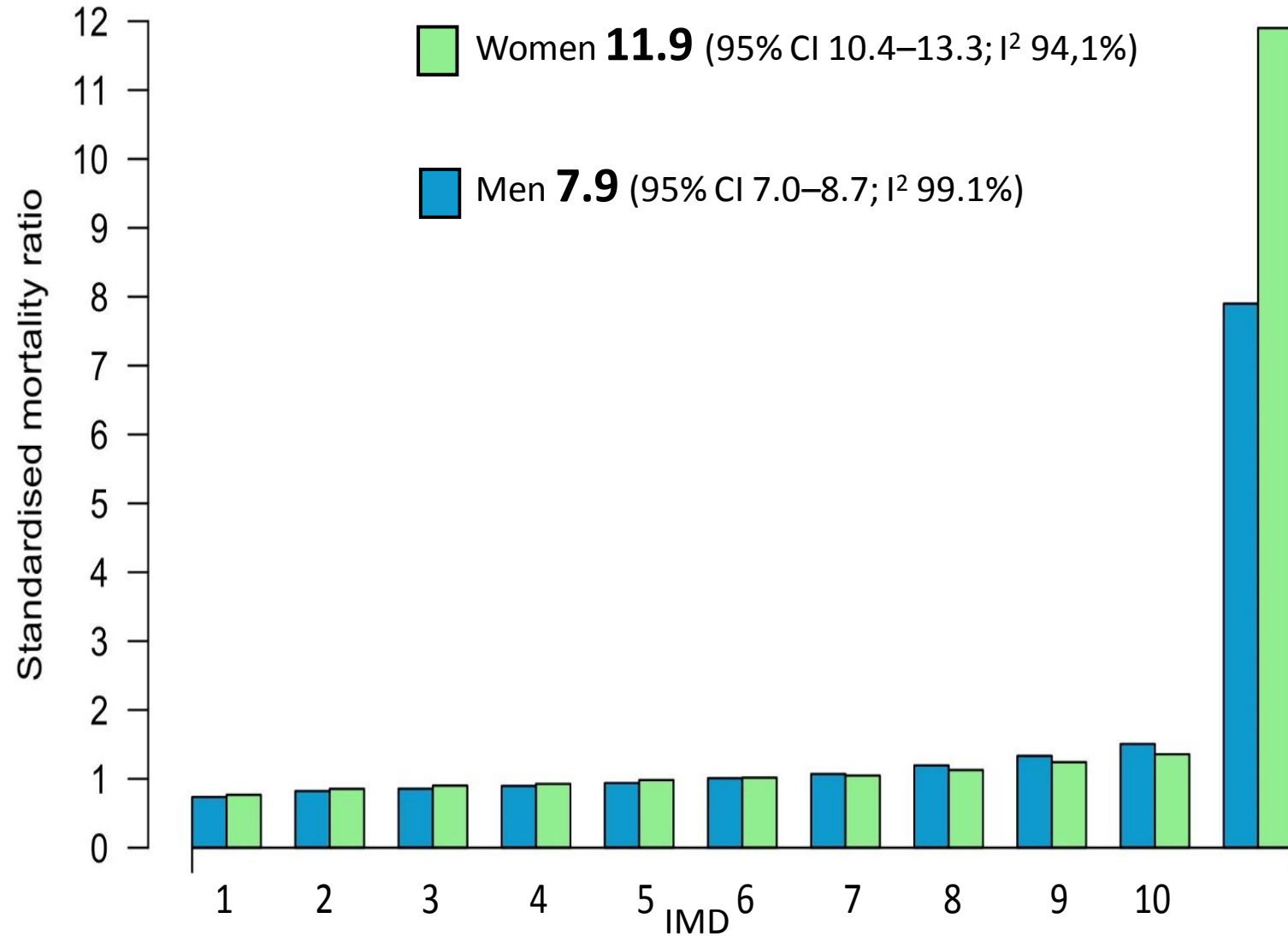


Mean age of death:
51.6 PEH
71.5 for people who
were IMD 5

Homeless people are dying young

Average age of death in the UK (ONS):

45 for men (88%)
43 for women (12%)



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

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2018>

Office of National Statistics 723 deaths in 2018.

Dying as a homeless person

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

Nick (age 52)



Gaps in Current systems

- Hostels & homeless services are taking burden of supporting people who are very unwell / “young olds” / people with cognitive impairment
- Lack of alternative places of care due to:
 - Young age
 - Mental health difficulties
 - Substance misuse



'Multi-morbidity and Young olds'

*When I first came into this I thought this is about recovery, it's not. I mean ... realistically ... it can't be. And it isn't. Very few people recover. **Specialist homelessness nurse***

*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"... you know?
Specialist homelessness nurse*

'Multimorbidity and Young olds'

Social services say 'they're still drinking, so we're not going to give them a package of care'. Even if they're drinking, they still need to get in and out of a bath, or use a commode. Their drinking doesn't mean they're not entitled to services. **Drug and alcohol worker**

"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, with limited resources
- Staff go way over and above their role
- Often have difficulty accessing adequate social services & medical support

Concepts in elderly care - 1: Frailty

- Distinctive health state related to the ageing process in which multiple body systems gradually lose their inbuilt reserves
- Risk adverse outcomes after apparently minor events
 - Dramatic change in physical, mental, functional health
 - Institutionalisation
 - Death
- Frailty is not:
 - Age
 - Long term condition
 - Disability



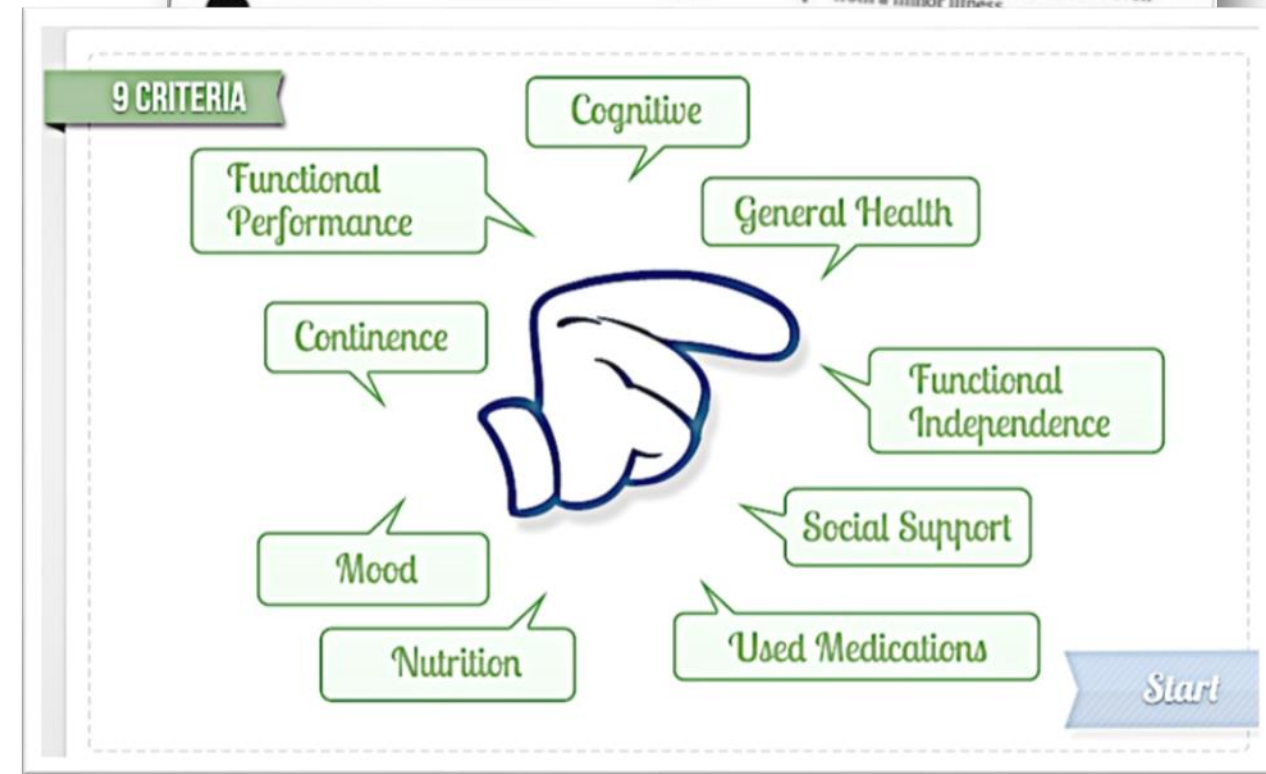
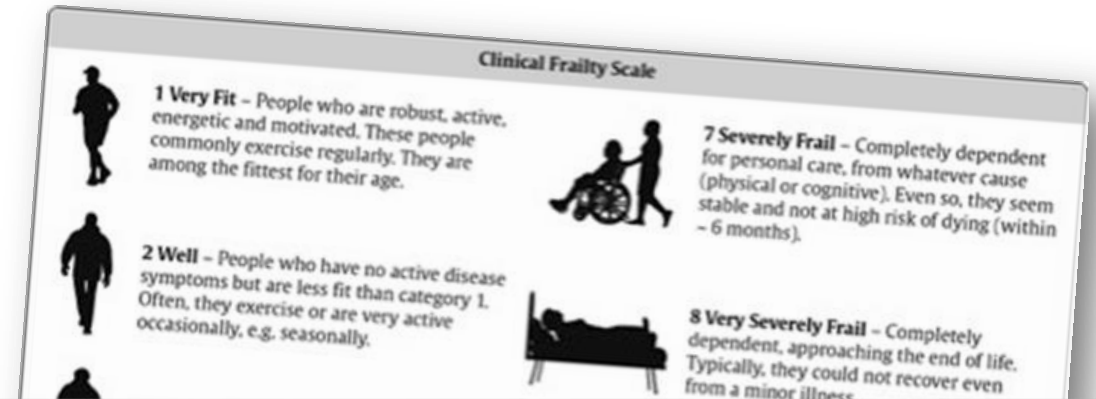
Frailty

- Phenotype model

1. Reduced strength
2. Reduced walking speed (gait speed)
3. Fatigue (self-reported exhaustion)
4. Low physical activity
5. Unintentional weight loss

- Cumulative deficit model

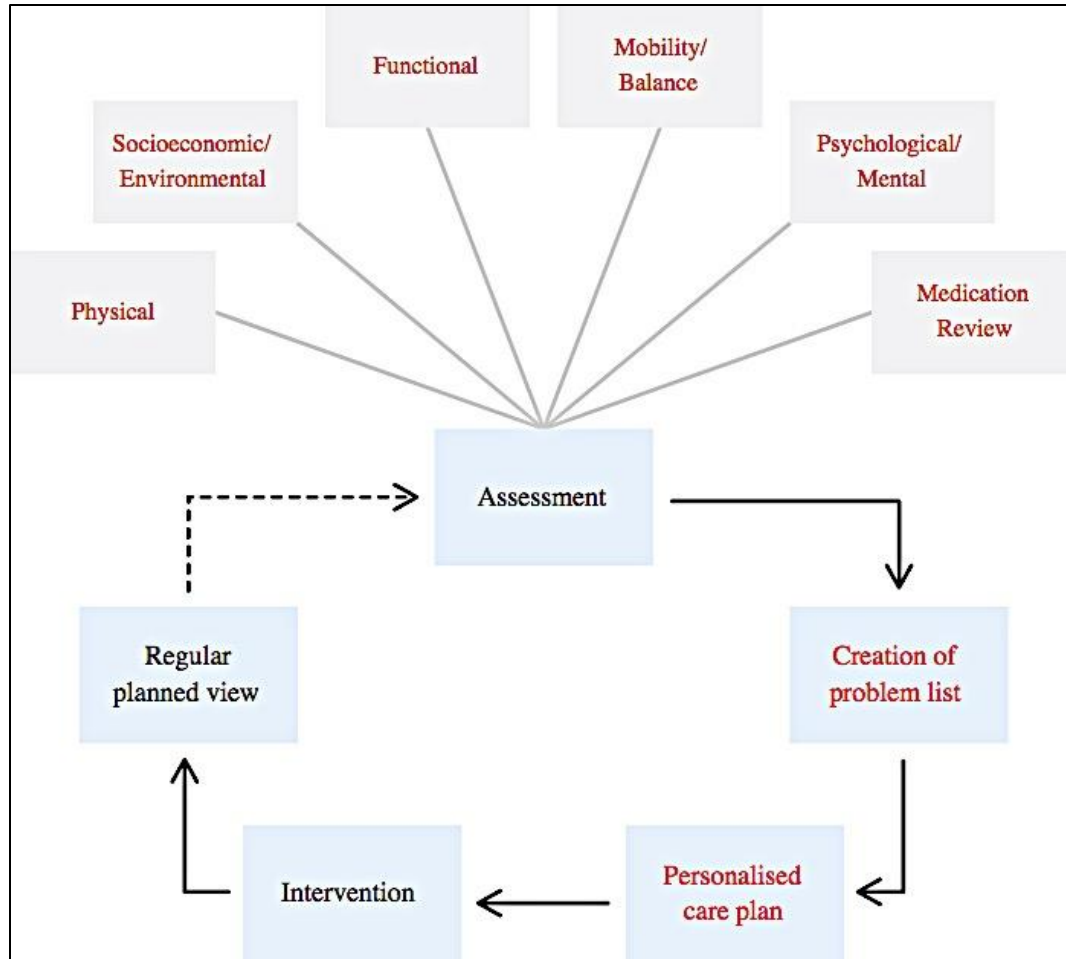
- Rockwood frailty scale
- Edmonton frail scale
- EFI



Frailty

- Varies in severity
- Frailty state is not static
- Recommendations:
 - Identification to proactively manage patients
 - Improve/maintain QOL, reduce risk of harm
 - Be patient-centred
 - Comprehensive Geriatric Assessment (CGA)

2: Comprehensive Geriatric Assessment (CGA)



- It's a process of care comprising a number of steps
 1. A multidimensional holistic assessment
 2. Create issues list and personalised care plan (patient-centred & goal-directed)
 3. Interventions
 4. Review
- Collaboration between patient, family, carers, health professionals
- Multi-disciplinary & multi-agency

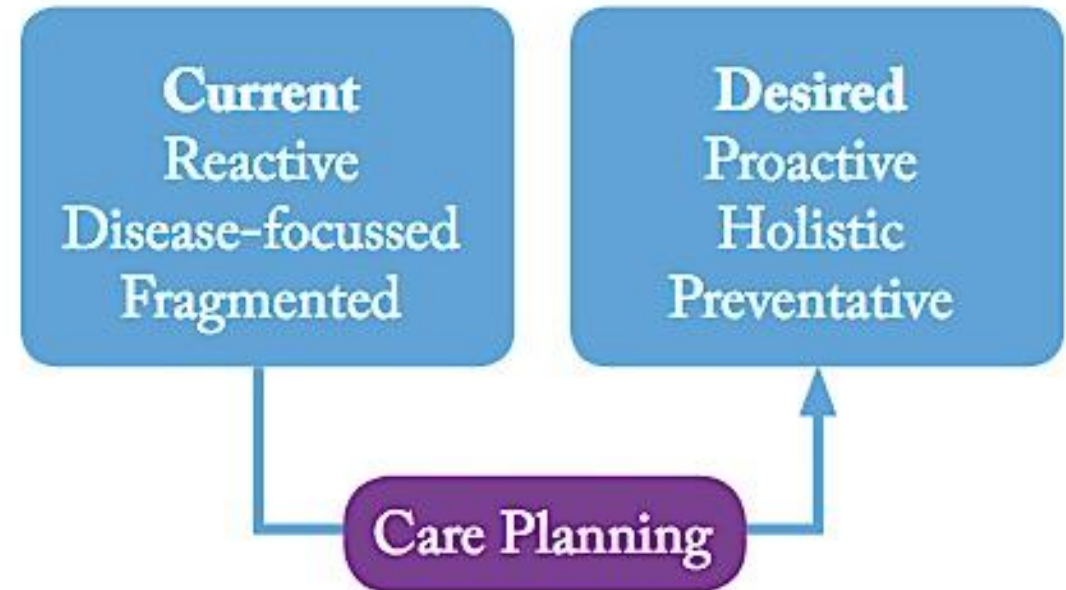
Comprehensive Geriatric Assessment (CGA)

- Will often include common geriatric conditions:

- Mobility & balance
- Falls & bone health
- Sensory impairments
- Cognition & mood
- Continence
- Weight loss & nutrition
- End of life care

- Benefits:

- In hospital: reduces mortality & increases independent living for older people
- In community: reduces hospital admissions
- Can reverse frailty



Existing research of frailty in homelessness

- Frailty impacted by the social determinants of health
 - Impact of homelessness or extreme social exclusion unknown
- Frailty: 4 US studies and 1 pilot study in Ireland
 - 54-60% prevalence (*Salem 2013, 2014, 2019; Hadefeldt 2017*)
 - Some used different models of frailty
 - No UK-based studies or published information
- Geriatric conditions: US and Irish studies found geriatric conditions were common (*Brown 2012; Ni Cheallaigh 2018*)
 - No UK-based studies or published information

Dublin study in more detail (Ni Cheallaigh, 2018)

- Assessments of physical and cognitive health in Sundial house in Dublin
- 32 purpose-built beds providing long-term accommodation for people with entrenched homelessness and drinking, with integrated nursing care and in-reaching primary care
- 11/20 (55%) residents were frail using Rockwood scale; 4/12 (33%) residents were frail according to Frailty phenotype tests
- Multimorbidity: 27/32 (84%) had multimorbidity, and mean number of long-term conditions was 6.3
- Also found falls, social isolation, and cognitive impairment were prevalent

Our study

- *Frailty, geriatric conditions and multimorbidity in people experiencing homelessness (PEH) in a hostel in London*
- Conceived May-June 2018
- Protocol & Ethics Aug-Dec 2018
- Data collection Feb-Apr 2019
- Analysis Jun-Sept 2019



Frailty study

- Setting
 - 42-bed hostel in London
 - Twice-weekly in-reach Inclusion Health nurse / GP clinic
 - Single homeless people aged over 30
- Study design
 - Cross-sectional observational study
 - 1 hour interview/questionnaire with hostel residents with basic observations recorded
 - Standardised assessments for geriatric conditions
 - Based on elements included in CGA
 - Collateral questionnaire for keyworkers



Participant characteristics

- All 42 residents invited to take part
 - 2 excluded
 - **33 participants** (83% of eligible residents)
- **Mean age 55 years** (range 38-74, SD=10)
- 91% male, 82% UK born, 45% age<16 schooling
- Smoking: 82%
- Alcohol: 73% dependent, 6% recurrent hazardous drinking
- Drugs: 36% current class A use, 24% former use
- 22% (7/31) engaged in D&A service

Participant characteristics

- Time in the hostel:

Time in this hostel	<1 year	15 (45%)
	1-2 years	9 (27%)
	>2 years	9 (27%)

- Homelessness: 85% history of rough sleeping

Lifetime homelessness (Cumulative duration: includes vulnerable housing & hostels)	<7 years	8 (24%)
	7-13 years	8 (24%)
	14-23 years	11 (33%)
	>23 years	6 (18%)
Lifetime rough sleeping (Cumulative duration)	Never	5 (15%)
	<1 year	11 (33%)
	1-5 years	5 (15%)
	>5 years	12 (36%)

Study outcome variables

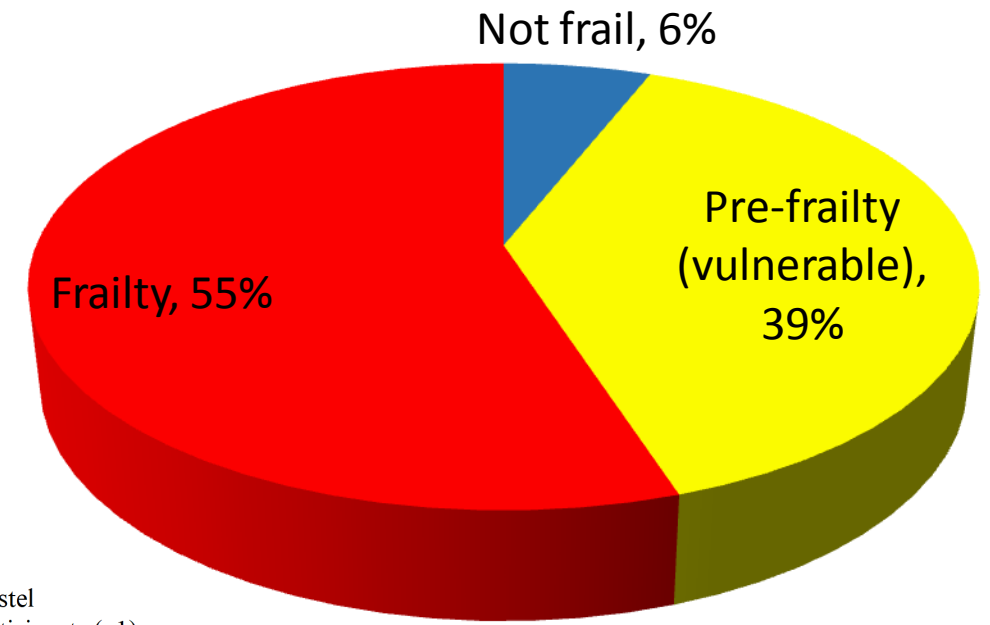
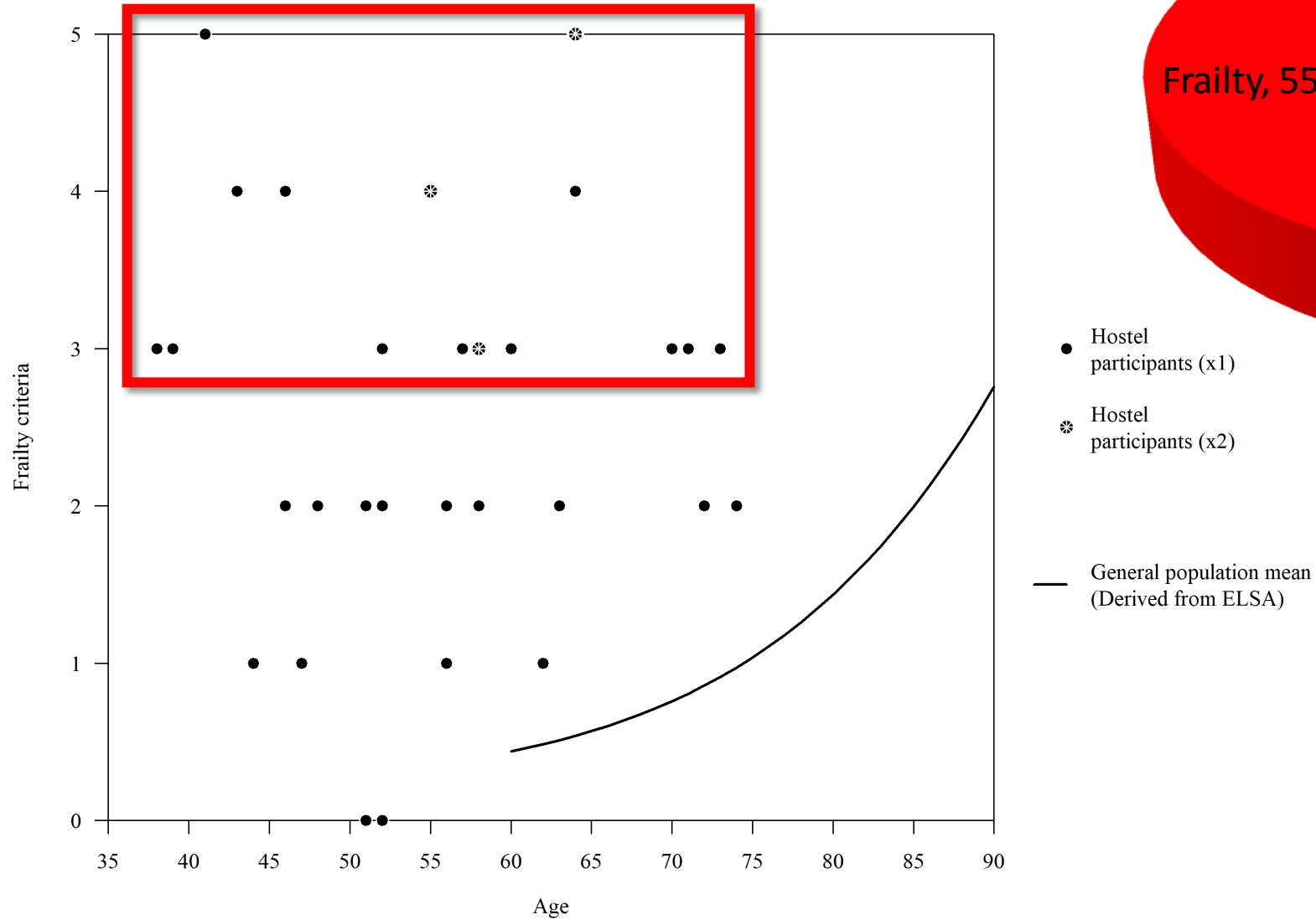
Primary outcomes

- Frailty
 - **Frailty phenotype**
 - Rockwood scale
 - Edmonton frailty scale
- Geriatric conditions
 - Cognitive impairment (RUDAS)
 - Falls* & fragility fracture risk (FRAX)
 - Sensory impairment
 - Vision (Snellen)
 - Hearing*
 - Mobility and balance impairment*
 - Incontinence (ISIQ-UI)
 - Orthostatic hypotension
 - Malnutrition risk (MUST)
 - Functional impairments (Katz/BIFS)
 - Low grip strength
 - Social isolation*

Secondary outcomes

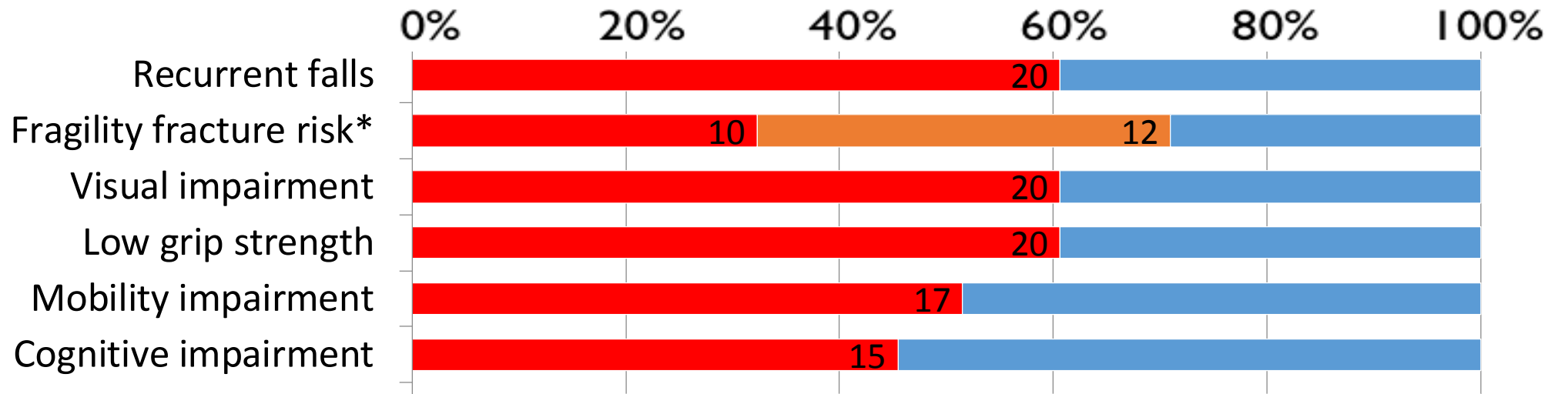
- Multimorbidity
 - Long-term conditions
 - Traumatic brain injury (TBI)
 - Depression (PHQ-9)
 - Self-rated / KW rated overall health
- Health & social care use
 - Medications (polypharmacy)
 - GP / OP / hospital attendances
 - Care packages
 - Social support
 - Advance care planning

Frailty



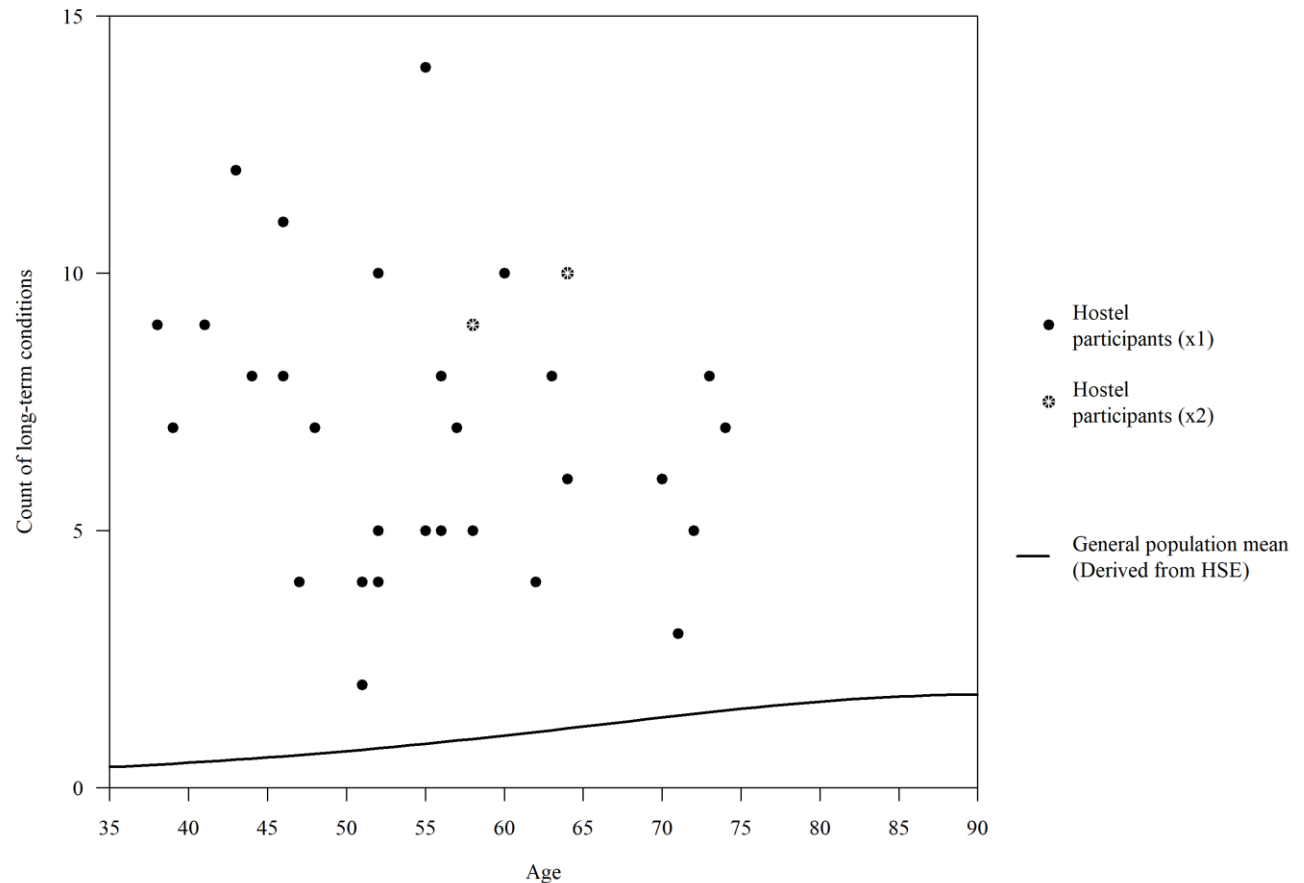
- Hostel participants (x1)
- * Hostel participants (x2)
- General population mean (Derived from ELSA)

Geriatric conditions



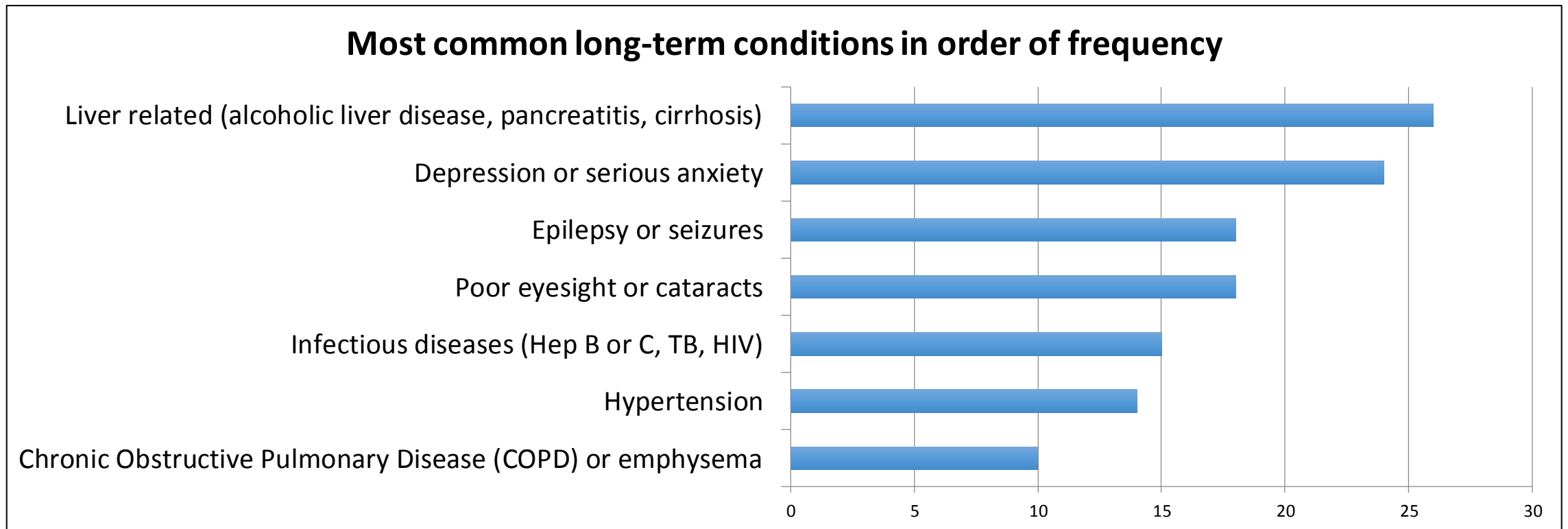
Multimorbidity

- Grouped into 39 disease categories
- 100% had multimorbidity (≥ 2 long-term conditions - LTCs)
- Mean 7.2 LTCs (range 2-12)

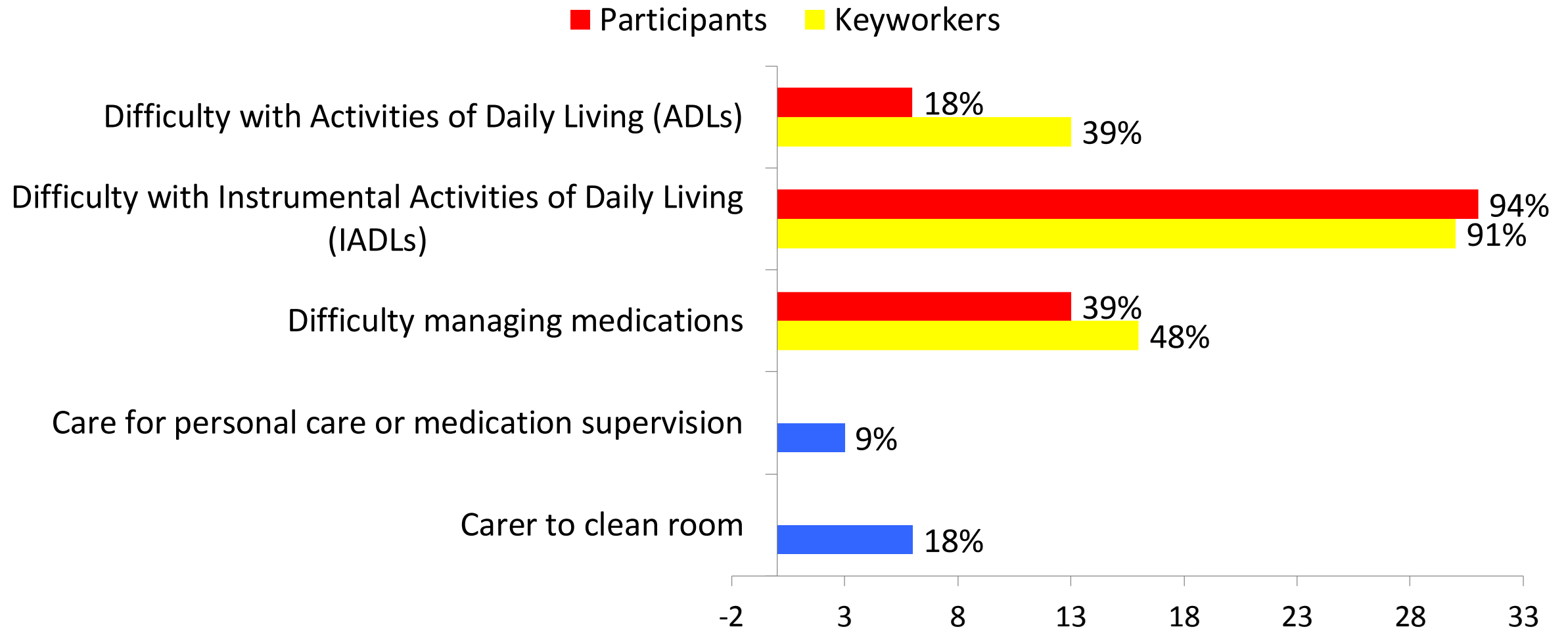


Multimorbidity

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Functional impairments



Findings

- High frequency & premature onset of frailty and geriatric conditions
- Frailty scores comparable to 89-year-olds in the general population
- Multimorbidity far exceeded the average for even the oldest people in the general population
- Despite in-reaching clinical services, many health needs were unmet, and functional assistance often lacking



Strengths and limitations

- High response rate: Established feasibility of holistic CGA-type evaluations
- Robust tools to assess for frailty and geriatric conditions
- Fried frailty phenotype comparable to population
- Collateral information for LTCs and functional impairments
- Small sample size
 - Couldn't analyse associations between certain characteristics and geriatric conditions, or estimate wider prevalence
- Not possible to generalise to other hostels
- However:
 - All had to have a local connection to the borough
 - Other evidence that this level of complexity is rife in other hostels/boroughs

Conclusions

- People with a history of rough sleeping often have very early onset frailty, long term chronic ill health and high support needs
- Health needs of people aged between 38-74 within a hostel environment were shown to be equivalent or worse than people in their 80's or 90's
- The burden of support for very unwell people often lies with frontline hostel and outreach staff, who struggle to get adequate social services support



Recommendations:

What's needed to address the inequity in care for people experiencing homelessness

- Clinical practice

- Health, Homelessness and social services sectors – a multidisciplinary approach
 - Proactively think about frailty / geriatric syndromes – incorporate into clinical assessments and interventions
 - Accurate functional assessments (needs may fluctuate) – to help facilitate appropriate social care support
 - Consider how to support with medication supervision
 - Consideration of how to address poor nutrition, incontinence, poor vision
 - Recognising burden of hostel staff
 - Need for clinical in-reach into hostels (GP, nurses) supported by wider MDT (Palliative care, Elderly care, therapists)

- Research

- How best to adapt the principals of CGA to this population

- Policy

- A national and local integrated homelessness strategy (including health, social care, public health & housing)
- Need for alternative places of care with more wraparound support
- *Choice in place of care, and care in place of choice*



©STIK

Listen to and involve people with lived experience

With thanks to:


Staff and residents working in the London Hostel

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Dr Megan Armstrong

UCL collaborative centre for Inclusion Health: Dan Lewer

Caroline.Shulman1@nhs.net
R.rogerswatson@nhs.net

 @carolineshulman
@Rafirw



Useful Resources

Homeless Link to find out about homeless hostels and day centers in your area

<http://www.homeless.org.uk>

British Geriatrics Society website for “Fit for Frailty” and “Comprehensive Geriatric Assessment toolkit” <http://www.bgs.org.uk>

London Housing Foundation Atlas to identify homeless services <https://lhf.org.uk/atlas/>

Advocating for homeless people around GP registration
<https://www.healthylondon.org/homeless/healthcare-cards>



Reporting a rough sleeper:
<http://www.streetlink.org.uk>

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