The homeless in the emergency department: a patient profile

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Abstract

Objective—To explore the possibility that homeless people use the accident and emergency (A&E) department as a substitute for primary care and to quantify the role of alcohol abuse in their attendances.

Methods—The study period lasted six months. Attendances of all patients registering with “No fixed abode” as their address were analysed from the A&E notes. Information gathered included details of the presenting complaint, general practitioner (GP) registration, and alcohol involvement in the presentation.

Results—135 homeless patients attended the department 233 times; 91% of patients were male with an average age of 40 years; 46% of attendances were during office hours; 81.5% of presentations were for minor problems; 65.2% of patients had co-existing medical problems, with 14.8% having a chronic alcohol problem; 23.7% of patients gave details of their GP and the remainder were either not registered or did not know their GP registration status; 29.6% of attendances directly involved alcohol and another 10.3% were requests for inpatient or outpatient alcohol detoxification; 42.1% of patients questioned said they were aware of the medical facilities available to homeless people in the community; 52.6% of those questioned said they preferred being seen in the A&E department when ill, with 23.7% preferring GP treatment and 10.5% attending community homeless clinics.

Conclusions—The local homeless population may be using the A&E department as a substitute for primary care even in the presence of homeless healthcare facilities in the community. Heightened awareness of these facilities may improve their uptake. Alcohol plays a large role in homeless people seeking medical help in the A&E department. More accessible community facilities for dealing with this problem in this patient group are needed.

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Key terms: homeless; primary care; alcohol abuse

the subject from 1993 where temporal, geographical and typographical classifications are discussed.² In the catchment area of Guy's Hospital, homeless services are provided by the “Three Boroughs Primary Healthcare Team”, covering Lambeth, Southwark, and Lewisham. Services include daily general practitioner (GP) sessions, dental sessions, nursing clinics, and a chiropody service at the local hostels and homeless centres.

Methods

The study period lasted six months, from January to June 1994. For the purpose of the study only patients who were recorded on the A&E computer system as being of “no fixed abode” (NFA) for their address were included. Whether or not all of these patients were “roofless”, that is, sleeping rough with no accommodation of any sort, was not ascertainable. The A&E notes for these attendances were analysed and the following information was collected: patient's name, sex, date of birth, date seen, time seen, presenting complaint, triage category, coexisting medical problems, GP registration, total number of presentations in the study period, and alcohol involvement in the presentation. The triage categories are numbered 1 to 5, with category 1 patients requiring immediate medical attention. Category 2 patients are seen within 20 minutes, category 3 within one hour, and categories 4 and 5 within three hours, depending on the nature of the problem. We were able to question some of the patients about their knowledge of the healthcare facilities available to them in the community, and their preference for place of treatment when ill, that is, A&E, GP, or homeless clinic.

Results

A total of 135 homeless patients presented during the study period, representing 233 attendances. Of these, 123 were male (91%). Overall age ranged from 18 to 73 years. The average age was 40 years. The proportions of patients presenting at different times during the day can be seen in fig 1. One hundred and sixty seven attendances (71.7%) were for non-trauma-related problems and 66 attendances (28.3%) were due to trauma; 81.5% of attendances fell into triage categories 4 and 5 (fig 2). Eighty eight patients (65.2%) had coexisting medical problems at the time of presentation and these are outlined in table 1. Thirty two patients (23.7%) gave details of their GP, and the remaining 103 patients (76.3%) were either not registered or did not know if they were registered (fig 3). This contrasts with an overall rate of 75%

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The Alcohol, Drug Abuse and Mental Health Administration of America defines a homeless person as “anyone who lacks adequate shelter, resources and community ties”.¹ There exist many different types of homelessness and different classifications have arisen as a result. These are outlined in Scott's review article on

Table 1 Coexisting medical problems

Coexisting problem	No of patients	Percent of total
Alcohol abuse	20	14.8
Psychiatric illness	27	20.0
IV drug abuse	10	7.4
COAD/asthma	11	8.1
Epilepsy	5	3.7
Diabetes	2	1.5
Peptic ulcer	3	2.2
Vascular ulcer	1	0.75
Amputee	1	0.75
Blind	1	0.75
Scabies	1	0.75
Eczema	1	0.75
Glue sniffing	2	1.5
Ischaemic heart disease	2	1.5
Anaemia	1	0.75
None	47	34.8
Total	135	100

COAD, chronic obstructive airways disease.

GP registration for the entire population attending the department during the study period.

Of the 233 presentations for this group, 69 (29.6%) directly involved alcohol, that is, the patient was ethanollic at the time of presentation or alcohol intake was the main factor in the patient attending the A&E department. Another 24 attendances (10.3%) were requests for inpatient or outpatient alcohol detoxification assistance.

One hundred and three patients (76.3%) attended the department only once during the study period, 16 (11.8%) attended twice, and 16 (11.8%) attended from three to 15 times.

We were able to question 38 patients on two issues relating to health care options available to homeless people (table 2):

Q.1 – Are you aware of the medical facilities available to homeless people in the community?

Q.2 – When ill, where is your place of preference for treatment?

Discussion

Estimating the numbers of homeless people in London is made difficult by the heterogeneity of this population. In 1991 Black *et al* estimated that at least 60 000 homeless people were living in hostels or sleeping rough in London.³ In the two districts they studied there were different patterns of homelessness and therefore different utilisation of acute medical services. This has implications for the allocation of resources to the various district health authorities. In 1992 Victor pointed out that although the homeless population appear to have the same rates of acute and chronic illnesses as the resident population of the areas studied, they use the GP, the A&E department, and hospital inpatient services much more frequently.⁴

From the results of our study a clear profile of the homeless patient attending our A&E department emerges. It is of a male patient, aged approximately 40 years. Forty six per cent

Figure 1 Time of attendances.

Figure 2 Number of attendances by triage group.

attend the department during office hours with a non-trauma-related problem which is of a low triage category and often related to alcohol intake. The patient is likely to have coexisting medical problems to contend with but is either unregistered with a GP or has no knowledge of who their GP is. Developing a patient profile helps us to focus our attention on areas where treatment can be improved and made more accessible to the patient.

Only 23.7% of the study population were able to give details of their GP. The remaining 76.3%, who were either not registered or had no knowledge of who their GP was, may be regarded as a broad group of patients who do not have a named GP. These figures differ greatly from those published by Victor in 1992 who found an overall GP registration rate of 92% among homeless people in the North West Thames Region.⁴ However, the population studied then consisted of homeless people living in bed and breakfast/hostel accommodation. Our study population is made up of "roofless" patients that is, people with no accommodation of any sort, and patients who, although "homeless", may be living in temporary accommodation, and may not wish to vol-

Figure 3 GP registration status.

Table 2 Response to questionnaire*

	Yes	No	No comment	A&E dept	Homeless clinic	GP
Q.1	16 (42.1%)	17 (44.7%)	5 (13.2%)			
Q.2			5 (13.2%)	20 (52.6%)	4 (10.5%)	9 (23.7%)

* See text for questions.

unteer this information for reasons of anonymity. The relative proportions of these two subgroups is uncertain. "Roofless" patients who are living rough and migrating from area to area in South East London are less likely to be registered with a GP than "homeless" patients in "temporary accommodation". A high proportion of "roofless" patients in our study group may explain the extremely low rate of GP registration.

Taking into account the low rate of GP registration, the fact that the majority of presentations to the A&E department were with low triage category problems, and the fact that 46% of attendances were during office hours, we suggest that this particular population may be using the A&E department as a substitute for primary care.

At the various hostels and homeless centres in the Lambeth-Southwark-Lewisham district, there are 30 weekly nursing sessions for homeless people, six weekly GP sessions, seven weekly dental sessions, and four weekly chiropody sessions. In addition there are at least six GP practices in the area which accept homeless patients at any time. Many of the attendances would have been more appropriately dealt with at these facilities. However, of the 38 homeless patients questioned only 42.1% were aware of their existence. Highlighting the availability of these services may increase their uptake.

We know that our homeless patients move from area to area in the South East Thames Region, and that they attend other A&E departments, homeless clinics, and different GPs. The use of a patient held portable medical record card, as suggested by Reuler and Balazs for the homeless mentally ill, may be useful in producing a degree of continuity of care for these patients.⁵ This is an area for further research.

Of the 135 patients in the study group, 20 (14.8%) admitted to having a chronic alcohol problem. Of the 233 attendances of this group

93 (39.9%) involved alcohol in some way. Welte and Barnes pointed out that, for a minority of homeless people, drinking is a contributory cause of their homelessness.⁶ Castaneda *et al* showed that homeless people had a history of alcoholism of earlier onset and increased severity, compared to people of fixed abode.⁷ This earlier onset of alcohol abuse may be a predictor of homelessness and drinking severity. Among adolescent homeless individuals in the USA the rate of drug and alcohol abuse is much higher than among non-homeless teenagers, and there is a tendency towards more aggressive behaviour in this population.⁸ There is undoubtedly a strong link between homelessness and alcohol problems and in our study group it is the single biggest factor in homeless people presenting to the A&E department. Access for these individuals to counselling and alcohol detoxification programmes is often difficult. In our A&E department there are two full time A&E dedicated psychiatric liaison nurses who provide advice and expertise in these areas. However, tackling this problem at a primary healthcare level may provide a more accessible and successful service in the long term.

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