

# London Health Strategy

## Rapid Review of Health and Homelessness

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The views contained in this report are those of the author/s, and may not reflect the views of the NHS Executive. The report is one of a series of rapid reviews on topics related to the health of Londoners, commissioned by the London Regional Office. They were intended to stimulate debate rather than provide a definitive picture of the topic.

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## 1 Introduction and scope of the policy questions

What are the health issues which need to be addressed for the particular population group or topic in London, and what is the evidence for this?

Tackling homelessness is a prominent part of the Government's social policy agenda. As the Prime Minister notes in his introduction to the Social Exclusion Unit's Rough Sleepers Report "The sight of a rough sleeper bedding down for the night in a shop doorway or on a park bench is one of the most potent symbols of social exclusion in Britain today". The "good reason for aiming to end rough sleeping", he observes, is that "it is bad for those who do it, as they are intensely vulnerable to crime, drugs and alcohol, and at high risk of serious illness, and premature death". Homelessness and poor health, this implies, are seen as inseparable 'problem twins' even from the highest reaches of government.

Rough sleeping is highly visible and captures the attention of the press. It is a measurable problem - by the relatively simple task of counting heads - and therefore can be made subject to a defined programme of action. However the very prominence of street homelessness tends to obscure the broader and more ambiguous situation facing people in acute housing need. For example, most accepted definitions of homelessness extend beyond rough sleeping, covering people in temporary lodgings, people in insecure accommodation, people shortly to be released from institutions, people involuntarily sharing accommodation with others, people living in accommodation that is unsatisfactory either due to its condition or their relationship with other occupants, and people sharing accommodation when they would prefer to live alone<sup>1</sup>. Such broader definitions implies not hundreds but thousands of affected people, some of whom can be defined and costed with accuracy (because they fall within official categories of need)<sup>2</sup>; others are the 'hidden homeless' - people who are not included in official statistics. The health problems of all these groups, but especially the more hidden forms of homelessness, are difficult to research and collate.

The considerable effort currently devoted to rough sleepers may reduce their numbers. However it is unlikely that these other categories of homeless will decline in the short term; on the contrary, given the general conditions of the housing market, the relatively fixed supply of temporary accommodation in London, the rise in the number of refugees and asylum seekers, and restrictions on budgets faced by placing agencies, it is likely that homelessness by all categories in London is set to worsen. By implication, health needs will rise, and services targeted at this group will also rise if commitments to reducing health inequalities are to be achieved<sup>3</sup>.

### The definitions of homelessness in this review

One further consequence of adopting a broader-based definition of homelessness is that a policy and action framework becomes less clear-cut. The Department of Environment, Transport and Regions (DETR) has designated lead responsibility for rough sleepers,

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<sup>1</sup> J Greve, et al, Homelessness in London, GLC Research Team, 1996

<sup>2</sup> London boroughs spent over £73 million from their general funds and nearly £19 million from their Housing Revenue accounts on temporary accommodation in 1997/98. This included nearly £18 million on bed and breakfast and over £14 million on leasehold dwellings. In addition, £48 million was spent by central government on Housing Benefit for statutorily homeless households in temporary accommodation in London. Source Homelessness Statistics, 1997/98 CIPFA, 1999.

<sup>3</sup> *Saving Lives: Our Healthier Nation*, Cm 4386 1999; *Independent Inquiry into Inequalities in Health: Report* (Chairman: Sir Donald Acheson) (TSO, 1998)

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supported by statutory and non-statutory providers, campaigns and others; but when a broader definition of homelessness is used, and factoring in the health dimension, the resultant framework of responsibilities appears more complex. DETR is not, in most cases, the lead agent, but that task shared between local authority housing departments, social services, environmental health, the NHS, criminal justice, mental health services, voluntary agencies, immigration, the police and many others. Because different services confront the 'problem twins' in different ways, an effective strategy therefore requires multidisciplinary working that encompasses different traditions of work with separate organisations. To make reference to the Prime Minister's words drawn from the Rough Sleepers Report once again, any new framework for action calls for "an integrated approach".

For the purposes of this review a simple definition of homelessness is used:

- i. People with experience of sleeping on the streets, in hostels, short-term accommodation, cold weather shelters, night shelters and other temporary accommodation. They are predominantly single people, but with an increasing proportion of asylum seekers and refugees
- ii. People living in temporary accommodation, often statutorily homeless and awaiting more permanent accommodation. They are predominantly families with children; refugees and asylum seekers; and people deemed vulnerable under the Housing Act 1986
- iii. People living in insecure or unsatisfactory accommodation (e.g. high density or shared occupation, poor fabric, poor cooking, washing or sanitary facilities)

The information in this report more effectively covers the first two groups. Unless otherwise stated, the term 'homeless people' is used to cover the entire spectrum of homelessness.

### A profile of homeless people in contact with agencies

Homelessness can affect people from any background but homelessness by its very nature is more likely to affect vulnerable, marginal, and socially excluded groups more than those with stable social networks and economic capacity, for example those with friends and family to draw upon.

A snapshot of information collected from the literature review and questionnaire shows the following:

- That upwards of forty different nationalities are represented amongst homeless families in London
  - In the population of homeless families in West London, there are over seventeen mother tongues, the predominant ones being Albanian, Arabic, English, and Farsi
  - The ethnic mix shifts over time and reflects the national immigration trends. In North Kensington the current refugee homeless population is dominated by people from Kosovo, Africa, the Middle East, Eastern Europe and South America
  - Many homeless families (especially amongst refugee and asylum seekers) are female-headed households, most with children
  - The homeless population of temporary hostels and night shelters is predominantly male and white. Approximately three-quarters are aged between 26 and 50
  - The majority of people sleeping rough are white, male with a little over 20 percent being of Irish origin
  - As well as adults, the homeless population also includes an unknown number of young 'runaways' or young people leaving care
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## Homelessness and health

The Primary Care for Homeless People Team (Camden and Islington) includes the following table in its Information Pack (1997/8). This sets out, in summary form, the main health implications of homelessness.

SLEEPING OUT	
Conditions	Health problems
Exposure, extreme temperatures	Respiratory problems – bronchitis, hypothermia, pneumonia, frostbite, poor circulation
Exposure – no shelter from noise or other people	Fatigue, depression/stress/mental health problems
No access to cooking and storage of food	Poor nutrition, malnutrition, impaired wound healing, lowered immune state, increased susceptibility of infection
No access to washing and toilet facilities No access to clean clothes	Skin complaints, gastro-enteritis, more susceptible to infection, dental problems, foot problems
Alcohol and/or drug misuse prior to or since sleeping out	IV drug use, abscesses, hepatitis B & C and HIV Alcohol use – gastro-intestinal problems, liver problems, cirrhosis
SHARED ACCOMMODATION – HOSTELS, HOTELS, B & Bs, SQUATS	
Conditions	Health problems
Shared amenities - toilets, bathrooms, kitchens, storage	High rates of spread of infection: gastro-enteritis, TB, childhood diseases, slow child development, poor nutrition, malnutrition
Poor amenities -heating, cleaning, lighting, maintenance	High rates of accidents, high rates of infestations, respiratory problems
Lack of privacy – space, security	Strain on relationships, depression, stress, risk of attack/violence
BOTH GROUPS	
Access to health care	
Difficult to access health services	Lack of continuity of care Lack of early attention to basic problems Lack of health promotion/health advice Lack of routine check-ups Difficult to access other health services as GP is often the gatekeeper

The problems of homeless people in seeking health care can be characterised, as below, as those of ‘access’, therefore employing the assumption that homeless people, as a socially excluded group, are subject to the ‘inverse care law’ (i.e., the assumption that people in greatest need of health or other services are the least able to acquire them). In practice, access problems may be due to a variety of explanations on both sides of the care giver/care seeker divide, including lack of financial or personal resources, powerlessness, fatalism, stigma, poor self-definition, cultural dissonance, language difficulties, and lack of knowledge. This may suggest that mainstream services may be unsuitable for some homeless people because they are not ‘mainstream’ people or that special targeting or training of care givers is needed to address these needs. This discussion is in subsequent sections.

### Access to primary health care

The general picture emerging from research findings is that where it is difficult for a member of the general public to register with a GP, it is even more difficult for a homeless person—particularly towards the rough sleeping end of the homelessness spectrum. Certainly there is copious evidence of the problems of GP registration for the homeless. In a recent unpublished

national survey of 887 projects working with homeless people, 42 percent felt there was 'easy' access to local GPs; a further 42 percent reported that access was 'variable' while 16 percent described it as difficult<sup>4</sup>. This pattern is replicated in London where an average of 50 percent of the 258 projects said it was 'easy'; 32 percent said it was variable and 18 percent that it was 'difficult'. It was observed that:

- London boroughs where access appeared the most problematic (according to the respondents) are Westminster, Islington and Barnet.
- In the areas where access was generally 'easy', this was due to willingness of a small number of local GPs to accept homeless people as patients, or where GPs provided services in hostels and day centres for homeless people
- This research also discovered that there were significant variations in access to GP services between quite small areas

A survey found that people in hostels and bed and breakfast hotels who had moved away from their place of origin were less likely to be registered with a GP, or to know of one with whom they could register, than those living in their place of origin<sup>5</sup>.

Furthermore:

- The more marginalised the homeless person (i.e. with experience of rough sleeping), the more difficulties there were in access GP services
- Projects working with homeless families recorded the reluctance of local GPs to accept them as patients and referred them to the Health Authority for allocation<sup>6</sup>

### GPs' reluctance to register the homeless

The stereotypical 'tramp' image can act to discourage GPs from registering patients. In such cases there is no request to retrieve the patient's medical notes from previous providers of care. Continuity of care is reduced and there is little opportunity for the GP to build up a relationship with their homeless patient. Health promotion and access to health screening may also be compromised.

The Royal College of General Practitioners (RCGP) approved a Statement on Homelessness and General Practice in March 1993. This observes that "homelessness and poor or inappropriate housing are major indicators and causes of ill-health and mental stress; work with homeless people therefore forms an important part of all a general practitioner's work." At the time of its acceptance it was agreed that it should be widely distributed to regional faculties around the UK. It has not been uniformly distributed to GPs but is available on request.

The earlier noted unpublished study referred to a focus group of GPs in an area where a significant number of homeless families were accommodated. Conversations within this group demonstrated that many GPs' thought that refugees and asylum seekers are 'on the make' and that their primary purpose for seeking a consultation with a GP was to get a medical letter for the LA Housing department.

In the case of homeless families recently arrived in an area, frequently the GP will have no background on the medical history of the family or their living or social conditions, a further

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<sup>4</sup> Unpublished research into access to General Practice by people sleeping rough, undertaken by the Centre for Housing Policy, University of York, commissioned by the Department of Health, 1999. This research is extensively referred to this review.

<sup>5</sup> Bines, W (1994) *The Health of Single Homeless People* University of York, Centre for Housing Policy

<sup>6</sup> telephone interviews with participants in the questionnaire

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background reason for their unwillingness to register them. While evidence of stigma is real, it finds its counterpoint in the large workload of many GPs for whom this perceived ‘demanding group’ is seen to be an extra burden too large to shoulder. In particular:

- The GPs feel overwhelmed by demand from this group, with the time needed for each consultation 60 percent longer than the average. The demands of homeless families is also greater, with many refugees and asylum seekers coming three times a week to the surgery.
- There is confusion amongst some GPs about the financial arrangements, believing that they would not be paid unless a patient has a permanent address
- GPs fear that they may be unable to meet their targets if they accept patients who may be transitory and unreliable in keeping appointments for immunisations and smears
- The major reason for reluctance to register homeless people is their fear of being inundated by people demanding mind-altering drugs. Without case notes, it would be impossible to identify the ‘deserving’ from the manipulative
- GPs perception of homeless people appears to be that they are difficult, uncooperative, and potentially physically threatening. However, other GPs working in inner city areas relate that their behaviour is no different from some other patients. Where there is a real threat of violence it is normally associated with a mental health or addiction problem (which may be exacerbated by housing conditions). These GPs felt that respect for the individual, combined with a well-managed surgery and waiting room, diminished the number and likelihood of threatening incidents.
- Many GPs believe that quality of care includes a preventive and curative approach. They feel they are unable to follow through this role when they do not have complete case notes, when contact is fleeting and short-lived, and where follow-through is often a low priority for the patient. Some feel they would be failing in their duty if they did not chase up patients who do not comply with a full course of treatment
- GPs are reluctant to register patients with language and comprehension difficulties
- Many GPs, lacking training in the needs of homeless people, experience lack of confidence.

The RCGP “urges its members to practice equity in its registration policy. Homeless people should be registered permanently wherever possible and integrated into all health profile and promotion activity within the practice. A permanent address is not necessary for registration.” It adds that the immigration status of patients is irrelevant to primary health care providers and that members should make use of available professional advocacy and translating services.

### Homeless people’s reluctance to visit GPs

Some homeless people may be ‘demanding patients’ but a more general phenomenon is their reluctance to seek medical treatment, thereby exacerbating the underlying medical, dental or ocular problem. This can result in acute episodes that are beyond the treatment capacity of the GP, necessitating a referral to A & E. In some cases homeless people may move relatively short distances and fall outside their GP’s catchment area. However the mobile and transitory lifestyle influences a homeless person’s quality and pattern of contacts in a variety of ways.

- The major priorities for many rough sleepers is finding food and shelter and – for some – a source of illicit drugs or alcohol
  - Many homeless people have low self esteem and lack of confidence which is linked with an assumption that they would be refused help
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- Past experience of unsympathetic treatment and refusal by a GP practice is projected forward as an expectation of future contacts
- Fear, rather than actual experience, of abusive reaction from health care staff may discourage help seeking
- Embarrassment due to low standards of personal hygiene and dirty clothes may preclude them seeking assistance which may lead to undressing
- There are practical problems of making an appointment (e.g., making an appointment over the telephone, or having to remember about an appointment days ahead)

Similar reactions to seeking health care from a GP surgery can be found within homeless families, particularly asylum seekers. Additional problems include lack of knowledge and information of the British system, including free access, and interpretation difficulties.

A specialist primary care team surveyed of the registration status of its 2178 clients in 1997/8:

- 11.2 percent were registered with a local GP
- 17.7 percent were registered with a GP attached to PCHP
- 71.25 percent were not registered with a GP

The following reasons were given by a sample of 773 clients for not registering with a GP:

- |                                 |                   |
|---------------------------------|-------------------|
| ▪ too mobile                    | 378 (49 percent)  |
| ▪ recently moved to the area    | 80 (10.3 percent) |
| ▪ had not considered it         | 67 (9 percent)    |
| ▪ refused by receptionist       | 54                |
| ▪ lack of information           | 31                |
| ▪ could not be bothered         | 22                |
| ▪ refused by GP                 | 25                |
| ▪ relied on specialist services | 15                |
| ▪ fear of refusal               | 7                 |
| ▪ language barrier              | 5                 |
| ▪ deterred by bureaucracy       | 5                 |
| ▪ did not think eligible        | 1                 |
| ▪ other reasons                 | 83                |

### Access to health information

The health and well being of homeless people is affected by their lack of access to the health education/promotion. This is caused by<sup>7</sup>:

- Limited contact with primary health care
- Lack of support and advice around the needs of homeless people to health promotion specialists
- Lack of collaboration between agencies
- Limited resources
- Lack of national and local strategies
- Negative attitudes and stereotypes of homeless people, which preclude a consideration of the needs of this group
- The marginalisation of health promotion
- Lack of evidence-based health promotion practice focusing on this group

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<sup>7</sup> Power, R et al (1999) *Promoting the health of homeless people: setting a research agenda*, London Health Education Authority

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A further study concludes that health promotion departments pay minimal attention to the needs of homeless people because <sup>8</sup>:

- Orthodox approaches to health promotion are not effective for homeless people
- They are excluded from Our Healthier Nation targets <sup>9</sup>
- There is little appropriate literature for this audience
- Although there were a number of initiatives to improve health promotion to this group, there was little co-ordinator which has resulted in ineffective use of resources
- There is little knowledge of role of health promotion units among specialist homelessness agencies

The report concludes that responsibilities lay with three stakeholders:

- i. health promotions departments should to:
  - have a named person with responsibility for homeless people
  - better publicise their work and role
  - produce literature that is appropriate to the life style of homeless people
- ii. health authorities should:
  - adopt flexible interpretations of Our Healthier Nation targets
  - encourages GPs to permanently register homeless people to facilitate access to health promotion within their surgeries
- iii. homelessness agencies should:
  - work with homelessness health specialists and health promotion departments to develop strategies in this area

A London-wide Health Promotion Forum should be established to share ideas and good practice.

### Access to healthy lifestyles

People sleeping on the streets are subject to damp and cold conditions; they are likely to have a poor diet; they are subject to violent physical attacks and rape; they lack sleep; their mental stability is likely to be affected. The resultant health problems are:

- Asthma and other chest complaints, including TB
- Coughs and colds
- Skin complaints and insect infestations
- Depression, stress and anxiety
- Problematic use of alcohol and illicit drugs

Great Chapel Street Medical Centre's statistics for 1998/9 show that the most common presenting problems of its 1183 new patients in the year were:

- drug related problems (21 percent)
- respiratory complaints (16 percent)
- alcohol problems (14 percent)
- dermatological complaints (12 percent)
- musculo-skeletal problems (10 percent) <sup>10</sup>

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<sup>8</sup> Hinton, T et al *The Icing on the Cake, A review of Health Promotion Initiatives for Single Homeless People in the North Thames Region*, funded by NHS Executive, North Thames HA

<sup>9</sup> While the four main 'Our Healthier Nation' targets do not address homelessness, with the partial exception of suicide, the general inequalities focus does.

<sup>10</sup> Statistics for the year 1<sup>st</sup> April 1998 – 31<sup>st</sup> March 1999

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A similar range of presenting problems are found amongst the clients of teams targeting homeless people. The 1997/8 statistics for the Primary Care for Homeless People team (Camden and Islington) reported that there were 10,770 consultations for 2188 people in that year, with the following breakdown:

- mental health (14.8 percent)
- musculoskeletal (12.4 percent)
- drug related (9.7 percent)
- respiratory (8.9 percent)
- dermatology (8.8 percent)
- alcohol related (8.2 percent)
- gastrointestinal (7.3 percent)

Homeless families in hotels face abysmal living conditions with “lack of ventilation, cockroaches and mice creating many health problems”<sup>11</sup>. The frequently cited health problems were asthma, depression and other stress related symptoms, repeated contraction of infectious diseases (coughs, colds, chest infections), women’s health issues (gynaecological, contraception, smears etc) and accidents to children. This report noted that health staff working with homeless families (for example, the Bayswater Families Centre and the Camden and Islington PCHP) are hampered by the suspicion on the part of the newly arrived homeless asylum seekers and refugees (who fear they are agents of the Home Office or spies from their own countries) and hotel managers (who are afraid of being reported to the Environmental Health Officers). With the increased demand for temporary accommodation, the standard of hotel accommodation is deteriorating; four-person families were being allocated one room, forced to share bathroom facilities, and given no access to a kitchen or catering facilities. Many properties expose residents to physical risk. The most common failing reported by Environmental Health Officers is fire safety, bedsit properties often fail on the provision of basic facilities, management standards and overcrowding.

Westminster Housing Department part-fund a Family Support and Outreach Worker who is based with the Bayswater Families Centre. Emulating a successful pilot scheme in Reading, this worker has been responsible for ensuring a systematic monitoring of the temporary accommodation in London W2 that is used by homeless families. A standardised form has been devised, for use by Health Visitors and other professionals, to feed the information back confidentially to Westminster Housing Department in order to regularly monitor the housing conditions. There have been some recent successes, for example one hotel has been thoroughly fumigated following complaints of insect infestations (cockroaches and bedbugs), skin irritation and psychological problems, especially amongst the hotel children. (HST)

Homeless families face mobility difficulties often due to out of borough placement by their placing authority. This disrupts the continuity of health care and prevents them from establishing a framework of tacit knowledge on an area and militates against the formation of informal support structures that can enhance their physical and psychological well-being.

Homeless people underutilising health care

- Newham : White indigenous families – perhaps because they know the system better and do not need the assistance of outside agencies

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<sup>11</sup> Health Action for Homeless People, (1999) *An Evaluation of a Pilot Peer Education Project*, Kensington, Chelsea and Westminster Health Authority.

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- Three Boroughs: young people, women and people from Black and minority ethnic communities
- HST: Few young people aged between 16 and 19, possibly as they are more attracted to the West End, with its targeted services.
- PCHP (C&I): Homeless families are now the 'hidden' client group, as all the funding is focused on homeless people sleeping rough.

## 2 Operationalising the policy questions

This paper provides information formulated in response to the following policy issues:

### Homeless peoples' needs

- What are the health needs of homeless people with experience of sleeping on the streets, in temporary and short-term accommodation?
- What are their unmet needs?
- What impact does their lifestyle have on their health and access to services?
- What are the needs of homeless refugee and asylum seekers?<sup>12</sup>

### Risks

- Are there pressing concerns presented by communicable diseases in to this group?
- Do homeless people expose the weaknesses in public health arrangements in London, if so what are the potential implications?
- In which ways does homelessness, and the link between homelessness and poor health, exacerbate other social problems?

### Barriers

- What are the barriers to mainstream primary care services?
- Mainstream versus specialist services: what are the advantages, disadvantages and preferences?
- What priority is given to homelessness by health authorities?

### Interventions

- What current initiatives enable homeless people to access services?
- What interventions are lacking?

### Knowledge

- What information exists on numbers and geographic 'pockets'?
- What do we know about the morbidity of homeless people?
- To what extent are new initiatives under the NHS White Paper influencing access to primary health care for this client group?

### Co-ordination

- Is there evidence of poor inter-agency working?
- How can multidisciplinary working on a local or pan-London basis be improved?
- What is the scope for London wide focus of activity?

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<sup>12</sup> The information contained in this report supplements the focus on homelessness and Black and Minority Ethnic communities, undertaken by Kusminder Chahal

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### 3 Methods

A review of NHS legislation and local policy and associated documentation:

- Health Improvement Programmes
- Information on 1<sup>st</sup> and 2<sup>nd</sup> wave PMS pilots
- Primary Care Act 1997
- Homelessness legislation and practice

Questionnaire to sixteen 'specialist' providers:

- 5 1<sup>st</sup> wave PMS pilots
- 4 prospective PMS pilots
- 3 multi-disciplinary (non medical) centres working with homeless families
- 4 primary health care and specialist medical services for homeless people

This achieved a 50 percent response rate, which was considered acceptable due to the very limited period of turnaround.

As a result of the questionnaire, additional telephone interviews were held with four of the agencies (included below)

Questionnaire to Health Authorities

A letter/questionnaire was sent to all London Directors of Public Health requesting information on homelessness interventions and notable examples of good practice and whether HImPs addressed homelessness.

Requests for information

A request for information was sent to the Royal College of General Practitioners. This elicited a copy of the Statement on Homelessness and General Practice and information on a recent conference organised with the Chartered Institute of Housing.

The London Research Centre supplied their latest data on patterns of homelessness in London, including data on refugees and asylum seekers

Face to face interviews with:

- Health Action for Homeless People
- Jude England, a researcher for the Access to General Practice for People Sleeping Rough (The Centre for Housing Policy, the University of York)
- Derek King and Maggie Rafalowicz at the Housing Corporation
- Peter Molyneux, Director of Health and Housing Project
- Andrew Griffiths, Assistant CE, The Chartered Institute of Environmental Health Officers

Telephone interviews and contact with:

- Fred Inman, Rough Sleepers Unit
  - Ros Dalby, Rough Sleepers Unit
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- Carlene Thomas, Environmental Health Officer Refugee Housing Working Group Coordinator
- Vicki Eves, NCH Action for Children, Bayswater Family Centre
- Jane Cook, clinical nurse specialist, Primary Care Health Team (Camden & Islington)
- Norma Golding, co-ordinator, Health Support Team, Parkside Health
- John Reacroft, project leader, Families in Temporary Accommodation (FiTA), Barnados
- Dr Claire Gerada
- Carlene Thomas, London Borough of Greenwich
- Paul Cavadino, NACRO
- Staff from several London health authority public health departments

Where possible, statements and observations made by interviewees are contained in this report.

### Literature Review

A selection of the cited literature appears in the appendix.

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## 4 Epidemiology

Patterns, distribution and trends; incidence and prevalence in London

Population data

Single people

In 1996, the London Research Centre estimated that there were 106,900 single homeless people in London. This included 63,000 'hidden homeless' people.

Rough Sleepers

In June 1998, as a result of a street count, it was estimated that 621 people were sleeping rough in Greater London<sup>13</sup>. The DETR has produced a table of 'Estimates of the number of people sleeping rough in England – June 1998'. It includes the 1998 Housing Investment Programme (HIP) estimate, together with the actual numbers identified on the street count. The most recent London data has been extracted below:

Local Authority area	1998 HIP estimate	Rough sleepers identified through street count (6.98)
Westminster	51+	237
Camden	51+	59
City of London	41 – 50	41
Tower Hamlets	51+	31
Brent	21 – 30	29
Croydon	21 – 30	25
Ealing	41 – 50	24
Kensington & Chelsea	21 – 30	23
Lambeth	11 – 20	20
Hounslow	No estimate	20
Islington	11 – 20	13
Richmond upon Thames	31 – 40	12
Hammersmith & Fulham	21 – 30	11
Haringey	41 – 50	8
Hackney	0 – 10	6
Waltham Forest	21 – 30	6
Barnet	21 – 30	2
Bromley	0 – 10	1
Harrow	0 – 10	0
Kingston upon Thames	0 – 10	0
Local Authority area	1998 HIP estimate	Estimate of rough sleepers where no street count (6.98)
Southwark	31 – 40	31
Newham	11 – 20	11
Greenwich	11 – 20	11

People in temporary accommodation

On an England-wide scale, in the second quarter of 1999, councils housed 7,580 households in bed and breakfast hotels, representing a 12 percent rise on the previous quarter. Numbers in hostel accommodation (including women's refuges) rose by 1 percent to 9,570. A similar number (9590) were deemed to be homeless at home whilst waiting for new accommodation

<sup>13</sup> Written Answer 85035 House of Commons, 19 May 1999

<sup>14</sup>. However, the rise in statutory homelessness appeared to have centred upon London and London accounts for 70 percent of the national usage of temporary accommodation <sup>15</sup>.

By the end of September 1998, the number of households living in temporary accommodation supported by London boroughs reached 52,932. Of these 34,192 (65 percent) were statutorily homeless under Housing Acts; the remaining 18,740 were destitute asylum seekers supported under the National Assistance Act 1948 or the Children Act 1989<sup>16</sup>. This is a marked reversal of trends. From a peak of 43,000 of homeless households accepted by local authorities under the Housing Act in 1992, the number of homeless households accepted under the Housing Act fell 36 percent to a low of 27,583 in March, 1997. 20 percent of households in temporary accommodation were placed bed and breakfast hotels. Around 70 percent of these were asylum seekers.

The most significant trend is associated with asylum seekers, many of whom are destitute <sup>17</sup>. The number of asylum seekers rose from around 4,000 applications per year to 44,000 in 1991, the great majority seeking assistance in London. Since the passage of the Asylum and Immigration Act of 1996 and the Housing Act 1996, local authorities main duties to asylum seekers varies according to immigration status. Asylum seeking households are not eligible for permanent social housing while their asylum application is outstanding.

The co-ordinator of a project working with homeless families in West London said that the number was now reaching the high proportions seen in the mid eighties. Two years ago, about three-quarters of the families were Westminster (i.e. local) placed residents. Now the proportion was nearer 50 percent Westminster and 50 percent other local authorities. The increasing numbers of people in temporary accommodation is associated with several trends reported by local authorities, including:

- An increasing use of bed and breakfast hotels and hotel annexes
- The use of poorer quality hotels
- Hoteliers demanding higher prices
- An increased use of out of borough placements
- An increasing number of households placed out of London
- Expenditure on temporary accommodation exceeding budgets <sup>18</sup>

A new national scheme for asylum seekers proposed in the White Paper, 'Fairer, faster and firmer – a modern approach to immigration and asylum' proposes a new national scheme for implementation in April 2000.

### Health trends: comparisons with general public

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<sup>14</sup> Property People, (16.9.99) *Homelessness on the increase again*

<sup>15</sup> Val White, Temporary Accommodation and Homelessness in London, May 1999, London Research Centre

<sup>16</sup> White, *ibid*.

<sup>17</sup> The Asylum and Immigration Act 1996 took away asylum seeker's rights to benefits if they did not apply at the port or entry. People who applied for asylum status before 1996, but whose application was refused, are also ineligible. Social Services responsibilities to asylum seekers arise from the National Assistance Act 1948 (for single people and childless couples) or the Children Act 1989 (for families with children, young people or unaccompanied children). These require Social Services Departments to assist people with accommodation and subsistence. Source: Homeless in London Bulletin 14, Asylum Seekers Special Edition Winter 1998/99.

<sup>18</sup> White, *ibid*

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One estimate of the life expectancy of someone sleeping rough is 42 years (compared with 74 for a man and 79 for a woman). The average age of death by natural causes is 46 years<sup>19</sup>. The suicide rate amongst people sleeping rough is higher than in the general public<sup>20</sup>.

A comparison between the self-reported health issues of homeless people (1280 living in hostels and bed and breakfast hotels and 507 rough sleepers using day centres and soup runs) and members of the general public participating in the British Household Panel Survey (5,000 plus households and 10,000 individuals) demonstrated that<sup>21</sup>:

- Over a third of hostel and B & B dwellers and well over half of the rough sleepers reported having more than one health problem, compared with a quarter of the general public
- A review of nine common health complaints showed that every health problem but one was much higher for the homeless, in the case of ‘wounds, skin ulcers and other skin complaints’, two or three time more evident<sup>22</sup>. The one exception – where members of general public were likely to more affected – was ‘heart complaints’.

### Communicable diseases

Communicable diseases are a major cause of ill-health in the United Kingdom, accounting for 17 percent of GP consultations, 4.4 percent of hospital admissions and 6.7 percent of deaths<sup>23</sup>. The Public Health Laboratory Service (PHLS) notes that while formal analysis and publication of the relationship between communicable disease and social inequality in the United Kingdom has been lacking in recent years, they suggest that there is an accumulation of evidence to show that the poorest fifth of the population, and particularly socially excluded groups such as the homeless, are at greater risk of communicable diseases.

Homeless people as a group are especially vulnerable to several major communicable diseases which have been allocated priority one status by PHLS<sup>24</sup>. These include, in particular, Hepatitis B and C, Tuberculosis and, considered under a separate heading, sexually transmitted diseases.

**Hepatitis B** virus (HBV) saw a 43 percent increase in the number of laboratory-confirmed acute cases in England and Wales between 1996 and 1998 (855 cases). The majority of cases occurred in injecting drug users (46 percent of total).

**Hepatitis C** virus (HCV) was identified in 1989. Reports of HCV infections doubled each year from 1992 to 1995. The total rose to over 3000 in 1997, due at least in part to increased diagnostic experience with the disease. Its prevalence in England and Wales is estimated at 0.5 percent to 1 percent of the general population, in a proportion of whom it causes chronic active hepatitis and cirrhosis.

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<sup>19</sup> Grenier.P (1996) *Still Dying for a Home* London: Crisis

<sup>20</sup> Baker, L (1997) *Homelessness and Suicide* London; Shelter

<sup>21</sup> Bines, W (1994) *The Health of Single Homeless People* University of York, Centre for Housing Policy

<sup>22</sup> The illness are: Chronic chest or breathing problems, heart problems, wounds & skins ulcers, musculoskeletal problems, fits or loss of consciousness, digestive problems, frequent headaches, and mental ill-health

<sup>23</sup> Catchpole, M et al, Quarterly Communicable Disease Review, January to March 1999, Journal of Public Health Medicine, Vol 21, No 3, pp.348-354

<sup>24</sup> PHLS overview of communicable diseases 1997: results of a priority setting exercise A Rushdy, M O’Mahony, on behalf of the PHLS Overview of Communicable Diseases Committee Communicable Disease Report Volume 8 Supplement 5 November 1998

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The link between Hepatitis B and C and homelessness is largely due to the high prevalence of intravenous drug use among some homeless people. Homeless ex-offenders are a subset of the homeless population at particular risk. A survey of offenders in prisons in proximity to London undertaken by PHLS in 1997-1998 (2807 men; 410 women; 713 male young offenders) indicated that Hepatitis B rates varied from 8.2 percent in males to 12 percent in females (with 3.9 percent prevalence among young offenders) and HCV rates from 8.7 percent in males to 11 percent in females (with 0.6 percent prevalence rate among young offenders). While these general rates were lower than expected when the population was broken down by history of intravenous drug use a strong association was found: 82 percent of those found to have HCV infection were drug users although the prevalence of HCV among the total population of injectors was lower than expected at 30 percent<sup>25</sup>.

Community studies disclose pockets of Hepatitis at even higher prevalence. A London-based GP providing health care to homeless people tested 550 patients and discovered that less than ten percent had HIV but over 50 percent had hepatitis C<sup>26</sup>. He added "...if someone has been injecting for three or four years you can almost guarantee they've got Hepatitis C".

Low immunisation rates among both institutionalised groups and among the general ranks of the homeless are one explanation. The World Health Organisation (WHO) recommended that all countries institute universal vaccination against Hepatitis B by 1997. The UK's current vaccination policy is selective. The target groups, such as drug injectors, are currently poorly covered. For example, although immunisation to prison inmates is free, the prison study noted above found that only 14 percent of men who had injected drugs had been immunised with Hepatitis B vaccine while 31 percent of women had been immunised. One health authority public health department informed us that in their recent ongoing contacts with their local prison (where prison health services were being supplemented by contracted NHS services) communication on patients was poor. Typically, medical notes suffered delay on inter-prison transfers.

**Tuberculosis** (TB) has declined as a health problem in England and Wales, with 5,608 cases notified in 1996 and about 400 deaths - although it is still accorded priority one ranking by PHLS. Tuberculosis notifications have remained fairly stable in the past decade, before which they had been falling gradually.

In the UK TB is linked with social risk factors including alcoholism, diabetes and intravenous drug use and has had a long association with special provision for the homeless; for many years a mobile X-ray services operated among hostels serving homeless men in London. Specialist health workers in contact with homeless families have identified TB amongst their clients. Due to concerns in the increase prevalence, an open access clinic is to be established in West London for TB screening<sup>27</sup>.

While the UK is a low-prevalence country TB remains the commonest bacterial cause of morbidity and mortality world-wide, with nearly 8 million new cases and 3 million deaths annually, mostly in developing countries. The influx of refugees and asylum seekers from Russia and Albania has resulted in the increase prevalence of open TB. There are particular risks and concerns when they are housed in close proximity to children with HIV, most of

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<sup>25</sup> Catchpole, *ibid*.

<sup>26</sup> Quoted in unpublished recent report on access to GPs

<sup>27</sup> This will be run jointly by the TB team at St Mary's W2, the Bayswater Family Centre and the Health Support Team (KCW)

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whom are refugees from sub-Saharan Africa<sup>28</sup>. Of more general concern is the potential for the spread of drug resistance strains of TB. The SMAC (Standing Medical Advisory Committee) Sub-Group on Antimicrobial Resistance notes that resistance is a major problem in many developing countries and may be imported into the UK<sup>29</sup> (for example by refugees and asylum seekers). It notes that earlier periods of ineffective treatment overseas raise the issue of resistance to drug treatment, which is linked to the fact that TB is treated with combinations of three or four agents for at least 6 months. Monotherapy leads rapidly to resistance by selecting spontaneous mutants but even with combination therapy resistance emerges when there is poor compliance by the patient, incorrect dosage or malabsorption of the drugs.

SMAC has called for faster diagnosis to identify patients requiring antimicrobial therapy but it has also been observed that as the disease becomes rarer in the UK, there is a consequent loss of skills in its management, leading to delays in diagnosis and treatment<sup>30</sup>.

### Sexual health risks

**Sexual health risks** include sexually transmitted diseases, unwanted pregnancy, poor uptake of preventive services, and prior or current vulnerability to sexual assault or abuse.

Gonorrhoea is an important indicator of the level of high risk sexual behaviour. After a falling trend, reports of gonorrhoea increased by 20 percent in 1996, with the largest rise being seen in teenage women in the Thames regions. Both males and females of young homeless are vulnerable to sexual exploitation and therefore are at elevated risk of contacting gonorrhoea and other sexually transmissible diseases. Some groups of refugees are former citizens of countries at risk from the spread of HIV/AIDS.

In interview with staff in homelessness agencies and health professionals expressed their concern about the sexual behaviour of young people sleeping rough. As an indicator of risk, a manager at an organisation working with homeless young people estimated that four out of ten young women residents were likely to get pregnant. This figure is corroborated by recent research that took place at another centre for homeless young people. Forty percent of the young women who participated in the research became pregnant between their first and second interview.

The problems of securing permanent registration with a GP restricts women's access to regular breast and cervical screening. A number of women refugees and asylum seekers have experienced sexual assault prior to their arrival in the country. An interview with a staff member providing support to homeless families in a number of boroughs cited the example of a woman from the Horn of Africa who contracted a sexually transmitted disease as a result of a rape. She was in fear of being stigmatised and ostracised if she consulted with a GP. As a consequence, there was a delay in treatment which has resulted in permanent damage to her reproductive system.

### Children

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<sup>28</sup> Comments from co-ordinator of Bayswater Family Centre

<sup>29</sup> SMAC (Standing Medical Advisory Committee) Sub-Group on Antimicrobial Resistance, *The Path of Least Resistance*, 1999

<sup>30</sup> Wares, DF et al, Delay in Diagnosis of Tuberculosis; of remaining concern in England and Wales, *Journal of Public Health Medicine*, Vol 21 No 3, pp. 355-356

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Various studies have documented the problems of unsatisfactory accommodation on children's health. Children's health and well-being is affected by circumstances like overcrowding; sleep patterns are disrupted by parents needing to occupy the same room in the evenings, for example. The opportunities for a nutritional diet are compromised by insufficient income, lack of advice on healthy eating on a small budget and limited, often unsanitary, cooking facilities. There are high accident rates in such circumstances<sup>31</sup>.

Many children from homeless families spend a considerable amount of time out of school, due to mobility restrictions imposed by the placing agency. This has an impact on their physical and psychological health. Research into the psychological health of children within homeless families accommodation found:

- nearly 50 percent of the under-fives showed at least one developmental delay
- one-third were attending special needs classes
- there is a high incidence of depression, disturbed sleep, over-activity, bed-wetting and soiling, toilet training problems, temper tantrums and aggression many were victims of violent or sexual abuse<sup>32</sup>

The support needs of children with special needs are typically identified at birth or at the onset of the disability and systems are put in place. Health staff have experienced problems in securing assessments with Child Development Teams for newly-arrived homeless children with disabilities. When treating such a child, GPs tend to focus on the immediate presenting problem rather than the child's longer-term needs. A likely explanation is that the GP normally expects that the support needs of a child with learning disabilities will have already been identified at an earlier age. In a response to our questionnaire, one respondent working with homeless families identified the health of children with special needs as one of the five most frequently presented health issues.

### Refugees and asylum seekers

Refugees and asylum seekers have diverse points of geographical origin and present a complex picture of needs. Mental distress is common amongst homeless asylum seekers and refugees. Some groups may have been psychologically traumatised before their arrival in the UK and their initial reception in this country, the isolation associated with a new environment, and the transitory life style that is experienced by all homeless families, may make refugees suspicious and distrustful of the police, social services and hospitals. Uncertainty about their refugee status – most being given 'special leave to remain' – means that expulsion is perceived an ever-presence background reality. There may be unwillingness to seek help for health problems as they may fear that this would jeopardise the granting of asylum<sup>33</sup>. These problems may be compounded by language and other communication difficulties, including cultural norms and structures of health belief which may militate against effective problem resolution by health and social services.

While many homeless families experience subsistence living, this is more extreme for asylum seekers and refugees, their income being often below Income Support levels. Destitute asylum seekers and refugees often receive no financial support at all. A pregnant woman may

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<sup>31</sup> Accidents, of course, do not just affect children.

<sup>32</sup> Quoted in HAS, (1995) *People who are homeless: mental health services*. London: HMSO

<sup>33</sup> David Robertson, Ganeesh Sathyamoorthy, and Richard Ford, Hounslow Blues, *Open Mind*, January/February 1999, pp.8/9.

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not be able to get adequate nourishment. Someone with diabetes may not be able to purchase their insulin-injecting equipment (when their needs cannot be met through prescriptions). A response from a PMS GP surgery indicated that there is a high rate of bowel parasites amongst his refugee patients from Asia. There is also a higher than average rate of hepatitis B amongst Kosovan refugees and asylum seekers

### Homeless families living in hotels

In 1997 a review was undertaken of homeless families and individuals in KCW Health Authority who were living in temporary accommodation (mainly B&Bs and hotels). The population included a large proportion of refugees and asylum seekers. It suggested that as new arrivals come into an area “there is often a need for crisis intervention, as people’s health, housing and social needs may have reached an acute point. In the longer term, although issues may not be completely resolved, if the right assistance has been provided initially, then people are able to cope much better with their particular situation ... and better able to access mainstream local practices for their primary health care needs.”<sup>34</sup>

A peer education health project in West London identified the following health needs and concerns amongst hotel residents and other new arrivals <sup>35</sup>:

- high rates of depression
- high rates of asthma
- many congenital heart problems amongst children
- difficulties in registering with GPs and experience of abusive GPs
- difficulties in getting referrals to secondary health services
- difficulty in accessing dentists
- a lack of knowledge about the services available from pharmacists
- a lack of know about emergency services
- environmental health problems and hazards, particularly for children in the hotels

### People with a history of mental illness

The 1996 OPCS Psychiatric Morbidity Survey found that mental health problems were nearly four times as common among hostel residents as in the non-homeless general population. Allowing for different means of measurement, severe mental illness is generally reported in 30 percent to 50 percent of the homeless families and other long-term residents of B&Bs and hotels, and above 50 percent in people using temporary hostels and sleeping out. Among middle-aged population the prevalence of schizophrenia and other psychoses is particularly high. Amongst the younger people (under 25 years old) there is higher incidence of depression, anxiety and impulsive self-harm <sup>36</sup>.

In the survey by Bines<sup>37</sup>:

- 28 percent of 1280 people living in hostels and B & B accommodation reported having mental health problems. One in eight had been an in-patient of a psychiatric hospital

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<sup>34</sup> Report to KCW HA meeting on 28 January 1998, which led to agreement to establish the Health Support Team

<sup>35</sup> Health Action for Homeless People (1999) *An evaluation of a pilot peer education project*, Kensington, Chelsea and Westminster Health Authority

<sup>36</sup> Dean, R. & Craig, T. (1999) *Pressure Points: Why people with mental health problems become homeless*. London: Crisis

<sup>37</sup> Dean, *ibid*

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- of the 507 people using day centres and soup runs (most of whom were sleeping rough), 36 percent of the day centre users said they had a mental health problem (and 1 in 5 had been an inpatient), compared with 40 percent of those using soup runs (with 1 in 6 having a history of inpatient treatment)
- 10 percent of the people in temporary accommodation said that mental health problems created difficulties in finding and keeping accommodation
- Less than a third of the people reporting to have mental health problems were receiving treatment.

An analysis of 633 homeless people in contact for the first time with one of the teams funded under the Homeless Mentally Ill Initiative (HMII) in 1996/7 demonstrated that:

- 144 (22 percent) were referred with depression
- 85 (13.5 percent) people had ‘eccentric or odd behaviour’
- 76 (12 percent) had a ‘history of mental illness’
- 64 (10 percent) people ‘wanted someone to talk to’<sup>38</sup>

Recent research into access to GPs<sup>39</sup> suggests that the feelings of stress, anxiety and depression are closely associated with life on the streets. For many, the problems of isolation and the attitude of society towards them exacerbated their situation.

There are varying estimates of the prevalence of severe mental illness:

- Connelly and Crown estimate to fall between 12 percent and 26 percent among single homeless people<sup>40</sup>
- Scott suggests that there is an overall prevalence between 30 percent and 50 percent amongst the hostel and shelter population<sup>41</sup>
- In a study of homeless adults in hotel accommodation (65 percent of whom had accompanying children), the incidence of mental morbidity was more than twice that of the domiciled population<sup>42</sup>

### Mental health combined with drug and/or alcohol use

Dual diagnosis patients (e.g. mental health/personality disorder and substance misuse problems) often present the greatest difficulty as perceived by health workers. A major problem cited is the lack of drug and alcohol services in London which are prepared to accept clients with a diagnosed mental health problem.

O’Leary’s study of 440 residents (most with a history of rough sleeping) in four cold weather shelters in the winter of 1996/7, focused on the occurrence of mental health combined with problematic drug and/or alcohol use<sup>43</sup>. She noted that 46 percent (203) had indication of a mental health problem; 23 percent (100) gave some indication; 17 percent (74) had a clear indication of a mental health problem. A further of 236 residents who were believed to have a mental health problem, 70 percent (167) were also perceived to be alcohol or drug dependent. Among this same client group, 62 percent (271) also had one or more health problems, of which 35 percent (97) had at least one (undefined) serious health problem.

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<sup>38</sup> Croft-White, C. (1998) *Evaluation of the Homeless Mentally Ill Initiative 1990 - 1997*

<sup>39</sup> see previous footnotes

<sup>40</sup> Connelly, J. & Crown, J. (1994) *Homelessness and Ill Health* London: Royal College of Physicians

<sup>41</sup> Scott, J. (1993) *Homelessness and mental illness*. *British Journal of Psychiatry*, 162, 314 - 324

<sup>42</sup> Victor, C., (1992) *Health status of temporarily homeless population and residents of North West Thames Region*. *British Medical Journal*, 305, 387 - 391

<sup>43</sup> O’Leary, J. (1997) *Beyond help?* London: National Homeless Alliance

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## Prisons and the mentally disordered offender

The Chief Inspector of Prisons' thematic report on young prisoners observed that on reception that approximately 25 percent were homeless or in insecure accommodation<sup>44</sup>. Several surveys indicate that between 40 percent to 50 percent released prisoners experienced rates of homelessness or insecure accommodation<sup>45</sup>. There is a large overlap between mental illness and the prison population and a further overlap between people discharged from prison and the homeless. Between 1986 and 1996 the number of restricted patients admitted to hospital suffering from mental illness (with or without other disorders) increased almost fourfold from 245 to 963 (largely due to an increase in the proportion of hospital admissions transferred from prison), achieving a total figure for restricted patients 2,586 in 1996. 931 restricted patients were released into the community in 1996<sup>46</sup>. Recent research has shown a clear link between lifestyle factors like alcohol and drug misuse and homelessness and reoffending<sup>47</sup>.

One psychiatrist has suggested that the stigma attached to ex-prisoners with multiple problems is a major reason for such difficulties: "Once they're out of prison, what do you do with them? There's a real dilemma in placing someone who's been in prison. A stigma is attached to them. Although we've got community mental health teams and many excellent voluntary support agencies, the ex-prisoner, called a mentally disordered offender, is an unwelcome guest. Half of them have drug dependency problems. That will exclude them at once from a number of places, however good hearted they are. If they have robbed someone aggressively or set fire to somewhere, even fewer hostels are willing to have them"<sup>48</sup>

Those discharged from psychiatric hospital or substance rehabilitation settings are often rehoused in areas with a high level of drug dealing or other form of heightened stress or deprivation where housing is affordable to housing or community care agencies.

## Dental care

The dental health of homeless people can be adversely affected by poor diet and the inaccessibility of washing facilities. The use of oral methadone can have an impact on dental health and treatment can be problematic if the patient is continuing to use drugs and the use of anaesthetics is potentially dangerous<sup>49</sup>.

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<sup>44</sup> *Young Prisoners*, Home Office, 1997

<sup>45</sup> NACRO, *Making a Fresh Start, Reducing crime by rehabilitating prisoners*, February, 1998.

<sup>46</sup> Chris Kershaw and Gary Renshaw, *Statistics of mentally disordered offenders in England and Wales 1996*, Research, Development and Statistics Directorate, Home Office, 10 September 1997

<sup>47</sup> Chris May *Explaining reconviction following a community sentence: the role of social factors*, Research, Development and Statistics Directorate, Home Office Research Study 192, 1999

<sup>48</sup> Trevor Turner, Mad, Bad or Sad, *RSA Journal*, no. 3-4 1999, pp.116-199,

<sup>49</sup> G Rayner and C Croft White, *A needs analysis of HIV in context of dentistry, pharmacists and optometrists*, unpublished research, Lambeth, Southwark and Lewisham Health Authority.

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## 5 Interventions available/current practice or policy

### Health Improvement Programmes

Health Improvement Programmes (HImPs) in London, led by health authorities but the product of partnership working between the NHS and local government, vary significantly in style, content, and depth as regards homelessness. The issue is mentioned, in passing, in most, usually in relation to policies related to mental health, drugs, refugees and regeneration, as well as in general statements about inequalities and public health or communicable disease. In some cases the main body of operational policy are found outside the HimP – and may not be reflected fully within them - and by and large health authorities with large numbers of homeless people have the more developed policies. In some cases the HImPs are aspirational documents; in particular cases they say little on the theme of homelessness and health, in other cases they represent attempts to establish targets, processes and mechanisms between the health and local authorities. What follows is an incomplete list of action points and plans from the HImPs that were returned following a request for information.

**Barnet HImP** notes that under one-third of housing applicants (1027) were accepted for housing and that there were 2184 homeless households in August 1999, over 900 of whom were placed in hotels or hostels. A day centre for the homeless was operated with services directly and indirect health related, incorporating user surveys. Actions recommended under the HimP included the funding of the day centre service, specialist health visitor for children/adolescents in housing need (funding unidentified), and reviews of psychiatric provision and wet hostel accommodation.

**Brent and Harrow HimP** details the broader links between health and housing and sets homelessness in the general context of the level of affordable accommodation. It refers to borough's housing needs survey showing that one-third of households in need thought that their housing was affecting their health and referred to the Harlesden Health Survey which identified 10 percent of households with someone living there who would otherwise be sleeping rough. It noted that a street count found no rough sleepers in Harrow in 1995 but nevertheless single homelessness was a "significant problem" with 349 people found to be priority need. The HimP sets out the general aim of ensuring "that all agencies work collaboratively to address homelessness and poor housing .." and presenting 11 objective for Brent, ranging from the development of "multi-agency baseline information" to "addressing the needs of homeless families in bed and breakfast". The 11 objectives for Brent ranged from "reducing the incidence of fuel poverty" to "introducing licensing for houses in multiple occupation". A further set of joint objectives covering both boroughs ranged from the reduction in the proportion of the population "living in overcrowded conditions" ... "to increase Housing Benefit take up and improved debt counselling". These objectives are presented with the list of agencies involved and a timescale for action.

**East London and City Health Authority** refers to "services for Homeless Mentally Ill people", setting the objective of maintaining coherence between services for homeless people and for mentally ill people following transfer of responsibility for homeless initiatives from DoH to the Social Exclusion Unit [in fact DETR], and ensure that development of continuing engagement explicitly takes account of the needs of homeless people".

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**Camden and Islington HAZ** refers to homelessness under 'Social Inclusion', noting that Camden has the highest and Islington the third highest rate of homeless acceptances in London, as well as 3,000 asylum seekers in two boroughs at any one time.

**Ealing, Hammersmith and Hounslow** reviews individual services in terms of their main weaknesses and notes "poor sensitivities to particular communities including people for English is not their first language, people with mental health problems and the homeless and roofless". It notes the existence of vulnerable young women, including young offenders, the homeless and transient population, and refugees, and the need to progress services for people with 'dual diagnosis' noting the potential need for pan-London tertiary provision, and support for a homeless project. Special projects include a project with Housing Departments to improve access to cooking facilities for people in temporary accommodation.

The **Hillingdon HimP** refers to the special chapter of the Annual Public Health Report, where mention is made of the links between homelessness and health and the rapid rise of homelessness in Hillingdon, with 950 new cases a year. It notes the housing service has developed a system of notifying health visitors of changes of address and the formation of the Healthy Hillingdon Strategy Group Homes for Vulnerable Groups Project, further training for health visitors and a multi-agency scheme for accommodation of 16-25 year old men and women.

The **Kensington, Chelsea and Westminster HimP** notes the high mobility of the population, the 9,000 people estimated as homeless in the two boroughs and the 500 people sleeping rough on a daily basis. Homeless and Refugees feature are one of seven action plans

**Redbridge and Waltham Forest HimP** notes the high prevalence of houses in multiple occupation (700) in Redbridge and the high rate of applications (1500) for rehousing in Waltham Forest by homeless families. The priorities for action was to "increase the supply of affordable housing", reduce dependency on Bed and Breakfast accommodation and develop special needs housing, via Housing Investment Strategies.

**Kingston and Richmond HimP** called for the review of housing policy for young people who did not meet the rehousing criteria, "develop action to cease use of bed and breakfast for families with young children" and "consider expanding community development initiatives to specific community groups such as refugees and asylum seekers..."

**Lambeth, Lewisham and Southwark and HimP** notes under "key issues" that "Refugees ... are more likely to be housed in temporary accommodation, have problems finding employment, have first language that is not English, live in the most deprived areas and are less likely to be registered with a doctor". The 1997/1998 Annual Report of the Director of Public Health mentions administrative simplifications to improve notifications for communicable diseases, involving GPs and local hostels.

The (draft) **Bexley and Greenwich Health Authority HImP**, noting that there were 349 adults and 287 children in Bexley and 672 adults and 278 children in Greenwich seeking asylum in December 1998 noted that the refugees' experience was often one of "sadness, trauma, discrimination and poverty". Under the heading of Cutting Inequalities says it would "improve access to health care and health care assessment by refugees and asylum seekers".

The **Bromley HimP** refers to a "Joint Commissioning Funded Refugee Strategy post".

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## Interventions targeted to homeless people

The following section gives examples of the principal interventions that target - or are accessed by – homeless people. There is no London-wide directory of health services for this client group to check the comprehensiveness or completeness of the information provided.

### Primary care services within projects for single homeless people

A recent survey of 1,019 homelessness projects in England (a 57 percent return rate on the questionnaire) identified that just less than 20 percent provided some GP services within their project. A further 75 percent of projects in London reported that a specialist GP service operated within their area<sup>50</sup>. There showed a high degree of use of these services, with users more likely to access primary care from this source, in preference to a local GP practice or A&E department.

The range of primary care services on offer varied amongst projects. Some received scheduled visits from primary health care workers – frequently local GPs and their practice nurses - on a weekly basis. Weekly sessions are provided by one of the primary care or mental health outreach teams (see below). Service users can receive treatment from a GP, a psychiatrist, senior registrar or psychologist, a nurse or a CPN. Health advice and information from a clinical nurse practitioner or other appropriately qualified staff is also available. Referrals are made to secondary and other specialist services where necessary, and support is also offered to project staff in dealing with clients with physical or psychiatric problems.

Although ‘on-site’ services are able to increase the take-up of primary care services by homeless people, there are concerns that the unavailability of this service out of hours (i.e. when service providers are not present at the project) delays treatment and attention to health problems, which subsequently become more acute.

Chiropody, dental and optician services are also available at some of the day centres. However, one problem is follow-through by clients. One optician (interviewed for a recent study) indicated that there was a box of unclaimed spectacles awaiting collection.

Many homelessness projects have a team member with designated responsibility for health. In some teams, there is a specialist health worker (who may be medically trained), whereas in others it is a shared responsibility amongst team members. Their role is to improve health awareness within both the staff team and service users, encourage clients to use visiting medical services, act as advocate on behalf of their clients, and act as liaison between external medical services and the client group.

### Special medical centres for single homeless people

There are a small number of premises-based medical centres that target single homeless people. The largest is Great Chapel Street Medical Centre, which was established in 1978. It provides a daily primary care medical services in central London through sessional inputs from a GP, psychiatrist, dentist, CPN, drug and alcohol specialist, social worker, and occupational therapist. There is high demand for services in London’s West End by homeless people who are transient or living in local hotels. The specialised supportive environment

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<sup>50</sup> Recent unpublished research in to access to GPs by rough sleepers

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makes it more accessible to people who, typically, lead a chaotic lifestyle and are unable or unwilling to use appointment systems.

### Primary care outreach teams

Three teams serve the areas where there is a high prevalence of single homeless people and families:

- Primary Care Health Project (Camden and Islington)
- Three Boroughs team (Lambeth, Southwark and Lewisham)
- Joint Homelessness Team (Westminster and Kensington & Chelsea)
- HHELP (Tower Hamlets and the City).

While they may have a static base where clients and patients can be seen by medical staff, a major aspect of their work is to provide outreach work and sessions in settings frequented by this client group. For example, one team provides weekly sessions in four drop-in centres or lunch clubs; eight direct access or short-term hostels; four cold weather shelters (in season); one medical centre for homeless people; and one inter-cultural therapy centre (for brief or long-term therapeutic interventions). In these settings, typical services include medical care, health advice and information, advocacy, support and referral to mainstream, specialist and secondary services. In addition, the teams offer:

- Support to GPs in the locality to facilitate in the registration of homeless people
- Information and local directories on services available to homeless people
- Holistic assessments of need that include the identification of needs around welfare benefits, housing issues, social care, education, etc
- Liaison with local authority departments to monitor and improve the living and environmental conditions for homeless people
- Training sessions and materials for staff working with homeless people in different contexts

### Mental health outreach

Many of the primary care outreach services come into contact with homeless people with mental health problems (see Section 4). In order to support less experienced workers and to offer assessment and intervention on the streets, the Homeless Mentally Ill Initiative (HMII) has funded six specialist teams since 1990. The aim of the multi-disciplinary outreach teams - each operating within a defined catchment area - is to “identify clients not in touch with statutory services, make an assessment of their needs, provide medical and social interventions and refer them to statutory services as appropriate.”<sup>51</sup> . Local need and pattern of demand has influenced each teams’ practice, creating variations between them.

The balance and representation of disciplines is influenced by the status of the managing agent. For example, the teams managed by health trusts tend to have a greater proportion of nursing to social care staff. Job descriptions reflect a sharing of team responsibilities, together with the utilisation of professional skills and the pursuit of specialist interests (such as young people, minority and ethnic communities, housing and resettlement, training and research.) Psychiatric input ranges from a full-time consultant psychiatrist post to sessional hours. Due to problems in attracting interest from appropriately qualified psychiatrists in the sessional posts, a number of the teams are without regular psychiatric input.

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<sup>51</sup> Craig, T., Bayliss, E., Klein, O., Manning, P. & Reader, L. (1995) *The homeless mentally ill initiative, An evaluation of four clinical teams*, Department of Health

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The principle roles of the teams are to:

- identify and contact homeless mentally ill people who are isolated from existing services, through regular outreach sessions on the streets, attendance at day centres and hostels for homeless people, and accepting referrals from professionals and the general public
- ‘engage’ with clients through the provision of practical and emotional support
- undertake an assessment of the client’s needs and to encourage them to move ‘indoors’ where appropriate
- initiate psychiatric and Mental Health Act assessments as required, and to support clients through in-patient treatment and the Care Programme Approach (CPA)
- provide a ‘care management’ role to individuals who require it, whilst they remain clients of the HMII
- negotiate and support the transfer of clients to community-based health, social care and housing services
- offer training and support to staff working in the homelessness field <sup>52</sup>

#### Voluntary sector weekend mobile primary care service

Crisis, the homelessness charity, and St John’s Ambulance run a mobile primary health care outreach service at weekends. A St John’s Ambulance vehicle is sited close to streets known to be used by people sleeping rough. Volunteers offer first aid, podiatry, and advice on health and housing. The ambulance is also used as a base for groups of nurses and first aiders to walk around the streets to engage with homeless people in health related activity <sup>53</sup>.

#### Dedicated health workers and forums targeting homeless people

A survey of health initiatives that focus on homeless individuals and families in London was undertaken in 1998. Activity was reported in twenty-seven boroughs. In addition to the multi-disciplinary teams described above, six boroughs – Barnet, Croydon, Enfield, Greenwich, Harrow and Waltham Forest - have Health Visitors or nurse practitioners who works specifically with homeless individuals and families.

A number of boroughs have established multi-disciplinary forums to monitor health and homelessness issues and to identify areas for attention, for example the provision of primary care advice and information within homeless projects; improved access to community care and housing services; support for rough sleepers using cold weather shelters<sup>54</sup>.

#### Accident and emergency services

Traditionally people who experience problems - for whatever reason - registering with a GP have used Accident and Emergency (A & E) services for their primary care needs. In a recent study of the use of the A & E Department at the Royal London Hospital <sup>55</sup>, only 3 percent of attendees were single homeless people. This included a group of “highly visible regular users who reflect common homelessness stereotypes – men, alcohol users and long-term

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<sup>52</sup> Text taken from Croft-White, C. (1998) *Evaluation of the Homeless Mentally Ill Initiative 1990 –1997*, Department of Health

<sup>53</sup> Information taken from the draft Williams, R. (1998), *Evaluation Crisis/St John Street Care Pilot* London: Crisis

<sup>54</sup> More detailed information can be found in Bardsley, M., and Rafalowicz, M, (1998) *Housing and Health in London: A survey of work in Health and Local Authorities* London: Housing Corporation and Health of Londoners Project

<sup>55</sup> Hinton, T. (1995) *Measuring Up: A study of how A & E services respond to single homeless people*, ELCHA/Corporation of London/London Borough of Tower Hamlets

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homeless.” There was also a group of younger people with mental health problems who had with multiple attendance. There were low levels of GP registration amongst the homeless users and no information was routinely given on the benefits of registration. The staff had not received any formal training about the care and health needs of homeless people and there were no specific policies in place. Homeless patients with urgent complaints received a comparable service to the non-homeless, the major problems encountered were the lack of washing facilities before treatment, the lack of privacy for those with mental health problems, the absence of any links or liaison with homelessness agencies in the area, and the high rate of people leaving before treatment occurred. The report recommends joint training and reciprocal visits with homelessness agency staff, clear discharge policies to the local specialist homelessness team, the creation of a directory and information file on homelessness and the establishment a store of replacement clean clothes.

An unpublished survey into access to GPs by people sleeping rough found that this group made more use of A & E departments than local GPs. The main issues arising from the use of A&E was the length of waiting time (which may be a common issue for many attendees), the negative attitudes of staff (at all levels), and the failure to do more that treat the presenting problem.

#### Primary care act pilots (PMS and PMS+)

A number of 1<sup>st</sup> and 2<sup>nd</sup> PMS pilots are targeting homeless people. (It is problematic to be precise on numbers as many refer to ‘deprived local communities’, ‘refugees and asylum seekers’ –, both of which are likely to encompass homeless people.) A report on PMS pilots and ‘rough sleeping’ provides some early insights into this model of care<sup>56</sup>. With the proviso that this data relates to a national survey (and anonymity of the brief case studies prevents the identification of London-based services), early findings suggest that the practice nurse plays a key role. They are able to:

- Assist with registration of patients and to provide some continuity of care to people sleeping rough
- Fill a void where it has been problematic to recruit a GP to the service (a reason given by some potential pilots for withdrawing from the scheme)
- Offer holistic health screening to the patients
- Undertake some outreach work, where appropriate, and take the service to the patient
- Allocate time to listening to patients’ concerns around issues that go beyond the health focus
- Appropriately divert patients away from lengthy consultations with the GP

Other findings from the PMS pilots include:

- The need for a longer than average consultation time
- The need for flexible opening hours when targeting rough sleepers
- The need to liaise and build links with a wide range of agencies, both within the health and homelessness arena
- The identification of problems in recruiting salaried GPs to work with this client group - a problem that is inherent in the PMS model
- The problems in identifying suitable training for the nurse practitioner
- The drawbacks of the nurse practitioner having limited powers to prescribe

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<sup>56</sup> Riley, A. *et al* (1999) *Rough Sleeping Report: Personal Medical Services Pilots: June 1999*, St Bartholomew’s and the Royal London School of Medicine and Dentistry

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- The problems of accessing interpretation services, which often has to be done over the telephone or via a relative
- The value of outreach services from a multi-disciplinary team that can offer a holistic response to people's needs
- The need for a non-judgemental service that neither criticises or condones people's lifestyles
- The value of a walk-in service with an open door policy, that is highly tolerant to the client group

#### NHS direct 'fair access'

A proposal has been accepted under NHS Fair Access to pilot dedicated phone points for homeless people using two agencies. The pilot scheme is a partnership between NHS Direct South London and Homeless Network<sup>57</sup>. A dedicated telephone exchange line programmed for NHS Direct calls only (with a telephone hood to provide a level of privacy) has been installed in the North Lambeth Day Centre (Waterloo) and the Gateway Project (a foyer scheme in Camberwell). The former has been selected as the pilot will complement the free phone services for welfare and housing issues. The latter already has established links with GPs and the pilot has the potential of being attractive to residents and would 'bolster the work of staff'<sup>58</sup>. The majority of the service users in both projects are homeless people who are either sleeping rough, in short-term hostels or temporary accommodation. The pilots will run for six months and be operational from mid-October 1999. After the initial capital outlay of £4,000, the running costs of the pilot are estimated at a further £4,000. This figure includes the cost of evaluating the scheme.

#### Drug and alcohol services

In recognition of the high levels of drug and alcohol use amongst homeless people, especially the single homeless, there is much evidence of joint work with specialist substance misuse services. This includes joint outreach work on the streets, regular sessions by a drug and alcohol counsellors within homelessness projects, and the secondment of specialist substance misuse workers to homelessness projects to increase staff understand and joint training opportunities. This practice also makes possible joint assessments to facilitate the identification of substance misuse, leading on to referrals to detoxification and rehabilitation services. Two significant barriers to treatment are long waiting times which reduces motivation and the lack of services that accept people with mental health needs in addition to their drug and alcohol use.

#### Access to other primary care services

In the recent unpublished research into access to GPs by homeless people, an indication was received on the accessibility of other primary care services by this client group:

- *chiroprody* services were the hardest to locate with 44 percent (of 677 respondents) reporting that access was difficult
- forty per cent (of 402 respondents) said that it was difficult to access *dental* services
- slightly less – 39 percent (of 385) – said that *opticians* were hard to access.

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<sup>57</sup> A similar pilot is also proposed in West London but its planning is not so advanced

<sup>58</sup> Working paper: NHS Direct Fair Access: NHS Direct South London working with the Homeless Network: Homeless Pilot.

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Project staff working with homeless families suggest that access to dental and optician services is easier than access to GPs.

### TB screening clinics

Due to the increasing incidence of TB amongst the homeless population in West London, a weekly open access TB screening service is being planned in a Family Centre frequented by homeless families. This need has arisen due to the concern of the acute TB service at St Mary's, which identified that the majority of its patients were refugees and asylum seekers in temporary accommodation<sup>59</sup>. The clinic will be run jointly by the Health Support Team, the Bayswater Family Centre and the TB team at St Mary's. The non-medical venue was chosen as the clinical setting can be overwhelming and off-putting for many people. The advantage of the joint approach is that there is an opportunity for additional input such as HIV testing (where requested), access to support in registering with a local GP and a general health assessment. It is hoped that the service will begin operation within the next few months.

### Special health promotion initiatives

A recent review of targeted health promotion initiatives studied ten health districts<sup>60</sup> and discovered that activity was confined to geographical areas where there is a substantial and visible homeless population. Examples are given below:

- East London and City: the development of a training programme for staff in hostels and housing associations (to be extended to day centres) addressing the sexual health needs of residents
- Barnet: the development of a training directory to increase take-up amongst professionals; the piloting of a 'health card' with details of how to access services, to be distributed by staff at Housing Aid Centres
- Camden and Islington: the funding of an HIV prevention outreach project to contact the 'hard to reach' with information, resources (condoms, injecting equipment etc) and referral to primary health and other related services
- Kensington, Chelsea and Westminster: joint work with Centrepont (working with young homeless people) to encourage health input into hostels and drop-in centres for young people; the development of mental health resources for young people; meeting the Health of the Nation targets through the multi-agency Kensington and Chelsea Health Alliance, with a focus on homeless families; the re-issuing and updating of the booklet, 'Eating and Health in Temporary Accommodation'
- Barking and Havering: the establishment of a Focus group to formulate a local strategy, to include a staff training programme on homelessness and a leaflet to tackle public attitudes to homeless people
- West London and Ealing: working towards a number of targets for homelessness including a reduction in winter deaths and an increase in awareness by homeless people of primary health care services.

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<sup>59</sup> A report by the Health of Londoner's Project found that only 25 percent of new arrivals at port-of-entry were receiving the recommended TB screening

<sup>60</sup> Hinton, T. (1999) *The Icing on the Cake*, Health Action for Homeless People, Brent and Harrow Health Authority, Queen Mary & Westfield College

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## 6 Effectiveness of interventions/equity

- **What does the literature say about effectiveness/costs/equity?**

Comments have been made in this report about the effectiveness of a range of health interventions, not all through the NHS. While we are cautious about making generalisations on the basis of a rapid review, we think the following comments may be useful.

### Effectiveness of the network of provision

Services supporting the health of the homeless should be seen as part of a network of London provision. Certainly a rising proportion of the homeless, the asylum seekers and refugees, do not have established ties to any particular borough. In practice while a network does exist in certain areas (for example hostel provision, activities undertaken between specialist advocacy agencies, or activities undertaken through special programmes, such as the Rough Sleepers Initiative), co-ordination on a London-wide level is relatively weak. Certain organisations collecting information or conducting advocacy, such as the LRC or the Health of Londoners Project, and we are informed, the Association of London Government, have attempted to stimulate an informed debate about policy aims and mechanisms. However part of the difficulty in establishing pan-London arrangements, in lieu of Greater London Authority, is that local authorities have little incentive to provide a more comprehensive response fearing that they may attract more claimants on their services, sourced from other boroughs (for example housing departments make out of borough placements of homeless people to temporary accommodation, expecting services in the receiving borough to accept the cost).

### Mainstream versus specialist services: the case of primary care and GPs

Effectiveness in primary care might covers the following qualities:

- Attracting patients
- Maintaining contact with patients
- Referring patients to secondary or specialist care (including rehabilitation, etc.)
- Quality of care
- Appropriateness of care in respect of patient's culture, language, etc.

Some primary care services provided through general medical practitioners have been shown to be variable when set against these principles. This fact has been well understood for many years and special provision has been established in regard to certain groups of the homeless to provide special targeted services. The debate about the value of specialist health provision for homeless people is therefore neither new or recent. The summary to the evaluation report on the first three years of Great Chapel Street Medical Centre (1978 – 81) states “(W)hile there was general agreement that separate services were undesirable, both government and pressure groups ... considered that in the short term a medical centre concentrating on the needs of the younger homeless might be able to fill one gap in the available services.”<sup>61</sup> Over thirty years later, this service - now in a much extended form - remains in much demand and is a central player in the provision of services to homeless people.

In 1997, a consultation of seven GP practices in North Kensington echoed the lines of the discussion from 30 years ago. “Some... felt that a specialist approach was required, whilst

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<sup>61</sup> Croft-White, C., Kitchener, P., MacGregor, S. (1982) *Health care of the Young Homeless in Central London: An assessment of Great Chapel Street medical centre 1978 - 1981*

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others believed that the integration of this group into mainstream was the only way forward and finally some felt that a mixture of the two approaches was required.”<sup>62</sup>

The case for specialist services can be found within the text of this report. Homeless families in temporary accommodation (B & Bs, hotels and hostels) face discrimination especially if they do not speak English, are not assertive about their rights, and have multiple needs. On arrival in a new country or area of London, many homeless families require intensive support and comprehensive health assessment. This is best done by a specialist service or team which can facilitate access to mainstream health services. In addition pockets of London (see Section Four) with a large number of transitory homeless single people and the high level of needs of families create pressure on local GPs’ workloads.

General practitioners are the gatekeepers to secondary care services and therefore without their involvement in the care of homeless people, this group may be denied access to additional forms of health care under the NHS. In practice however, more widespread registration may only be realisable where additional support is provided to GPs to encourage them to register homeless people. Recent unpublished research into access to GPs by rough sleepers identifies that there is overwhelming support for integrated services within mainstream provision. However, further work was needed to assist this client group to focus on their primary health needs and to make mainstream services responsive. In the meantime, there is consensus that there should continue to be access to primary health care services through on-site services, outreach teams and specialist medical provision (many of which are described in Section 5).

Projects working with homeless families recognise such dilemmas. Although there are specialist health services in some ‘family centres’, the thrust has been to encourage registration with local doctors. The advantages of using mainstream services are that it provides families with a role model for the future and emphasises their eligibility to mainstream services. This practice also begins to address the barriers that exists among some GPs unwilling to register homeless people as patients. (There are examples of GPs – or their receptionists – who, by default, registered hotel-dwellers when a street number was given as an address, omitting reference to the hotel name.)

The opinions and preference of homeless people reflect a similar ambivalence. People who used the targeted services as they thought the practitioner was more sympathetic and understanding than ‘mainstream’ GPs. Other homeless people, however, believed that they – like other members of the general public - should be able to register as a permanent patient with a GP of their choice.

Effective principles of working can be found when they can encompass a collaborative model of joint working. One example of joint working can be found in the West London area, where there are a large number of homeless families. In order to improve access to primary and secondary health care, the Bayswater Families Centre works closely with the Parkside Homeless Health Support Team (HST) and local health visitors. There are also strong working relations with Westminster Social services and local child and adolescent mental health services. Two primary mental health workers are jointly based at the Centre and a local Comprehensive school in order to improve the responsiveness of services to meet the needs of refugee children.<sup>63</sup> HST also has Service Level Agreements with seven GP practices in Bayswater and Paddington. This identifies a named person within the HST team who attends

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<sup>62</sup> Report to KCW HA: 28 Jan 1998

<sup>63</sup> Factsheet: Bayswater Families Centre, Jan to March 1999

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each practice regularly, ensures that comprehensive health assessments are undertaken of new homeless clients, and facilitates patients' access to nurse practitioners, health visitors and support workers. This arrangement is reciprocated by the secondment of a practice nurse from each surgery to HST to share skills and increase collaboration. Joint outreach sessions to hotels take place with nurses and practice managers from the surgeries. Similar close links have also been established with other primary care services (including health visitors and midwives), community mental health services, the Social Services, Housing and Environmental Health departments of the local authority.

### Accident and emergency services

Comments were earlier made about homeless people's use of A&E services, although in general the use of A&E for basic primary care treatment constitutes inappropriate use. We are not aware of any attempts to estimate the cost inappropriate utilisation due to denial of care provision at an appropriate level (primary care).

### Communicable diseases

It was noted that the UK remains a low prevalence country for most communicable diseases but that the homeless are a vulnerable 'marker' group in several respects; they have poorer health status, some homeless people are at greater risk of needle sharing, and they have the potential, in the case of refugees, to carry with them untreated, or ineffectively treated, communicable diseases from high prevalence countries.

Effectiveness of interventions is measurable by, for example,

- immunisation rates among high risk groups
- effective access to primary care to ensure early treatment
- better training of clinical staff to recognise symptoms
- compliance with disease treatment programmes and maintenance of continuity of care
- the monitoring of high risk groups entering the country.

Consideration of the first (prisons) showed immunisation coverage was poor, for the second issue, the fact that continuity of care is itself weak suggests that disease monitoring is also ineffective, while research by the Health of Londoner Project has suggested that port of entry communicable disease monitoring is poor.

### Sexual health

Genito-urinary services in London are, for the most part, open access services provided in major hospitals and satellite clinics. Research shows that major centres do see a very wide spectrum of clientele. Their commitment to complete confidentiality mean that they attract people unwilling to seek help from primary care providers or family planning services.

The question arises as to whether this format of walk-in service provision is able to address the range of needs thrown up by people disadvantaged by homelessness, language difficulties, or vulnerability or cultural difficulties expressed by some refugee groups towards communicable diseases and diseases like HIV.

### Mental health services

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Effectiveness of mental health services in the capital, have, as elsewhere, come under recent close scrutiny. One of the chief stress points of the services concerns individuals at the boundaries between hospital psychiatric care, prison and homelessness. Most services focus on the severely mentally ill (level 3 of the CPA), on the other hand many homeless people suffer 'low priority' mental distress. As a response the HMII teams are extending their remit to include homeless people in this category. Given these pressures it is easily possible to understand why the mental health problems of other groups in need, such as refugees, are not a prominent focus for services.

### Housing standards

One problem compromising the effectiveness of provision is that the environmental health departments are not always informed of the placement of homeless families and refugees in their borough by placing authorities<sup>64</sup>. It has been recommended that the establishment of a nominated officer system across environmental health and social services.

Environmental health monitoring of houses in multiple occupation (HMOs), focussing on standards of accommodation, amenities, overcrowding, etc., varies considerably across London. Some local authorities, like Camden, operate a registration scheme for HMO's making it the legal responsibility of the owner, manager or agent to register the property. DETR have consulted on a country-wide scheme for registration but a new system is not likely to be established in the short term.

### Costs

No literature available to the researchers addressed the issue of costs of services to the homeless in any consistent way, taking into account, for example, the comparative costs of different models of service provision. There are US studies on the comparative costs of various forms of drug treatment or rehabilitation but it is questionable whether their results apply to the UK.

### Equity

Government public health policy emphasises the tackling of health inequalities, however equity considerations have complex implications when viewed on a pan-London basis. For example applying the equity principle would suggest that homeless people should have the same level of service or rights to access to services wherever they are in London. However, the pressure of homelessness, viewed as a set of demands upon services, vary considerably from borough to borough while there are few uniform characteristics or needs to the homeless themselves. In practice broad equity considerations do have force, and anecdotal evidence suggests that priority given to the needs of homeless people vary considerably; for example our analysis of HImPS suggests that different health authorities make varying efforts to meet the needs of this client group.

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<sup>64</sup> As Bed Sit Action, August/September 1999 reports, "One one occasion, a HMO with a direction order limiting the occupancy to 20 people was found to be purporting to be a B&B with 64 asylum seekers living there. Nearly all of the residents had been placed there by one authority and one simple phone call would have revealed the restrictions placed on the property"

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## 7 Gaps in the knowledge base

What further research is required? Where is evidence lacking and what questions still need to be answered?

Research questions might be divided between clinical, social, and economic studies on health and homelessness. This Rapid Review has not touched on all areas of research and literature, much of which may be unpublished.

1. This report began by noting the prominence given to Rough Sleeper means that there is far more current research in this area of need. Inconsistency of data collection systems for rough sleepers reduces the robustness of comparisons over time and between surveys.
  2. There is far less research into the health needs of homeless families and the health of people coming from various forms of institutionalised care, with the partial exception of the homeless mentally disordered offender.
  3. Homeless adult refugees and asylum seekers suffering from mental distress emerge as a rapidly growing area of need. There are questions about a) access to services London-wide and b) models of effective, culturally sensitive interventions for refugees and asylum seekers with mental health problems.
  4. We have identified little research into assessment of support needs or intervention models for homeless children, particularly those living in temporary accommodation.
  5. We are not aware of research into the health consequences of the enforced mobility to which families in temporary accommodation are subjected (i.e., out of borough and out of London placement).
  6. There is research into the prevalence of communicable disease in institutional and community settings. We have not identified a body of research on effective models of interventions in this area or on effective protocols for assuring mass immunisation of groups at highest risk.
  7. There is very little information on the cost-effectiveness of different service types and formats.
  8. There may be value in researching the effectiveness of HimPs and HAZs on the health of homeless people and in researching the effectiveness of these initiatives in developing multidisciplinary models of working.
  9. This report has highlighted the lack of information on successful health promotion strategies targeting homeless people.
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## 8 Policy implications for London

- **On the basis of the available evidence, what action, in the short, medium and long term, would have the greatest impact in terms of health improvement for Londoners**

*London-wide electronic information directory and communication framework.* Information in booklet form is quickly made out of date. Internet-based information, in contrast, can be quickly and cheaply updated and the information can be accessed from most offices. One example where this technology is already used is Hostels on Line, which provides regularly updated information from direct access hostels through the internet.

A special internet site for the co-ordination of homelessness information has the potential of being an effective low cost mechanism for linking resourcing and information about resources. The website could be used for mainstream and specialist workers supporting the homeless and the use of secure internet technology would potentially allow more rapid and efficient contact between authorities, thereby reducing transaction costs, and it would generate economies of scale by concentrating information resources. Concentration of information skills would also offer improved information validation. Website information would not be for direct public use and would be password protected to allow access to accredited users only, although any website could incorporate a public access section.

The potential range of information might include:

- A London-wide geographical database of contacts, specialist resources, with overlays for local authority and health authorities, with capacity for direct email between contacts
- A compendium of relevant policies and procedures adopted by different authorities along with legal information
- Legislation and its practical implications for service providers
- Information on welfare benefits
- Links to sources of housing and health information
- A local directory of services within the geographical system, allowing GPs and other health staff to print off information to patients and to inform themselves (some relatively crude translation packages are available to filter English language information to other languages).

*Strategic leadership and common aims.* Strategic leadership is needed to resolve common problems of multiple agency working. The key to partnership working is a unified strategy on homelessness and health as set out for example in HimPs, Community Plans and Community Care Plans. There is obvious potential for the GLA and the office of the Mayor to lend their authority to the development of common aims, working protocols, and broadening public knowledge about homelessness, its causes and its remedies.

*Training:* there are a number of good examples of training programme on health and homelessness – and for associated ‘problem groups’ like drug misusers; the key problem is getting them universally employed. Training is particularly required in a number of areas:

- For GPs, receptionists and other practice staff to overcome stereotyping homeless people, and to build knowledge and skills in working with this client group
  - For project staff in homelessness agencies, on health promotion and communicable disease, and how to get the best from health services
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- For other primary care specialists, on identifying the pressures of working with this client group
- For all groups in contact with homeless people, stressing the benefits of multidisciplinary, cross-organisational working

*Communicable diseases:* The homeless, because they are mobile, move between institutions, and are exposed to high levels of risk, dramatise the weak points in the London's system of communicable disease surveillance and control. Communicable disease issues range from screening at port of entry for refugees to poor preventive and treatment efforts for Hepatitis B and C and TB. What needs to be established is a holistic perspective applying across institutions and providers which is able to maximise continuity of treatment and provide a total view of disease risk management.

*GPs, Primary Care Groups, Primary Care Trusts:* Access to GP services have been highlighted as an enduring problem theme. PCGs in London might be influenced to adopt common protocols in a variety of areas as they applied to socially excluded groups. These protocols might be complemented by training materials to help GPs to understand the needs and obligations to homeless patients. Guidance is needed on:

- How to include homeless people in local needs assessment and developing practice population profiles
- Training opportunities
- Registration rights of homeless people
- Good practice in liaison arrangements with other agencies with equal responsibility for this patient group
- Information on what is available in the locality, and how to help patients access it.

*Electronic medical records:* Historically patient record keeping in primary care is has been built upon the assumption of long-term relationships with patients. In most cases this works well but this review has highlighted one group of patients where this assumption is erroneous. Typically, the homeless move between different services and treated without the benefit of medical records. The homeless are therefore a prime group for the development and testing of electronic patient records. Individual patient records can be drawn from, for example, an NHS Direct secure website.

A number of specialist primary care agencies have joined together to develop a client-held medical record for homeless people. This record would serve as a health diary and would also hold information about housing and social services contacts. This initiative is currently being evaluated by Health Action for Homeless People.

*Health promotion:* There is little co-ordination and an approach is needed that brings everything together and prevents people re-inventing the wheel. There needs to be cross-London focus to identify evidence-based initiatives.

*A re-visiting of the Notification Systems:* the structure of informing local health services of (homeless) families moving into an area has broken down under the strain of multiple 'placement' agencies. This now needs to be revisited to ensure that homeless families do not slip through the net and can be quickly targeted by specialist health professionals.

*Common HMO Licensing Protocols:* This is not merely a London issue, but the resolution of this issue is more pressing in London than elsewhere and therefore may require action before the evolution of a national system. The GLA can take the lead in supporting London

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authorities to develop common licensing protocols and helping share experience on the means of effective administration and control.

*Greater flexibilities:* This has commenced with the Primary Care Act 1997. However, greater use should be used of the new opportunities to make primary care services more flexible, accessible and acceptable to single homeless people and families.

*Link workers:* Link workers within A & E departments can disseminate information about homeless people's needs and local services, act as advocates for homeless patients being 'discharged' to hostels or local primary care services, and help resolve potential areas of dispute.

*Access to interpreters:* Many refugees and asylum seekers receive inadequate service because health care staff do not access local interpretation services. This may be due to lack of information of their availability or lack of foresight. Greater attention should be given to make these services available and utilised as and when required.

*Housing:* London is experiencing an increase in homelessness that is attributable for the most part in an adequate supply of permanent new dwellings in the social rent sector. If for some groups of homeless people the answer to problems of health and well being are soluble through the provision of permanent and habitable accommodation, for other groups of homeless it may require more. For example for those vulnerable to drink, drugs, or reoffending it may be suitable housing away from sources of risk.

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