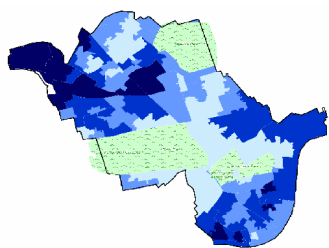


Homeless Health Needs Assessment Executive Summary

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1: Introduction

The City of Westminster continues to have a higher rough sleeping population than any other Local Authority in England and Wales. The updated Rough Sleeping Strategy, developed jointly by Westminster Council, NHS Westminster and the Metropolitan Police published in June 2010 has as a key objective to integrate related strategies (DAAT and NHS Westminster) to tackle inequalities and to protect and serve socially excluded service users. This homeless health needs assessment was completed to inform the development of this strategy.

2: Homelessness in Westminster: An Overview

Westminster has more people without a roof over their head than any other Borough in England. Nationally, 25% of all rough-sleepers are in Westminster, and this amounts to 50% of rough-sleeping activity in London. Estimating the size of the population likely to be in need of specialist rough-sleepers health services in Westminster is challenging¹.

In Westminster 2,172 rough sleepers were contacted by Building Based Services (BBS's)² in Westminster in 2008/09. Of the those, 1,235 (77%) were seen 3 times or less. Within the wider picture of new people and transient

¹ In order to provide a robust estimate this needs assessment has drawn upon a number of data sources including data from the street count, the CHAIN database and specialist homeless health primary care services. See the main report for further explanation

² In Westminster, Building Based Services is the model of delivery – contacted by a street team and then referral to local day centre, where the street team can undertake a more comprehensive assessment and support offered

people, there is smaller, more static group of around 300 per annum consistently on the street (though not always in Westminster). Within this figure there are two key priority groups, rough sleepers refusing all offers of services (circa 150) and 'revolving door' clients referred to as 'returners', moving in and out of services or prison and back onto the streets (circa 35). During that same time period, 3,373 people accessed specialist homeless primary care services in Westminster during this same period (2008-09).

This needs assessment examines the health and well-being needs of rough-sleepers – this includes current rough sleepers, those who have a recent history of rough-sleeping, those living in the rough sleeper pathway in Westminster and those members of the homeless community who are using specialist primary care services. This has been chosen for a number of reasons. The health needs of rough sleepers are “severe, neglected, complex and overlapping” and they carry the highest burden of ill health and health inequalities, and it is a significant issue for Westminster.

3: The rough sleeping population in Westminster

The majority of rough sleepers in Westminster are males aged 26-45 years; Half were White British, with White Other and Black African other commonly recorded ethnic backgrounds. Most are of UK nationality. However an increasing proportion of rough sleepers from A10 countries are rough sleeping.

A disproportionate number of rough sleepers in Westminster have institutional histories although recent trends suggest the number is decreasing.

4. Health and Homelessness

Housing and health are inextricably linked, with homeless populations experiencing significant health inequalities. Poor health can be attributable to becoming homeless whilst some health problems are caused by, play a part in

and also then prevent people from moving from the streets or temporary housing into more stable accommodation;

At the beginning of 2009 NHS Westminster and Westminster City Council jointly commissioned a Homeless Health Survey; 217 people were surveyed. A Service User event was held in July 2009 – 74 chaotic rough-sleepers attended.

Overall 72% of people reported having at least one long term illness – Mental health problems most commonly reported, with 39% reporting some form of depression. Almost two thirds reported suffering difficulty sleeping or tiredness, and a quarter of people reported respiratory symptoms. Other reported long-standing illnesses included skin, bone, joint and muscle problems, and liver disease.

Despite this, the majority of homeless people in Westminster perceive themselves to be well; 58% of people surveyed reported their health as excellent, good or very good. This is surprising, but could result from how people who are homeless rate their own health in the context of the challenges that they face, but is also likely to negatively impact help seeking behaviour, thereby reducing access.

5: Access to health services

Homeless people experience barriers to accessing appropriate health care. In the survey homeless people reported social issues – such as user motivation, social prejudice and stigma – as more significant barriers to good health, with relatively few citing drug and alcohol use, underlying chronic health conditions and access to prescribed drugs as barriers.

Overall GP registration was high – 81% of respondents reported being registered with a GP, and a review of primary care contact with The

Westminster 150 (TW150)³ revealed that high number of people (71%) were in touch with specialist primary care. However, it also demonstrated that services were less likely to reach those most in need – the second largest group (22%) did not have an active⁴ relationship with any primary care practice. The vision for these specialist services in Westminster is to respond to those who fall through the gaps of other (mainstream) health services. Therefore, the clinicians need to be supported to focus resources and innovation on the neediest patients.

Homeless people use services such as A&E and the London Ambulance Service to address routine non-emergency health needs. The majority of London Ambulance Service call outs and A&E presentations for homeless people in Westminster were for a deterioration of pre-existing long term conditions, which could be avoided through more timely management of said conditions in primary care.

Communication and links between acute trusts and hostel and BBS's are needed to create a mechanism for earlier identification of clients in hospital and allow better planning on discharge; It is clear that acute hospital trust emergency staff are key players in the provision of health services for homeless people in Westminster but have little involvement in planning care post hospital discharge.

Training is needed for hostel and BBS staff to enable them to deal with chronic health problems. Hostel and BBS staff reported feeling unable to manage chronic illness and supervise medication and treatment plans, particularly out of hours.

.Recommendations

- Greater and more detailed knowledge of the health needs, and how they overlap with other homeless people is needed for TW150

³ Westminster City Council Rough Sleepers Team has identified a cohort of 148 people, known as the Westminster 150 (TW150) who are at risk of severe entrenchment.

⁴ Contact in the last 12 months

- Specialist services need to be commissioned in a way that targets their resources at the most needy people with mainstream services providing the bulk of care for newly homeless people.
- Improved out of hours primary care is needed for homeless people in Westminster to reduce the number of ambulance call outs, A&E attendances and unscheduled hospital admissions;
- Training is needed for hostel and BBS staff to enable them to respond to acute situations and manage chronic illness;
- A&E and unscheduled hospital admissions should be routinely monitored – in particular from St Mary's, St Thomas' and UCLH
- Stronger working links are needed between hospital discharge teams and homelessness services to establish appropriate care, support and accommodation on discharge from hospital;

6: Substance misuse

Substance misuse and homelessness are inextricably linked; as well as being one of the most important causes of homelessness, substance misuse is an important maintaining factor in homelessness. The prevalence of substance misuse amongst homeless people is high⁵;

- 67% were found to misuse alcohol (46% were dependant). Alcohol users were more likely to be rough-sleeping. There is a relationship between problematic alcohol use and a previous history of drug misuse – of former PDU's not receiving substitute medication, 47% described their alcohol use as problematic.
- 45% were current problematic drug users (PDU)⁶ and the majority were using crack, cannabis and heroin. The age profile was younger than that of those who misuse alcohol, and were more likely to be hostel residents. 28% were currently prescribed methadone. According to the Homeless Health Survey, 71% of all people prescribed methadone reported that they continued to use heroin. Of note is that of those using heroin on top of methadone in Westminster, the majority were on

⁵ Westminster Drug & Alcohol Teams Clean Break audit 2008

⁶ Problematic Drug users are defined as injecting opiate and/or crack cocaine users

a prescription of between 30 and 89mls of methadone which may be too low to control withdrawal.

Recommendations

- Further support is needed for former drug users to help these people abstain from both problematic drug and alcohol use.
- Treatment programmes should be structured appropriately to manage people with poly-drug use.
- People who misuse substances have complex health needs that are likely to impact on one another, highlighting the need for joined up and coordinated care.

7: Mental Health

Mental health problems are much more common amongst homeless people than in the general population. Between 22% and 48% of patients seen in primary care have a mental health *diagnosis* – however, this is lower than expected, and likely a reflection of inadequate data collection. Current mental health services appear to be meeting the needs of homeless people with severe mental illness – an estimated 95% of homeless people with a severe and enduring illness are engaged with services. Overall, for those patients accepted onto the specialist CMHT⁷ caseload, good patient outcomes were achieved. Transition support (between the specialist CMHT and other CMHT) was identified as a gap.

However, stakeholder feedback report confusion about the assessment criteria for the specialist CMHT, and that for people who not meet the threshold for a care programme approach there is unmet need. They report difficulties accessing timely help for clients – crisis services were described as particularly difficult to access for those people actively misusing drugs and/or alcohol. Great Chapel Street Dual Diagnosis clinical nurse specialist (CNS)

⁷ Community Mental Health Team

was more likely to see people with mental health problems (52.4% of consultation) than dual diagnosis (18%).

People with personality disorder and dual diagnosis are underrepresented amongst those accessing specialist services. The Great Chapel St Psychiatrist slots are not fully used; suggesting that the current appointment based system currently adopted may not be accessible. However, this also may be around awareness, as few stakeholders from the community and voluntary sector were aware of either the CNS or psychiatrist service.

Women are overrepresented in crisis management services (JHT and inpatient care) suggesting a greater mental health need. People with mental health issues and blood-borne virus highlighted the impact long-term anti-retrovirals can have on mental health. Lack of engagement with mental health services, thus prevented some people contemplating treatment for other health conditions.

A high proportion of people with common mental disorders are undiagnosed and the proportion of people with common mental disorders accessing services is poorly understood. The national guidance on Improving Access to Psychological Therapies (IAPTS) excludes people who are actively using substances and, therefore generally accessibly by most of this population.

Feedback from stakeholders suggests that even though third sector workers have the most direct contact with homeless people with mental health problems, they feel they may not have the skills needed to support them appropriately.

Analysis of the JHT care pathway and the Great Chapel Street psychiatry service highlighted lack of awareness by homeless services and, therefore, initiatives are required to increase engagement with specialist services and understand the underlying reasons for this.

Recommendations

- An improvement in data collection is needed, particularly at primary care level to understand the level of need.
- Stakeholders identified personality disorder as one of the main service gaps – and training on this issues for the voluntary sector workforce
- Further work is needed to better understand how to improve the well-being of a client group that has high levels of anxiety and depression.
- Initiatives are required to increase awareness and engagement with specialist services and understand the underlying reasons for this.
- Underused services should be reconfigured to address existing service gaps, for example, common mental disorders or awareness and signposting to the service increased so that it is used to capacity.
- There is, therefore, a need to provide or develop services for those people that find it difficult to engage and adhere to care plans, such as long-term rough sleepers with longstanding personality disorder.
- Further work is needed to understand transition between mental health services and how this can be improved to maintain mental well-being and housing stability

7: Other chronic illnesses

As a result of their lifestyles, including such things as exposure, crack smoking or femoral injecting, homeless people are more likely to experience chronic health problems, and develop complications earlier than the general population.

Homeless people are at increased risk of respiratory disease, coronary heart disease, diabetes and hypertension, but less likely to be diagnosed and receive ongoing treatment and management, and there were wide variation in the prevalence of chronic conditions in homeless practices and highlights a need for improved identification and data collection to further understanding.

Given that services report seeing health problems in homeless people aged 30-50 that would normally be expected in someone much older, it is essential

that long-term conditions are diagnosed in a timely manner and managed appropriately in primary care.

Homeless people were aware of what to do to address their health issues, however, because of other issues, notably substance misuse, they were unable to prioritise other health. A peer support mechanism was identified as a way to increase access to health services.

Recommendations

- There is a need to improve the identification of people with undiagnosed chronic conditions at a primary care level so that these conditions can be managed in line with recommended guidelines;
- Services managing long-term conditions should be flexible and accessible for homeless people;
- All opportunities need to be taken to reduce the prevalence of risk factors for long-term conditions such as substance misuse and smoking;
- Peer mechanism would be a beneficial to increase access to health services.

8. Physical health problems

Homeless people have poor foot, ocular and skin health – foot problems particularly can cause significant pain and discomfort. Additionally, they often do not present to services until problems are severe.

Current specialist podiatry services are oversubscribed - hostel residents find it particularly difficult to access specialist podiatry services at daycentres. Further work should investigate the potential development of the service - Dr Hickey's Surgery may be a viable option for this.

The number of homeless people not accessing, but requiring ophthalmic services in Westminster is likely to be high

Numbers accessing primary care services for skin problems is lower than expected despite high numbers of reported skin issues. This may mean people do not seek medical attention for their skin problem or if they are engaging with health services, they do not report their problem to their GP, nurse or health care professional as they may have other health issues that need more urgently addressed. The majority of skin conditions are readily amenable to primary care management.

Recommendations

- Further work should, therefore, explore how the capacity of podiatry services for the homeless population in Westminster can be developed.
- Further work may explore the need for health promotion work to both prevent skin problems in the first instance and raise awareness, recognising the need for treatment

9: Blood-borne viruses

The prevalence of BBVs in the homeless population is high, with people living in hostels more likely than current rough sleepers to be tested for BBVs – though this is likely as a result of testing programmes offered within hostels. Of those screened in that programme, 47% were hepatitis C positive, 10% hepatitis B positive and 10% HIV positive (a large proportion of HIV cases were not new diagnoses).

Blood-borne viruses are associated with significant morbidity and mortality and often result in long term illness. Despite this, the uptake of hepatitis B vaccination is low – especially for completion of the three-dose course – and the number of homeless people accessing treatment for BBVs is low. All people diagnosed positive for HIV and the majority of those diagnosed with hepatitis C would be expected to be accessing treatment. Currently, less than half of those diagnosed positive for a blood-borne virus have accessed treatment.

Recommendations

- Innovative methods are needed to incentivise uptake of vaccination.
- Information given to people upon a positive diagnosis is poor and inconsistent at some testing locations;
- Training is needed for third sector staff regarding information around BBVs and what a positive diagnosis means and treatment pathways.
- Integrated working and information sharing is needed to coordinate the care of people with BBVs and manage their co-morbidities;
- Further work is, therefore, needed to understand this unmet need and identify barriers to accessing services as well as understanding current treatment pathways and services.

As part of the JSNA Rolling Programme of needs assessments, NHS Westminster has undertaken a hepatitis C needs assessment, available on the Westminster City Partnership website.

10: Tuberculosis

Homeless populations are disproportionately affected by tuberculosis – they are more likely to have advanced TB, less likely to complete the course of treatment, putting them at risk of developing multi-drug resistant TB.

The incidence of TB in Westminster has decreased in recent years; in contrast to the situation in London, which has remained consistently higher. Based on national evidence, three rough sleepers a year will acquire TB and nine new TB notifications will have a history of being homeless in Westminster;

Overall the uptake of TB screening in Westminster is high; in October 2008, 63% of those targeted for screening attended – this represents a 42% increase on previous screening. However, there is wide variation in uptake between screening sites i.e. generally hostels and day centres

Recommendations

- The MXU is successful in identifying and managing TB in the homeless population in Westminster, and this initiative needs to continue
- Uptake of TB screening across Westminster varies (range: 19%-100%) and further efforts are needed to improve uptake at those sites where it is low;

11: Oral health

The dental health of homeless people is poor – 74% report having lost at least one tooth, and the average number of missing teeth was nine. At the Service User Day, 56% participants identified dental needs as their top health priority. Teeth were identified as the most important aspect of physical appearance, and that missing teeth and poor oral hygiene had a significant negative impact on self-esteem, and restricted economic and social inclusion.

Given the poor oral health experienced by homeless populations, the number of people accessing dental care is significantly lower than expected - less than 50% of the homeless population uses the specialist homeless dental service, and only 21% accessed any dentist in the last year.

Local evidence suggests that the current service may not be acceptable to and accommodate the lifestyles of patients for which it is commissioned - The specialist dental service operates on an appointment basis, however, despite all appointment slots being regularly booked up with patients, many do not attend for their appointments. A more proactive approach should be adopted to increase awareness and use of the dental service since the current approach is clearly not promoting engagement with the service.

Recommendations

- Qualitative work with people may help identify some of the barriers to accessing dental services within the borough and thus inform future service development.

- Underused services should be reconfigured to address existing service gaps.
- Currently little consideration is given to preventative models of care for homeless people in Westminster – this would not focus solely on intervention based methods and can be easily addressed with health promotion interventions and potentially be delivered in non-dental settings.

12: Lifestyle factors

Smoking is common in homeless people and they smoke heavily – it is also the cause of preventable illness and death in the UK. Heavy drinkers have significantly more tobacco-related oral problems such as oral and face cancers.

Homeless people report wanting to quit, yet smoking is the least likely of all the addictions to be addressed by specialist services, and the use of mainstream smoking cessation services is also low.

10% of respondents of the Homeless Health Survey reported not eating any meals, whilst 20% of hostel residents and 34% of rough sleepers reported eating three meals a day. Only 16% of respondents reported consuming five or more portions of fruit a day – compared to 29% nationally.

Malnutrition is common amongst homeless people – but it is not recognised as such, and more commonly viewed as signs of excessive and prolonged substance misuse. The majority of homeless people are fed at daycentres or hostels and, therefore, both daycentres and hostels play a significant role in supporting change and providing nutritional meals.

73% of people reported wanting to eat well – but barriers to healthy included:

- lack of money or difficulties managing money
- health problems (physical and mental)
- lack of cooking and food storage facilities.

Some people, although they have the ability to cook, choose not to because of a lack of confidence; for these people other interventions are necessary to encourage them to cook and build confidence.

Recommendations

- A more innovative approach is needed to engage with smokers who want to quit and whom have difficulties accessing mainstream health services.
- Training is needed for homeless people to develop cooking skills, budget for food on limited incomes and learn about nutrition

13: Emerging Trends

Demographic trends

The proportion of rough sleepers contacted of UK nationality is decreasing, whilst the proportion from A10 countries is increasing. This may alter the health needs services are faced with – e.g. a move away from problematic drug use towards alcohol dependency – alter resource allocation, or require a new skills base e.g. other languages.

Health & Social Care trends

As a result of recent increases in the availability and success of drug treatment, problematic drug users are living for longer, but with long-term health problems associated with both a history of substance misuse and homelessness. Westminster is starting to see health problems in people aged 30-50 that would be expected in people much older. Consequently the health and social care needs of homeless people in Westminster may change – this will include an increase in domiciliary care services, palliative care services, cognitive/brain impairment services

National Drug Treatment

Whilst Westminster will always encourage abstinence as a care plan goal, the reality of the situation is that the treatment system works with highly chaotic clients whose misuse is entrenched and abstinence is not necessarily the

client's desired outcome – e.g. they may wish to reduce frequency of use. For those clients who achieve their outcome, but fail to become abstinent, this will no longer be reflected as a favourable outcome for Westminster.

The Commissioning climate

The economic climate of the NHS is changing. As a result delivering specialist homeless health services in Westminster will be challenging, highlighting the need for efficient services.

Appendix A: Rough Sleeping Strategy Health Priority Actions

Integrate the Health & Social Care Strategies to protect and serve socially excluded service users.

Primary and Emergency Care - Key Targets and Actions

- Increase late night-opening and targeted street outreach by clinical medical staff working in partnership with BBS teams.
- Ensure that hostel residents and rough-sleepers have annual health check, and a care plan approach is adopted for those with significant health problems.
- Review services and interventions to make sure that they are meeting the needs of our homeless population.
- Develop a model of transition to support ex-homeless people and ensure they stop using specialist services and develop a positive relationship with mainstream General Practitioners.
- Support clients in their journey to more stable housing, by ensuring that healthcare is part of their move-on support.
- Ensure that the Local Enhanced Service is reconfigured to include provision to ex-homeless populations.
- Work with acute trusts to link them into the wider homelessness sector, ensuring that pathways in and out of hospital are improved.

Substance Misuse - Key Targets and Actions

- Implement the newly commissioned integrated drug and alcohol treatment model for the city.
- Ensure appropriate provision for hazardous, harmful and dependent drinkers' forms part of the new treatment plan.
- Improve the health outcomes from continuing use drinkers, and those not currently interested in structured alcohol treatment.
- Review hospital liaison and discharge, and where possible employ IT solutions to improve continuity of care for this group.

- Initiate work to understand prescribing options for homeless people in Westminster to ensure optimal levels of prescribing as well as alternatives to methadone prescribing.
- Continue the upward trend in BBV screening, vaccination and treatment rates and develop information sharing protocols around this between drug and alcohol, primary care and supported housing providers.
- Improve the oral health of the homeless and drug-using population.
- Ensure that the provision of smoking cessation interventions is embedded in the new drug and alcohol treatment plan devised by the DAAT.
- Work with the Drug Intervention Programme (Police, Probation, DAAT) and prison health and substance misuse service to increase the health and housing outcome substance mis-users involved in the criminal justice systems

Mental Health - Key Targets and Actions

- Ensure that counselling services are available for people who meet the criteria and who do not need access to secondary care services.
- Ensure that homeless people also have access to the existing range of well being services that we will establish over the next period.
- Identify effective routes into relevant services for those with dual diagnosis.
- Review the needs of people who require primary care mental health services and 'Improve Access to Psychological Therapies' (IAPT).