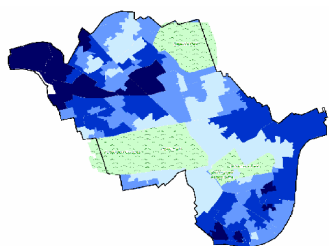


Homeless Health Needs Assessment

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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. Numbers have significantly reduced over the last ten years as a result of concerted action (see appendix 3). There is now a renewed commitment to find solutions that would mean an end to rough sleeping and associated street activity. Rough sleeping shortens life expectancy and marginalises people. The street activity associated with rough sleeping 'hotspots' (begging, street drinking) cause alarm and distress.

The updated Rough Sleeping Strategy, developed jointly by Westminster City 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.

Since 2005 Westminster City Council has successfully commissioned key Building Based Service (BBS) providers to meet strategic objectives designed to reduce rough sleeping across Westminster. One of the key objectives of this model was to minimise the need for people to remain on the streets to receive a service. This innovation has resulted in a sustained reduction in rough sleepers in Westminster.

In 2008/09 the BBS contacted 2,172 verified rough sleepers. This group is made up of a mix of people who either self refer, are met on the streets, or are referred or signposted to services. BBS, Outreach Teams and the Metropolitan Police Safer Streets Unit (SSHU) all target new arrivals with the aim of reconnecting people new to rough sleeping back to their last settled address where they still have community links, family and friends. This action may be swift and immediate or it may follow assessment and case work to secure a long lasting solution.

The majority of those rough sleeping on the streets of Westminster do not have any significant connection with the borough. Usually they have become homeless elsewhere and gravitated to central London to sleep on the streets and join an established street culture. Consequently key arrival points, such as Victoria, are put under great strain. This has led to an emphasis on reconnection back to an individual's home area. A pan London Reconnection Protocol has been promoted by Westminster and the Department of Communities and Local Government (CLG), and endorsed by the London Mayor. The next step required is the implementation of a National Reconnection Protocol.

As well as facilitating reconnection BBSs can also introduce rough sleepers to a wide range of specialist services, and make referrals to accommodation both inside and outside of Westminster. In particular, many of the more long term rough sleepers have problems which require primary health care, substance misuse issues, mental health conditions or a combination of all three.

The joint Rough Sleepers Strategy reinforces our emphasis and targeted approach adopted by all our stakeholders. Solutions will be identified that break the cycle of individual rough sleepers who revolve in and out of services and accommodation, and positively target those who have been on the streets the longest to prevent premature deaths and provide positive and acceptable alternatives facilitated by the personalisation agenda.

Needs Assessment Scope

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.

2: Homelessness: An Overview

Key Messages:

- **Westminster has more people without a roof over their head than almost any other Borough in England.**
- **The homeless community of Westminster appears more transient than other areas in the UK.**
- **In Westminster 1,914 rough sleepers were contacted by outreach or BBS's in Westminster in 2007/08 rising to 2,172 in 2008/09.**
- **3,373 people accessed specialist homeless primary care services in Westminster during 2008-09.**

2.1. What is homelessness?

The Housing Act 1996 defines a person as homeless if there is no accommodation that they are entitled to occupy. In this case entitlement may relate to either an interest, for example, they are an owner or tenant, an expression of implied licence to occupy, or some other law giving the right to remain in occupation or restricting the right of another person to recover possession. It also considers a person to be homeless if they have accommodation but cannot secure entry, they have nowhere to place their accommodation e.g. a caravan, or it is unreasonable for someone to continue to occupy the accommodation.

The statutory homeless are those households that are eligible for assistance under the Housing Act 2003, and the local authority has a duty to accommodate. There are also a significant number of people who are homeless but not eligible for statutory assistance.

In real terms, therefore, someone who is homeless is someone who does not have anywhere to stay, or someone who is vulnerable or inappropriately housed.

Homelessness is not a fixed state, and homeless populations are often highly mobile, moving between different types of accommodation/sleeping arrangements in different areas such as bed and breakfasts, hostels, staying with friends and relatives, squatting and rough sleeping. Therefore, formal services may not always be aware of the full extent of different homeless populations.

Homelessness is both a cause and effect of ill health and homeless people are vulnerable to health inequalities and social exclusion. However, the demand, unmet needs, and barriers to access, are not similar to all members of this group.

2.2 Why is homelessness an important issue in Westminster?

Rough sleeping is the most extreme form of homelessness, indicating 'rooflessness'- the lack of somewhere inside to stay. Although rough-sleepers constitute a very small sub-group of the homeless, the number of people experiencing rooflessness in Westminster represents one of the largest numbers in England. Nationally, 25% of all rough-sleepers are in Westminster, and this amounts to 50% of rough-sleeping activity in London. Located in the heart of London, Westminster is one of the most expensive places to buy or rent property and demand for affordable accommodation is high. London is a capital city, a major source of employment and a hub for services. Additionally, it is thought that homeless people are also attracted to Westminster because of a number of other local factors, including:

- transport links that feed into the city (Westminster is a major national and international rail and bus termini).
- an active drugs market
- high levels of street handouts
- access to a range of specialist services

A major focus of this needs assessment is on rough sleepers. 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. Homeless people are identified as

a vulnerable group for whom targeted interventions are needed to reduce health inequalities (Tackling Health Inequalities: A Programme for Action 2003). In response to this, NHS Westminster commissions specialist primary care and mental health services for this population.

2.3 Estimating the number of people who are currently rough sleeping or who have a recent history of rough sleeping in Westminster

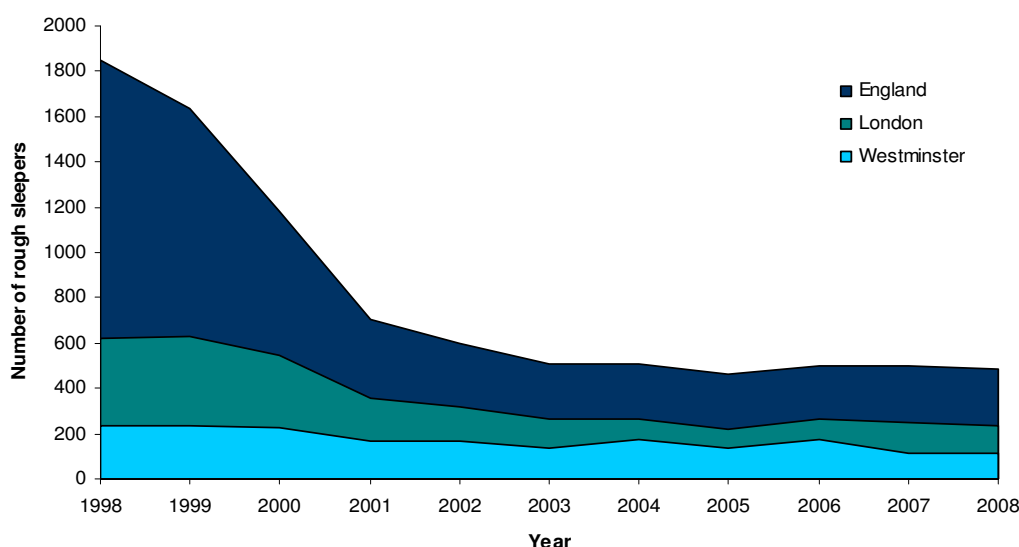
Estimating the size of the rough sleeping (or recent rough sleeping) population likely to be in need of specialist health services in Westminster is challenging. In order to provide a robust estimate this needs assessment has drawn upon a number of data sources including data from the street count, the CHAIN database and specialist homeless health primary care services.

2.3.1 Street count

Westminster undertakes regular counts of people who sleep in streets, parks and open spaces. Street counts take a snap shot of rough sleeping on a single night. They are the major means of monitoring rough sleeping and are a valuable performance indicator reported to central government. The benefits and limitations of assessing the numbers of people sleeping rough through counts on a single night have been examined in detail in the evaluation of the Government's Rough Sleeping Unit (Randall and Brown, 1999). This evaluation concluded that street counts are a valid means of measuring the relative scale of problems between areas and of changes over time, within an acceptable margin of error.

Since the first count in 1998 the number of rough sleepers in Westminster has been falling, in line with trends in London and England. Westminster rough sleeping population accounts for almost a quarter of all rough sleepers in England and a half of all rough sleepers in London. Between 1998 and 2003 the reduction in the number of rough sleepers in Westminster was less marked than that observed in London and England. This is likely to be due to the more entrenched nature of rough sleepers in Westminster.

Figure 2.1 Rough sleeper counts: 1998-2008



The demographics of the rough sleeping population in Westminster have also changed in recent years; significant work has and is being done with people being successfully reconnected and accommodated.

The proportion of people sleeping rough in Westminster (and also in London) who are of British nationality has declined, whilst the proportion from Central and Eastern Europe rose at the end of 2004 upon the expansion of the European Union, remaining relatively constant since this time. Latest available figures suggest that 35% of rough sleepers in Westminster are EU accession state (A10) nationals.

A10 nationals have the right to reside in the UK but have a particular process, the Workers Registration Scheme (WRS), to pass through before they are have full state protection which includes benefit entitlement and access to housing. A10 nationals who have not registered on the WRS are entitled to primary and emergency health care, but not elective secondary care (e.g. alcohol and drug treatment).

Latest available figures (September 2009) counted 89 core rough sleepers and 24 A10 nationals in Westminster.

Figure 2.2: Trends in core rough sleepers- not including A10 in Westminster: 2002-2009 (rough sleeper count)

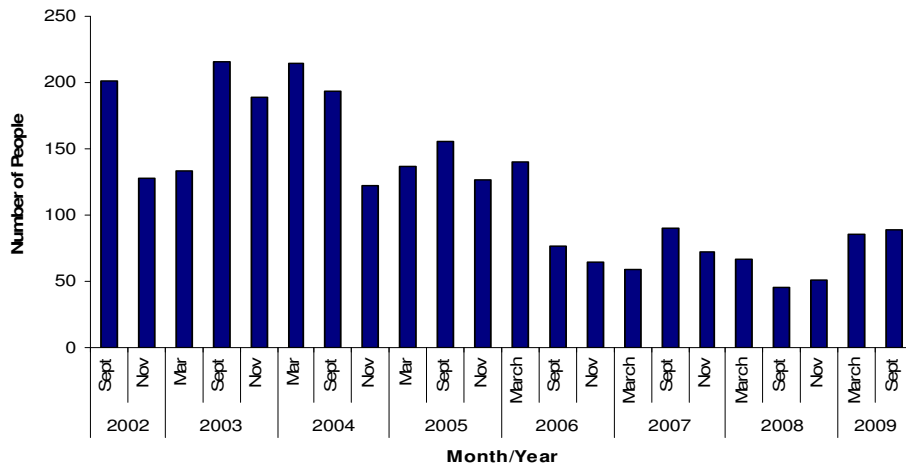
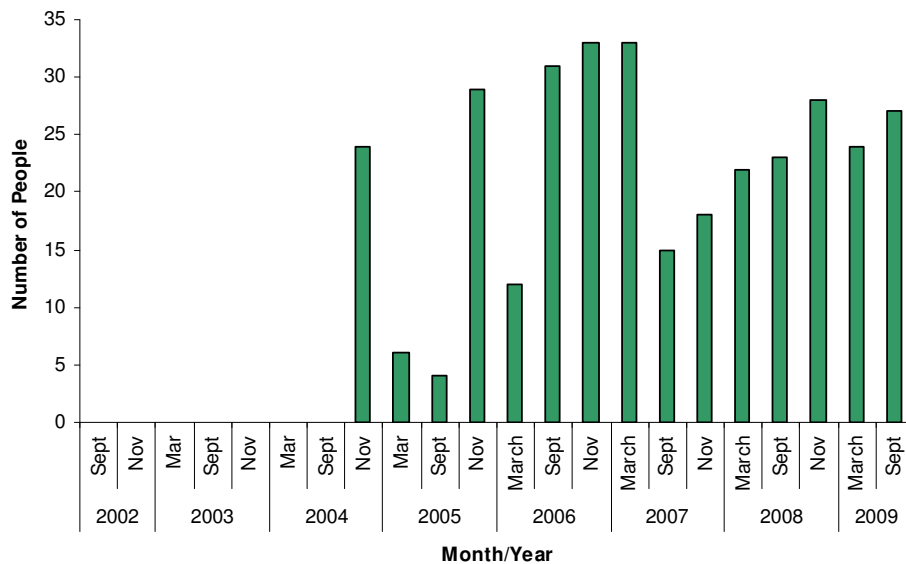


Figure 2.3: Trends in accession state nationals sleeping rough in Westminster: 2002-2009 (rough sleeper count)



2.3.2 CHAIN

The Department for Communities and Local Government funds the CHAIN¹ database which records the details of interactions between rough sleepers

¹ The Combined Homeless Action and Information Network (CHAIN) records all interactions between rough sleepers in London and homeless services.

and homelessness agencies, including outreach teams, daycentres and hostels. CHAIN records different types of contacts including street contacts as well as bedded down contacts, as verified by a designated worker. CHAIN tracks rough sleepers on a continual basis so provides a more complete and detailed assessment of the number of rough sleepers in Westminster.

For 2008/09, CHAIN data demonstrated:

- 2,172 verified rough sleepers were contacted by services in Westminster in 2008/09. This is an increase from 1914 in 2007/08.
- Of these 2,172, 1,611 had a bedded down street contact in the year and so were known to have slept rough in Westminster in 2008/09. This is an increase from 1506 in 2007/08.
- 826 people rough sleeping were new to the streets. This means they had not previously been contacted by any of the BBS teams that report to CHAIN and were verified as rough sleepers during 2008/09.
- 615 of the verified group (1,611) were only seen rough sleeping once in 2008/09 and 1,235 (77%) were seen 3 times or less.
- Outreach and BBS teams succeeded in reconnecting or booking into accommodation 619 people, 28% of the 2,172 people contacted during the year (this figure significantly underestimates the number of reconnection actions undertaken, as the old CHAIN database did not record this adequately)
- 526 people had a total of 776 booking in actions. This indicates that people can be booked into accommodation (the same type or different) more than once in a year.
- 389 positive move-ons were achieved in 2008/09.

The homeless population in Westminster appears particularly mobile, within the wider picture of new people and transient people, there is smaller, more static priority cohort 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).

CHAIN also documents the support needs and institutional histories of rough sleepers. In 2008/09, excluding data coded as 'not known':

- 47% had alcohol support needs, 36% had drug support needs and 42% had mental health needs.
- 33% had previously been in prison, 11% had previously been in care, and 5% had previously been in the armed forces.

The CHAIN demographic profile has consistently shown:

- 87% of rough sleepers found in Westminster are male
- Approximately 50% of rough sleepers met in Westminster are white British
- Less than 1% of rough sleepers met in Westminster are under the age of 18.

2.3.3 People accessing specialist homeless primary care health services

Data describing the number of rough or recent rough sleepers accessing primary care services in Westminster can be considered alongside CHAIN data to estimate the size of the current and recent rough sleeping population for which Westminster City Council and NHS Westminster are commissioning specialist homeless health services.

Latest available data shows that in 2008/09:

- 2,193 people accessed Dr Hickey's Surgery
- 1,851 people accessed Great Chapel Street Health Centre
- 1,500 people accessed the Homeless Health Team

Of those people accessing the three specialist primary care services, some are securely housed and, therefore, not currently or recently rough sleeping. Evidence from providers suggests that approximately 57% of those accessing Great Chapel Street, 51% accessing Dr Hickey's Surgery and 80% accessing the Homeless Health Team are either current or recent rough sleepers.

A recent review by one of the service providers suggests that the overlap in usage between the three specialist health services is low (O'Reilly); therefore, overall this suggests that 3,373 rough sleepers or recent rough sleepers are accessing specialist homeless primary care services in Westminster.

2.4 Conclusion

Describing accurately the incidence and prevalence of rough sleeping in Westminster is challenging and several estimates have been made here. For the purposes of this needs assessment, the most recent CHAIN figure (2,172) is considered the most useful as the baseline prevalence.

3: The rough sleeping population in Westminster

Key Messages:

- **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.**
- **The majority of rough sleepers contacted were of UK nationality, however an increasing proportion of rough sleepers from A10 countries are rough sleeping in Westminster;**
- **A disproportionate number of rough sleepers in Westminster have institutional histories although recent trends suggest the number is decreasing.**

3.1 Demographics of current and recent rough sleepers in Westminster

As stated earlier CHAIN data demonstrates 2,172 rough sleepers in Westminster during 2008-9. Of those 87% were male and most were aged 26-45 years. 13% were aged over 55 years. This age and gender profile is consistent with previous years.

Half of the verified rough sleepers were White British, with White Other and Black African other commonly recorded ethnic backgrounds.

The majority of rough sleepers contacted were UK nationals, however an increasing proportion of rough sleepers from A10 countries were contacted in 2008/09.

A disproportionate number of rough sleepers in Westminster have institutional histories; 33% had previously been in prison and 11% had previously been in care. 5% of rough sleepers had been known to have previously been in the armed forces; this is a reduction on previous estimates.

Figure 3.1: Rough sleepers in Westminster by age

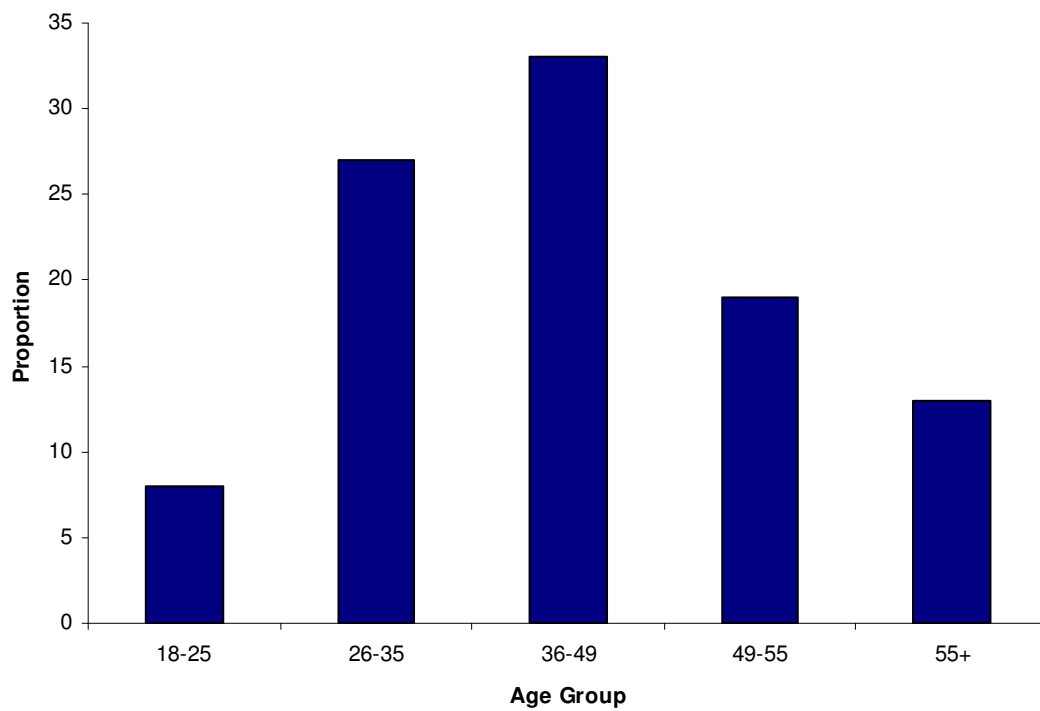


Figure 3.2: Rough sleepers in Westminster by ethnicity

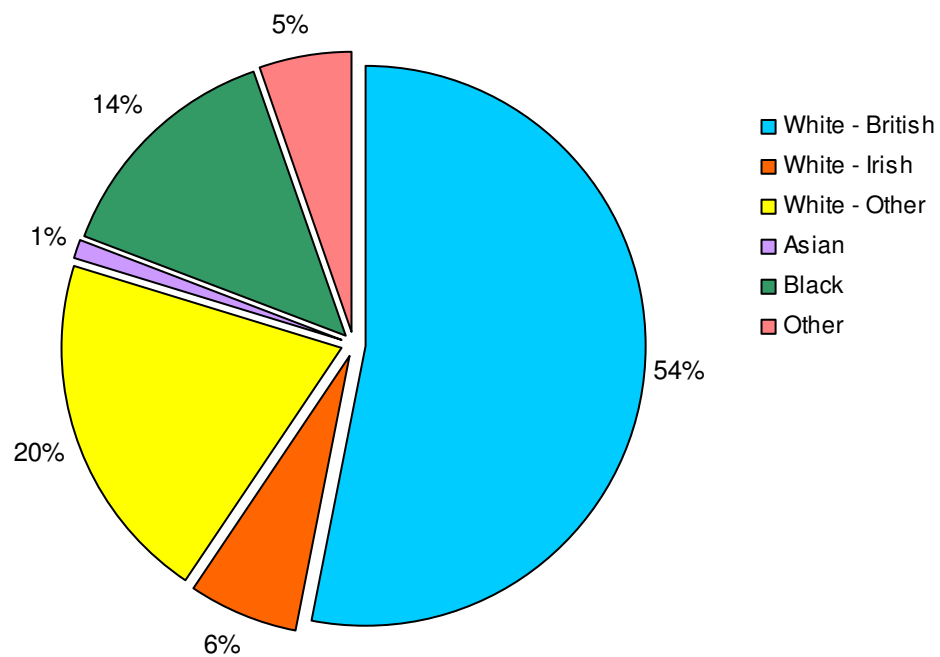
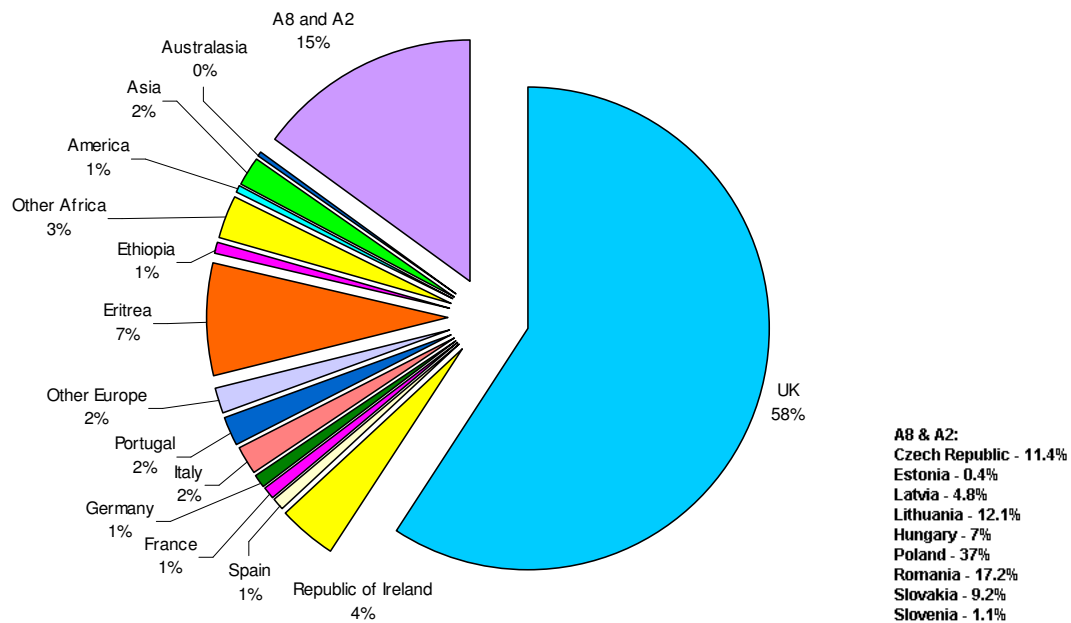


Figure 3.3: Rough sleepers in Westminster by nationality



3.2 Conclusions

The majority of rough sleepers in Westminster are men aged 26-45 years – many of whom are from the UK. Rough sleepers from A10 countries also represent a significant proportion of rough sleepers in Westminster – a proportion that is increasing. Future services plans should, therefore take into account the likely future increases in the number of rough sleepers from outside the UK, particularly A10 countries.

4. Health and Homelessness

Key messages:

- **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;**
- **In a local survey of rough sleepers and hostel residents 72% of participants reported having at least one long term illness;**
- **Commonly reported long term conditions included mental health problems, skin, bone, joint and muscle problems, liver disease and respiratory illness.**

4.1 Relationship between health and homelessness

The life expectancy of homeless populations is significantly lower than that observed in Westminster as a whole; the life expectancy of someone who sleeps rough can be as low as 42, compared with 79 for males in Westminster and 83 for females. (Griffiths 2002 & NHS Westminster 2009)

Housing status and health are inextricably linked, with homeless populations experiencing significant health inequalities. Homeless populations are more likely to suffer from a range of health problems including substance misuse, physical and mental health problems.

Whilst some aspects of poor health are attributable to being homeless, some health problems such as substance misuse and mental health problems can actually play a part in becoming homeless in the first instance and also then prevent people from moving from the streets or temporary housing into more stable accommodation.

The reasons why homeless people experience poorer health than the general population are complex but include:

- chaotic lifestyles of homeless people
- health may not be a priority to homeless people
- poor previous experience of healthcare/services
- reactive use of health services, such as A&E.

People in temporary accommodation and rough sleepers experience worse health than the general population. Although relatively dated, Bines' research highlights the difference in health status between the general population and homeless populations. In a study of homeless people in a range of settings, an estimated four out of ten people residing in hostels and B&Bs and six out of ten people sleeping rough, report more than one health problem compared to 20% of the general population (Bines, 1994).

Homeless people suffer largely the same conditions as the general population, but more often and more severely. Many of the health problems experienced by rough sleepers are directly caused or exacerbated by a lack of shelter and warmth.

Poor physical health includes higher rates of tuberculosis and blood borne viruses than the general population, poor condition of feet and teeth, respiratory problems, skin diseases and wounds, injuries sustained as a result of violence or accidents and musculoskeletal conditions. Mental health problems encompass a wide range of conditions including depression, personality disorder and schizophrenia whilst substance misuse includes drug and alcohol dependency; alcohol, heroin and crack cocaine use being relatively high amongst street populations.

4.2 Health problems experienced by homeless people in Westminster

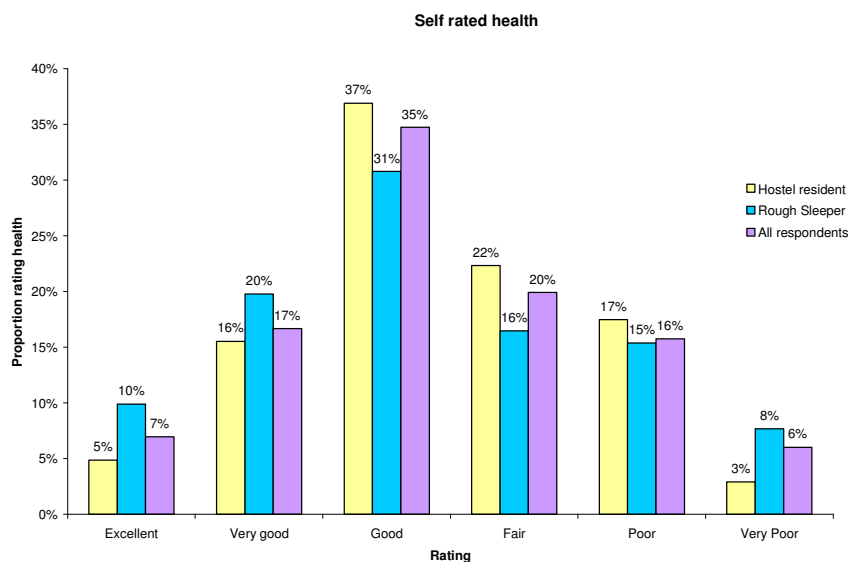
At the beginning of 2009 NHS Westminster and Westminster City Council jointly commissioned a homeless health survey; the aim of this was to inform future commissioning decisions by providing an overview of the health status

of Westminster’s homeless population, exploring the usage of current health services and identification of areas of unmet need.

217 people were surveyed at a range of locations, including day centres, hostels and supported housing, to capture a representative sample of Westminster’s homeless population.

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 given the breadth of evidence which demonstrates the poor health of people who are homeless. However, this could also be a result of how people who are homeless rate their own health in the context of the challenges that they face. Rough sleepers were more likely to rate their health as excellent or very good, however they were also more likely to rate their health as very poor.

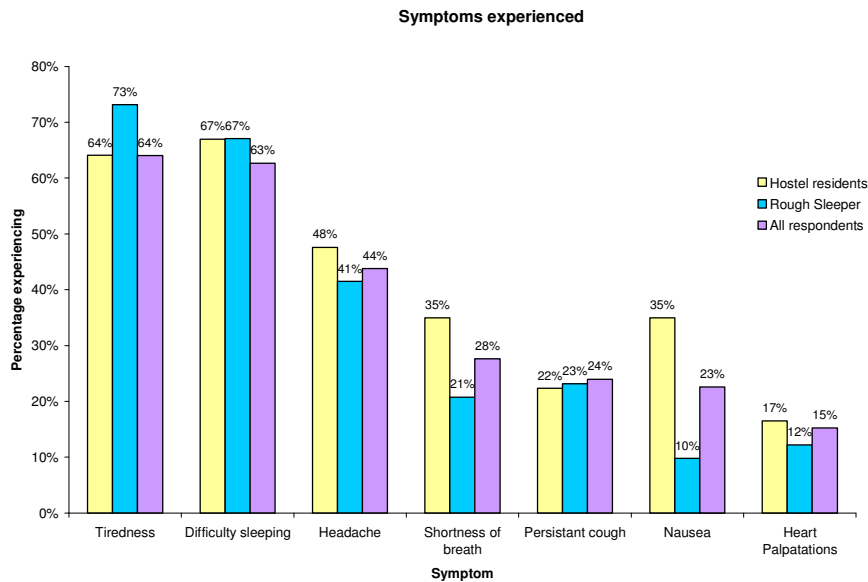
Figure 4.1: Self reported health of rough sleepers in Westminster



Participants were asked about illnesses and symptoms, almost two thirds reported suffering difficulty sleeping or tiredness in the last month, and approximately a quarter of people reported respiratory symptoms (24% persistent cough and 28% shortness of breath). Overall 72% of people reported having at least one long term illness; this was higher in the hostel/supported housing population at 81% compared to the rough sleeping

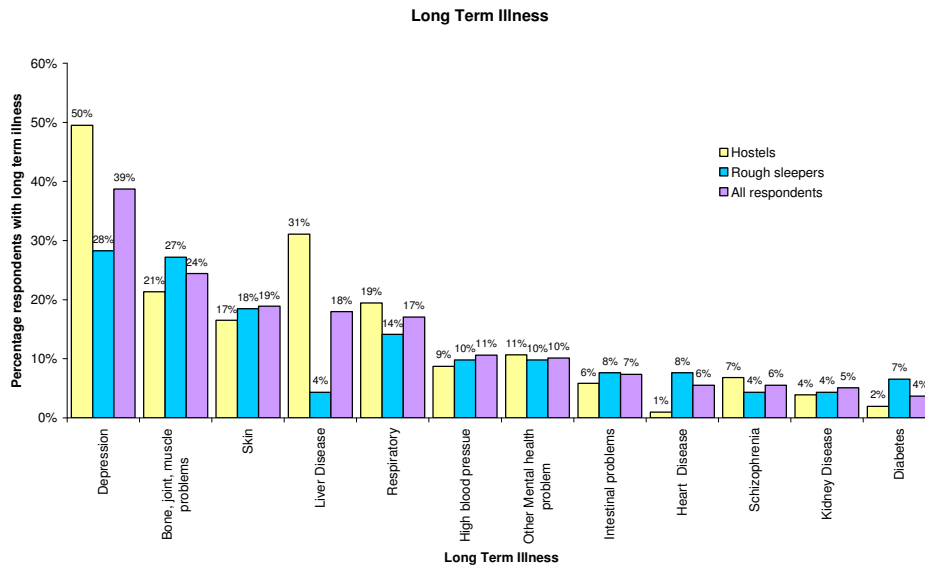
population, 63%. This is thought to reflect better diagnosis of long term illness in the hostel/supported housing population compared to the rough sleeping population rather than a higher prevalence of long term illness per se.

Figure 4.2: Symptoms experienced by rough sleepers in Westminster



Mental health problems were the most commonly reported long term condition; with 39% reporting some form of depression. Other reported long-standing illnesses included skin, bone, joint and muscle problems, liver disease and respiratory illness. It is notable that there are more symptoms described in figure 4.2 than long term conditions reported (figure 4.3) which may reflect undiagnosed disease.

Figure 4.3: Long term illness experienced by rough sleepers in Westminster



4.3 Conclusions

When surveyed, rough sleepers in Westminster reported a range of illnesses and symptoms. The majority reported at least one long term illness. Commonly reported conditions included mental health problems, skin, bone, joint and muscle problems, liver disease and respiratory illness.

5: Access to health services

Key Messages:

- **Homeless people experience barriers to accessing appropriate health care; the reasons for this are wide ranging and include user motivation, social prejudice and stigma, but also factors that are more adaptable such as the specific design and provision of primary care services;**
- **Homeless people use services such as A&E and the London Ambulance Service to address routine non-emergency health needs. Although these services provide high quality care to stabilise acutely unwell people, ongoing sustainable care to improve long term health can not be delivered in such settings;**
- **The majority of London Ambulance Service call outs and A&E presentations for homeless people in Westminster were for acute incidents associated with pre-existing long term conditions and, therefore, likely reflect a number of unmet needs;**
- **There are likely to be a number of presentations and call outs which are appropriate due to exacerbation of a long-term condition, but this could be avoided through more timely management of long term conditions in primary care to prevent health deteriorating to the point where emergency care is required;**
- **Communication and links between acute trusts and hostel and BBSs are needed to create a mechanism for earlier identification of clients in hospital and allow better planning on discharge;**
- **Training is needed for hostel and BBS staff to enable them to deal with acute emergencies as well as improved provision of support, particularly out of hours.**

Despite the high levels of health need in homeless populations, people who are homeless often face barriers accessing primary care and other health services. As a result, the health of homeless people may not be effectively

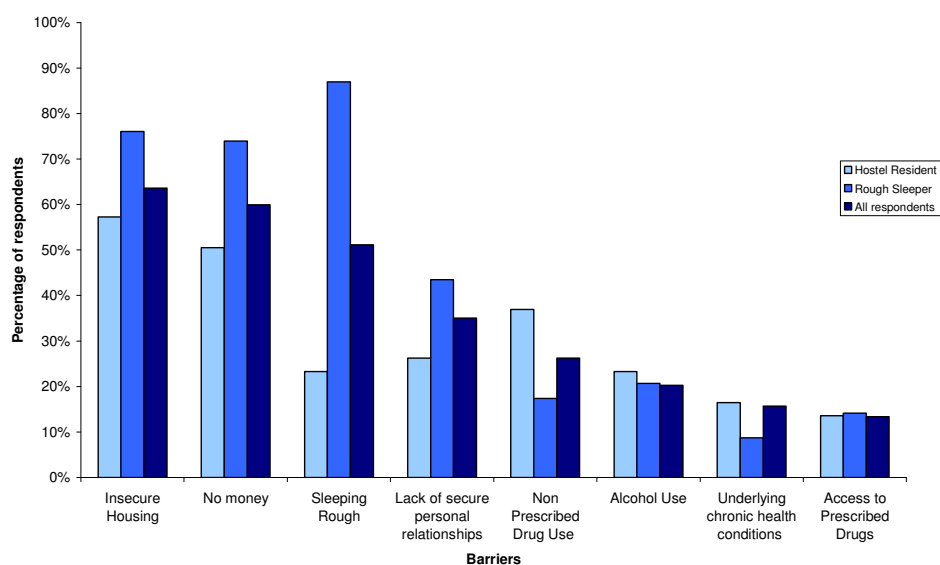
managed and can continue to deteriorate. Furthermore, homeless people tend to use services such as A&E for problems best managed in primary care.

Whilst some of the barriers to appropriate health care could be attributable to the design of services, research by Crisis suggests that factors associated with being homeless have a role. Evidence suggests that people quickly adapt to becoming homeless in order to survive –generally within three weeks. The longer one is homeless, the harder it becomes to use mainstream services and thus encourages reliance on specialist homeless services and emergency services. People may continue to use these services long after their accommodation situation has stabilised (Grenier, 1997).

5.1 Perceived barriers to healthcare

In the Homeless Health Survey respondents were asked about barriers to feeling in good health. 87% of rough sleepers reported sleeping rough as a barrier to good health as did 23% of hostel residents. 64% of respondents reported insecure housing and 60% lack of money as barriers. The majority reported social issues as the main barriers to good health, with relatively few citing drug and alcohol use, underlying chronic health conditions and access to prescribed drugs as barriers.

Figure 5.1: Barriers to good health identified by homeless people



5.2 Primary care

Primary care for homeless people in Westminster is primarily delivered by three specialist providers, the Homeless Health Team (provided at three day centres), Dr Hickey Surgery and Great Chapel Street Medical Centre.

Historically homeless people have found it particularly difficult to register with GPs; Bines (1994) reported that between 20% and 39% of homeless people were not registered with a GP. A question was asked in the Westminster Homeless Health Survey about registration with a GP; overall 81% of respondents reported being registered with a GP. This was higher for hostel residents than for rough sleepers; 99% of hostel residents were registered with a GP compared to 63% of rough sleepers.

Of those rough sleepers not registered with a GP, 16% said this was because they were unable to and 20% said that this was because they did not want to.

In 2004 a Homeless Locally Enhanced Service (LES) was introduced to improve the primary healthcare provision for homeless people in Westminster; 16 practices in Westminster are currently signed up to the LES.

According to the LES, 1,034 homeless people in Westminster are currently registered with mainstream GPs signed up to the LES. Although informative, this number should be treated with caution as until recently place of residence was recorded only at time of first assessment. It is possible that the LES may include people who are no longer homeless. Updating place of residence on the homeless LES on a regular basis is, therefore, recommended.

Dr Hickey's Surgery is the only GP in Westminster that permanently registers homeless people - the Homeless Health Team and Great Chapel Street can temporarily register patients. 1,494 people are currently registered at Dr Hickey's Surgery.

National guidance is to permanently register homeless patients; however, in Westminster there is the concern that improved access to GPs may attract

homeless people to the City. Failure to implement registration for homeless people in other parts of the UK means that people stay on Westminster practice lists and their care remains the responsibility of NHS Westminster long after they move on. More robust evidence is needed to assess the impact of increasing the number of GPs in Westminster who can permanently register homeless patients.

5.3 The Westminster 150 use of specialist services

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. They commission support services to provide case management for to this group; additional funds, access to beds and innovative responses are offered.

A review of the engagement and care of TW150 was conducted by specialist primary care teams. Clinicians identified those with active relationship with primary care teams over the last 12 months. One GP practice compiled the list which was confirmed by the second GP practice. The allocation was defined by attendance at specialist services, not GP registration. Therefore, for people that attended several services, the developed relationship service was the one that saw them most frequently.

Figure 5.2: Contact with specialist services for TW150 in a one year period

	No of TW150 clients	%
DHS	54	37
Seen no one	33	22
HHT	26	18
GCS	24	16
Other GP	5	3
Deceased	5	3
Never seen	1	0.7
n=148		

Analysis revealed that high a number of people (71%) were in recent touch with specialist primary care, and another 3% saw other local GP's. It should be noted that frequency of attendance was not examined.

However, the review demonstrated that services were less likely to reach those most in need – the second largest group (22%) did not have an active relationship with any primary care practice. One individual was not listed at all, despite having been here for at least 5 years.

Current services did not seem able to respond flexibly to the needs of this group, yet for many this was one of the few health services with which they have an ongoing relationship. Clinicians in all the specialist services reported that these entrenched and complex patients were a key client group. The vision for these specialist services in Westminster is to respond to those who fall through the gaps of other health services. Clinicians need to be supported to focus resources and innovation on the most needy people.

5.4 London Ambulance Service

London Ambulance Service responds to 999 calls across London, providing emergency care. There is some evidence to suggest that homeless populations use ambulance services disproportionately more than the general public; recent research demonstrated that ambulances are called to St Mungo's hostels on average twice a week (St Mungo's, 2008).

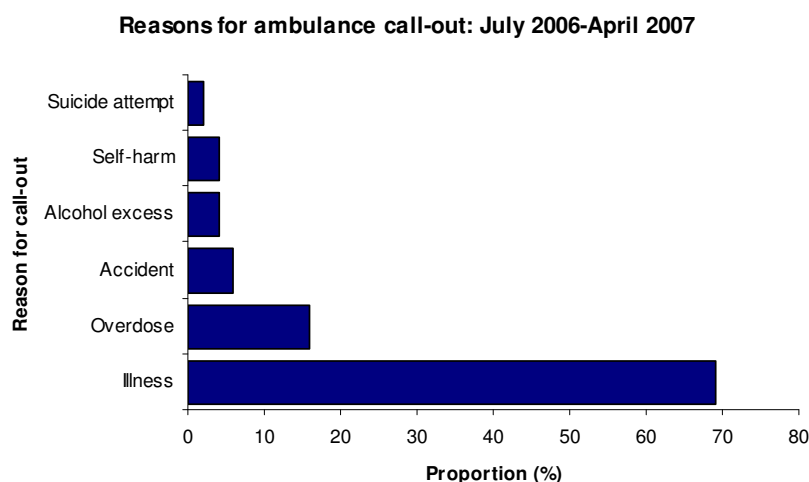
It is thought that this could reflect the particular health needs of this population in that care is only sought when health problems have deteriorated to the point where urgent medical attention is required. Additionally, ambulance call outs could be for non-urgent health problems.

5.4.1 Patterns of ambulance use

A sample of hostels in Westminster was selected to assess the use of the London Ambulance Service by homeless people in Westminster between 2006 and 2009. These hostels were selected on the basis that they had capacity to accommodate more than 100 people, and included hostels catering for both men and women with a range of support. The four hostels were located at various locations across the borough. In total the hostels had capacity to house 554 people at any one time. Between April 2006 and March 2009 the number of ambulance calls at these four hostels increased from 104 to 207; a two-fold increase over a three year period.

In addition to local analysis of ambulance call-outs, between July 2006 and April 2007, St Mungo's conducted a similar study (St Mungo's, 2008). Overall, results were consistent with the Westminster 2006-2009 analysis. 44% of calls occurred within traditional out of hours times (lower than the 67% reported locally), with ambulances commonly called in response to illness rather than accidents.

Figure 5.3: Reasons for ambulance call outs



A wide range of acute medical emergencies were responsible for ambulance call-outs to St Mungo's hostels, including seizures, collapsing, coughing or vomiting blood, severe pain and difficulty breathing. The majority were the result of pre-existing medical conditions including asthma, diabetes, coronary heart disease, epilepsy and substance misuse among others. Appropriate management of such long term chronic conditions in primary care could potentially prevent conditions from exacerbating to the point where emergency care is required.

Multiple call-outs to the same person were also common in the St Mungo's study. Of the 57 people, 12 (21%) had repeat call outs. 42% of all ambulance call-outs resulted in the individual being taken to A&E, with 24% resulting in hospitalisation.

5.4.2 Service user feedback

In depth interviews (Ipsos Mori, 2006) conducted in a sample of homeless people had generally positive views about the London Ambulance Service, with some people interviewed describing a relationship with London Ambulance Service staff as they become more familiar with them as a result of repeat call-outs.

The general consensus amongst homeless populations agrees that the key role of the London Ambulance Service is to stabilise patients and provide care until taken to hospital. In most cases an ambulance would only be called in

the case of an emergency; the perception of what constituted an emergency was similar in homeless people and the general population.

5.4.3 Stakeholder feedback

Local evidence suggests that it is often the hostel/ BBS worker who calls the ambulance. At the 2009 Homeless Health Summit many hostel and BBS staff reported feeling unable to manage chronic illness and as a result call for an ambulance when they are unclear about what to do. Local experience suggests that during working hours, hostel and Building Based Services workers have good links with specialist providers such as Dr Hickey who they will phone for advice, but that at night this is not available.

5.5 Accident and Emergency and unscheduled hospital admissions

A question was asked about use of A&E services in the Homeless Health Survey; 37% of people reported using A&E at some time in the last year; this is equivalent to 982 people in Westminster.

Of those people that reported attending A&E, 45% reported visiting St Thomas' and 15% St Mary's hospitals; reflecting that more hostels are located in the south of the borough, closer to St Thomas' Hospital.

5.5.1 Local A&E attendances

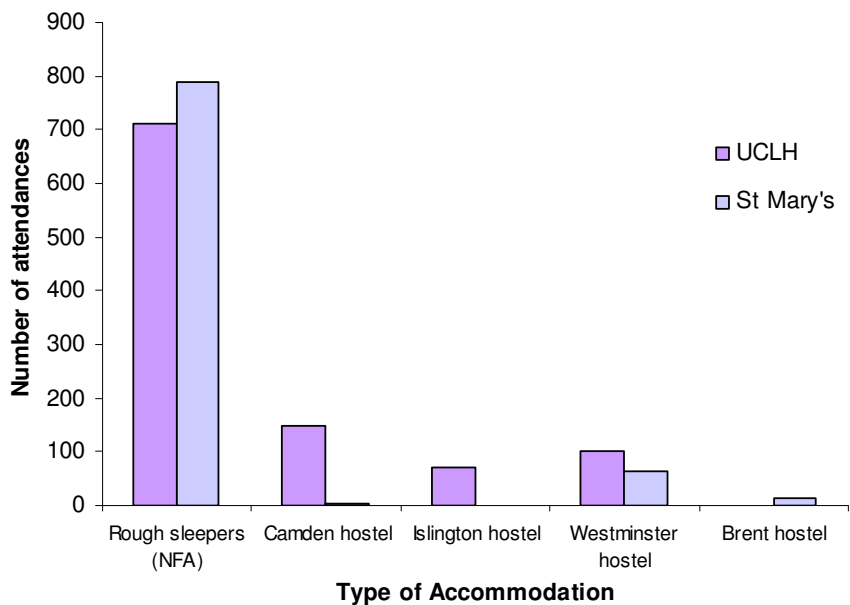
As part of this needs assessment, NHS Westminster commissioned a local study into A&E and unscheduled hospital admissions for people living in direct access hostels or people with no fixed abode (NFA) attending University College London Hospital (UCLH) and St Mary's Hospital.

5.5.2 A&E attendances

In 2008, hostel dwellers and rough sleepers accounted for 1,902 A&E attendances, of which 300 led to hospital admission. This is particularly high, especially since data from St Thomas' Hospital was not considered in this study.

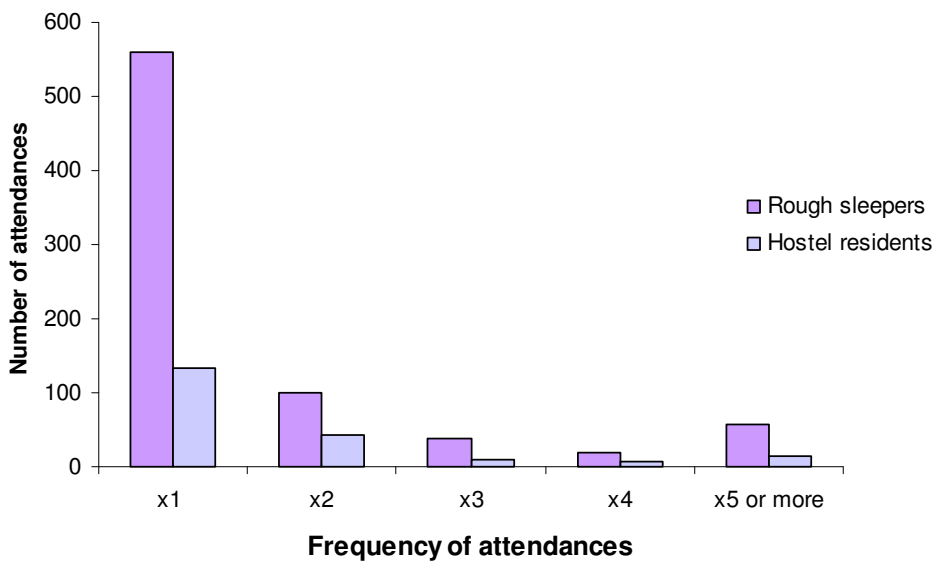
Rough sleepers accounted for 79% of admissions, followed by Westminster hostels (9%) and Camden hostels (8%).

Figure 5.4: A&E attendances by accommodation status



1,008 patients accounted for 1,902 A&E attendances; an average of 1.9 attendances per person per year for St Mary's hospital and 2 attendances per person per year for UCLH. 71% of patients who attended A&E in 2008 did so only once, however, 7% attended A&E five or more times in the year, with some patients attending in excess of 20 times in the year.

Figure 5.5: A&E attendances by frequency of attendance



For those rough sleepers registered with a GP, 40% of those attending St Mary's and 27% of those attending UCLH were registered with a Westminster GP. A small proportion were registered with GPs in neighbouring boroughs, including Camden, Islington and Brent, however, 55% of attendances at UCLH and 26% of attendances at St Mary's were registered with GPs from other London boroughs and others across the UK; this reflects the high number of rough sleepers that end up in Westminster but whom originate from other parts of the UK and also other countries outside the UK.

5.5.3 Unscheduled admissions

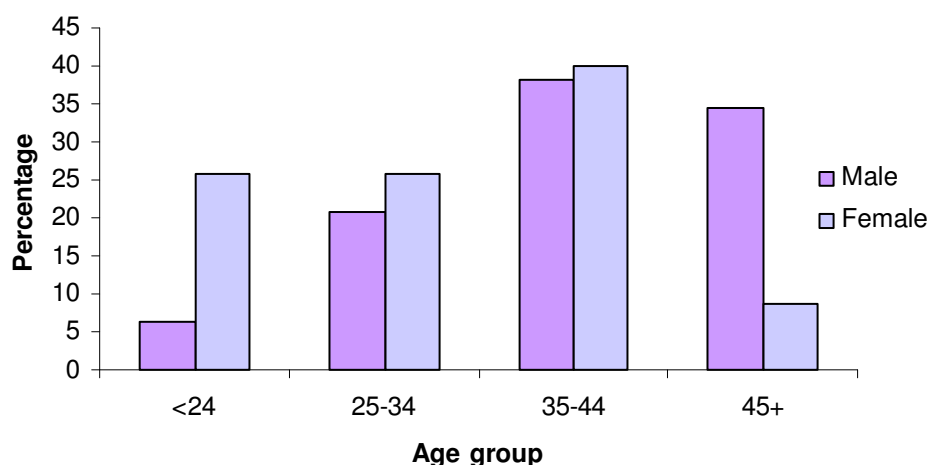
Unscheduled admissions describe those admissions to hospital that are not planned i.e. emergency admissions. Overall 15.8% of A&E attendances in this cohort resulted in an admission to hospital. In addition to admission via an A&E route, a number of admissions were transferred from other hospitals or followed GP contact.

Rough sleepers accounted for 65% of unscheduled admissions to St Mary's hospital; this is in contrast to UCLH in which hostel residents accounted for the majority of unscheduled admissions (54%).

268 people accounted for 330 admissions; this represents an average of 1.2 admissions per patient – this was similar for both St Mary's Hospital and UCLH.

A more detailed analysis of unscheduled admissions to UCLH showed that men accounted for 76% of admissions. The majority of men and women admitted were aged 35-44, however, peaks in the number of admissions were observed for men over the age of 45 and women under the age of 24.

Figure 5.6: A&E admissions at UCLH by age and sex



The majority of patients admitted to UCLH were admitted for one day or less – this may be a consequence of the A&E four hour target with a large number of patients being admitted to recover from the effect of drugs and alcohol to avoid breaching the four hour A&E target. As a result of the short length of stay, limited data is available pertaining to the speciality to which patients are admitted. Of those with a speciality recorded, the majority of admissions were to General Medicine for a period of 1-2 days.

5.5.4 Stakeholder Feedback

At the Homeless Health Summit a workshop was held on A&E and out of hours care to identify what stakeholders believe to be the reasons for presentations to A&E and how barriers to accessing care can be overcome.

Stakeholders believed that the high number of attendances at A&E was a result of difficulties accessing primary health care services. Although the three main daycentres in Westminster provide primary care services almost daily, stakeholders reported a lack of appropriate medical cover for both physical and mental health problems which led to A&E attendance.

Hostel and BBS staff reported feeling unable to manage chronic illness and supervise medication and treatment plans.

Some A&E presentations and unscheduled admissions were thought to be a result of poor discharge plans from earlier admissions, particularly for long-term conditions.

Some homeless people received opportunistic detoxification and stabilisation whilst in hospital which was difficult to maintain in discharge if the person returned to an environment where drug and/or alcohol use is prevalent. Stakeholders thought that hospitals should have access to CHAIN and that liaison between hospitals' other services staff was a priority.

Stakeholders also thought it was important to gather feedback identifying the barriers to accessing services regularly.

5.6 Conclusions

Homeless people experience wide-ranging barriers to accessing appropriate health care. Such barriers include user motivation, social prejudice and stigma, as well as factors associated with the provision and design of health care services.

The majority of London Ambulance Service local call outs and A&E presentations were for acute incidents associated with long-term conditions. This suggests that there may be some room for improvement in primary care services to manage long term health problems and a need for further training and support for hostel and BBSs to manage chronic conditions.

It is clear that acute hospital trust emergency staff are key players in the provision of health services for homeless people in Westminster with little involvement in planning care post hospital discharge.

The majority of homeless people in Westminster were registered with a GP with registration more common in hostel residents than rough sleepers. Despite this there seemed to be poor awareness of out-of-hours services.

5.7 Recommendations

- 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;
- 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;
- Greater and more detailed knowledge of the health needs, and how they overlap with other homeless people is needed for TW150;
- Specialist services to be commissioned in a way that targets their resources at the most needy people with mainstream services providing the bulk of care.

6: Substance misuse

Key Messages:

- **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 high;**
- **A significant proportion of homeless people are likely to have co-existing drug and alcohol problems;**
- **Amongst those using drugs problematic poly-drug use (crack and heroin) is common and further work is needed to understand the relationship between crack and heroin use;**
- **There is a relationship between continued alcohol use and a previous history of drug misuse;**
- **Using heroin on top of a methadone prescription is commonly reported amongst homeless people in Westminster;**
- **The number of Westminster homeless residents who access treatment for substance misuse needs to be increased.**

Substance misuse and homelessness are inextricably linked; in a Crisis survey of homeless people in London, 63% stated alcohol and/or drug use as the reason for becoming homeless (Fountain & Howes, 2002).

As well as being a causative factor for becoming homeless, substance misuse may be triggered by homelessness and dependence is more likely to result the longer a person is homeless, with evidence suggesting that substance misuse is an important factor in maintaining homelessness – furthermore, substance misuse can potentially lead to a worsening housing situation (Fountain & Howes, 2002).

Estimating the prevalence and patterns of substance misuse amongst homeless people in Westminster is difficult. Therefore, in order to determine the prevalence and patterns of substance misuse amongst Westminster's homeless population, a range of data sources have been drawn upon – these include both local and national data sources:

- national research such as that undertaken by Crisis
- National Treatment Agency (NTA) modelled prevalence
- Clean Break Survey
- Homeless Health Survey

When interpreting the data it is important to note the context in which the data has been collected and whether it is applicable to the population for which services are commissioned. The Westminster Drug and Alcohol Action (DAAT) commissions services specifically for Westminster residents, however, the Homeless Health Survey included Westminster and non-Westminster residents who were homeless in Westminster and, therefore, not all of those people included in the survey are eligible for DAAT commissioned services (they are, however, eligible for primary care services).

6.1 Expected number of people using misusing alcohol

The World Health Organisation (WHO) describes three categories of alcohol misuse which this needs assessment has adopted:

- hazardous drinking – drinking above recognised 'sensible' levels but not yet experiencing harm
- harmful drinking – drinking above recognised 'sensible' levels and experiencing harm
- dependent drinking – drinking above 'sensible' levels and experiencing harm and symptoms of dependence.

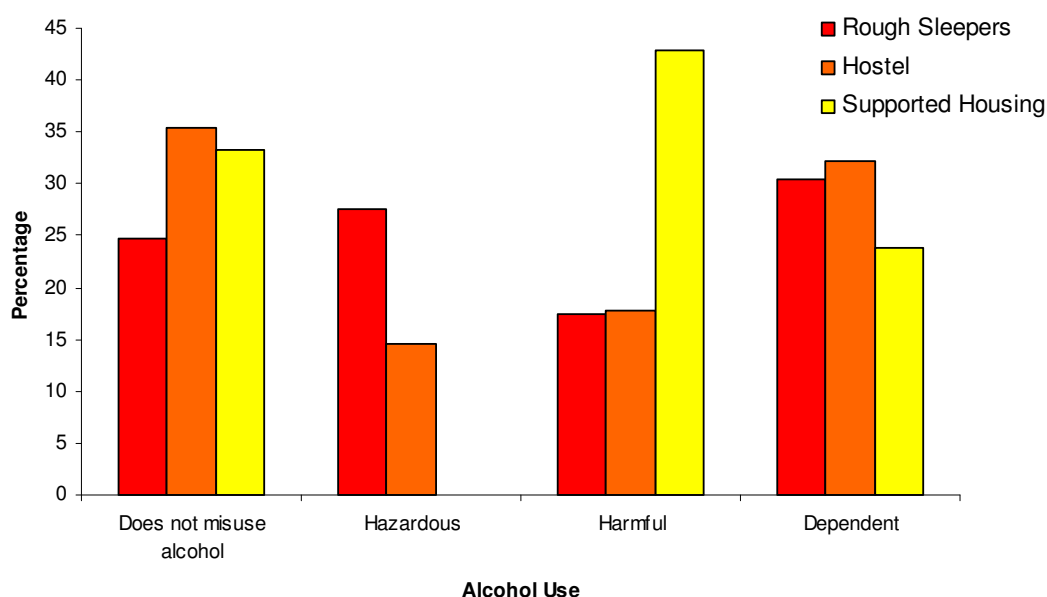
A question was asked in the Homeless Health Survey regarding how often people drank alcohol, when people drank and how much people drank. Overall, 20% of respondents reported drinking on a daily basis at a level that is harmful to their health. In a 2002 Crisis Survey of people who had a history of sleeping rough in London in the last six months, 68% reported using alcohol

in the last month with 37% reporting alcohol dependence (Fountain & Howes, 2002). Furthermore, 47% of people recorded on CHAIN were noted to have alcohol support needs – this was even higher for revolving door rough sleepers (62%). The comparatively low level of alcohol use reported in the Homeless Health Survey is probably due to underreporting or sampling issues. Some people may not wish to disclose the true extent of their drinking and those who drink to excess may be less likely to engage with services and thus take part in the survey.

6.2 Patterns of alcohol use

As a snapshot survey of hostel dwellers and frequent contacts of BBSs, the Clean Break audit assists hostels and BBSs gain a better understanding of the needs of people and trends of substance misuse. Of those surveyed in 2008, 67% were found to misuse alcohol; of those misusing alcohol the majority were dependent alcohol users (46%), followed by harmful drinkers (29%) and hazardous drinkers (25%). The prevalence of alcohol misuse was highest amongst current rough sleepers (75%) compared to 65% and 67% of hostel and supported housing residents respectively; this is consistent with the Homeless Health Survey.

Figure 6.1: Alcohol use by accommodation type



The lower proportion of people drinking to excess in hostels and supported housing is thought to be due to some hostels and supported housing not accepting people with alcohol issues and the behaviour of heavy drinkers makes it more likely that they are moved on or evicted.

The proportion dependent on alcohol is lower than expected; this is thought to reflect the fact that alcohol use was reported and interpreted by key workers and also the fact that current rough sleepers (in which the prevalence of alcohol dependence is thought to be high) represented 18% of the sample population.

The majority of harmful, hazardous and dependent drinkers were men (97%) mostly aged 35-54 years. Men are overrepresented in this group, however, the age profile is consistent with the homeless population in Westminster.

6.3 Expected number of people using illicit drugs

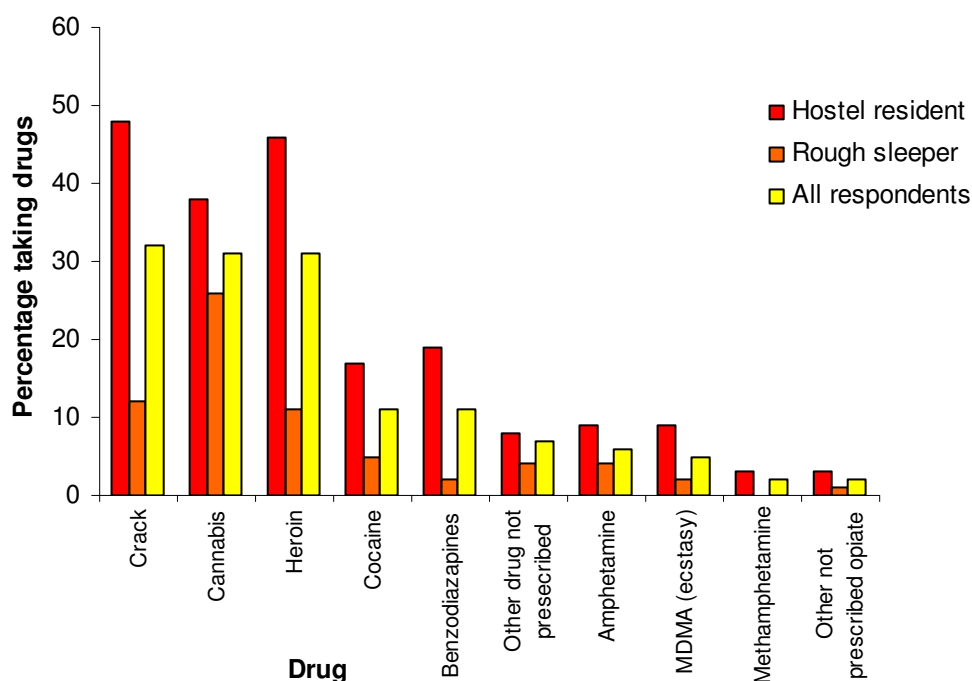
A question was asked in the Homeless Health Survey about the use of illicit drugs. Overall, 47% of respondents reported taking an illicit drug in the last month; this was higher for hostel residents (66%) than for rough sleepers (32%) and is equivalent to 1,021 homeless people in Westminster using illicit drugs.

The reported prevalence of illicit drug use in the Homeless Health Survey is much lower than expected, however, it is higher than that reported on CHAIN; 36% of people recorded on CHAIN were noted to have drug support needs. Evidence from published research suggests that the prevalence of illicit drug use amongst homeless people in Westminster is likely to be much higher. In a 2002 Crisis Survey of people who had a history of sleeping rough in London in the last six months, 83% reported drug use in the last month (Fountain & Howes, 2002).

The low reported prevalence in the Homeless Health Survey and CHAIN did not appear to be associated with the inclusion of A10 nationals rough sleeping in Westminster. Anecdotal evidence suggested that the prevalence of alcohol

misuse as opposed to drug misuse was greater; however removing these people from the analysis showed little variation in the results.

Figure 6.2: Illicit drug use amongst homeless people in Westminster



Of those people reporting drug use, the majority were using crack, cannabis and heroin. Reflecting the overall difference in drug usage, fewer rough sleepers reported using crack, heroin and/or cannabis compared to hostel residents, however, there was much less disparity between the proportion of rough sleepers and the proportion of hostel residents reporting cannabis use.

6.3.1 Problematic drug use

Drug treatment services focus on problematic drug users (PDUs) - those using opiates (heroin, morphine or codeine) and/or crack cocaine.

Of those PDUs the majority were using both opiates and crack cocaine, overall 44% of hostel residents and 9% of rough sleepers reported using both.

Using methodology from Centre for Drug Misuse Research, the National Treatment Agency (NTA) estimates that the overall prevalence of problematic drug use in Westminster is 19.87 per 1,000 population. Based on the

Homeless Health Survey, this extrapolates to approximately 630 problematic drug users who are homeless in Westminster.

6.3.2 Patterns of problematic drug use

As a snapshot survey of hostel dwellers and frequent contacts of BBSs, the Clean Break audit can facilitate understanding of the patterns of problematic drug use amongst those that use drugs problematically.

The Clean Break audit has adopted a number of categories to describe drug use according to housing needs. These include:

- chaotic drug users – defined as using multiple times a day, using unsafe practices, funding drug use illegally and needing a high level of staff input to maintain a hostel need
- unstable drug use – defined as having periods of instability and periods of binging/chaotic drug use which, at times, is putting their accommodation at risk
- stable drug use – defined as being able to successfully maintain accommodation with some support despite drug use.

Of those sampled in the 2008 Clean Break audit, 45% were current problematic drug users.

For those people currently using opiates and/or crack cocaine, the majority were considered stable (52%), with 32% unstable and 16% chaotic. Although the majority of problematic drug users are considered stable with regards to their problematic drug use and their accommodation, 48% are not, highlighting the importance of successfully addressing problematic drug use.

Table 6.3: Problematic drug use by type of drug use

Type of drug use	Proportion of all class A drug users
Stable	52%
Unstable	32%
Chaotic	16%

The profile of problematic drug users amongst the homeless population is younger than that of those that misuse alcohol. Whereas most people that misuse alcohol were aged 35-54, the majority of problematic drug users were aged 25-44. As is the case for those that misuse alcohol, the majority of problematic drug users were men (91%).

6.3.3 Methadone use

Of those surveyed in the Homeless Health Survey, 28% were currently prescribed methadone – this was particularly high amongst hostel residents, 50% compared to just 4% of rough sleepers. As residents in a relatively stable environment, hostel residents are more likely to be prescribed opiate substitutes than rough sleepers.

6.3.4 Former problematic drug users

Of the former problematic drug user category recorded on the Clean Break audit, 35% were being prescribed methadone, an additional 5% were being prescribed Subutex and 60% were not receiving any opiate substitute medication. Of those who were not receiving any substitute medication 47% described their alcohol use as problematic. This suggests that further support is needed to prevent people from replacing problematic drug use with alcohol misuse.

Table 6.4: Current status of former problematic drug users

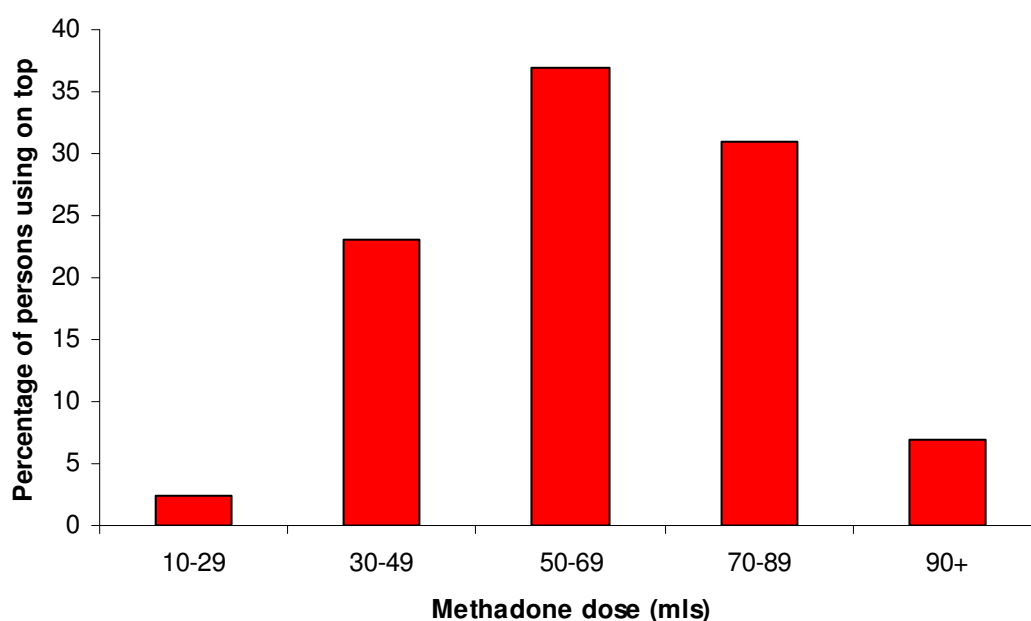
	Proportion of former illicit drug users
Former user – prescribed methadone	35%
Former user – prescribed subutex	5%
Former user – current problem drinker	28%
Former user – no illicit/prescribed drug use or problematic drinking	32%

6.3.5 Current problematic drug users

It is known that some people who are prescribed methadone also continue to use heroin. According to the Homeless Health Survey, which included Westminster and non Westminster residents, 71% of all people prescribed methadone reported that they continued to use heroin.

According to the National Institute for Health and Clinical Excellence the usual maintenance dose for methadone is between 60 and 120mls (NICE, 2007). Of note is that of those using heroin on top of methadone in Westminster, the majority were on a prescription of between 30 and 89mls of methadone which may be too low to control their need for heroin.

Figure 6.5: Proportion of current problematic drug users (opiates) prescribed methadone by methadone dose



6.4 Problematic drug use and alcohol misuse

Problematic drug use and alcohol misuse are not exclusive, a number of people use opiates and/or crack cocaine as well as misusing alcohol. Approximately 14% of people recorded on CHAIN in 2008/09 had both alcohol and drug support needs, however further evidence suggests that the prevalence is much higher.

In the Clean Break audit, 34% of people drinking at levels described as harmful, hazardous or dependent were current problematic drug users and a further 6.3% were former problematic drug users. Furthermore, evidence suggests that there is a link between concurrent alcohol and illicit drug use. This suggests that a significant number of people are likely to have

simultaneous drug and alcohol problems and treatment services should be tailored appropriately.

6.5 Homeless people accessing substance misuse services in Westminster

6.5.1 Problematic drug use

The National Drug Treatment Monitoring System (NDTMS) collects information on residents accessing structured care planned treatment. Although not all clients will meet the eligibility criteria for homelessness, housing problems are particularly prevalent for this client group.

Latest available data shows that 1,828 Westminster residents were newly presenting for treatment in 2007/08. Of these 30% were classified as no fixed abode (defined as sleeping rough, using night hostels or sleeping on a different friend's floor each night); this is equivalent to 548 people.

Furthermore, an additional 30% of people newly presenting for treatment were classified as having a housing problem (defined as staying with friends as a short-term guest, night winter shelters, direct access short stay hostels, short term B&B or squatting); this is equivalent to 548 people.

The Homeless Health Survey asked a question on the use of health services in the borough. 22% of respondents reporting accessing specific drug or alcohol services in the last year.

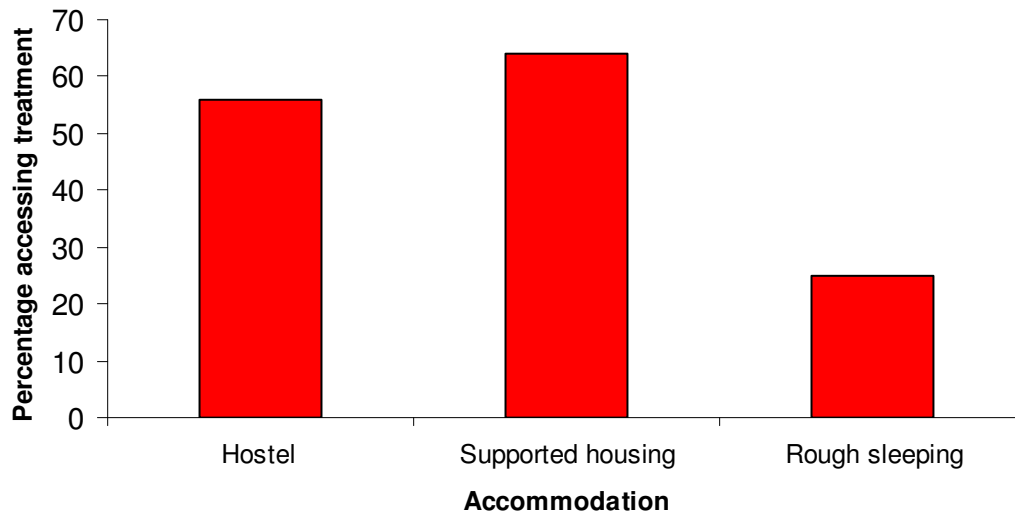
6.5.2 Alcohol

Of those who reported drinking heavily on a daily basis in the Homeless Health Survey, only 35% reported having accessed alcohol treatment services in the last year.

In the Clean Break audit, this figure was higher; 43% of those drinking at levels described as hazardous, harmful or dependent had accessed an alcohol treatment service in the last year. People drinking dependently were most likely to access treatment (52% reported accessing treatment), compared to those drinking harmfully (40%) and hazardously (31%). This

suggests that more interventions may be needed for those drinking hazariously or harmfully before dependence develops.

Figure 6.8: Proportion of homeless people misusing alcohol accessing alcohol treatment by type of accommodation type

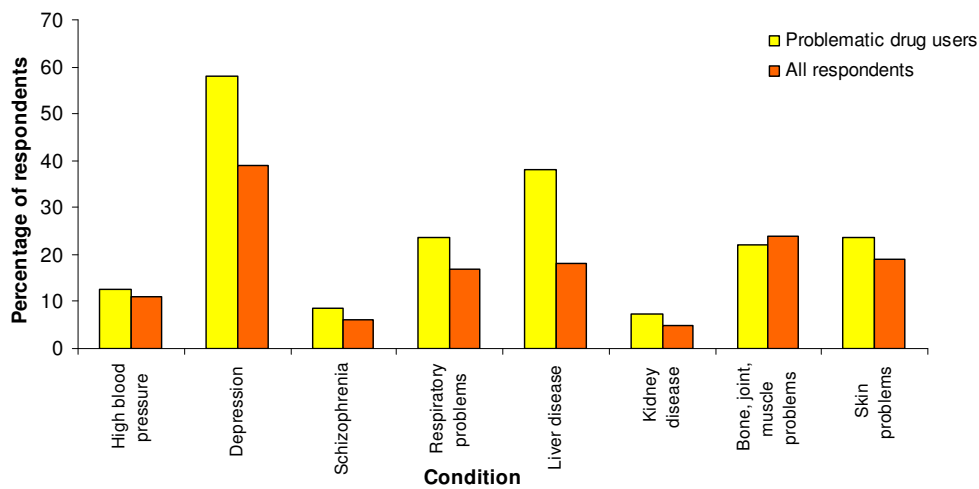


At the Service User Event, participants showed awareness of the impact that drugs and alcohol had on their health and well-being. 47% viewed alcohol and 33% viewed drugs as important health issues. Participants recognised the difficulty of dealing successfully with dependence and reported prioritising less complex health problems which they are more likely to be able to address successfully.

Participants also identified substance misuse as a barrier to accessing services for other health and social needs as obtaining drugs or alcohol is often prioritised above other health services.

The Homeless Health Survey found that the prevalence of long-term conditions was higher amongst those people that reported problematic drug use (compared to all respondents).

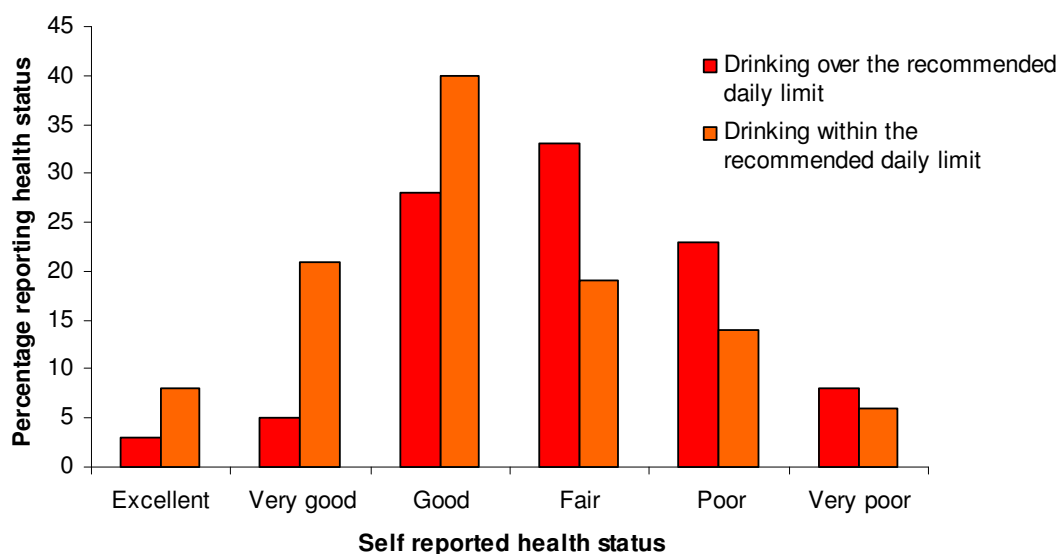
Figure 6.9: Long-term health conditions amongst PDUs in Westminster



89% of problematic drug users reported having a long-term illness; higher than the 73% reported by all respondents. The prevalence of depression and in PDUs is notably higher than that for all respondents. The prevalence of liver disease is also notably higher in PDUs which is likely to reflect the high prevalence of hepatitis C related to intravenous drug use.

Those who reported drinking in excess were more likely to report very poor, poor or fair health than those who were not drinking to the same extent; 64% of heavy daily drinkers and 39% of those drinking within the recommended daily levels reported very poor, poor or fair health.

Figure 6.10: Self reported health status of heavy alcohol users



Those drinking in excess were also more likely to report a long-term health condition than those drinking within the recommended daily limits; 85% of those drinking more than recommended reported at least one long-term condition compared to 70% of those drinking sensibly.

6.7 Problematic drug use and mental health problems

The Royal College of General Practitioners defines dual diagnosis as ‘a situation where a person has concurrent needs arising out of both mental health problems/mental illness and substance misuse’. Substance misuse refers to the problematic, harmful or dependent use of substances including illicit and legal drugs as well as alcohol. Mental health problems refer to a broad spectrum of mental health problems ranging from common mental health problems through to severe and enduring mental illness.

As a concept, dual diagnosis arose in response to a lack of services for people with mental ill health and substance misuse issues. The Department of Health describes four possible relationships:

- a primary psychiatric illness precipitates or leads to drug use
- use of substances makes the mental health problem worse or alters its course
- intoxication and/or substance dependence leads to psychological symptoms
- substance misuse and/or withdrawal leads to psychiatric symptoms or illness.

Limited robust data is currently available describing those in Westminster who have dual diagnosis. Overall, 19% of people on CHAIN were identified as having alcohol and or drugs and mental health support needs; evidence from Clean Break suggests that this proportion is even higher.

6.8 Stakeholder feedback

At the Homeless Health Summit a workshop was held on the health problems of those long-term homeless people who continue to use drugs and/or alcohol. This workshop highlighted that despite increases in the availability and success of drug and alcohol treatment programmes, some people are not

currently engaged or interested in engaging with current treatment programmes.

6.9 Conclusion

Substance misuse and homelessness are inextricably linked; as well as being a key cause of homelessness, substance misuse is an important maintaining factor in homelessness.

Amongst those people using illicit drugs, heroin and crack were the most common drugs - very few people reported using heroin or crack in isolation, the majority reporting using both crack and heroin. Accordingly treatment programmes should be structured appropriately to manage people with poly-drug use.

Patterns of methadone prescribing for homeless people appear complex and variable. Hostel residents appear much more likely to be prescribed methadone than current rough sleepers, even after accounting for the higher levels of opiate use in the hostel population. Amongst former opiate users levels of methadone prescribing is relatively low; whilst this may be appropriate and reflect the needs of people, there is a relatively high number of former opiate users who are not prescribed methadone (or subutex) but who are drinking problematically. This suggests that further support is needed for former drug users to help these people abstain from problematic drug and alcohol use. Amongst those people prescribed methadone, a high proportion continued to use heroin on top.

Data pertaining to the number of homeless people who misuse substances accessing drug or alcohol services is variable, however, it is clear that the number of people accessing care needs to be increased.

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

Key messages:

- **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 – this is lower than expected, and likely a reflection of inadequate data collection;**
- **Current 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;**
- **Stakeholder feedback, suggests that for people who do not meet the threshold for a care programme approach there is an unmet need;**
- **Women are overrepresented in crisis management services (JHT and inpatient care) suggesting a greater mental health need;**
- **People with personality disorder and dual diagnosis are underrepresented amongst those accessing specialist services;**
- **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;**
- **Awareness of clinical thresholds and the range of services is poor amongst third sector workers – as a result some people may not be referred;**
- **Feedback from stakeholders suggests that even though third sector workers have the most direct contact with homeless people with mental health problems, they may not have the skills needed to support them appropriately.**

Mental health problems are much more common amongst homeless people than in the general population. Mental health problems include both:

- common mental health problems such as anxiety, depressive disorders, depressive episodes, phobias and panic disorders, amongst others
- severe and enduring mental health problems such as schizophrenia, schizotypal and other delusional disorders, manic episodes, bipolar affective disorder and other affective disorders with psychotic symptoms.

Poor mental health can not only cause homelessness but it can be a direct consequence of being homeless. Good mental health is not only important from a health and well-being perspective, but it can be necessary for people to improve their housing situation.

Mental health is an important issue for homeless people in Westminster. At the Service Users Health and Homeless Event, 44% of people cited mental health as particularly important for good health and well-being (Groundswell, 2009).

7.1 Defining mental health

The World Health Organisation (WHO) states that mental health can be “conceptualized as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2001). As such, mental health is greater than just the absence of mental illness, but includes the notions of positive self-esteem, coping mechanisms and the importance of empowerment and control.

The presence of mental illness and behavioural disorders is described by the WHO “as clinically significant conditions characterized by alterations in thinking, mood (emotions) or behaviour associated with personal distress and/or impaired functioning...such abnormalities must be sustained or recurring and they must result in some personal distress or impaired functioning in one or more areas of life...they are also characterized by specific symptoms and signs, and usually follow a more or less predictable natural course, unless interventions are made” (2001).The disorders are

pathological phenomena rather than variations on what is perceived as “normal” by the prevailing culture.

The diagnostic categories for Mental Health are described in the International Classification of Disease Version 10, table 7.1.

The main UK prevalence study, the Office of National Statistics Psychiatric Morbidity (NPMS) Study (Singleton *et al*, 2001), suggests the use of three categories to describe mental health disorders: psychotic disorders, neurotic disorders and personality disorders (table 6.2). However, in terms of where and how services are delivered, it is useful to consider mental health problems in terms of common mental disorders (CMDs) and severe mental illness (SMI).

Table 7.1: ICD-10 Mental and behavioural disorders

ICD 10 Code	Category	Sub category
F00- F09	Organic, including symptomatic, mental disorders	Dementia in Alzheimer’s Disease
F10- F19	Mental and behavioural disorders due to psychoactive substance use	Harmful use of alcohol, opioid dependence syndrome
F20- F29	Schizophrenia, schizotypal and delusional disorders	Paranoid schizophrenia, delusional disorders, acute and transient psychotic disorders.
F30- F39	Mood [affective] disorders	Bipolar affective disorder, depressive episode
F40- F48	Neurotic, stress-related and somatoform disorders	Generalized anxiety disorders, obsessive-compulsive disorders
F50- F59	Behavioural syndromes associated with physiological disturbances and physical factors	Eating disorders, non-organic sleep disorders.
F60- F69	Disorders of adult personality and behaviour	Personality disorders
F70- F79	Mental retardation	Mild mental retardation
F80- F89	Disorders of psychological development	Specific reading disorders, childhood autism
F90-	Behavioural and emotional disorders with	Hyperkinetic disorders

F98	onset usually occurring in childhood and adolescence	
F99	Unspecified mental disorder	

Table 7.2: NPMS categories mapped to ICD-10 Mental and behavioural disorders

NPMS Category	ICD 10 Disorders Included
Psychotic Disorder	<ul style="list-style-type: none"> • Schizophrenia, • Schizotypal and other delusional disorders • Manic episodes and bipolar affective disorder • Other affective disorders with psychotic symptoms
Neurotic Disorder	<ul style="list-style-type: none"> • Mixed anxiety and depressive disorder • Generalised anxiety disorder • Depressive episode • All phobias • Obsessive compulsive disorder • Panic disorder
Personality Disorders	<ul style="list-style-type: none"> • Obsessive-compulsive • Avoidant • Schizoid • Paranoid • Borderline • Antisocial • Dependent • Schizotypal • Histrionic • Narcissistic

The spectrum and severity of conditions that encompass mental health disorders is both broad and complex. Accordingly, the services that deliver care to and manage people with mental health problems are numerous and the pathways into and between these services are sometimes difficult to navigate.

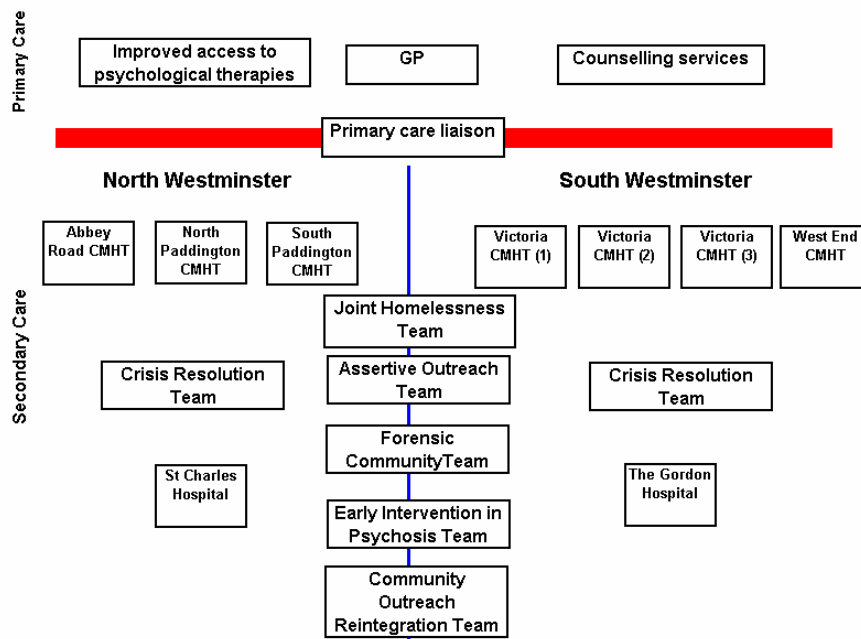
7.2 Overview of mental health services and pathways in Westminster

With regards to where and how mental health services are delivered, it is useful to consider mental health problems in terms of common mental

disorders and severe mental illness. However, personality disorder and dual diagnosis will also be considered separately as at the Homeless Health Event they were highlighted as particular areas of need.

An overview of mental health services in Westminster is provided in figure 7.1

Figure 7.3: Overview of mental health services in Westminster



7.2.1 Severe mental illness

Services for people with SMI include those that respond to and prevent crises, those that stabilise a person’s mental health and those that facilitate reintegration.

Homeless people with SMI in Westminster are managed by mental health services including community teams (community mental health teams and the Joint Homelessness Team, JHT) as well as psychiatry services delivered in primary care settings.

Table 7.4: Overview of statutory mental health services used by homeless people in Westminster

Crisis response and access	Stabilisation	Reintegration
Psychiatry at Great Chapel Street	Community mental health teams (CMHT)	Community Outreach Reintegration Team (CORT) JHT
Crisis Resolution Team	Joint Homelessness Team (JHT)	
A&E Psychiatry Service	Early Intervention Service for Psychosis (for people aged 14-35 years)	
Out of Hours Crisis Service	Waterview Centre	

Crisis response and access

Where people are registered with GPs, GPs usually undertake initial assessment for people who present with mental health problems and where appropriate prescribe medication and/or refer to counselling or other services. Where an SMI is suspected, a member of the community mental health team (CMHT) or community psychiatric nurse (CPN) would conduct a more detailed assessment. If an immediate response is required then a crisis mental health assessment would be arranged. This is usually carried out by the on call psychiatrist at the local A&E department or mental health hospital or potentially by the duty service at the local CMHT. Where an SMI is identified, the individual would usually be accepted onto the caseload of a CMHT or Joint Homelessness Team (JHT) for further assessment treatment and support.

Great Chapel Street Psychiatrist

Great Chapel Street provides twice weekly satellite sessions led by specialist registrar psychiatrists. This service is described as operating both a drop in and appointment based service, but is advertised as appointment only. Each session consists of four 30 minute appointment slots with an open one hour

slot at the end. Initial assessments can take up to one hour (i.e. two slots) whilst follow up sessions take 30 minutes (one slot).

Crisis Resolution Team

There are two crisis resolution teams (CRTs) in Westminster – one in the North of the borough and one in the South. CRTs manage people with SMI who are currently experiencing acute and severe psychiatric crises which without the involvement of the CRT would require hospitalisation.

Stabilisation

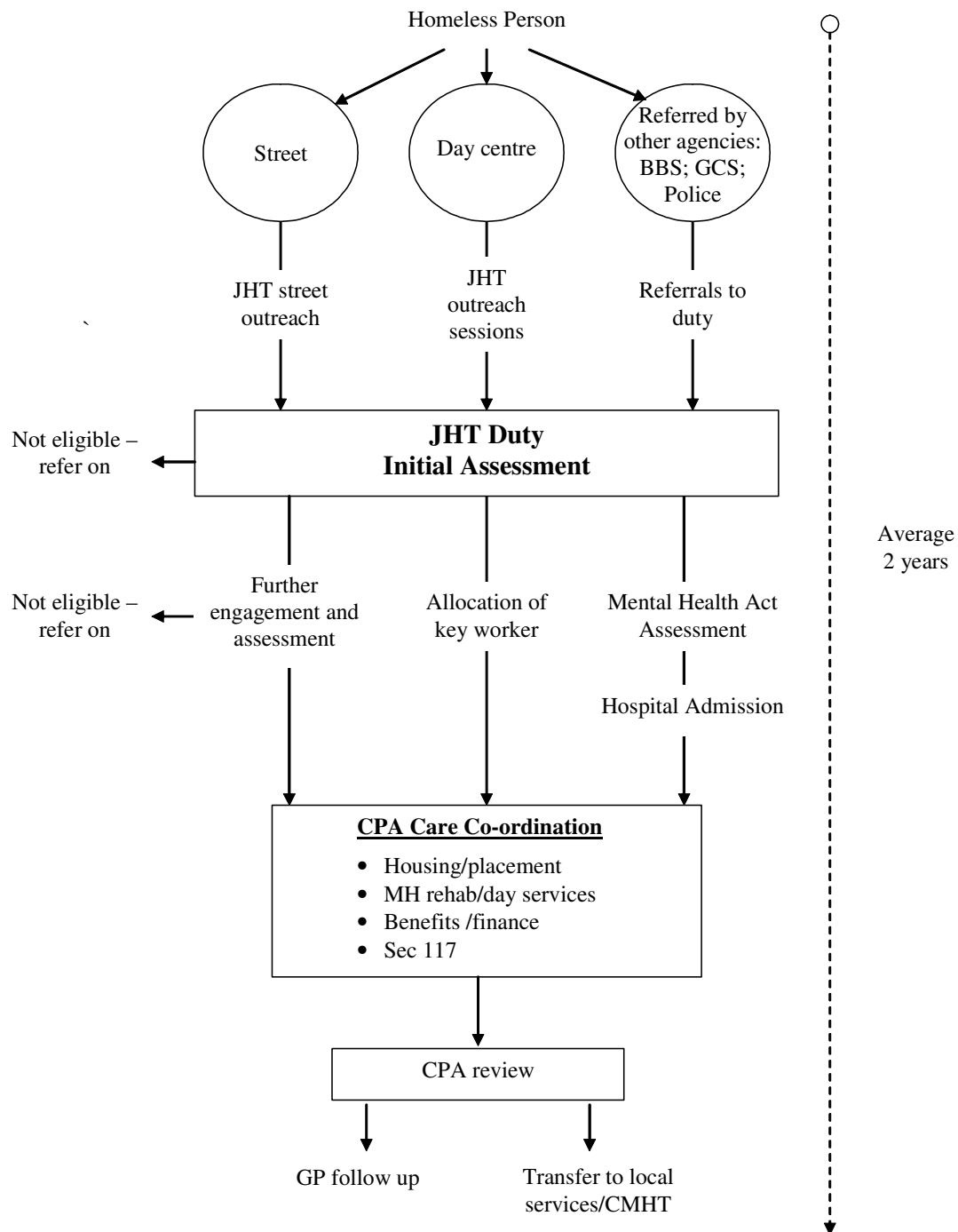
Joint Homelessness Team

The JHT predominantly manages homeless people with SMI, with those people with common mental disorders usually directed to primary care services such as Great Chapel Street or the Dr Hickey Surgery where there are mental health nurse attachments.

The JHT is a specially commissioned mental health service for rough sleepers in Westminster, though activity suggests it is, in effect, a community mental health team designed to respond to barriers to accessing treatment for SMI experienced by the homeless community.

The JHT is primarily an outreach service which actively finds patients both on the streets and in daycentres; formal referrals to the JHT, therefore come from a range of sources, including daycentres, BBS and primary care amongst others. For example, if BBS make a referral to the JHT, the JHT go out on the street with BBS to engage with people. Upon referral there is an initial assessment and if the referral is deemed appropriate, then further engagement and support is available, with patients managed under a care programme approach.

Figure 7.5: Joint Homelessness Team Care Pathway



Source: Joint Homelessness Team

Community Mental Health Teams

Community mental health teams (CMHTs) are multidisciplinary teams providing mental health care in defined localities. The threshold for accessing

care delivered by CMHTs is relatively high. CMHTs provide care to two groups of people:

- most patients treated by the CMHT will have time limited disorders and be referred back to their GPs after a few weeks/months when their condition has improved.
- a small number of patients will remain under the care of the CMHT for ongoing treatment, care and monitoring over a period of several years.

This will include people who need specialist care for:

- severe and persistent mental disorders associated with significant disability, predominantly psychoses
- longer term disorders of lesser severity but which are characterised by poor treatment adherence requiring proactive follow up
- any disorder where there is a significant risk of self harm or harm to others, or where the level of support required exceeding that which a primary care team can offer
- disorders requiring skilled or intensive treatments not available in primary care
- complex problems of management and engagement such as patients requiring interventions under the Mental Health Act (1983), except where these have been accepted by an assertive outreach team
- severe disorders of personality where these can be shown to benefit by continued contact and support, except where these have been accepted by assertive outreach teams or a specialised personality disorder team.

The Waterview Centre

The Waterview Centre provides a non-urgent service, mainly for people with a primary diagnosis of personality disorder or other mental health problems where personality disturbance complicates their treatments. The primary aim of the service is to facilitate people to develop coping mechanisms and avoid unplanned use of inpatient care and emergency services.

Early Intervention for Psychosis Team

The Early Intervention Psychosis Team is a non-urgent service working with people aged 14-35 with a first episode of psychosis that would trigger clinical thresholds for CMHT referral.

For further information on the Early Intervention Service please see the Joint Strategic Needs Assessment on Early Intervention for Psychosis.

Reintegration

CORT

The Community Outreach Rehabilitation Team (CORT) is an assertive outreach team working with people who have a long-term mental health problem, who are typically hard to engage. The CORT takes referrals from CMHTs and acute wards.

The JHT also has a role in reintegration working with people who have severe and enduring mental illness who are hard to engage.

7.3 Common mental disorders

Primary care is the main identifier of people with mental health problems. People with common mental health problems are primarily managed in primary care, either by a GP or by the counselling service (or both).

NHS Westminster funds a counselling service with one WTE counselling lead in addition to sessional counsellors. This service is delivered in primary care settings in both surgeries and day centres where other primary care is delivered.

Table 7.6: Primary care counselling services for homeless people in Westminster

Service provider		Counselling services provided
Dr Hickey Surgery		2 sessions counselling
Great Chapel Street		2 sessions counselling
Homeless Health Team	The Passage	2 sessions counselling
	Connections@St Martins	Counselling sessions currently being piloted
	West London Day Centre	1 session counselling

In addition to those mental health services outlined, some support for low level mental health problems is provided for people in hostel accommodation. For example, the Leinster Square Hostel was recently reconfigured to specifically meet the needs of rough sleepers with low level mental health needs.

7.3.1 Dual diagnosis

The dual diagnosis service in Westminster operates as a ‘virtual team’ in which dual diagnosis workers are placed within CMHTs but meet together and are managed as a team. Integration of dual diagnosis workers into mental health teams facilitates mainstreaming of services as highlighted in the Department of Health’s Good Practice Guide (2002). This means that the service is a ‘psychiatrist driven service’ i.e. that support is only available if you have already being diagnosed with an SMI.

The team consists of 3.5 WTE specialist worker/nurse posts and one clinical lead, geographically located across the borough. However, in recognition of access difficulties for homeless people, 1.0 WTE clinical nurse specialist does see homeless people who are not clients of CMHTs in a low-threshold service which is located at the Great Chapel Street Medical Centre.

7.4 Number of homeless people with diagnosed mental health problems

The detection of mental health problems amongst homeless people usually occurs in a primary care setting and, therefore, primary care data can provide an estimate of the prevalence of mental health problems in homeless people in Westminster. Primary care data on homeless people is collected via Vision, a database which records contacts and health information about people in attendance at Great Chapel Street, Dr Hickey's Surgery or the Homeless Health Team.

The way in which Vision currently records data makes it difficult to identify the number of people diagnosed with specific mental health problems; this is primarily because there are many data fields, often poorly defined. For example, there are general fields such as mental illness and mental health problems in addition to more specific diagnosis fields including schizophrenia and borderline personality disorder. A person with borderline personality disorder could, therefore, potentially be classified as borderline personality disorder, mental illness or mental health problem.

Evidence suggests that a high proportion of homeless people have a mental health problem, either undiagnosed, or if their condition is diagnosed it may not be recorded - this is because it is generally accepted amongst healthcare professionals that almost all homeless people have some form of mental health problem, with personality disorder being particularly common.

Of those patients seen by Great Chapel Street on at least one occasion in the last three years, 27% have been diagnosed with a mental health problem. The most commonly reported mental health problems included anxiety, depression and bipolar disorder.

Of those patients seen by the Dr Hickey Surgery, 22.5% have been diagnosed with a mental health problem.

958 patients seen by the Homeless Health Team in 2008/09 have been diagnosed with a mental health problem at some time during their care. It is,

however, difficult to compare data to Great Chapel Street and Dr Hickey’s Surgery as drug and alcohol use is classified as a mental health disorder under the current data collection system. It is, therefore, likely that the proportion of patients with a diagnosed mental health problem is similar to other primary care services for homeless people².

The low recorded prevalence of mental health problems amongst patients accessing primary care services likely reflects inadequacies in data collection and potentially high numbers of patients with undiagnosed mental health problems who are not accessing services rather than a low prevalence of mental health problems amongst homeless people in Westminster.

Because there is likely to be a small amount of overlap in use of primary care services, for example some patients that are seen at Great Chapel Street will also be seen by the Homeless Health Team, it is difficult to estimate the proportion of homeless people in Westminster who have been diagnosed with a mental health problem. Further analysis of the Vision system, looking at the cohort of patients as a whole (as opposed to analysing data on a site by site basis) will provide a more accurate indication of the number of people with a diagnosed mental health problem.

Table 7.7: Number of people in contact with primary care services for the homeless diagnosed with a mental health problem

	Number with a diagnosed mental health problem	% of patients seen with a diagnosed mental health problem
Homeless Health Team	958	48%
Great Chapel Street	990	27%
Dr Hickey’s Surgery	337	22.5%

Source: Vision

² The association between substance misuse and mental health has previously been highlighted. Evidence suggests that substance misuse and mental health problems are closely associated and so it could be argued that (although not comparable to other primary care data due to different definitions of mental health problem) data from the Homeless Health Team provides a more accurate reflection of need.

Because of the described data limitations with regards to primary care data, a range of data sources have, therefore, been drawn upon to provide estimates of the prevalence of mental health problems amongst homeless people in Westminster.

7.5 Serious mental illness (SMI)

There is little consistency in the published literature as to how serious mental illness is defined. SMI may be a severe neurotic disorder such as severe depression, anxiety, panic disorder or psychotic disorders such as bipolar affective disorder and schizophrenia. SMIs generally respond well to drug treatment and psychological therapies which can be delivered in primary care with support from specialised services, although some people have complex needs which require input from specialist mental health services.

People with SMI are often socially excluded, find it hard to sustain social and family networks and obtain and sustain employment.

7.5.1 Ascertaining the number of homeless people with serious mental illness

The NPMS suggests that the prevalence of serious mental illness in UK adults is ten times as high amongst homeless people compared to the general population.

Other data sources suggest that the prevalence of SMI amongst homeless populations is even higher than that reported in the NPMS. In a recent systematic review by Rees (2009), the prevalence of SMI was found to be between 25% and 30%. 31% of people contacted by outreach or BBS (equivalent to 590 people) were documented to have mental health needs on CHAIN, however, CHAIN data does not distinguish between common mental disorders and SMI and so such data does not provide a useful prevalence of SMI amongst homeless people in Westminster.

Table 7.8: Prevalence of serious mental illness

Prevalence	of	UK Population	Homeless people
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SMI	aged 16-74 (95% CI)	aged 16-74 (95% CI)
National Psychiatric Morbidity Survey	0.5% (0.4, 0.7)	5.0% (3.7, 6.3)
Rees (2009) Literature Review		25-30%

Source: ONS Psychiatric Morbidity Survey among Homeless People, 1994 and ONS Psychiatric Morbidity among Adults Living In Private Households, 2000 and Rees (2009).

Based on the prevalence estimates derived from the NPMS and Rees literature review, between 109 and 652 people in Westminster are homeless and have a SMI. However, many of these people will be transient and not expected to remain in Westminster long enough to access mental health services. Therefore, based on the flow, stock, returner model, a more realistic estimate of the number of homeless people with an SMI is 67- 400 people.

7.5.2 Ascertaining the number of homeless people with serious mental illness accessing services

Determining the number of people with SMI accessing services is problematic and involves analysing data from a range of sources; this includes Central and North West London Foundation Trust contracting activity data, data extracted from primary care databases, data collected locally from the JHT and some data is derived from a recent audit of case notes for the Joint Strategic Needs Assessment for Mental Health. Further work in the future may include additional local audits of case notes of homeless people accessing community mental health services such as the Victoria and West End CMHTs to determine the main mental health conditions which homeless people are presenting to services with.

Furthermore, as previously described, because of the transience of the homeless population, many people who are contacted by outreach or BBS are supported to get off the streets and are reconnected back to their home areas within a 2-3 week window. Whilst these people are likely to use primary care

services during their time in Westminster, they would not be expected to access mental health services for SMI as they are unlikely to be in Westminster long enough to undergo initial assessment to decide whether management under a care programme approach is required.

Given the difficulties providing a robust estimate of the number of homeless people with SMI (and, therefore, those in need of services), estimates of the proportion of homeless people with SMI accessing services should be interpreted with caution.

The number of homeless people with SMI accessing services will be considered in the context of crisis response and access, stabilisation and reintegration.

Crisis response and access

Great Chapel Street psychiatrist

424 consultant psychiatric slots are provided at Great Chapel Street annually. Between April 2008 and April 2009, 185 consultations took place, representing 44% of appointment slots; therefore, over half of the appointment slots were not used. This suggests that with the appointment based system currently adopted, the service may not be accessible for patients, resulting in a high number of DNAs.

Of the 185 consultations in the specified time period, 126 patients were seen, the majority with low mood, personality disorder and schizophrenia. The high number of patients seen with low mood is surprising since a psychiatrist would usually be expected to see those people with the most complex mental health needs and not those with common mental disorders.

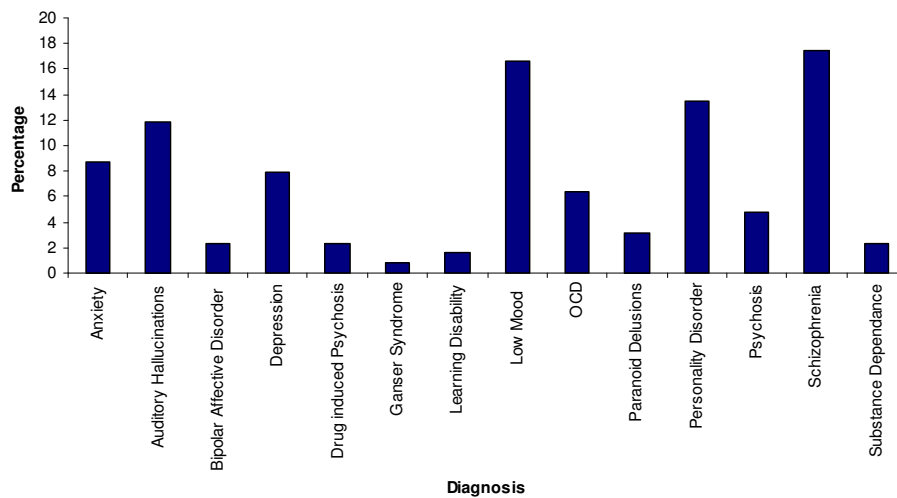
However, this may be explained by the fact that people with common mental disorders often come forward seeking help with symptoms compared to people with SMI who are often more reluctant to come forward.

Managing patients with less complex needs such as low mood is not an appropriate use of a service that is expected to see those patients with more complex needs, although anecdotal evidence suggests that this may be a result of psychiatrists seeing patients who present with less complex needs opportunistically to fill vacant appointment slots.

A&E Psychiatry Service, Out of Hours Crisis Service and the Crisis Resolution Team

Further data is needed pertaining to the use of the A&E Psychiatry Service, the Out of Hours Crisis Service and the Crisis Resolution Team by homeless people in Westminster in response to mental health crises.

Figure 7.9: Diagnosis of patients seen by Great Chapel Street psychiatrist, 2008/09



Source: Great Chapel Street

Inpatient care

During 2008/09 there were 216 episodes of inpatient care (for people who were homeless at the time of admission), attributed to 144 people. This represents 18% of all episodes of inpatient care associated with mental health problems. There was no significant difference between the number of rough sleepers and the number of hostel/supported housing dwellers admitted;

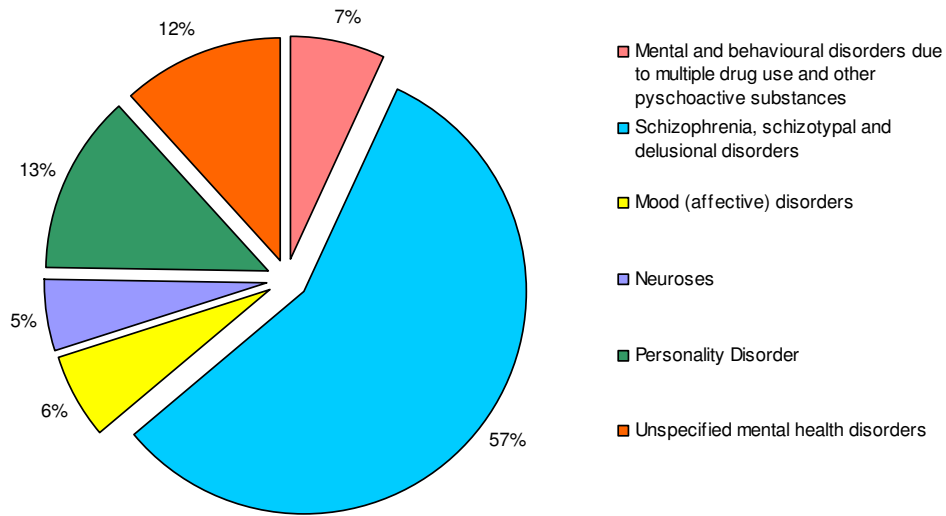
rough sleepers accounted for 49% of admissions whilst hostel/supported housing residents accounted for 51%.

For those admissions for which a diagnosis was recorded, schizophrenia, schizotypal and delusional disorders accounted for the highest proportion of admissions (57%), followed by personality disorder (13%) and unspecified mental health problems (12%). Unsurprisingly, the majority of referrals were for SMI.

Diagnosis data was not available for almost 20% of admissions, suggesting that further work should include improving the collection of data. Currently data is collected on the basis of payment and not for health intelligence purposes.

Men accounted for 64% of admissions whilst females accounted for 35%. The prevalence of mental health problems (particularly psychoses) in the general population is higher in men than women and the majority of homeless people in Westminster are male (88% of contacts on CHAIN in 2007-2008 were male), therefore, males are expected to account for a higher proportion of admissions than that observed. This suggests that the number of inpatient admissions for women is disproportionately high; this is likely a reflection of the high level of need amongst women who are homeless, particularly rough sleepers.

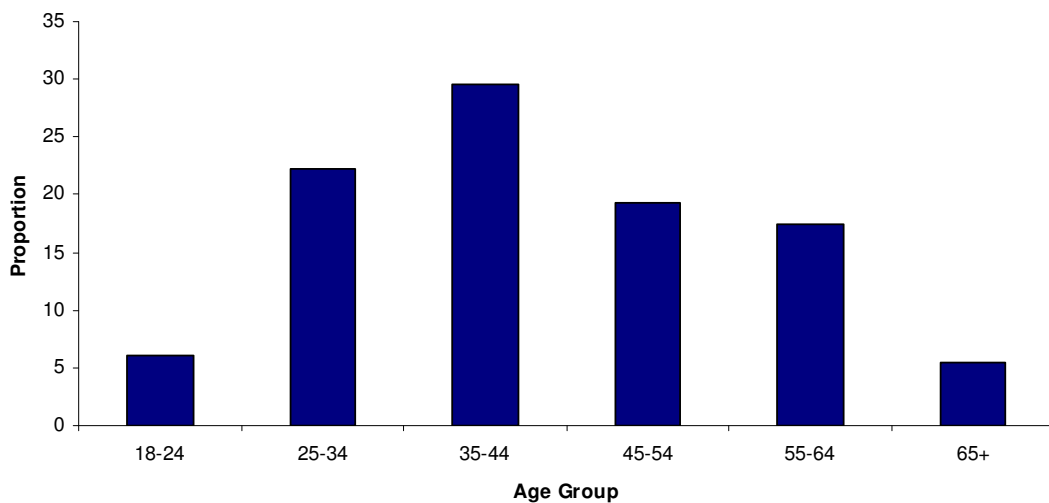
Figure 7.10: Inpatient admissions by diagnosis



Source: CNWL

In terms of the age profile of admissions, the majority of admissions were in the 25-34 and 35-44 age groups. This is unsurprising as the prevalence of mental health disorders is high in these age groups and the majority of homeless people in Westminster are aged 26-49.

Figure 7.11: Inpatient admissions by age



Source: CNWL

Stabilisation

2007 CNWL audit of patients accessing community mental health services, including the JHT

In 2007, an audit of notes took place from CMHTs, the COURT, JHT and Early Intervention Service; this found that 10.4% of people accessing community care were homeless (rough sleeping, hostel dwellers or supported housing). This suggests that in 2007 between 13% and 31% of homeless people with mental health problems were accessing community mental health services. The majority of those accessing services had severe and enduring mental health problems; three quarters of presentations were for psychoses, with neuroses and personality disorder accounting for, 21% and 4% of cases respectively.

Joint Homelessness Team

Between January and December 2008, 253 referrals were made to the JHT, an increase of 13% since 2007 (224 referrals).

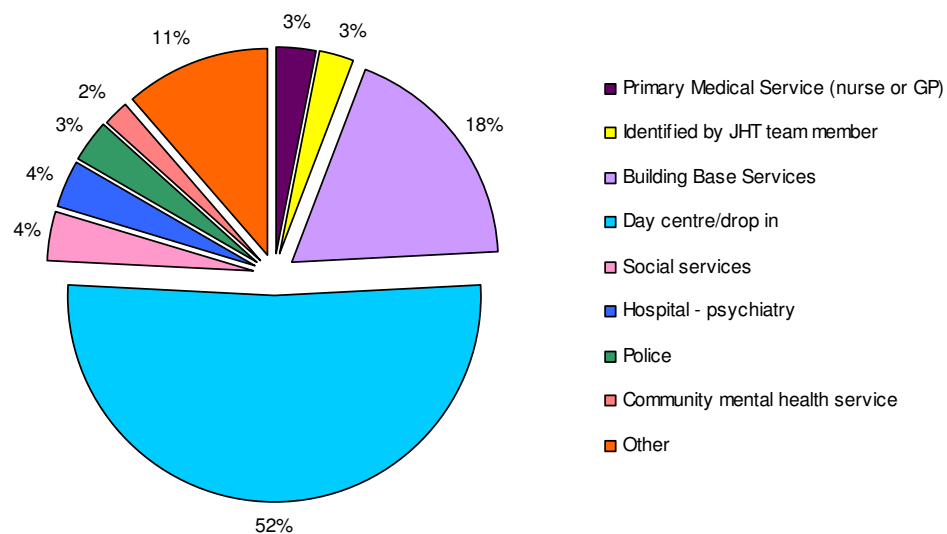
The majority of referrals to the JHT came from daycentres and drop in services (52%) followed by BBS (18%), however, from the available data it is unclear what proportion of referrals come from the Homeless Health Team (i.e. are referrals from the Homeless Health Team coded as day centre referrals or primary care referrals). BBS refers to referrals from both daycentres and outreach teams - building base staff have the belief that referrals are more likely to be successful if they come via the Homeless Health Team.

Of the 253 referrals, 88% were known to be street homeless and sleeping out. A small number of people that were not rough sleeping were using night shelters, rolling shelters, hostels or supported independent housing.

Men accounted for 74% (187 people) of referrals; this is slightly lower than expected given that 88% of the verified rough sleepers recorded on CHAIN are male (2008/09). Evidence from local providers suggests that the overrepresentation of women amongst referrals to the JHT is because serious

mental health issues have a greater impact on why women sleep rough compared to men, despite the fact that they generally have more accommodation options available to them than men. Therefore, a higher proportion of female rough sleepers than male rough sleepers are likely to experience severe mental health problems and be referred to services.

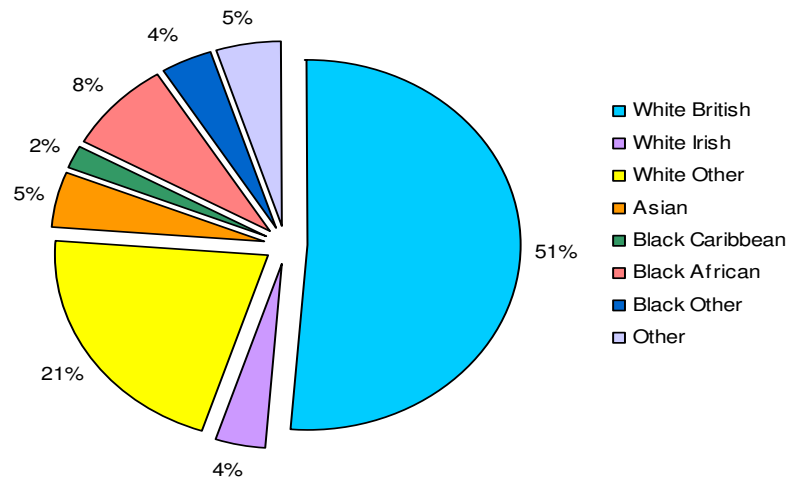
Figure 7.12: Source of referral into the JHT



Source: Joint Homelessness Team

The majority of referrals to the JHT were aged 26-64 reflecting the age profile of the rough sleeping population. Of those people with ethnicity recorded, the majority were White British (51%), followed by White Other (21%) and Black African (8%). Given the ethnic make up of the rough sleeping population, people from BME and White Other communities are overrepresented and men and White British people are underrepresented in referrals to the JHT.

Figure 7.13: Ethnicity of referrals to the JHT



Source: Joint Homelessness Team

With regards to foreign nationals, of those referred in 2008, 3% were A8 nationals, 13% from other EU countries and 8% were from countries outside of the EU - no A2 nationals were referred. Such foreign nationals tend to have irregular immigration status and, therefore, are often people with no recourse to public funds.

In 2008, 38 people with no recourse to public funds were referred to the JHT; this included failed asylum seekers and other people with no recourse to public funds such as people with no rights to housing who are, therefore, rough sleeping. The JHT is able to assess people for support under Section 21 of the National Assistance Act, or in the case of people who have been admitted to hospital under a treatment order, aftercare under Section 117 of the Mental Health Act provides for accommodation and support.

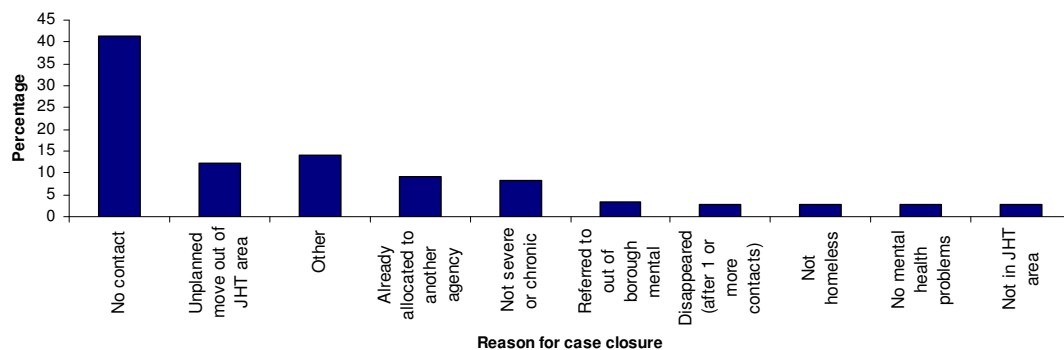
The proportion of rough sleepers who are unable to access public funds because of their immigration status is projected to grow substantially and it is likely that JHT referrals and caseload will reflect this growth.

JHT referrals: case closure

In 2008, 172 cases were closed and, therefore, not case managed after initial assessment³. Inferences drawn from available data (assuming that most referrals are assessed within three months of referral) suggests that over half of referrals to the JHT are not case managed; the majority of either move out of the area or no contact could be made with people.

The reason for case closure in the majority (41%) of cases was because no contact could be made with the client. This is unsurprising given the chaotic and transient nature of street populations. Often outreach teams refer people seen on the street, but these people often move on outside Westminster and either are not seen again or come back several months later. These people do not engage well with services and have usually declined offers of accommodation.

Figure 7.14: Reasons for case closure after initial assessment, 2008



Source: Joint Homelessness Team

Of those people who had a full assessment and appropriate contact with the JHT, a small proportion of cases had their cases closed after initial assessment because they did not have severe or chronic mental health problems or were not homeless; this suggests that the vast majority of referrals to the JHT are appropriate.

³ From the data available it is not possible to directly compare referrals in 2008 to number of cases closed in 2008 as it is not known whether these figures refer to the same patients.

9% of cases were closed because the individual was already under the care of another agency; whilst this suggests that there may be poor link up and communication between services leading to a small number of unnecessary referrals, it is usually the case that an individual is known to an out of borough service and this is only discovered after a referral has been made.

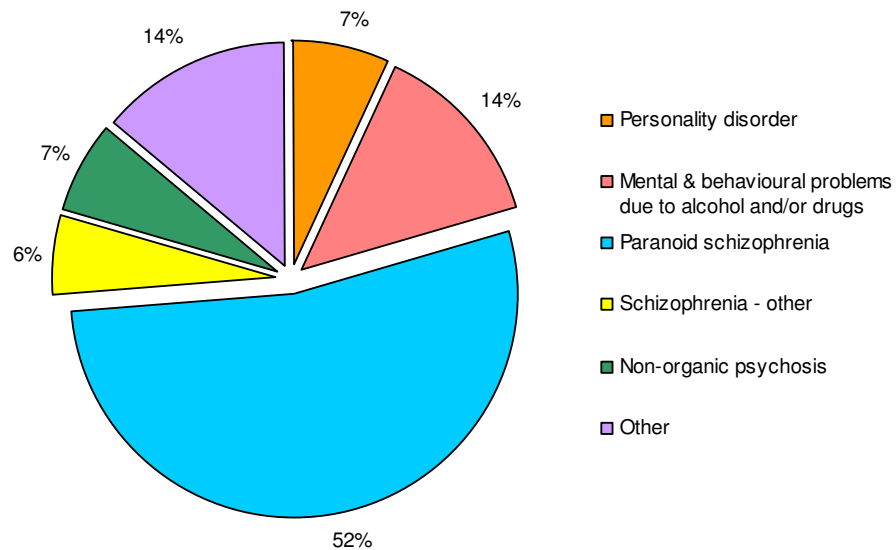
Once engaged and receiving treatment from the JHT, very few people return to the streets; less than 10% of service users are thought to return to the streets, some of which can be attributed to Mental Health Act tribunals discharging people from their section against the advice of the treating team.

JHT open caseload

As at December 2008, 151 people were on the open caseload of the JHT. The majority of people case managed by the JHT have a severe mental illness; 52% of people in touch with the JHT had a diagnosis of paranoid schizophrenia, 14% had a primary diagnosis of mental and behavioural problems associated with drugs and alcohol and 7% a primary diagnosis of personality disorder. Given the high estimated prevalence of personality disorder amongst homeless people, the proportion of patients with a primary diagnosis of personality disorder is expected to be higher.

Men accounted for 77% of people case managed and this reflects the gender profile of referrals into the JHT (74% men). The majority of people taken on and case managed by the JHT were aged 41-64; however, given the age profile of referrals to the JHT and the age profile of the homeless population of Westminster, the proportion of people aged 26-40 that are case managed is lower than expected.

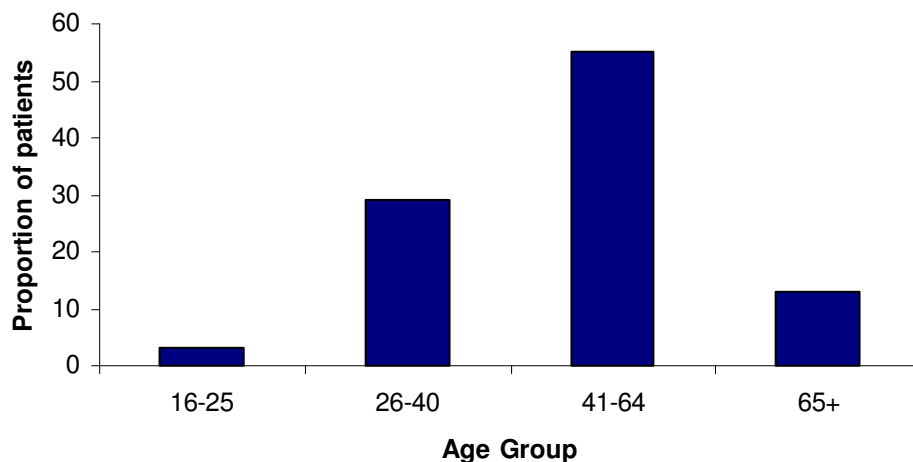
Figure 7.15: Diagnosis of patients case managed by the JHT



Source: Joint Homelessness Team

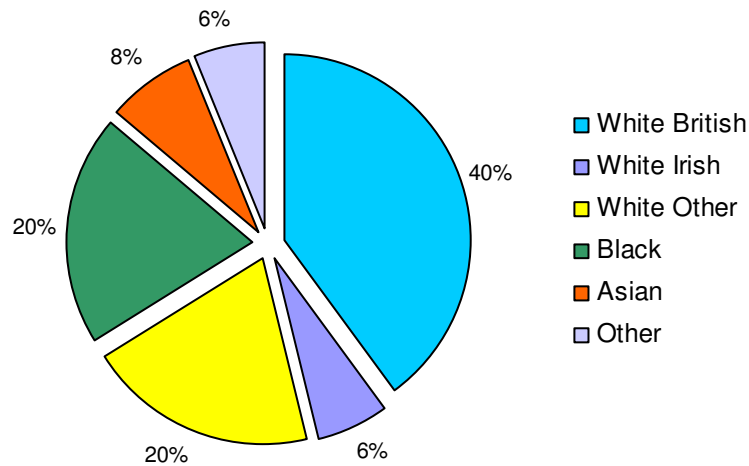
Overall the ethnic profile of those people case managed by the JHT is similar to that of referrals to the JHT and given the ethnic mix of the homeless population in Westminster, people from BME and White Other communities are overrepresented in the JHT caseload.

Figure 7.16: Age profile of patients case managed by the JHT



Source: Joint Homelessness Team

Figure 7.17: Ethnicity of patients case managed by the JHT

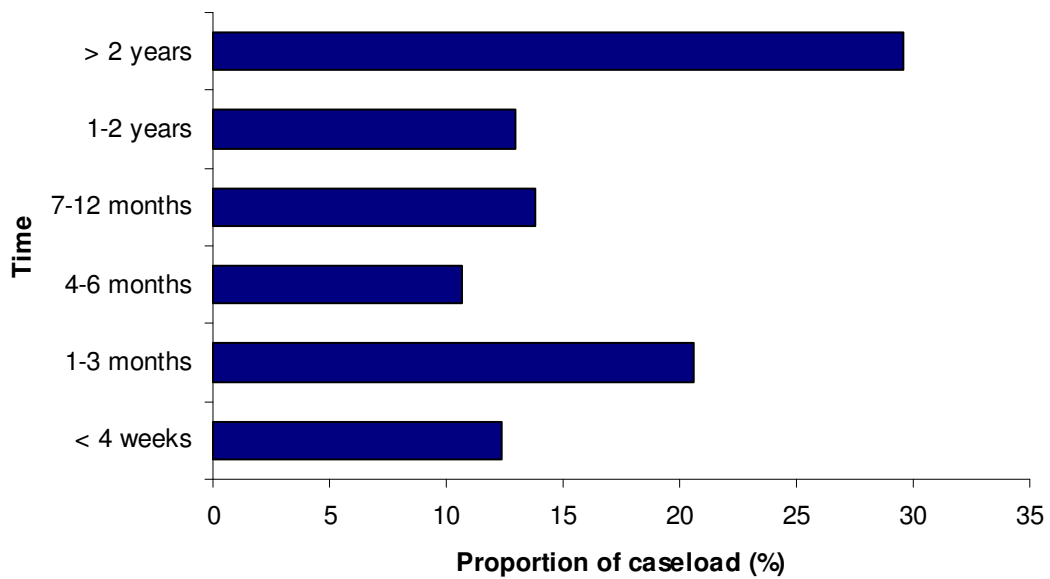


Source: Joint Homelessness Team

Analysis of the length of time that clients have been in touch with the JHT provides an insight into the needs of the people accessing the service. The JHT appears to cater for a range of needs with some patients seen for a few months and others under their care for a much longer period of time. Of all active cases during 2008, 30% had been in contact with the JHT for a period longer than two years, suggesting that a significant proportion of the client base have complex, on-going needs that cannot be dealt with on a short-term basis.

The long follow up time is also indicative of complex and changing accommodation needs. After referral, the process of engagement and assessment can be prolonged as people with SMI are often difficult to engage. Once engaged, for many, assessment occurs in a hospital setting. Hospital admissions for people being assessed by the JHT is often lengthy, not because of delayed discharge, but because of the complex needs of the people.

Figure 7.18: Length of time in follow up



Source: Joint Homelessness Team

Upon discharge from hospital, people are placed in suitable accommodation, however, this accommodation may break down and the process of assessment starts again. Only when an individual is stable in accommodation can they be discharged from the care of the JHT.

45% of clients had been in contact with the JHT for less than six months; this, however, does not directly translate to 45% of patients seen being 'discharged' from the JHT or the client case 'closed'. As a snapshot of current activity, the data presented demonstrates how long the current caseload of patients have been seen by the JHT; from the data available it is difficult to distinguish between those patients who have been discharged, those lost to follow up and those patients who are relatively new to the service and whom may go on to be in long term follow up.

Community Mental Health Teams

Community care

In 2008/09, 149 homeless people were seen by CMHTs representing 2.5% of all patients accessing CMHTs in a community setting in Westminster. Of the 149 people accessing community care, 17% were rough sleepers and 83%

hostel/supported housing residents. Although the proportion of rough sleepers accessing CMHTs appears low, it is likely that rough sleepers are more likely to be seen by the JHT, a mental health service aimed specifically at rough sleepers.

51% of people were seen by the Victoria CMHTs, 32% by the West End CMHT and 17% by the Abbey Road CMHT. This is unsurprising since most hostels in Westminster are located in the West End and south of the borough.

Of those accessing community care 61% were male and 39% were female. The age range of those accessing community care is reflective of the age profile of the homeless population in Westminster.

Outpatient care

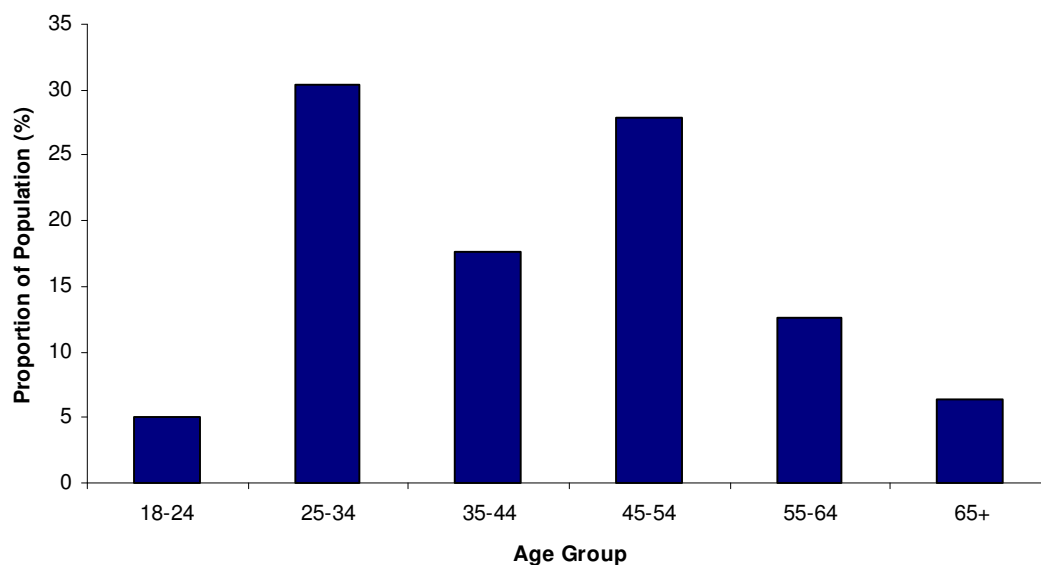
In addition to community care, patients may be seen in a formal outpatient clinic, usually under the auspices of a consultant clinician. In 2008/09, there were 4,192 episodes of outpatient care of which homeless people accounted for 177 episodes (4%), all of whom were hostel or supported housing residents; no rough sleepers were seen in a formal outpatient setting.

Of the outpatient care delivered to homeless people in Westminster, 41% was delivered via the three Victoria CMHTs, again as expected given the large proportion of hostels found in the south of the borough.

79 people accounted for the 177 episodes of care; this is equivalent to on average 2.2 contacts per person.

Of those accessing outpatient care 44% were female and 56% male. People accessing outpatient care are more likely to be younger than those accessing CMHT care provided in the community; 30% of people accessing CMHTs in an outpatient setting were aged 25-34 compared to 18% of people accessing CMHT care in a community setting. Given the age profile of the homeless population in Westminster, people aged 35-44 appear to be underrepresented amongst those people accessing outpatient care.

Figure 7.19: Age profile of people accessing CMHTs in an outpatient setting



Source: CNWL

Reintegration

See previous section on JHT caseload

7.5.3 Stakeholder feedback

The views of professionals such as third sector staff who engage with mental health professionals on behalf of their clients are particularly important for assessing how well current services are meeting the complex needs of the homeless population.

At the Homeless Health Summit, participants reported difficulties accessing timely help for their clients; crisis services were described as particularly difficult to access for those people actively misusing drugs and/or alcohol (NHS Westminster & Westminster City Council, 2009).

The capacity of services such as the JHT and CMHTs was considered insufficient and, therefore, a major barrier to access. This, however, most likely relates to the clinical thresholds needed to access the JHT and CMHT

and the comments made by stakeholders likely refer to the inability of those people who do not meet the threshold for JHT or CMHT care management to access appropriate services.

Stakeholders reported being confused about who the JHT will accept for assessment and some reported feeling that the process of accessing assessment was cumbersome and lengthy. Participants stated that they would like more flexibility in the criteria in which the JHT uses when assessing clients.

The drop in psychiatrist service at Great Chapel Street can provide rapid assessments for people; however, few stakeholders from the community and voluntary sector were aware of this service.

Overall, for those patients accepted onto the JHT caseload, stakeholders were very positive about the holistic service and good patient outcomes these people received.

Transition between mental health services and aftercare was seen as an important gap in services which can have a negative impact on client's well-being; this related to arrangements between the JHT and the CMHTs, but also with third sector partners. Communication was considered key to this, however, often communication was described as poor. Stakeholders stated that a more transparent pathway would facilitate the transition of clients care between services, particularly where third sector organisations were involved; third sector organisations reported rarely being aware of transition arrangements and when they are aware, information is usually incomplete.

Concerns were raised about the vulnerability of clients moving between services, particularly those moving through the housing pathway. Stakeholders felt that other specialist support was needed around resettlement and meaningful inclusion in their local areas.

7.5.4 Conclusions on homeless people with SMI

Given the difficulties ascertaining the number of homeless people with SMI in Westminster described earlier, it is difficult to determine the proportion of people with SMI who are in contact with mental health services. However, from the available data sources some estimates can be made – these however, should be interpreted with caution.

Based on an estimated 67 homeless people with a psychotic disorder in Westminster (according to the NPMS), the proportion of people with psychoses accessing specialist care is over 100%, even after adjusting for any overlap between patients seen by the JHT and CMHTs This suggests that NPMS prevalence estimates for SMI are inaccurate and provide an underestimate of the number of people in Westminster who are homeless and have psychosis or other SMIs.

Table 7.20 proportion of people with SMI accessing specialist care

Estimated to have a severe mental health problem		Joint Homeless Team	Community Mental Health Teams		% of estimated to have a severe mental health problem accessing care
			Outpatient care	Community care	
Based on ONS prevalence	67	151	79	149	>100%
Based on published literature	400				95%

Based on the prevalence of SMI amongst homeless people in the published literature, 95% are currently accessing specialist mental health services; this compares to 71% of people with psychoses in Westminster as a whole accessing community care. This high proportion is unsurprising given the services that are available for SMI in Westminster; Westminster specifically commissions the JHT to meet the needs of rough sleepers with SMI who are particularly hard to engage with.

Stakeholder feedback, however, suggests that there is an unmet need with regard to SMI amongst homeless people in Westminster, with capacity of the JHT and CMHTs considered inadequate. This most likely relates to the clinical thresholds required for a care programme approach by the JHT and CMHTs.

Whilst this needs assessment has categorised mental health problems in terms of SMI and CMD (because that is how services are delivered), mental health problems are perhaps best viewed in terms of a spectrum of varying degrees of severity and complexity. From stakeholder feedback, there appears to be a population of homeless people in Westminster who have complex and possibly severe mental health problems, beyond that described at common mental disorders, but who do not meet the clinical thresholds required for the care programme approach of the JHT and CMHTs. Many stakeholders describe difficulties in accessing services for this population group and there appears to be a need for services for this group.

People with personality disorder are likely to fall into this group - people with personality disorder represented only 4% of the CMHT caseload and 7% of the JHT caseload. Given the high prevalence of personality disorder amongst homeless people, the number of people with a diagnosis of personality disorder accessing specialist mental health services is lower than expected.

Further work is needed to determine the best way to deliver mental health services to this group, for example, is a new service needed or should existing services be more flexible in terms of the client base they manage?

For those people accessing services, clinical and patient outcomes are good, however, given the stakeholder feedback, further work is needed to understand points of transition between services and how this can be improved to maintain mental well-being and housing stability; this will involve the input of appropriate voluntary sector partners as well as building based services and hostel staff. Furthermore, anecdotal evidence suggests that there is a need to improve access to cognitive behavioural therapy and occupational therapy for people with SMI.

7.6 Common mental disorders

Common mental disorders describe mental health conditions that cause marked emotional distress and affect daily function, though they do not usually affect insight or cognition. Common mental health disorders include depression and anxiety and are usually managed by GPs and primary care teams.

CMDs are, however, often undiagnosed and, therefore, people are less likely to be seen and supported by health services. Consequently, CMDs can potentially lead to long-term disability and premature mortality.

7.6.1 Ascertaining the number of homeless people with common mental health problems

The NPMS suggests that the prevalence of common mental health problems in UK adults is twice as high amongst homeless people compared to the general population (Singleton et al, 2001).

Local data suggests that the prevalence of common mental health problems amongst Westminster's homeless population is even higher than that reported in the NPMS. In the Homeless Health Survey, 39% reported having depression and 10% other mental health problems, suggesting that at least half of the homeless population has some form of mental health problem (NHS Westminster, 2009). In regular surveys of their hostel residents, St Mungo's suggests the proportion of residents with mental health problems is between 57% and 85% (St Mungo's 2009).

Table 7.21: Prevalence of common mental disorders

	UK Population aged 16-74 (95% CI)	Homeless people aged 16-74 (95% CI)
National Psychiatric Morbidity Survey	16.4% (15.4, 17.4)	36.5% (33.7, 39.3)
St Mungo's prevalence estimates		57% - 85%

Source: ONS Psychiatric Morbidity Survey Among Homeless People, 1994 and ONS Psychiatric Morbidity Among Adults Living In Private Households, 2000 and St Mungo's.

Based on the prevalence estimates derived from the NPMS and St Mungo's Surveys, between 793 and 1,846 people in Westminster are homeless and have a CMD. However, again many of these people will be transient (see chapter 1) and not expected to remain in Westminster long enough to access mental health services. Therefore, based on the flow, stock, returner model, a more realistic estimate of the number of homeless people with a CMD is between 287 and 667.

7.6.2 Ascertaining the number of people with common mental disorders accessing services

At the time of writing, no data was available on the number of people with CMDs accessing primary care counselling services at Great Chapel Street, the Dr Hickey Surgery and daycentres. Furthermore, it is unclear how many homeless people benefit from support for low level mental health problems provided by hostels.

In order to accurately assess whether current services are appropriate for and are meeting the needs of people with CMD in Westminster it is essential that such data is collected and analysed.

In the absence of such data, evidence from the published literature and from local visionary events suggests that many people with CMDs are undiagnosed (NHS Westminster, 2009). In the instances where a diagnosis has been made, people find it difficult to access services either because current services are not accessible or they do not access services because of competing health and housing priorities.

7.6.3 Stakeholder feedback

Stakeholders attending the Homeless Health Summit thought that there was little service provision for people with lower level mental health problems and those that do not meet the referral criteria of the JHT or CMHTs (as discussed previously). Furthermore, stakeholders felt that there was little information available to them to signpost clients to appropriate support services (NHS Westminster, 2009).

Stakeholders also described the problems associated with self-medication. The extent of self-medication was thought to be particularly underestimated – the implication being that poor access to appropriate mental health service had a negative impact on drug and alcohol use.

7.6.4 Conclusion on homeless people with CMD

Prevalence estimates suggest that between 287 and 667 people in Westminster are homeless (stock and returner) and have a CMD. Data from primary care providers of homeless services in Westminster suggests that a high proportion of people with CMD are undiagnosed.

There is limited data pertaining to the proportion of people with CMDs accessing services and, therefore, the level of unmet need, however, stakeholder and service user feedback suggest that there is limited service provision for homeless people with low level mental health needs.

Cognitive behavioural therapy is a NICE approved treatment for people with anxiety and depression. Westminster is currently rolling out a programme to increase access to this form of psychological therapy (IAPT). It is important to ensure that homeless people benefit from this level of mental health support. The national guidance excludes people who are actively using substances and, therefore, further work is needed to better understand how IAPT can improve the well-being of a client group that has high levels of anxiety and depression.

Provision of support for people with low level mental health needs in hostels should be further explored. The Leinster Square reconfiguration describes positive outcomes for its residents with regards to mental health and social needs. At the Homeless Health Summit many stakeholders voiced a need for support services such as CBT to be delivered in hostel settings, particularly for those people who find it difficult to access services.

7.7 Personality Disorder

Personality disorder is a prevalent mental health problem which causes considerable distress. It remains one of the least understood and most

challenging of psychiatric diagnoses and has been recognised as a national area of concern, with government policy stating that people with personality disorders should have access to specialist mental health services (NIMHE, 2003).

Personality disorder can vary in severity and can be considered as both a common mental disorder and a severe and enduring condition, depending on its manifestation. Although the number of homeless people with personality disorder is accounted for in the prevalence estimates for both CMDs and SMI, it is useful to highlight the high prevalence of personality disorder as a distinct condition as there is research to suggest high-levels of personality disorder in homeless populations and some anecdotal evidence to suggest that homeless people in Westminster with personality disorder are particularly challenging to engage with.

Personality disorder is defined by the NPMS as ‘an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence and early adulthood, is stable over time and leads to distress or impairment.’

People with personality disorders experience considerable social exclusion, discrimination and distress; they are at increased risk of mental illness, substance misuse, social problems and the rate of suicide is seven times greater than the general population (Crawford *et al*, 2007).

The abolition of the ‘treatability test’, a requirement under the 1983 mental Health Act, which made the provision of compulsory services dependant on the ability to successfully treat a condition, has considerably changed the way in which personality disorder is viewed.

7.7.1 Ascertaining the number of people with personality disorder

Surveys among hostel clients and providers of homeless services suggest that a high proportion of homeless people have characteristics of personality disorder, but many people are undiagnosed. In a recent survey of homeless services in England, providers reported that as many as two thirds of clients

presented with signs of personality disorder. In a survey conducted in one of St Mungo's hostels, this was much higher; a clinical psychologist found that 85% of clients had personality disorder (St Mungo's, 2008), whilst a survey in Edinburgh within a sample of homeless people found that 70% had at least one diagnosable personality disorder and 40% had two or more (Fox & Watters, 2009).

7.7.2 Ascertaining the number of people with personality disorder accessing specialist services

Given the high prevalence of personality disorder amongst homeless people, the number of persons with a diagnosis of personality disorder accessing specialist mental health services is significantly lower than expected.

For more information on personality disorder and this service please see the Joint Strategic Needs Assessment on personality disorder available at <http://westminstercitypartnership.org.uk/Partnerships/Health%20and%20Wellbeing/JSNA%20%20Completed%20Needs%20Assessments/JSNA%20-%20Personality%20Needs%20Assessment.pdf>

Although this needs assessment was not specific to homeless people in Westminster, it recognised that the number of homeless people with personality disorder in contact with services was considerably lower than expected. Furthermore, it highlighted that support for homeless people with personality disorder was likely to come from homelessness voluntary agencies and healthcare staff where there is regular contact.

7.7.3 Stakeholder feedback

Stakeholders described personality disorder as one of the main challenges encountered working with homeless people in Westminster. BBS report that personality disorder is one of the main barriers to moving people through the housing pathway and out of homelessness (NHS Westminster, 2009).

Stakeholders identified personality disorder as one of the main service gaps with regards to mental health services for homeless populations, particularly those with low level personality disorder. Building base services and hostel staff reported that often they were the professionals who had most contact

with people, yet they do not possess the skills to meet the needs of their clients. Given the level of direct contact that building base service and hostel staff have with people, stakeholders recognised the need for training around personality disorder and many expressed a desire to be trained in cognitive behavioural therapy (CBT).

Stakeholders also felt that current services for personality disorder should be more proactive in meeting the needs of homeless people with personality disorder, particularly lower level personality disorder providing greater flexibility than is currently offered to increase the accessibility of the service.

7.7.4 Conclusions on personality disorder

The prevalence of personality disorder amongst homeless people is high and unsurprising. Personality disorder is one of the main barriers to moving people through the housing pathway and out of homelessness.

Given the high prevalence of personality disorder amongst homeless people, the number of people with a diagnosis of personality disorder accessing specialist mental health services is lower than expected.

7.8 Dual diagnosis

Similarly to personality disorder, the prevalence of dual diagnosis amongst homeless people in Westminster has been considered separately. Local evidence suggests that not only is dual diagnosis a common problem amongst homeless people, but people with dual diagnosis have particular difficulties accessing appropriate care.

7.8.1 Ascertaining the number of people with dual diagnosis (see also chapter 6)

Limited robust data is currently available describing those people in Westminster who are homeless and have substance misuse problems and a mental health problem. In a study to determine the prevalence of dual diagnosis amongst patients using community mental health, forensic or substance misuse services Stathdee *et al* 2002 suggested that 20% of community mental health clients, 43% of psychiatric inpatients, 56% of

forensic patients and 83% of substance misuse clients had indications of dual diagnosis.

Generalisation from this study is, however, difficult as the study did not consider those people not in touch with services. Furthermore, given the clinical threshold of mental illness required to access specialist mental health services, this study is unlikely to capture those people with common mental disorders.

Local prevalence estimates derived from CHAIN and the Clean Break audit suggests that there is further uncertainty regarding the prevalence of dual diagnosis amongst homeless people in Westminster; this suggests the need for further work to provide more robust estimates.

Furthermore, data describing the number of people with mental health problems who are habitually using drugs such as cannabis is also limited and further work is needed to identify the extent of this problem.

The low reported prevalence figures contradict the views of local professionals working with homeless people in Westminster. Accordingly, further robust local prevalence estimates for dual diagnosis are needed to assess the need for dual diagnosis services in Westminster.

Although no data is currently available describing the number and characteristics of people within CMHT using substances, anecdotal evidence suggests that it is primarily people with mental health problems using recreational and casual drugs habitually, such as cannabis, as opposed to problematic drug users i.e. people using crack and heroin.

7.8.2 Ascertaining the number of people accessing dual diagnosis services

Due to the complexity of dual diagnosis in the homeless population, the service also provides case work via Great Chapel Street and clients without an SMI, can be referred for treatment and support. However, only 18% of the

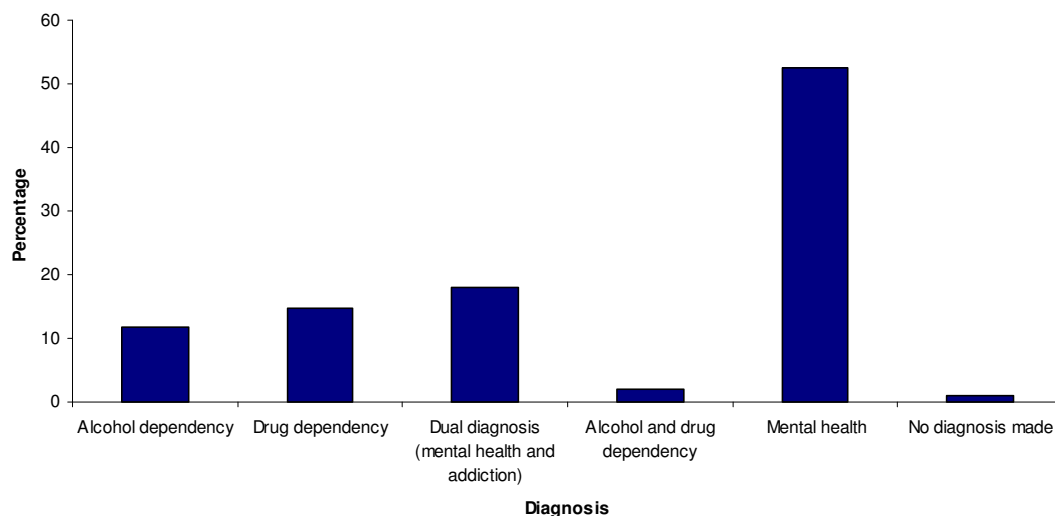
caseload was defined as people with dual diagnosis, equivalent to 197 consultations in 2008/09.

Given the complexity of this problem and the range in 'severity' of problems which encompass dual diagnosis, whether current dual diagnosis services are meeting the needs of the population will be assessed in a separate needs assessment.

The clinical nurse specialist (CNS) at Great Chapel Street specialises in dual diagnosis. In 2008/09 the CNS had 1,093 consultations and, alongside the GPs, manages the majority of cases, most of whom have common mental health problems. The CNS also triages the more complex cases to either the satellite psychiatrist led clinics at Great Chapel Street, the duty service at the West End CMHT or the JHT.

People with mental health problems accounted for 52.4% of the Great Chapel Street CNS's consultations, substance misuse (alcohol and/or drugs) for 28.5% and dual diagnosis for 18% of consultations. Given the high prevalence of mental health problems amongst people with alcohol and/or drug problems, the proportion of patients seen by the CNS with dual diagnosis is lower than expected at 18%. The CNS at Great Chapel Street specialises in dual diagnosis and so misdiagnosis of cases is unlikely; what is more likely is that people with dual diagnosis are either being referred to other mental health services or are not being referred to services at all .

Figure 7.14: Diagnosis of patients seen by the Great Chapel Street CNS, 2008/09



Source: Great Chapel Street

7.8.3 Stakeholder feedback

At the Homeless Health Summit, participants reported that there were a lack of services and statutory support for people with dual diagnosis that do not meet the clinical thresholds for CMHTs or the JHT; this was especially true for dual diagnosis. Building base services reported feeling isolated, trying to create a support plan for people in addition to navigating services (NHS Westminster, 2009). Again, awareness of the dual diagnosis service at Great Chapel Street was poor.

7.8.3 Conclusions for Dual Diagnosis

Local evidence suggests that dual diagnosis is a common problem amongst homeless people in Westminster, but people with dual diagnosis have particular difficulties accessing appropriate care. Although a more in depth needs assessment on dual diagnosis will be undertaken, findings suggest that the dual diagnosis service at Great Chapel Street is predominantly seeing people with mental health problems, rather than those with substance misuse and mental health problems.

7.9 Other mental health services

7.9.1 Number of people accessing other services for mental health problems

Primary care is the main identifier of people with mental health problems. If an individual is not accepted as suitable for statutory mental health services or referred to (and engaged with) condition specific services, the expectation would be that they are managed in primary care. Therefore, primary care manages both CMD and SMI, sometimes in conjunction with the specialist mental health services. These services should be considered as well as the ongoing management by GPs.

Table 7.9: Other mental health services provided in primary care settings

Service provider		Services provided
Dr Hickey's Surgery		1 session community psychiatric nurse
Great Chapel Street		10 sessions dual diagnosis (CNS)
Homeless Health Team	The Passage	1 session psychiatrist (provided by JHT)
	Connections@St Martins	1 session psychiatry (provided by JHT)
	West London Day Centre	1 session community psychiatric nurse (provided by JHT)

7.9.2 Dr Hickey Surgery

In the last year, 2,193 patients were seen by GPs at the Dr Hickey Surgery; of these patients, 318 (17%) presented with severe mental illness. Of the patients seen by nurses during the same time period, 17% (212 patients) were seen for a severe mental illness. It is, however, likely that the number of patients seen with mental health problems, particularly common mental disorders, is much higher, however, data pertaining to patients seen by the community psychiatric nurse is not routinely collected.

7.9.3 Homeless Health Team

With the current data collection systems in place, it is not possible to determine the number of patients seen by GPs or nurses from the Homeless Health Team for mental health problems. However, 31% of patients seen by

either a nurse or GP on at least one occasion in 2008/09 at the West London Day Centre had a mental health problem identified in the last year. 29% of patients seen at The Passage and 29% of patients seen at Connections at St Martins who had seen either a GP or nurse in 2008/09 had a mental health problem identified in the last year.

Anecdotal evidence suggests that although the West London Day Centre sees the fewest number of patients, it tends to see those people with the most complex needs in terms of mental health and high risk offenders; therefore, the consultation time with these clients tends to be longer and thus fewer patients are seen.

Table 7.10: Number of patients seen by the Homeless Health Team who had a mental health problem diagnosed in the last year

Day centre	Number of patients seen by GP or nurse	Number of patients seen who had a mental health problem recorded in the last year
West London Day Centre	382	118
The Passage	879	258
Connections at St Martins	719	209

Source: Vision

7.9.4 Great Chapel Street

See section 7.3.1 and 7.8 on dual diagnosis

With the exception of Great Chapel Street, limited data is available describing the type and severity of mental health problems that are being managed by GPs and nurses in primary care settings. Improved data collection will allow an assessment of the number of people being managed with specific mental health problems and common mental disorders and, thus, help determine whether primary care mental health services are meeting current needs.

7.10 Service User feedback

At the Service User Day, people rated mental health as the third most important health problem after teeth and alcohol use (Groundswell, 2009).

More generally, service users were exercised about the need for integration of services around mental health, substance misuse and physical health. On many occasions, people reported not being able to receive the support they needed, but if they did access services they reported frustration in having to access a number of different services for their needs.

For clients with mental health issues, but without a diagnosed SMI, access to services was described as variable, care was viewed as insufficient and it was felt that mental health services (other than CMHTs and the JHT) were unable to meet the needs of complex clients. People with personality disorder, those with common mental health problems and also those using drugs and alcohol were key groups who found services difficult to reach.

Participants at the blood-borne virus focus group highlighted the essential role of mental health in the management of other conditions. For example, interferon forms part of the clinically indicated treatment for hepatitis C, however, a common side effect of treatment is depression which needs to be appropriately managed. Lack of engagement with mental health services, thus prevented some people contemplating treatment for other health conditions.

7.11 Conclusions

It is generally accepted that most people who are homeless have some form of mental health problem, either a common mental disorder or a serious mental illness, although personality disorder is considered to be one of the most common conditions.

Published evidence suggests that many people remain undiagnosed, particularly those with common mental disorders and personality disorder. Locally a lack of robust data makes it difficult to estimate the prevalence of specific mental health problems amongst homeless people in Westminster.

Improvements in data collection are needed, particularly at primary care level to better understand the prevalence of mental health problems.

Based on the stock and returner model, an estimated 95% of people with serious mental illness are accessing specialist services, suggesting current services are meeting the needs of people with SMI.

However, for those people who do not meet the clinical threshold for a care programme approach, including people with personality disorder, dual diagnosis and low level mental health needs such as depression and anxiety, there appears to be an unmet need with current service provision not meeting the needs of the significant number of people with CMD.

Despite there being some unmet need for mental health problems, some services appear to be underused such as the Great Chapel Street psychiatrist. This service should either 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.

Analysis of the JHT care pathway and the Great Chapel Street psychiatry service highlighted that non-engagement with services is unsurprisingly common and, therefore, initiatives are required to increase engagement with specialist services and understand the underlying reasons for this.

On the whole, current services provide care for those people that present to services who can adhere to treatment/care plans and attend appointments, although in the case of the JHT, the majority of people that access the service accessed through assertive outreach and assessment under the Mental Health Act. 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.

It is difficult to assess gender representation in services. Although there are more homeless men than women, overall men appear to be underrepresented

amongst those accessing specialist mental health services. However, because women have many more accommodation options available to them than men, it is thought that the majority of women who sleep rough have either substance misuse problems or SMI which will skew the proportion of women who are rough sleeping accessing services. Therefore, the JHT, which provides a service for rough sleepers would be expected to have a higher proportion of women than, for example, CMHTs who see more hostel/supported housing residents than rough sleepers.

8: Other chronic illnesses

8.1 Association between chronic illness and homelessness

As a result of their lifestyles homeless people are more likely to experience chronic health problems than the general population. Furthermore, as many long-term conditions require ongoing medication and monitoring, people who are homeless are more likely to develop complications as a result of their long-term condition than the general population because of the barriers to accessing healthcare that they face.

Homeless people are at increased risk of respiratory disease because of the high prevalence of smoking, poor nutrition and environmental exposures; common respiratory diseases experienced by homeless people include asthma, chronic obstructive pulmonary disease and bronchitis.

There is also evidence to suggest that homeless people are more likely to suffer from diseases such as coronary heart disease, diabetes and hypertension but less likely to be diagnosed and receive ongoing treatment and management.

8.2 Ascertaining the number of homeless people in Westminster with chronic illness

In 2004 a homeless locally enhance scheme (LES) was introduced to improve the primary healthcare provision for homeless people in Westminster; 16 practices in Westminster are currently signed up to the LES. The LES records a number of core standards, including chronic disease prevalence amongst homeless people.

Compared to the prevalence of long-term conditions in the Westminster registered population (as recorded on the Quality and Outcomes Framework, QOF), the prevalence of long-term conditions of people registered on the homeless LES is high; the prevalence of respiratory conditions is twice as high amongst homeless people compared to the Westminster general population, whilst the prevalence of diabetes is three times higher.

The recorded prevalence of chronic illness amongst patients attending Dr Hickey’s Surgery is comparatively low compared to both the Westminster general population and the prevalence recorded on the Homeless LES, whilst the prevalence amongst patients attending Great Chapel Street is slightly higher, particularly for COPD.

Table 8.1: Prevalence of chronic illness amongst homeless people in Westminster

	Prevalence			
	Homeless LES Prevalence	Dr Hickey’s Surgery	Great Chapel Street	Westminster Population (QOF)
Respiratory (COPD and asthma)	4.0%	2.0%	12%	2%
Diabetes	8.0%	1.0%	5.0%	2.7%
Hypertension	*	3.2%	*	

* no data available

The wide variation in the prevalence of chronic conditions in homeless people reflects poor understanding of the prevalence of long-term conditions amongst homeless people in Westminster and highlights a need for improved data collection to further understand this.

8.2.1 Diabetes

Diabetes is characterised by a raised blood glucose level resulting from either a lack of, or insensitivity to, the hormone insulin. There are two main types of diabetes; Type 1 and Type 2. Type 2 diabetes often develops in later life as a response to a diet high in sugar over many years. In the first instance it is often managed by dietary interventions rather than administration of insulin.

Diabetes can lead to serious complications, including coronary heart disease, stroke, renal failure, amputation and blindness. Diabetes can also reduce life expectancy by up to 10 years.

The modelled prevalence of diabetes in Westminster is approximately 4.17% and so the reported prevalence amongst homeless people of between 1 and 8% is within the expected parameters.

Although the prevalence of diabetes amongst homeless people is similar to the modelled prevalence in the Westminster general population, the aetiology of disease is likely to differ. Evidence from Dr Hickey's Surgery suggests that many of those people who are homeless and diabetic have insulin deficiency as a result of pancreatic damage due to alcohol and drug use. These people represent a more severe form of diabetes not readily categorisable as Type 1 or Type 2; this often results in a more severe disease and consequently more damaging complications.

The management of diabetes, particularly blood glucose control is likely to be poorer amongst homeless people than the general population. Control of blood glucose levels is essential and reduces the risk of long term complications such as coronary heart disease, peripheral vascular disease and diabetic retinopathy.

Furthermore, diabetes is likely to be further complicated in those homeless people with a history of injecting drug use. Current and former injecting drug users, depending on their injecting practices pose a high risk for the development of peripheral vascular disease. Regular and ongoing injecting results in vein damage, with injectors of crack cocaine particularly at risk. Injecting crack cocaine results in vein damage due to its relative insolubility, the anaesthetic effects of cocaine and the impurities that crack cocaine is cut with. Femoral injecting and smoking also damage the blood supply, therefore, further increasing the risk of peripheral vascular disease in homeless populations.

8.2.2 Hypertension

Hypertension is said to occur when a person's blood pressure is consistently higher than recommended levels – a blood pressure of 140/85 in the general population or 130/80 in people who have had a heart attack or stroke, or who have coronary heart disease and/or diabetes.

Nationally, nearly a third of people (31.7% of men and 29.5% of women) have hypertension. Hypertension rarely makes people feel ill and so as a condition it often goes undiagnosed.

There is limited data available describing the number of homeless people in Westminster with hypertension. 3.2% of people registered at Dr Hickey's Surgery were on a register for hypertension, significantly lower than the expected prevalence in the general population. This in part is a reflection of the different age profiles of the homeless population and the general population of Westminster. However, given the high prevalence of drug and/or alcohol use and the association between substance misuse and hypertension, the aetiology of hypertension in homeless people is again likely to differ from the general population.

Given that people with hypertension are three times more likely to develop heart disease or have a stroke than people with normal blood pressure, and that untreated hypertension can also lead to kidney failure or eye damage; it is essential that people with high blood pressure are identified and treated, thus reducing their cardiovascular risk.

The number of homeless people with undiagnosed hypertension is likely to be high and, therefore, there is considerable scope to improve the identification and management of people with high blood pressure in Westminster and further reduce the risk of people developing CVD.

8.2.3 Respiratory diseases

COPD describes a range of conditions characterised by airflow obstruction that leads to persistent and progressive breathlessness. Smoking is the main risk factor for COPD, however smoking drugs such as crack cocaine also contributes to respiratory disease.

Asthma is characterised by episodes of wheezing and difficulty in breathing resulting from inflammation of the airways. Common triggers that exacerbate

asthma allergens include dust mites and pollen, air pollution, cigarette smoke, exercise, respiratory infections and exposure to cold air.

The recorded prevalence of respiratory disease amongst homeless people is, unsurprisingly higher than that found in the general population. The prevalence varies from 2% to 12%, however, published literature suggests that the actual prevalence is likely to be much higher, indicating that some people are likely to be undiagnosed.

Often it is difficult to characterise obstructive pulmonary disease accurately as either atopic and reversible (asthma) or irreversible (COPD). This is partly because patients do not find it easy to access spirometry services which are needed for a definitive diagnosis and partly because the majority of patients have reversible airways obstruction due to smoking drugs – this may help to explain the low reported prevalence.

8.3 Service user feedback

At the service user day, participants reported being able to address chronic health problems as one of the most important issues to them. Often people reported being aware of what to do to address their health issues, however, because of other issues, the most significant of which was substance misuse, they were unable to prioritise other health problems.

Participants reported wanting a mechanism to gain peer support to accompany them to health services to not only ensure that they attend appointments, but can support them to deal with gatekeeping staff, can help record information given by health professional and can act as an advocate.

8.4 Conclusions

Overall the number of homeless people with chronic illnesses including respiratory diseases, hypertension and diabetes is lower than expected. This, in part, is likely to be due to data recording issues and, therefore, improvements in data capture are required. Additionally, as is the case amongst the general population, a large proportion of affected people are likely to be undiagnosed and, therefore, not benefiting from ongoing treatment

and management. Furthermore, anecdotal evidence suggests that even for those people where a diagnosis has been made, follow up and management of affected people is poor due to poor engagement with health services.

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.

8.5 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.

9: Physical health problems

Key Messages:

- Homeless people have poor foot, ocular and skin health;
- Homeless people often do not present to services until their potentially preventable problems are severe;
- Current specialist podiatry services are oversubscribed;
- Hostel residents find it particularly difficult to access specialist podiatry services at daycentres;
- 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.

9.1 Foot health

9.1.1 What are the foot problems experienced by homeless people and how many people experience them?

Homeless people present with foot disorders include those commonly seen in the general population such as corns, bunions, hammer toes, verrucas, heel fissures, ingrown toenails, mycotic infections, high arched cavoid feet, flat feet and biomechanical problems and those particular to this group such as trench foot and severe blistering.

A number of factors contribute to the increased risk of foot problems experienced by homeless people (Gardiner, 2009) including

- increased risk of diabetes and diabetic complications
- walking long distances
- mental health problems which may lead to self neglect
- poor hygiene
- exposure to hot, cold and wet environments
- poor nutrition
- lack of money to purchase well fitting footwear and nail clippers

- not removing shoes or socks
- self treating foot problems which can lead to complications such as infection – patients often report self-medicating for foot pain with alcohol or drugs
- smoking
- sharing showers which can lead to spread of infection
- sleeping in awkward positions may lead to oedematous feet and legs
- substance misuse, for example injecting in the feet
- migration from other countries with UK rare conditions such as polio, rickets or injuries
- being drunk which carries an increased risk of assault and falls, alcohol related peripheral neuropathy and diabetes.

In addition this group may experience particular barriers in accessing foot health services, for instance, illiteracy, language barriers, embarrassment and mental health problems. This can result in late presentation with severe symptoms.

Foot problems can cause significant pain and discomfort. Early detection and treatment of foot problems, education regarding foot hygiene and the access to adequate footwear have the potential to greatly improve the lives of homeless people in Westminster.

In Westminster, 12% of people attending Great Chapel Street in the last three years and 28% of people presenting to the Homeless Health Team had a diagnosed foot problem.

9.1.2 Podiatry services for homeless people in Westminster

In Westminster podiatry services are delivered in several primary care settings. The Homeless Health Team provides four podiatry sessions a week, one at each of the three day centres (West London Daycentre, The Passage and The Connection at St Martins) and one session at Great Chapel Street.

The podiatry service operates in such a way as to increase ease of access to the service. The service is run on a drop in basis and is promoted using clear posters and leaflets with pictures in daycentres and at Great Chapel Street. On the day of the clinic flyers are distributed in seating areas at day centres. At the day centres people do not have to sit in a waiting room and wait their turn, they carry on doing whatever they are doing and the podiatrist finds them when it is their turn.

9.1.3 Number of people accessing specialist homeless podiatry services in Westminster

Overall an estimated 10% of homeless people in Westminster have accessed podiatry services delivered in primary care settings for homeless people; this is lower than the predicted number of homeless people thought to have poor foot health.

Table 9.1: Number of consultations with specialist podiatry services, 2008/09

Location		Number of consultations
Great Chapel Street		222
Homeless Health Team	The Passage	237
	Connections@St Martins	207
	West London Day Centre	129

Evidence suggests that the podiatry service is often oversubscribed with many people being turned away. In the nine month period, June 2008 to March 2009, 101 people were not seen because of capacity within the service, the majority of whom were turned away from St Martins. There could, therefore, be scope to expand the service. Further work should investigate the potential development of the service; given the high proportion of Westminster's homeless population that reported attending Dr Hickey's Surgery in the

Homeless Health Survey and the lack of a foot clinic at this surgery, Dr Hickey's Surgery may be a viable option for this.

As part of the National Service Framework (NSF) for diabetes, all diabetics should have yearly neurovascular foot checks. It is recommended in the NSF that vulnerable groups such as those from lower socio-economic groups should be specifically targeted due to their increased risk of serious diabetic foot complications such as amputation. This check can be carried out by a GP, nurse or podiatrist. Although the number of homeless people with diabetes presenting for foot checks is unknown, it is likely to be low given that people tend to present when they have a problem. Further work is needed to determine the number of diabetics receiving the recommended foot checks to identify areas of met and unmet need.

9.1.4 Conclusions on foot health

Without data describing the prevalence of specific foot problems experienced by homeless people in Westminster it is difficult to determine whether services are currently meeting the needs of the population. Currently Vision (primary care data collection system) only records data related to podiatry visits as free text so it is difficult to extract data on reasons for visiting the podiatrist. Specific Read codes for Vision could potentially be developed to capture data on the number of patients presenting with specific foot problems to inform health promotion and healthcare interventions. Future health surveys could also include specific questions on foot health to give an indication of the level of need in the Westminster population.

In the absence of data, anecdotal evidence from service providers suggests that current services do not have the capacity to meet the demand for services. Further work should, therefore, explore how the capacity of podiatry services for the homeless population in Westminster can be developed.

9.2 Ocular health

9.2.1 What are the eye problems experienced by homeless people and how many experience them in Westminster?

Evidence suggests that homeless populations are more vulnerable to poor ocular health than the general population; homeless people are two times more likely to report difficulty seeing compared with the general population (Bines, 1994)

Although published literature describing the prevalence of ophthalmic disorders in homeless populations is limited, there is evidence to suggest that conditions such as glaucoma and cataracts are more common than in the general population (Bharadia, 2006 and Pitz et al, 2005). The number of people with uncorrected vision, e.g. needing spectacles, is also higher in homeless people. Those homeless for more than three years were more likely to have poor vision than those who had been homeless for less than one year. Homeless people are also more likely to experience poor ocular health as a result of accidents and deliberate harm

A number of factors associated with homelessness increase the risk of poor eye health, these include:

- High rates of smoking which over time can lead to eye disease
- Living in areas of high pollution leading to dry, irritated eyes
- Not being able to afford an eye test or spectacles
- Losing, breaking or having spectacles stolen
- Increased risk of being in an accident or being assaulted resulting in physical damage to the eye.
- Difficulty adhering to treatment regimes for conditions such as glaucoma or blepharitis.

9.2.2 Ophthalmic services for homeless people in Westminster

Vision Care for homeless people provides eye care services to vulnerable people who cannot or choose not to access mainstream services available through the NHS. Services include screening for ocular health, free eye tests and provision of spectacles.

Vision Care run a weekly clinic at The Passage and sees on average 6 people each week; however, in a recent study awareness of this service amongst other providers of homeless health services was poor. This is the only specific ocular health service aimed specifically at homeless people operating in Westminster.

Some healthcare providers report having established good working relationships with local mainstream opticians who are prepared to see patients on an informal basis.

9.2.3 Conclusions on ocular health

Given the likely high prevalence of poor eye health and vision problems that can be corrected by glasses in homeless people, the number of people not using, but requiring services is likely to be high, suggesting an unmet need in Westminster.

9.3 Dermatology

9.3.1 What skin problems do homeless people experience and how many experience them?

Homeless people are especially vulnerable to skin conditions such as infection, largely because of poor hygiene, unbalanced diet and exposure to the elements. Common skin conditions strongly associated with homeless include:

- pruritus
- body-lice infestation
- folliculitis
- tinea pedis (athlete's foot)
- scabies
- impetigo

A recent study looked at the prevalence of skin infections amongst the sheltered homeless in France; 38% had at least one skin infection compared with 0.5% of the general population. Extrapolating this to the Westminster population, 825 homeless people may have a skin condition – many of which

are treatable. This number may, however, be much larger as this study did not look at the prevalence of skin conditions in rough sleepers. Evidence suggests that the prevalence of skin infection is higher in rough sleepers than in those in hostels or supported housing and so it is likely that nearer to 50% of the homeless population in Westminster has skin health needs.

In the Homeless Health Survey, a question was asked whether the respondent had a long term illness (from a specified list); 17% of hostel/supported housing residents and 21% of rough sleepers reported having a long term skin condition. This is lower than the prevalence in the published literature. This may reflect the fact that some skin conditions are acute and short-lasting, but also reflect the perceived importance of skin conditions compared to other health problems; other long-term health problems on the list of options included depression, liver disease and respiratory illness, which may have been perceived as more serious health problems by respondents.

9.3.2 Dermatology services for homeless people in Westminster

With the exception of The Caravan which provides a wound management service, there are no specialist dermatology services for homeless people in Westminster – services are provided by GPs and nurses in primary care, included Dr Hickey’s Surgery, Great Chapel Street and the Homeless Health Team.

27% of patients presenting to Great Chapel Street had dermatological conditions, equivalent to 989 people. The most commonly diagnosed skin condition was a subcutaneous tissue infection followed by psoriasis, eczema, abscess and impetigo.

Table 8.2: Presentations to the Homeless Health Team and Great Chapel Street for dermatological conditions, 2006-2009

Dermatological condition	Homeless Health Team		Great Chapel Street	
	n	%	n	%
Abscess	95	5.7	177	4.8

Cellulitis	79	4.8	151	4.1
Eczema	95	5.7	177	4.8
Folliculitis	28	1.7	78	2.1
Impetigo	84	5.1	177	4.7
Psoriasis	109	6.6	197	5.3
Skin lesions	123	7.4	101	2.7
Subcutaneous tissue infection	209	12.6	384	10.3

28% of patients presenting to the Homeless Health Team had dermatological conditions, equivalent to 464 people. The most commonly diagnosed skin condition was subcutaneous tissue infection followed by skin lesions and psoriasis.

9.3.3 Conclusion on dermatology

The prevalence of skin conditions amongst homeless people in Westminster is high, however the number presenting to primary care services is lower than expected (estimated prevalence of 50% compared to 27-28% presenting to primary care services). Further work should explore the underlying reasons for this, one of which may be the low perceived importance of skin conditions in the context of other health and social problems. 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 to be more urgently addressed.

As is the case in the general population, the majority of skin conditions are readily amenable to primary care management. Further work may explore the need for health promotion work to both prevent skin problems in the first instance and raise awareness, recognising the importance of good dermatological health and the need for treatment.

10: Blood-borne viruses

Key Messages:

- **The expected prevalence of BBVs in the homeless population is high;**
- **People living in hostels are more likely than current rough sleepers to be tested for BBVs;**
- **The uptake of hepatitis B vaccination is low and innovative methods are needed to incentivise uptake of vaccination;**
- **The number of homeless people accessing treatment for BBVs is low;**
- **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, what a positive diagnosis means, harm reduction and treatment pathways;**
- **Integrated working and information sharing is needed to coordinate the care of people with BBVs and manage their co-morbidities.**

Blood-borne viruses are associated with significant morbidity and mortality and often result in long term illness. Because of the high numbers of homeless people who are problematic drug users, homeless populations are disproportionately affected by blood-borne viruses such as hepatitis C, hepatitis B and HIV. Injecting drug use (IDU) is the main risk factor for hepatitis C and approximately 90% of all newly diagnosed infections occur in IDUs.

10.1 Expected number of people infected with hepatitis B, C or HIV

The National Unlinked Anonymous Survey of IDUs estimates that the prevalence of hepatitis C amongst IDUs is 43% (44% in people who have injected in the last year); this is 86 times higher than the estimated prevalence in England as a whole (0.5%).

The Health Protection Agency recently published local prevalence estimates indicating that the prevalence of hepatitis C in London amongst IDUs was higher than any other part of the country. Over 50% of the injecting population in London are thought to be infected with hepatitis C, with the majority of those injecting for more than 5 years likely to be infected with hepatitis C. Based on the prevalence of IDU amongst Westminster's homeless population, there may be as many as 624 people infected with hepatitis C.

The Health Protection Agency suggests that one in six IDUs have had hepatitis B infection (either past or current); based on this prevalence, approximately 208 homeless IDUs in Westminster have been exposed to hepatitis B.

As well as being transmitted through intravenous drug use, Hepatitis B can also be transmitted through sexual contact and so it is likely that the number of homeless people in Westminster that have been exposed to hepatitis B is higher. New cases of hepatitis B are continuing to occur despite the availability of a vaccine.

The prevalence of HIV amongst IDUs is estimated to be around 3.9%; this suggests that 49 people who are homeless in Westminster have HIV infection. Again, as is the case for hepatitis B, because HIV is also transmitted by other routes, including sexual contact, the number of people who are homeless and have HIV is likely to be higher.

10.2 Ascertaining the number of people tested for hepatitis B, C or HIV Testing

A question was asked in the Homeless Health Survey about testing for blood-borne viruses and also positivity for blood-borne viruses.

The proportion of homeless people reporting being tested for blood-borne viruses was similar for hepatitis B, C and HIV; this is likely to reflect the fact that testing for the three viruses occurs at the same time.

Table 10.1: Testing for blood-borne viruses

	% of homeless tested	
	Hostel resident	Rough sleeper
Hepatitis C	79%	32%
Hepatitis B	79%	33%
HIV	75%	32%

Hostel residents were much more likely to have been tested than rough sleepers and this is most likely a result of testing programmes offered within hostels and associated services.

There are a number of testing services in Westminster delivered under the auspices of the Westminster Blood-Borne Virus Service which was established in 2008. The service is a partnership between the Westminster Drug Project, CNWL and the Hungerford Drug Project (HDP) and aims to improve the detection of BBVs, prevent the long term sequelae associated with BBVs and prevent onward transmission of BBVs by screening problematic drug users.

As part of Westminster BBV Service, the Hungerford Drug Project provides a screening service for problematic drug users who are homeless on a non-appointment basis as part of a range of primary health care services.

Between April 2008 and March 2009, HDP screened 162 people of whom 121 (75%) were problematic drug users. The proportion of those screened that were positive for BBVs was high; of those screened, 47% were hepatitis C positive, 10% hepatitis B positive and 10% HIV positive. The number of people diagnosed as HIV positive was particularly high, however, further investigation showed that a large proportion of cases were already known about and, therefore, not new diagnoses.

In addition to the Hungerford Drug Project, screening and vaccination is targeted at problematic drug users at a range of locations across Westminster, however, from available data it is not possible to identify how many of those screened are homeless.

From the data available we do not know whether those people who are being tested are recent initiates to IDU or are long term problematic drug users. If the majority of clients that are presenting to HDP for testing are long-term problematic drug users, the prevalence of hepatitis C would be expected to be higher, however, if those presenting have only recently commenced injecting, given the harm reduction measures that have been introduced in recent years a lower prevalence would be expected.

Further work describing the demographics and characteristics of those people presenting to testing services such as HDP would be beneficial and allow comparison with the demographics and characteristics of problematic drug users in Westminster. Not only will this facilitate evaluation and development of BBV testing services in Westminster, but it will identify potential areas of unmet need e.g. particular subgroups such as ethnicity, accommodation status and country of origin amongst others, who are not presenting to testing services, but whom are likely to be positive for BBV infection.

It should be noted that other services that constitute the Westminster Blood-Borne Virus Service work with homeless populations, however, currently data can not be disaggregated to identify those people that are homeless. Therefore, to better understand the use of services by homeless people, data collection should be adapted to allow analysis of data pertaining to those people who are homeless.

10.3 Ascertaining the number of people diagnosed with hepatitis B, C or HIV

The Clean Break audit conducted at the end of 2007 found that 28% of those surveyed were hepatitis C positive; this is significantly lower than expected given the estimated prevalence in London amongst IDUs. This low prevalence most likely reflects an unmet need in that a large proportion of homeless people with hepatitis C are undiagnosed and suggests a need for improved screening initiatives.

The Homeless Health Survey also asked a number of questions about the prevalence of blood-borne viruses. Overall, the prevalence of blood-borne viruses reported in the Homeless Health Survey was lower for rough sleepers than for hostel residents; this may reflect a number of differences between hostel residents and rough sleepers. The higher prevalence of blood-borne viruses amongst hostel residents may be a consequence of higher rates of infection amongst homeless people and may be a result of sharing needles and other injecting paraphernalia amongst hostel residents, it could reflect increased awareness of blood-borne virus status amongst hostel residents or it could reflect a higher prevalence of disease associated with the higher levels of drug use amongst hostel residents compared to rough sleepers.

Table 10.2: Prevalence of blood-borne viruses

	% of homeless tested reporting positive status	
	Hostel resident	Rough sleeper
Hepatitis C	60%	41%
Hepatitis B	40%	26%
HIV	56%	31%

The self-reported prevalence of BBVs was particularly high in this survey and unlikely to reflect the actual prevalence in this population. Further investigation is needed at a local level to understand the underlying reasons for this, however, the high prevalence may reflect a poor understanding of the questions asked in the Homeless Health Survey. Accordingly, these prevalence estimates should be interpreted with great caution.

10.4 Number of people vaccinated against hepatitis B

A vaccine is available to immunise against hepatitis B infection (this is delivered via three separate injections); although England does not have a universal screening programme for hepatitis B, immunisation is offered to high risk groups, including IDUs.

Data pertaining to levels of immunisation amongst homeless people in Westminster is limited; data from the Homeless Health Survey suggests that 39% of the homeless population has been vaccinated against hepatitis B,

equivalent to 1,035 people in Westminster. Rates of immunisation were higher in the hostel population (55%) compared to the rough sleeping population (21%), again reflecting the lower uptake of blood-borne virus services experienced by rough sleepers.

It is, however, difficult to draw robust conclusions from such survey data. Nearly one fifth of respondents in the Homeless Health Survey could not remember if they had been immunised, and of those that reported being immunised, 65% reported being immunised in the last year.

As a vaccine delivered in three doses, all three doses are required to evoke an immune response. From the Homeless Health Survey data it is impossible to elucidate how many of those immunised completed the vaccination schedule (and are, therefore protected against hepatitis B), however, drawing inferences from other health conditions and service use, it is likely that the proportion of people failing to complete the full vaccination course is high.

In addition to providing a testing service, the Westminster BBV Service provides a hepatitis B and A vaccination service. In 2008/09, HDP administered the first dose of the hepatitis B vaccine to 36% of those people who attended for BBV screening, however, only 12% of those attending for screening returned for the third dose of the vaccination.

Dr Hickey's Surgery offers vaccination to all new patients, however, they also report a low uptake.

The relatively low proportion of people vaccinated against hepatitis B may reflect the fact that some people will already be immune to hepatitis B, either through previous vaccination or infection. However, the low proportion of patients attending for the third dose of vaccine (compared to those attending for the first dose) suggests poor uptake of the complete vaccination course; this is unsurprising given the chaotic lifestyles of problematic drug users and suggests that innovative methods are needed to incentivise problematic drug users to attend for all three vaccine doses.

10.5 Ascertaining the number of people receiving treatment for blood-borne viruses

A range of treatment for hepatitis B, C and HIV are available, usually delivered in a secondary care setting. To date limited data is available pertaining to the number of homeless people positive for blood-borne viruses who are accessing treatment. Some indication of the numbers ever having accessed treatment is, however, available from the Homeless Health Survey

Table 10.3: Treatment for blood-borne viruses

	% of homeless tested positive accessing treatment	
	Hostel resident	Rough sleeper
Hepatitis C	47%	8%
Hepatitis B	28%	0%
HIV	42%	0%

Overall the proportion of those people testing positive for blood-borne viruses accessing treatment was low, particularly for hepatitis B; this is, however, unsurprising as hepatitis B is often an acute infection that is cleared without the need for treatment.

Unlike for hepatitis B, HIV and hepatitis C usually persist in the body (approximately 80% of people infected with hepatitis C develop chronic infection) and require treatment whether to clear the virus in the case of hepatitis C, or manage the virus in the case of HIV. Therefore, 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, with rough sleepers significantly less likely to access treatment than hostel residents; this is most likely a reflection of the more chaotic lifestyles of those people sleeping rough and competing health and social problems experienced by rough sleepers.

The treatment of active infection amongst homeless people in Westminster, therefore, appears to be an area of particular unmet need, with a very small

number of infected people accessing treatment. 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 is currently undertaking a hepatitis C needs assessment. This needs assessment provides a more detailed analysis of treatment pathways and met and unmet need for people with hepatitis C in Westminster, including those people who are homeless. The needs assessment can be accessed from:

<http://westminstercitypartnership.org.uk/Partnerships/Health%20and%20Wellbeing/Pages/JSNA.aspx>.

10.6 Stakeholder feedback

Stakeholders attending the Homeless Health Summit workshop on blood-borne viruses highlighted that awareness of testing and treatment was a particular issue with regards to BBVs – both for clients and workers. Participants commented on their different skills and knowledge in the area, highlighting knowledge gaps concerning the post-test treatment pathway for BBVs; this suggests a training need for workers such as BBS staff and hostel workers.

Access to testing was generally considered good, however, coordination of testing services with other services such as counselling was suggested as beneficial to the client.

Lack of service integration was also emphasized with regard to the BBV treatment pathways, particularly hepatitis C. Participants described how it was very easy for clients to ‘fall through the net’ upon referral to secondary care if, for example, they miss one hospital appointment.

Communication with treatment services was viewed as poor – confidentiality protocols were viewed as a significant barrier to communication and data sharing, to the detriment of the client.

Sexual health was also addressed in the context of BBVs. Participants felt that little emphasis was given to sexual health and that further support for workers was needed to encourage clients to be tested, access treatment and take preventative methods.

10.7 Service user feedback

To further understand the issues surrounding testing and treatment uptake for BBVs for homeless people in Westminster, a focus group was held with hostel residents.

Overall participants reported a lack of information around testing, particularly when they receive a positive result – this is particularly apparent from the fact that many clients appear to have tested positive for a BBV on more than one occasion suggesting that often people do not understand the impact and relevance of their test result. Furthermore it suggests that upon identification of being BBV positive, people are not being referred to secondary care for treatment consideration nor are they offered harm minimisation advice as well as advice such as lifestyle adaptations they can make to prevent the development of conditions such as cirrhosis associated with long term BBV infection. It should, however, be noted that there were some exceptions to this, notably Westminster Treatment Centre.

When asked about treatment, participants highlighted the need for multidisciplinary care, for example, to help them reduce their alcohol intake and manage mental health side effects associated with treatment for hepatitis C.

The main barriers to accessing treatment for hepatitis C were seen as lack of knowledge about what treatment entails and current injecting drug use - treatment for hepatitis C is currently contraindicated for current injecting drug users.

10.8 Conclusion

Evidence suggests that the prevalence of BBVs is relatively high amongst homeless people in Westminster, although many people remain undiagnosed - this is particularly the case for hepatitis C.

In recent years there has been progress with regards to testing and vaccination of homeless people, particularly those using drugs problematically. However, those residing in hostels/supported housing are much more likely than rough sleepers to have been tested for a BBV or received vaccination against hepatitis B, suggesting that further work is needed to engage with rough sleepers. Furthermore, with regards to vaccination, of those who attend for the first dose of the hepatitis B vaccination, very few return for the second or third doses. Innovative methods are, therefore, needed to ensure that people receive all three doses of the vaccine and develop an immune response.

The proportion of people who reported testing positive for BBVs receiving treatment was low, particularly for rough sleepers. Although testing for BBVs has public health benefits in terms of promoting harm reduction and safe injecting practices that can reduce transmission of BBVs, the main aim of testing is to identify infected people and channel such people into services for treatment.

Whilst progress is clearly being made on the testing front with the establishment of the Westminster Blood Borne Virus Service, there is little evidence of people identified as positive being channelled into services and receiving treatment.

11: Tuberculosis

Key messages:

- Homeless populations are disproportionately affected by tuberculosis;
- 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;
- 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.

11.1 Homelessness and tuberculosis

In the UK, TB tends to be concentrated in communities within large cities, such as London. The incidence of TB in London has increased from 21.2 per 100,000 per year in 1987 to 43.2 per 100,000 per year in 2007. Notifications in London now account for approximately 45% of all notifications in England (Health Protection Agency, 2009).

Homeless populations are disproportionately affected by TB; recent evidence suggested that 10% of TB patients had a history of homelessness and 4% were currently sleeping rough (Storey *et al*, 2007). In a recent study of all TB cases who should have been receiving TB treatment in London as of July 1st 2003, the overall prevalence of TB was 27.1 per 100,000. This compares to a prevalence of 788.1 per 100,000 in homeless people. Overall, homeless people represented 6% of all TB cases (Storey *et al*, 2007).

Homeless people are more likely to have advanced TB. They are also less likely to complete the course of treatment, putting them at risk of developing multi-drug resistant TB. In the London cohort study, 45.5% of homeless people with TB were non-adherent to treatment within the first two months, 15.4% were lost to follow up by services within six months and 39% showed resistance to at least one treatment drug (Storey *et al*, 2007).

A number of factors have been shown to increase the risk of acquiring TB and the impact on health amongst homeless people. These include:

- the number of undetected cases is high in homeless populations
- poor nutrition and weakened immunity increases the risk of initial infection and speeds the progression to active disease
- delayed diagnosis means that cases are more severe and more likely to be infectious
- some lifestyle behaviours such as smoking crack cocaine can mimic the symptoms of TB, thus delaying diagnosis
- overcrowded sleeping arrangements makes the spread of TB more likely.

TB treatment takes a minimum of six months; which is often problematic for homeless people who have conflicting priorities, substance misuse problems, lack of understanding regarding TB, mental health problems, and/or are living on the streets or other unsuitable accommodation.

11.2 TB in Westminster

The number of notifications of TB in Westminster has remained relatively constant in recent years; in 2007 (latest available data), there were 86 notifications, representing 2.6% of all notifications in London (Health Protection Agency, 2009).

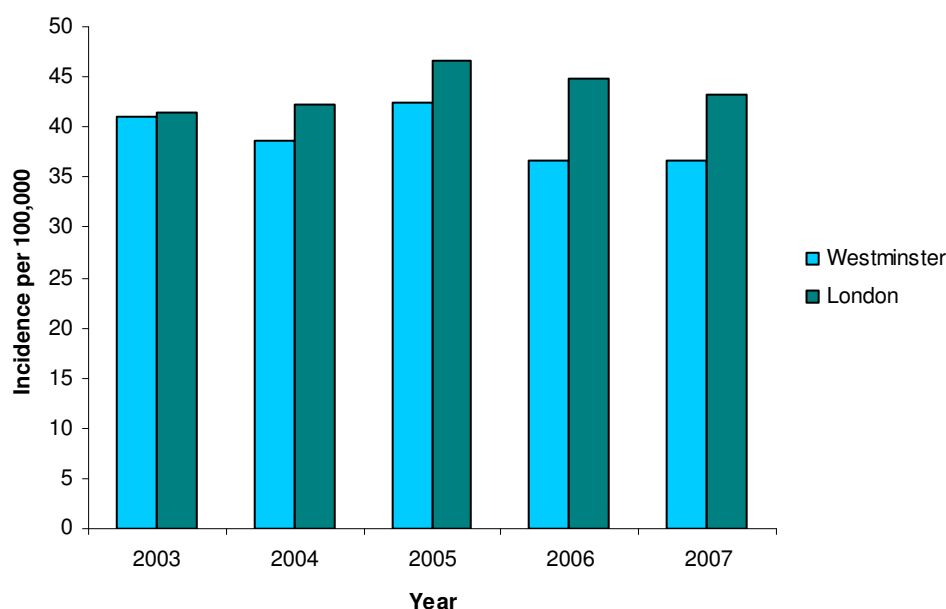
Although the number of notifications in Westminster has not changed significantly, the proportion of all notifications in London that Westminster accounts for has fallen from 2.9% in 2003 to 2.6% in 2007.

Table 11.1: Notifications of TB in Westminster and London: 2003-2007

Year	Number of notifications in Westminster	Number of notifications in London	Proportion of London cases notified in Westminster (%)
2003	89	3,049	2.9
2004	85	3,129	2.7
2005	97	3,479	2.8
2006	85	3,362	2.5
2007	86	3,265	2.6

The number of new cases (incidence) of TB in Westminster has decreased in recent years. This is in contrast to the situation in London, in which, despite some year on year fluctuations, the incidence of TB has remained consistently higher than that in Westminster.

Figure 11.2: Incidence of TB in Westminster and London, 2003-2007



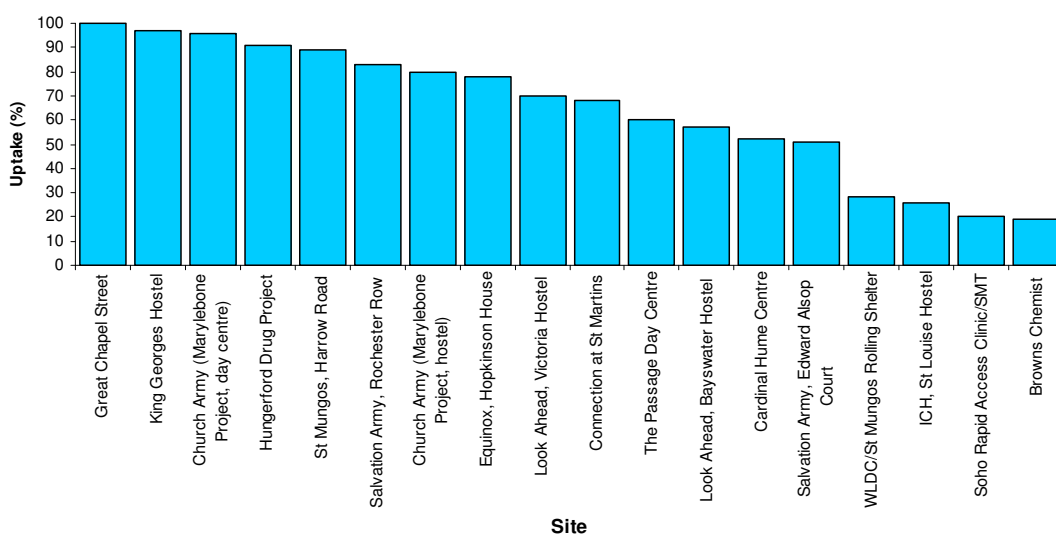
Based on national evidence suggesting that 4% of new TB notifications are in rough sleepers and 10% of all TB notifications had a history of being homeless, three rough sleepers a year will acquire TB and nine new TB notifications will have a history of being homeless in Westminster.

11.3 Detecting TB in Westminster

The Mobile X-Ray Unit (MXU) is an accessible and flexible TB screening service aimed at population groups identified as being at high risk of TB; these groups include homeless people, prisoners, drug users and street drinkers. As an active screening initiative, the MXU aims to find cases of TB at an early stage of disease progression and, therefore, before a person becomes infectious, helping prevent onward transmission of the infection. The MXU visits a number of locations in Westminster twice a year, allowing all local service users to access screening.

In October 2008, from an identified target population of 1,127, 716 people attended for screening; this is equivalent to an uptake of 63%, and a 42% improvement on previous screening efforts. Variation in uptake across the borough was observed with Great Chapel Street having a 100% uptake and Browns Chemist only a 19% uptake (though Brown's would not be expected to have 100% uptake). Despite the fact that rough sleepers are a very transient population the variation between hostels accommodating rough sleepers is of note.

Figure 11.3: Uptake of TB screening in Westminster



Of those screened, 1% of people required follow up to confirm or exclude TB, whilst 1% had evidence of previous TB infection. Less than 5 people were found with active TB, however, this represents a rate of active pulmonary disease that is not known to health services of around 300 per 100,000, this compares to 10 per 100,000 in the general population, representing a 30-fold increase.

11.4 Conclusions

The incidence of TB amongst homeless people in Westminster is decreasing; this is most likely a result of the MXU initiative, identifying infected people at an early stage of disease progression before a person becomes infectious, helping prevent onward transmission of the infection.

Given the number of cases identified by the MXU and the number of cases of TB expected in homeless people derived from the published literature, the MXU unit appears to be successful at identifying cases. However, at least one case of active TB was thought to be missed in Westminster due to non-attendance and the uptake of screening remains variable across the borough. Further work is still required to ensure that the improvement on previous years screening efforts is maintained.

12: Oral health

Key messages:

- **The dental health of homeless people is poor – homeless people in Westminster report, on average, having nine missing teeth;**
- **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;**
- **Local evidence suggests that the current homeless services 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;**
- **Furthermore, many patients who initially attend for treatment fail to return for treatment completion;**
- **Currently little consideration is given to preventative models of care for homeless people in Westminster.**

12.1 Association between homelessness and oral health

Although data on the prevalence of oral health problems of homeless people is limited, published studies consistently report a high clinical and perceived need for oral health care amongst homeless people. The high prevalence of alcohol and substance misuse amongst homeless populations is also known to be associated with tooth decay and damage.

Hostel/supported housing residents and rough sleepers have a higher DMFT⁴ than the general population as well as a higher prevalence of dental pain, gum disease, plaque accumulation and missing teeth.

⁴ DMFT index is a general indicator of the dental health status of a population. DMFT refers to decayed (D), missing due to caries (M), filled (F) and teeth (T). The lower the DMFT index score, the better the dental health of a population.

A number of factors contribute to the poor oral health experienced by homeless people:

- poor diet and nutrition
- poor oral hygiene
- smoking
- injury (accidental or violence)
- substance misuse.

12.2 Number of homeless people with oral health needs

In the Homeless Health Survey, people were asked how many (if any) missing teeth they had. Missing teeth was used as a proxy measure for oral health; often decay and infection leads to teeth falling out, or sometimes self extraction or emergency dental extraction because of the poor condition of the tooth and associated pain.

74% of respondents reported having missing teeth; this proportion was similar for hostel dwellers and rough sleepers. On average, people reported having 9 missing teeth. Applied to the Westminster population, as many as 1,607 homeless people are likely to have dental health needs.

Teeth were identified as the most important aspect of physical appearance by participants. Participants also reported that missing teeth and poor oral hygiene had a significant negative impact on self-esteem. Furthermore, participants reported that poor oral health also restricted economic and social inclusion as it prevented participants from entering unknown situations such as job interviews and making new acquaintances, all of which are identified as critical in supporting people to move out of homelessness and drug and alcohol dependency and reduce the risk of future relapse.

At the Service User Day, participants identified dental needs as their main health priority and when questioned further in groups they identified access to good quality conservation and restoration dentistry as something they would like.

12.3 Number of homeless people accessing dental services in Westminster

In order to assess the number of people accessing dental services in Westminster dental activity data was analysed. Categories of dental treatment are classified according to a banding system (1-3) - the band of treatment determines both the units of dental activity (UDA) carried out by a dental practitioner and the amount that a patient is charged for their treatment.

In Westminster, dental services include mainstream dental practices in addition to the specialist dental service for homeless people provided at Great Chapel Street, which provides 4 sessions of dental care a week (equivalent to 2 days).

According to the Homeless Health Survey, 21% of people have accessed a dentist in the last year; this is equivalent to 456 people. Rough sleepers were least likely to have seen a dentist; 13% of rough sleepers had seen a dentist in the last year compared with 23% of hostel/supported housing residents.

12.3.1 Number of homeless people accessing the Great Chapel Street Dental Service

In 2008/09 271 patients were seen by the dentist at Great Chapel Street, equivalent to 12.5% of the homeless population in Westminster. 456 homeless people reported using dental services in the Homeless Health Survey, so less than 50% of the homeless population uses the specialist homeless dental service.

In terms of age, the majority of patients were in the 35-44 years age group; this is unsurprising given that most homeless people in Westminster are aged 36-49 (as recorded on CHAIN) and indicates that those people who are using the service are typical in terms of age of the homeless population in Westminster.

In terms of dental activity, Great Chapel Street delivered 1,177 UDAs in 2008/2009. Of those 1,177 units of dental activity delivered, 5.7% were band 1, 38.5% for band 2 and 55.1% for band 3 treatments. The proportion of

UDAs for band 2 and 3 treatments is higher for Great Chapel Street than for Westminster as a whole, whilst the proportion of band 1 treatments was lower. This suggests that people using the Great Chapel Street dental service are more likely to require complex dental treatments than people using NHS dental services in Westminster as a whole.

Figure 12.1: Proportion of patients seen by age group: 2008-2009

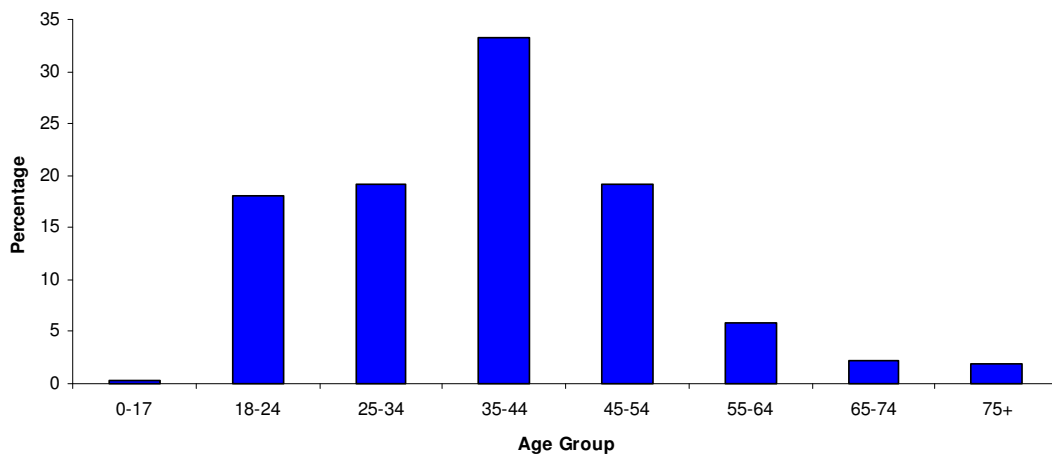
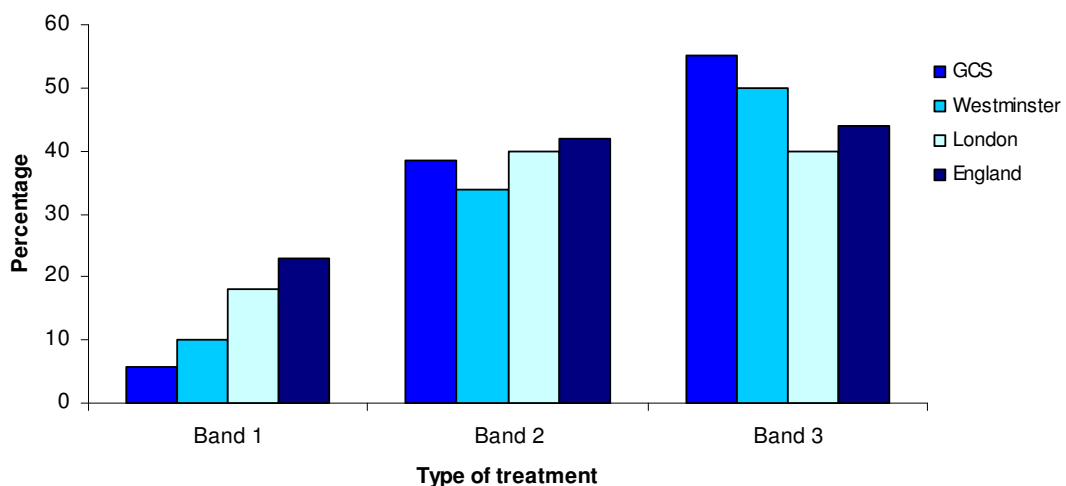


Figure 12.2: Proportion of UDA by treatment band: 2008-2009



This is as expected given the poor oral health of homeless people and the fact that it is well established that homeless populations engage poorly with health

services, particularly those that operate on an appointment only basis and who most likely present to health services at a time when they are symptomatic (i.e. experiencing pain) and when more complex treatment is needed.

The dental service at Great Chapel Street operates on an appointment basis; however, despite all appointment slots regularly being booked up with patients, the service reports that many patients do not attend for their appointments. Additionally, many patients who do initially attend for treatment fail to return for completion of their treatment. This suggests that the current service provided may potentially not be acceptable to and accommodate the lifestyle of patients for whom it is currently commissioned.

12.3.2 Number of homeless people accessing mainstream dental services

Currently limited data is available relating to the number of homeless people presenting to general dental practitioners (GDPs) in the borough.

Dr Hickey's Surgery reports that the majority of their patients use local mainstream dentists within the Victoria and Pimlico area however, with the NHS dental contract that is currently in operation, it is likely that many homeless people have difficulties registering with a general dental practitioner.

Based on the self-reported use from the Homeless Health Survey and comparing this to actual activity at Great Chapel Street Dentistry service, an estimated 287 homeless people are potentially accessing mainstream dental services.

12.4 Conclusion

Given the poor oral health experienced by homeless populations, the number of people accessing dental care is significantly lower than expected. Homeless people in Westminster report that they would like to access dental services and at the recent Health and Homeless Health Event, 56% of people reported that teeth were one of the most important health issues.

There is a clear need for dental care services for homeless people in Westminster; the current service, however, does not seem appropriate for the needs of the population for which it is commissioned, given the low numbers of people turning up for appointments. Given the success of drop in services, engagement and compliance with dental services may be improved by offering dental treatment on a drop in basis. Qualitative work with people may help identify some of the barriers to accessing dental services within the borough and thus inform future service development.

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. Models of care such as that provided by the specialist podiatry service should be explored to improve dental health promotion, improve access to the Great Chapel Street Dental Service, encourage re-attendance and generally engage with the people for whom the service is commissioned.

A number of qualitative surveys suggest that homeless populations view oral health and dental treatment as key to improving their overall health and well-being. There is some evidence to suggest that the impact missing teeth extends beyond that of health; social inclusion and participation as an active member of society may also be limited as a result of the cosmetic impact of having missing teeth.

Other areas of further work may also look at preventative approaches and not focus solely on intervention based methods; for example information pertaining to how often homeless people brush their teeth, do they have access to toothbrushes and appropriate toothpastes, would be beneficial as these may be barriers to good oral health that can be easily addressed with health promotion interventions and potentially be delivered in non-dental settings.

13: Lifestyle factors

Key Messages:

- **Smoking is common in homeless people and they smoke heavily;**
- **Homeless people report wanting to quit, but smoking is the least likely of all the addictions to be addressed by specialist services;**
- **It is thought that the use of mainstream smoking cessation services is low;**
- **Homeless people do not eat healthily but the majority would like to;**
- **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;**
- **Training is needed for homeless people to develop cooking skills, budget for food on limited incomes and learn about nutrition.**

The lifestyle choices that people make can influence their health for better or for worse and are a major contributor to the health inequalities experienced by homeless people in Westminster. There are many reasons why people make different lifestyle choices; factors include differences in the choices available, access to health services and material resources.

13.1 Smoking

Smoking is the principle cause of preventable illness and death in the UK; most die from one of the three main diseases associated with smoking – chronic obstructive pulmonary disease, coronary heart disease and cancer.

In addition to the significant health costs associated with smoking, smoking can have significant financial costs for those that smoke. Smoking 20 cigarettes a day costs approximately £1,600 a year and, therefore, smoking can account for a large proportion of financial expenditure in populations that already experience significant financial hardship.

13.1.1 Prevalence of smoking amongst homeless people in Westminster

Smoking rates among homeless people are much higher than in the general population; this is because the routes by which people become homeless are also associated with smoking. For example, unemployment, leaving school without qualifications, being in care and childhood poverty, both increase the likelihood of becoming homeless and are associated with higher smoking rates (Crosier, 2004).

Smoking amongst homeless people may also be viewed as a means of social interaction; offering and sharing cigarettes may help overcome social barriers and help build relationships with other homeless people.

According to recent research, 90% of rough sleepers and 68% of hostel residents smoke (Gill *et al*, 1996). In the Homeless Health Survey, 70% of rough sleepers and 85% of hostel residents reported smoking. This is significantly higher than the 26% of adults in the adult population in England that reported smoking in the Health Survey for England 2006 (Craig & Mindell, 2008). Accordingly, there are likely to be between 1,694 and 1,716 smokers amongst Westminster's homeless population.

Homeless people are more likely to smoke than the general population, evidence suggests that homeless people are:

- more likely to take up smoking and less likely to quit
- more likely to be exposed to second hand smoke
- smoke cigarettes with higher levels of tar
- smoke hand rolled tobacco
- smoke cigarettes without a filter
- inhale more deeply
- leave a shorter stub
- smoke cigarette butts from discarded cigarettes which spreads infection (Crosier, 2004).

As a result, people that are homeless and smoke are likely to be more nicotine dependent than smokers in the general population and, therefore, at increased risk of smoking related diseases such as chronic obstructive pulmonary disease. Furthermore, heavy drinkers have significantly more tobacco-related oral problems such as oral and face cancers; this is because alcohol is thought to act as an alkaline base which interacts with carcinogens in cigarettes, amplifying their effects.

13.1.2 Quitting smoking

NHS Westminster has a target to decrease the level of smoking in the adult population to 10% or less by 2012.

Anecdotal evidence suggests that the proportion of homeless people who want to quit smoking is similar to the proportion of all smokers that want to quit, however, they find it harder to do so. Dr Hickey's surgery has reported a recent surge in interest in quitting smoking, particularly amongst former drug and alcohol users who are now 'addicted to abstinence'.

Despite the well documented health effects and the high prevalence of smoking amongst homeless people, smoking is the least likely of all of the addictions to be tackled in a homeless health setting. This is particularly the case for those people who have mental health problems and/or substance misuse problems where the prevalence of excessive smoking is likely to be highest (Hinton *et al*, 2001). Other health and housing problems are often viewed as more pressing, particularly by services, and so smoking cessation is often not seen as a priority.

Mainstream stop smoking services in Westminster are available from community pharmacists, GPs, community based teams and in local hospitals. Although there are no stop smoking services delivered specifically in settings such as day centres and hostels, there is likely to be some health promotion and smoking cessation activity, although information pertaining to this is limited.

A recent health equity audit found that Westminster's smoking cessation service was equitable and reaching those people most at need (NHS Westminster, 2006); however, the use of smoking cessation services by homeless people was not specifically addressed. Given the large volume of evidence describing the poor engagement with health services by homeless people and the fact that the majority of homeless people have other health and social problems that they view as a priority, the use of main stream smoking cessation services in Westminster by homeless people is likely to be low.

In a recent review of smoking, homelessness and health, the Health Development Agency (Crosier, 2004) recognised four major actions needed to help homeless people who smoke quit:

- recognition that smoking is a major cause of ill health
- making smoking cessation services more accessible
- offering a smoke free environment
- providing resources for those who want to quit.

A range of initiatives to help homeless smokers quit smoking are in place across the country and include designated smoke free areas within hostels, smoking cessation groups run at daycentres and improved information and communication related to the different smoking cessation aids available.

13.1.3 Conclusions on smoking

People who are homeless are much more likely to smoke than the general population, however, many homeless smokers want to quit. Although homeless people have access to mainstream smoking cessation services there are currently no specific NHS Westminster smoking cessation services delivered to homeless people in Westminster. A more innovative approach is needed to engage with smokers who want to quit and whom have difficulties accessing mainstream health services. This may include delivering smoking cessation services in convenient and easily accessible locations and times, as well as improving access to information about what different stop smoking services are available.

13.2 Healthy Eating

13.2.1 Association between homelessness, healthy eating and nutrition

Diet and nutrition is strongly associated with health and well-being and is key to maintaining a healthy weight and good health. Poor nutrition is recognised as a cause of morbidity and mortality; diets that are high in fat, sugar and salt and low in fruit, vegetables and fibre are associated with increased risk of heart disease, stroke and some cancers.

People that are homeless are more likely than the general population to be malnourished and less likely to have a healthy, balanced diet; this is because homeless people experience barriers to healthy eating, including low income, lack of accessible and accurate information on what constitutes a healthy diet, poor accessibility to affordable healthy foods and lack of opportunity to develop cooking skills (including poor literacy skills and reduced access to well equipped kitchens).

Accordingly, the problems associated with limited food intake and poor nutritional content of foods consumed are compounded by malabsorption due to the compromised health status of homeless people.

Malnutrition is, therefore, common amongst homeless people – this is characterised by low body weight, muscle wastage and signs of vitamin and mineral deficiency such as skin lesions, prolonged wound healing and bleeding gums. Often these symptoms are not recognised as associated with malnutrition, but more commonly viewed as signs of excessive and prolonged substance misuse.

Research conducted amongst homeless people in inner London boroughs found that hostels were the main providers of food to homeless people, with supplementary food either bought or provided by daycentres.

In addition to the barriers to healthy eating and good nutrition described, a number of factors contribute to the poor nutritional status of homeless populations, including substance misuse, blood-borne viruses, TB and mental health problems.

Drugs and alcohol

Addiction and prolonged and heavy use of drugs and alcohol are associated with both reduced appetite and as a result of organ damage, bleeding, vomiting and diarrhoea, the malabsorption of foods. Damage from heavy, long-term alcohol use is extensive; alcohol contains empty calories and so nutrient intake is poor – this is combined with changes in urine excretion, vomiting, diarrhoea and intestinal bleeding.

Additional problems that are common amongst people that misuse drugs and alcohol include:

- constipation – this is associated with opiate use and a low fibre diet
- anorexia – this is associated with opiate and stimulant use as well as mental health problems
- low body weight, poor nutritional reserves and impaired immune system – these are a result of prolonged inadequate nutrition associated with chaotic lifestyles, multi-drug use, poor nutritional knowledge and lack of skills.

Blood-borne viruses and TB

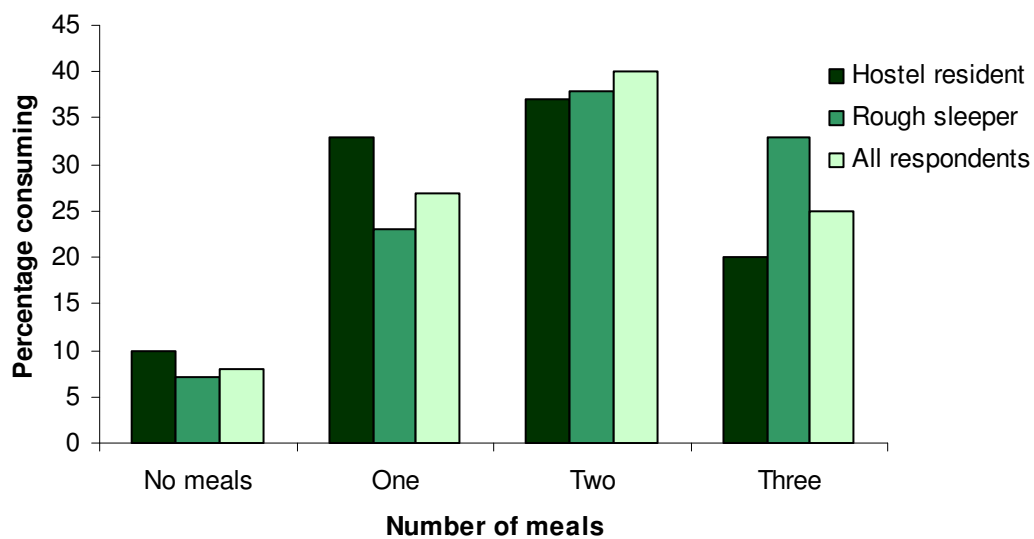
Infection with blood-borne viruses and TB can also affect the nutritional status of people; a number of factors contribute to this, including:

- reduced food intake through loss of appetite, gastro-intestinal symptoms and oral infections
- altered metabolic requirements creating an increased need for nutrients to maintain body weight
- malabsorption.

13.2.2 Healthy eating amongst Westminster's homeless population

The Homeless Health Survey asked a question about what meals the respondents had eaten the day before the survey to try and elucidate what quantity of food homeless people in Westminster were consuming. 10% of respondents reported not eating breakfast, lunch or dinner, whilst 20% of hostel residents and 34% of rough sleepers reported eating three meals a day.

Figure 13.1: Number of meals consumed in the previous day



78% of people reported eating at least one portion of fruit and vegetables the previous day; this is lower than the proportion who reported eating at least one portion of fruit and vegetables in England (91%). Rough sleepers were more likely than hostel residents to report eating at least one portion of fruit and vegetables with 83% and 76% respectively reporting eating at least one portion the previous day.

The Government recommendation for the consumption of fruit and vegetables is five portions of fruit and vegetables a day. Overall 16% of respondents reported consuming five or more portions the day before, with 21% of rough sleepers and 15% of hostels residents consuming five or more portions. This is lower than the proportion of people nationally meeting the Government recommendation; in the most recent Health Survey for England, 29% of people reported consuming five or more portions of fruit and vegetables a day.

Homeless people eat less healthily than the general population, with hostel residents more likely to eat no meals or just one meal a day and consume fewer portions of fruit and vegetables than rough sleepers. Reasons respondents quoted for not eating healthily included:

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

Overall, 73% of people reported wanting to eat well with the majority highlighting the role of day centres in supporting healthy eating and providing healthy food as well as learning to enjoy food and having an established routine.

13.2.3 Conclusions on healthy eating

Homeless people experience significant barriers to eating healthily; however, the majority of people would like to eat more healthily. The majority of homeless people access food via day centres or hostels and, therefore, both daycentres and hostels play a significant role in supporting change and providing nutritional meals.

Currently little is known about the nutritional value of meals provided by daycentres and hostels in Westminster; further information is required regarding food provision in hostels and daycentres to inform any interventions delivered in the hostel and daycentre environment.

In addition to improving access to fresh fruit and vegetables and balanced meals, further work should explore how innovative methods can be used to improve the nutrition of homeless people and help people develop skills to enable them to prepare and cook meals for themselves (for example cooking classes and provision of cooking equipment).

Any approach to nutrition requires a balanced approach, considering the tension between ensuring that people are adequately nourished without

encouraging dependency. Inner London research highlighted the need for clear support pathways to enable clients to successfully move into self-catering accommodation, with people demonstrating evidence of cooking skills as a pre-cursor to moving on. Interventions should include training in all of the skills required to successfully cook including budgeting, translating menus into shopping lists, sequential processing, menu planning and cooking skills.

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.

14: Emerging Trends

Key Messages:

- **The proportion of rough sleepers of UK nationality contacted is decreasing, whilst the proportion from A10 countries is increasing;**
- **Consequently the health and social care needs of homeless people in Westminster may change;**
- **Westminster is starting to see health problems in people aged 30-50 who have lived on the street that would be expected in people much older;**
- **The number of people with chronic illness will rise, increasing the need for palliative care for homeless people;**
- **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.**

This needs assessment has provided a detailed overview of the current health status and health needs of homeless people in Westminster. However, when planning future services, commissioners and providers need to take into account likely demographic trends as well as consider the changing health and well-being needs of people and the evolving commissioning climate of the NHS.

14.1 Demographic trends

The number of rough sleepers seen by outreach or BBS's has been relatively stable in recently years, however between 2007/08 and 2008/09 there was an increase of 248 rough sleepers met on the street.

In recent years the proportion of rough sleepers contacted of UK nationality has decreased from 67% in 2005/06 to 59% in 2008/09. The proportion of non-UK rough sleepers contacted has increased, especially A10 nationalities.

Table 14.1: Trends in the nationality of rough sleepers contacted in Westminster

Nationality	2005/06	2006/07	2007/08	2008/09
UK	67%	60%	59%	59%
A8 & A10	7%	14%	12%	15%

In 2005/06 rough sleepers from A10 countries represented 7% of rough sleepers contacted in Westminster; this rose to 15% in 2008/09. This rise may also be linked to an increase in the number of rough sleepers who are people with no recourse to public funds.

Future services plans should, therefore take into account the likely future increases in the number of rough sleepers from outside the UK, particularly A10 countries as well as people with no recourse to public funds. As a result of the increasing proportion of rough sleepers originating from A10 and other countries, there may be a shift in patterns of substance misuse such as problematic drinking becoming more prevalent.

14.2 Health and social care trends

As a result of recent increases in the availability and success of drug treatment and harm reduction programmes, fewer problematic drug users are dying from drug-related causes such as overdose. Consequently problematic drug users are living for longer. The increased life expectancy of problematic drug users means that there are an increasing number of problematic drug users with long-term health problems associated with both a history of substance misuse and homelessness.

Furthermore, there are some people who are not currently engaged or interested in engaging with treatment programmes. Because of their resistance to current treatment programmes, these people lack the support needed to stabilise their drug and/or alcohol use and consequently experience poor health and well-being. As a result Westminster is starting to see health problems in people aged 30-50 who have lived on the street that would be expected in people much older.

Long term substance misuse is likely to have significant implications for accommodating people experiencing poor health as a result of long-term substance misuse. Already a small number of people have been moved to costly long-term social care provision due to alcohol related cognitive brain impairment. This is a need which may increase in the future. Furthermore, there is likely to be an increased need for domiciliary care.

The number of homeless people with a history of problematic drug use and/or a history of smoking is likely to increase. Consequently the number of people experiencing tobacco related harm as a result of long-term tobacco use is likely to increase. Accordingly the number of people with tobacco related illnesses such as COPD, cancer, blindness and cardiovascular disease will rise, increasing the need for palliative care for homeless people.

14.3 National Drug Treatment

The National Drug Treatment Monitoring System (NDTMS) is the only recognised reporting system on substance misuse. It is, therefore, vital to ensure completeness and compliance in order to benchmark and evidence Westminster's treatment outcomes. As NDTMS is a national system, the definitions and codes are generic. This can result in some of the fields lacking the level of detail needed to evidence commissioning decisions, resulting in the DAAT sourcing this data through other means, for example the contrast between the NDTMS broad definition of housing problem and the eligibility for homelessness services.

Funding for treatment services in Westminster is primarily made up of PCT funding and the National Treatment Agency's Pooled Treatment Budget (PTB) allocation. The methodology used to calculate PTB allocation has been amended and is now based on the 'caseload complexity of the local treatment population; the mix of cases of problem and other drug users and area cost differential' in a move to equalise allocations nationally. While there are three components to the funding, the reality is that 75% relates to the number of people in effective treatment. Therefore, not only getting drug users in treatment but also retaining them is of paramount importance. For a client to

be deemed to be in effective treatment they have to be retained in treatment for 12 weeks or be discharged prior to this opiate and crack cocaine free.

In September 2010 Westminster will be launching a new treatment system with north and south integrated services which aims to increase the accessibility and capacity of services as well as addressing the current discrepancy between Drug and Alcohol funding. Within the new system it is vital that Westminster ensures that PDUs and those with high dependency are prioritised, in order to secure future funding arrangements and maximise outcomes to people and the wider community.

In April 2009 the NTA amended the discharge codes to ensure that client outcomes are more clearly defined. While this enables greater clarity this change means that clients can no longer 'complete treatment' and be deemed as a successful discharge should they continue to misuse any opiates or crack cocaine. Therefore, whilst Westminster will always encourage abstinence as a care plan goal, when working with highly chaotic clients whose misuse is entrenched, it is not always the residents desired outcome. 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. The client may seek support in reducing the frequency of use, changing the route of drug use (e.g. injecting or smoking) and/or the amounts of substances being used. Those clients who achieve this outcome, but fail to become abstinent, will no longer be reflected as a favourable outcome for Westminster.

In summary, the homeless population are a specific cohort; anecdotally it is known that their substance misuse is more chaotic than securely housed residents and the needs they present with are often far more complex. The NDTMS, whilst a useful tool for performance and trend monitoring, lacks much of the detail needed to evidence commissioning decisions for this cohort.

14.4 The Commissioning climate

The NHS is moving towards delivering better healthcare closer to home - this includes the establishment of GP led health centres and polyclinics.

Additionally there are condition specific developments such as improving access to psychological therapies (IAPT). It is essential that the Homeless Health Commissioner develops working links with other commissioners to ensure that the needs of homeless people are considered in future mainstream service provision and that the commissioning of specialist homeless health services are considered in the context of wider developments.

The economic climate of the NHS is also changing. In recent years of economic growth there have been rising levels of funding, however, given the wider financial context cost savings are likely to be needed. As a result delivering specialist homeless health services in Westminster will be challenging, highlighting the need for efficient services.

Because of such efficiency drives, evidence of effectiveness in the form of performance monitoring data is essential. However, the ability of homelessness services to evidence their effectiveness is compromised by the type and quality of data collected. This will be a significant challenge for commissioners and services in the next two years.

Mainstream data collection does not capture main activity and impact, and accordingly this is something that will need to be addressed in order to meet the challenge of restricted NHS funding in the next 5 years. Specialist homelessness services are extremely expensive in comparison to other primary care services, however, in comparison to A&E and acute care provides a more relevant understanding of the costs to the NHS in terms of inadequate responses to the health needs of the homeless community.

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Appendix A: Rough Sleeping Strategy Health Priority Actions

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

Accident and Emergency Care

Key Targets and Actions

Year 1:

- 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.

Year 1, 2 and 3:

- 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

Our objectives

- To increase the number of problematic drug users in effective treatment.
- To reduce the number of A&E alcohol related hospital admissions.
- To improve education, training and employment opportunities for all service users along the drug and alcohol treatment pathway.

Key Targets and Actions

Year 1:

- 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

Year 1:

- 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.

Year 2:

- Review the needs of people who require primary care mental health services and 'Improve Access to Psychological Therapies' (IAPT).

Appendix B: Specialist homeless primary care services in Westminster

Homeless Health Team: The Homeless Health Team is a nurse-led team delivering satellite primary care health services in the three day services that are part of the BBS Partnership. The temporarily register patients, and have also have sessional GPs that deliver GP sessions

		The Passage	West London Mission	Connections @ St Martins
Monday	nurse	9-2	9-1.15	9-2 nurse session
	GP	9-10.30	12.30-1.30	
Tuesday	nurse	9-2	9-1.15	9-2 nurse session
	GP		12.30-1.30	10-11.30 GP session
Wednesday	nurse	9-2	9-1.15	9-2 nurse session
	GP	9-10.30	10-11.30	10-11.30 GP session
Thursday	nurse	9-2	9-1.15	9-2 nurse session
	GP		12.30-1.30 GP session	10-11.30 GP session
Friday	nurse	9-2	9-1.15 nurse session	9-2 nurse session
	GP	9-10.30	12.30-1.30 GP session	

Dr Hickey Surgery: Unlike mainstream general practices which serve residents in a specific geographical area, Dr Hickey Surgery is a specialist GP practice, which provides primary care to the homeless community in Westminster. As well as providing mainstream care, permanent registration, and is well-experience in responding to the health needs of rough-sleepers, the practice is also a significant clinician in the management of substance misuse. Doctor and nurse sessions are run every weekday morning and afternoon, except Wednesday afternoon, when in-reach primary care into 4 local hostels is available

Great Chapel Street Medical Centre: Great Chapel Street Medical Centre is another surgery which is exclusively for the use of people who have experienced homelessness. Great Chapel Street does not prescribe opiate substitution therapy and can only temporarily register patients. Doctor and nurse sessions are run every weekday morning and afternoon, except

Wednesday and Friday mornings. The practice also houses the special needs dentist and additional mental health interventions.