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Rough sleepers: health and healthcare

A review of the health needs and healthcare costs of rough sleepers in the London boroughs of Hammersmith and Fulham, Kensington and Chelsea, and Westminster

Summary

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Authors

The lead authors are Colin Brodie, Sarah Carter and Gayan Perera for Inner North West London PCTs (Hammersmith and Fulham, Kensington and Chelsea, and Westminster), and Jane Jones from Broadway for the qualitative research.

Supporting authors are Jamila Aboulhab, Sinan Rabee and Simon Young for Inner North West London PCTs.

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About Broadway

Broadway's mission is to support, challenge and inspire homeless people as they make their journey from the streets to a home, going straight to the causes of homelessness, tackling poverty, ill health, unemployment and the chronic lack of housing. Its vision is that every person finds and keeps a home. You can find out more about Broadway on the website, at www.broadwaylondon.org.

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Foreword

There are nearly 3,500 people recorded as sleeping rough in our inner London boroughs of Hammersmith and Fulham, Kensington and Chelsea, and Westminster. Other than the fact that they have no homes, they are no different to anyone else living in our boroughs and they rely on our NHS health services to provide care and treatment when they need it; to work with other agencies to ensure they can continue to live well and to support them to lead healthy lives.

This report makes clear, with evidence, that the health of homeless people is important for us not only as GPs and commissioners of healthcare, looking to get the best quality and most affordable outcomes, but as members of a caring society which values people's lives. Furthermore, it shows that there is a case to be made for changing the way we do things in primary and secondary care, and in partnership with other organisations – in particular our local authorities.

The qualitative report, in itself, is a powerful read for all of us who work to commission and provide healthcare – GPs, hospital doctors, nurses, other healthcare professionals, practice managers and receptionists. The insight from rough sleepers, and from healthcare and other professionals on the ground, is compelling in so much as it reveals that we need to lead cultural and systemic shifts to remove the barriers to good health for rough sleepers, posed by both structural and individual factors.

We cannot ignore the needs of homeless people: and we haven't. The health and wellbeing of rough sleepers is part of our commissioning strategies, and the findings in this report will help us turn strategy into reality. The cost to homeless people's health and wellbeing, and to the health service, is too high not to take action.

Dr Ruth O'Hare

Chair, Central London Clinical Commissioning Group

Dr Tim Spicer

Chair, Hammersmith and Fulham Clinical Commissioning Group

Dr Mark Sweeney

Chair, West London Clinical Commissioning Group

Executive summary

The purpose of this research is to inform future decision-making by contributing to the evidence base for rough sleepers in inner London. A review was undertaken in Hammersmith and Fulham, Kensington & Chelsea, and Westminster, which describes rough sleepers health needs and usage, evaluates the cost of healthcare, identifies existing models of service delivery, and summarises the evidence for interventions targeting rough sleepers.

Local data shows that there are 3450 rough sleepers in inner North West London. 933 of those were matched with an NHS number and, through an anonymous data matching process, their interactions with the health service have been analysed.

The information summarised in this report has been gathered through an analysis of healthcare data, a literature review, and qualitative research with homeless people and healthcare professionals undertaken by the homelessness charity Broadway. Each piece of research, along with its methodology, is set out as an annex to this report. All references used in this summary have been chosen as part of the literature review methodology outlined in the annex document.

Key findings from the report are:

Rough sleepers use more secondary health services, and therefore cost more. National estimates show that the homeless population consumes about four times more acute hospital services than the general population, costing at least £85m per year. The 933 rough sleepers analysed in inner North West London used secondary care at a cost of £2.4 million. Rough sleepers access A&E seven times more than the general population, and are more likely to be admitted to hospital as emergencies, which costs four times more than elective inpatients.

Rough sleepers have more health needs. When rough sleepers attend hospital, they average seven A&E attendances per patient, nearly 10 appointments per patient for outpatients, and nearly three inpatient admissions per patient. They also present with more co-morbidity – one in five who had contact with hospitals had three or more diseases.

There are specific barriers to accessing services for rough sleepers. Rough sleepers face a number of attitudinal and structural barriers to accessing healthcare. These include discrimination by health professionals, not being allowed to register with a GP, a lack of knowledge of services, a lack of continuity of care, and cost. Fear of stigmatisation and health as a low priority are also significant barriers.

But there are things that can be done. Interventions and models of care have been developed, and are being used, to provide a better system of care for rough sleepers.

The report provides evidence to commissioners about rough sleeper health needs and health service use in order that they can make decisions and design services that not only improve the health of homeless people, but do so in a way that can reduce both financial and resource pressures on the health system – in particular A&E services.

In inner North West London, it is clear from the evidence produced in this report and its annexes that there is a case for developing a model of care, working with local authorities and third sector organisations, to ensure better health outcomes for rough sleepers through better coordination of services, sharing information about pathways and services available, removing barriers where there need not be any, reaching out to rough sleepers and taking healthcare to where they are, promoting health and wellbeing, and leading a change in cultural attitudes towards homeless people.

This report focuses on the health needs of current and former rough sleepers. Current rough sleepers stay on the streets or in other locations such as in doorways, stairwells, parks or on night buses. Recent rough sleepers are often accommodated in hostels and supported housing for homeless people, where they are still considered to be homeless. Rough sleepers are a specific group of homeless people which does not include hidden homeless people such as sofa surfers and squatters or statutory homeless groups such as families in temporary accommodation. However as this definition is not always used by other organisations or in other research the terms 'rough sleeper' and 'homeless' are largely used interchangeably.

1: Rough sleepers: health and healthcare

Summary

- Rough sleepers experience stark health inequalities – rough sleepers' life expectancy is 30 years shorter than the average population.
- Rough sleeping is associated with tri-morbidity, complex health needs and premature death.
- They face barriers to accessing health services and don't use them when and where they are needed.
- Hospital discharge is often not managed well and rough sleepers leave hospital without the support they need.
- Secondary healthcare costs at least five times more for rough sleepers than the general population.

A home is not just about having a roof over your head, it provides roots, identity, a sense of belonging and a place of emotional wellbeing. Homelessness is about the loss of all of these, and after years of declining trends, 2010 marked the turning point when all forms of homelessness began to rise[1].

There are many complex factors which may make people vulnerable to homelessness, including emotional or physical trauma in childhood, poor relationships within the family, unemployment, a lack of education and qualifications, substance misuse, mental illness, debt and poverty, or institutionalisation[2,3].

Dave's decline into homelessness and substance misuse all began when he split up with his partner:

> *'I had this nice flat in Richmond, had a relationship thing and decided to go away for a while [...] and when I came back I thought I'd have the flat, but I didn't have the flat and then I was staying with friends and stuff and from then, you don't want to lean on your friends too much do you? So I ended up being homeless, and heroin helps though: that's great that stuff, take that: yay I'm homeless!'*

Under the Health and Social Care Act 2012, Clinical Commissioning Groups and Local Authorities, alongside the NHS Commissioning Board and Public Health England, have a duty to have regard to the need to reduce inequalities between the people of England. As rough sleepers experience substantial health inequalities, local commissioners will need to work together to ensure that their health and social care needs are being addressed as effectively as possible.

1.1 How many rough sleepers are there?

Homelessness is a particular issue in London where half of England's rough sleepers are located.

According to the CHAIN database, 5,678 people slept rough at some point in London during 2011/12, an increase of 43 per cent on the previous year's total of 3975[1]. 3450 of these were identified as sleeping rough in the inner North West London area – Hammersmith and Fulham, Kensington and Chelsea, and Westminster.

About the CHAIN database

The CHAIN (Combined Homelessness and Information Network) database is commissioned and funded by the Greater London Authority and managed by Broadway. It records information about contacts and work done with rough sleepers and members of the wider street population in London. Outreach teams, hostels, day centres and a range of other homelessness services across London access and update the system.

1.2 The health needs of rough sleepers

Homeless people experience poorer levels of general physical and mental health than the general population, and there is a substantial evidence base documenting multiple morbidities and complex health needs.

The life expectancy for rough sleepers is 30 years shorter than the average population in the United Kingdom[4,5].

Rough sleeping is associated with tri-morbidity (the combination of physical ill-health with mental illness and drug or alcohol misuse), complex health needs and premature death[6,7]. National research identifies the most common health needs of homeless people as drug dependence, alcohol dependence, mental ill-health, and dual diagnosis[3].

George explained how his poor physical health impacted upon his mental health and substance misuse. He had been prescribed oxycodeine by his GP as pain relief for a trapped nerve in his back and recalls:

> *'I was crying with it (the pain), like getting so depressed [...] I told my doctor, I said, look I've found myself now buying heroin which I've never been on in my life, to smoke in a roll up 'cause it's the same as the tablets.'*

Many homeless people die from treatable medical conditions: HIV, liver and other gastro-intestinal disease, respiratory disease, acute and chronic consequence of drug and alcohol dependence. This is backed up by the local quantitative research carried out.

The following are the most commonly associated conditions for homeless people[3,4,6,7]:

- drug dependence and associated adverse effects
- alcohol dependency and associated adverse effects

- mental ill-health, including people with personality disorders
- physical trauma
- infections, including hepatitis B & C and HIV/sexually transmitted infections
- inflammatory skin conditions
- skin infestations
- respiratory illness (including asthma)
- disability
- learning difficulties

Sleep deprivation also affects people's mental health. Chris, who suffers with depression, described how the difficulty of getting a good sleep takes its toll on his mental health and makes him become irritable and aggressive:

'I'm lucky if I get 3 to 4 hours of sleep a night. Like I say, I go to the park through the day, if it's a good day like this, but if it's raining you go to the library: you sit there trying to read a book and before long you start (snoring) and they say you can't sleep in here. You go to a railway station, a train station, and it's the same, you get the police- come on you can't sleep here: out! They chase you out if they see you sleeping. [...] If I don't get a decent sleep, if somebody says the wrong word to me I'm snapping at them: I'm like a wee ankle-nipper.'

The most common health needs of rough sleepers

- drug dependence
- alcohol dependence
- mental ill health
- dual diagnosis

1.3 The barriers for rough sleepers accessing health services

Homeless people have identified a number of barriers to accessing services[9]. These can include discrimination by health professionals, a lack of continuity of care, problems accessing drug and alcohol services, lack of knowledge of services, and cost. Fear of stigmatisation and health as a low priority are also significant barriers[8,9].

'They [homeless people] tend to look at us [professionals] in the same way we look at them. They tend to have the same negative views of us as hostile towards them, which is very sad and it's not necessarily true, [...] but it does happen, so if they perceive hostility or an unreceptive response they can become hostile and the whole situation escalates.'

- Nurse

'I had one doctor, when I was living at (hostel) and I went over there because I was really depressed and I sat down and he went: No, I don't give out pills. But I didn't ask for pills! And he went: You are from that hostel across the road aren't you?'

- Former rough sleeper

Language and culture can be a barrier. There is evidence that an increasing proportion of rough sleepers in London are from Central and Eastern European countries, and recent research at a specialist clinic for asylum seekers and refugees found that 91 out of 112 patients (81%) were homeless and presented with a range of complex needs[7,10].

'I think there's another group of rough sleepers, who everybody kind of knows is out there, but is turning a blind eye to because they actually shouldn't be in London, but they are: they're undocumented migrants, or they're Eastern Europeans. [...] There's a whole wadge of people that the system is blind to, so they get sick, so they end up in hospital.'

- Healthcare professional

Barriers to accessing healthcare as reported by rough sleepers

Not seeking help for health needs

- Neglecting health as a form of self-harm
- Health not seen as a priority
- Not accepting diagnosis e.g. some people with a personality disorder

Communication and understanding of the system

- Difficulty communicating health needs
- Poor engagement and communication skills
- Lack of understanding of the system

Stigma

- Experience of stigma and discrimination from health professionals
- Gender discrimination

Fear

- Fear and denial of ill-health
- Fear of officials and clinical settings

Negative perceptions and experiences

- A belief from healthcare workers that the rough sleeper can't be treated (especially amongst people with personality disorders)
- Previous negative experiences of healthcare
- Negative perceptions of health services
- Embarrassment and low self esteem

There are organisational and administrative barriers such as inflexible appointment systems or the mistaken assumption on the part of the GP practice that there is a need for an address to register with a GP.

'Some reception staff aren't adequately trained on who is eligible for healthcare and how to... I mean the NHS doesn't have any clear guidelines on who is eligible for healthcare or not... and also the guidance on what people need to register. [...] Many patients that we register say I had a nightmare- I went to this surgery they asked me for this- I've just moved into the area, I don't have any bills in my name etc.'

- Healthcare professional

In addition, there can be lack of coordination between organisations, or departments within organisations, or simply attempts to pass a homeless person off for some else to deal with. A hospital worker cited the case of a young man in a wheelchair who had been sleeping rough and whose health had significantly deteriorated as a result:

'He'd been to (the borough) council a few times, but basically they said that it was a disability problem so he went to social services. Social services were saying we can't do anything for him until he's housed- yes- we're happy to take him on, but if he doesn't have any housing, we can't provide any care.'

Structural barriers to accessing health services

Rough sleepers refused access to services

- Being turned away through lack of a local connection to the area
- Not being allowed to register with a GP because of no proof of identity
- Inflexible registration and appointment systems
- Lack of access to information and referrals
- Not allowed to access drug and alcohol treatment

Lack of co-ordination between services

- Dual diagnosis and co-existing substance misuse problems
- Differing mental health services with different criteria
- Lack of continuity of care

Additional costs

- Cost of travelling to healthcare or following discharge
- Costs of clothing if they have had to be destroyed during treatment or if wet/soiled

For more detailed explanation of these points please refer to the qualitative research annex

1.4 Issues identified with discharge and move on from services for rough sleepers

'I said "what have I got to do, cut myself in front of you?" She said "basically, yes, for us to keep you here that's what you would have to do." It was terrible.'

- Rough sleeper on discharge from mental health unit

If a homeless person finds themselves admitted to hospital there are further factors to consider for their recovery and health and wellbeing once they leave. Discharge planning following a hospital admission is vital to ensure that homeless people are not discharged back onto the streets or to inappropriate accommodation, and to ensure that they continue to receive the care that they need and reduce further readmissions[11].

Issues with discharge

The qualitative research identified hospital discharge as a significant problem for rough sleepers

- early discharge before the patient felt their health needs had been met
- discharge without housing needs being addressed
- failure to communicate effectively with the relevant agencies prior to/ upon discharge
- discharged without clothing or transport.

2: The healthcare utilisation and costs of rough sleepers

Summary

- Secondary healthcare costs are at least five times more for rough sleepers than the general population
- They access A&E seven times more than the general population
- They are more likely to be admitted to hospital as emergencies which costs four times more than elective inpatients
- They are four times more likely to attend outpatient health appointments(with DNA's removed) compared with general population
- They stay in hospital twice as long as the general population
- They have more co-morbidity. One in five rough sleepers who had contact with hospitals had three or more diseases
- Their healthcare usage increases over time
- Hospital usage is highest among 30-49 year old men and cost significantly higher than the general population
- Most rough sleepers had clinical conditions related to mental health, trauma and orthopaedics, digestive system and ophthalmology
- Nearly half of those rough sleepers who attended to hospitals have attended all three (outpatient, inpatient and A&E) hospital services

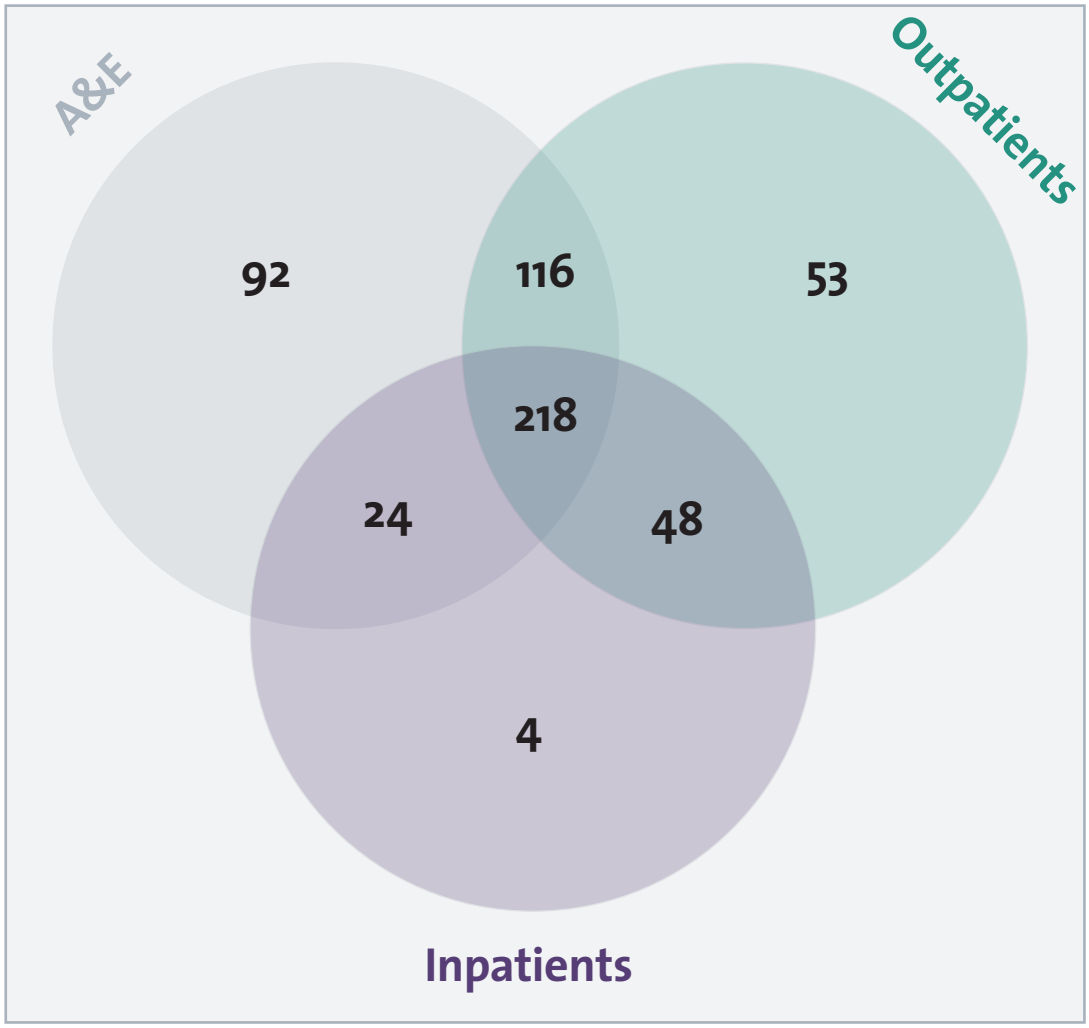
Rough sleepers are less likely to access primary care than the general population and, instead, turn to secondary care through A&E. Out of those rough sleepers that were matched by the CHAIN database with NHS numbers within Hammersmith and Fulham, Kensington and Chelsea, and Westminster, 933 patients (27%) of that rough sleeper population had registered with a GP in the boroughs.

From national estimates the homeless population consumes about four times more acute hospital services than the general population, costing at least £85m per year[12]. For inpatient costs this rises to approximately eight times the general population.

Figure 1, shows a Venn diagram of service use by rough sleepers (for whom the NHS number is known) and shows that a large proportion of users engaged in all three

services. It is worth noting that 395 patients with known NHS numbers do not fit this diagram and therefore look as though they did not use any secondary health services within the study period. However, because rough sleepers may use alternative names and identities we cannot assume that they did not use the services.

Figure 1: Venn diagram of services used by matched rough sleepers



For those rough sleepers who attended hospital services, the average A&E attendances per patient was seven. There was an average of nearly 10 appointments per patient for outpatients, and nearly three inpatient admissions per patient. Out of 933 rough sleepers who were registered with a GP, nearly 50% attended A&E, 50% had outpatient appointments, and one in three had inpatient admissions. The total cost for A&E, inpatient and outpatient hospital services for those 933 rough sleepers was £ 2.34 million. Figure 2 shows the hospital use by rough sleeper community in inner North West London for A&E services, inpatient and outpatients services.

When data from January 2010 to June 2012 were reviewed, the A &E attendance rate among rough sleepers was seven times higher than the rate for the general population. When stratified by age bands, the attendance rate is significantly higher for rough sleepers in all the age bands compared with the general population. However, the gap in older age groups is smaller between rough sleepers and general population. This could be due to better survival among the general population and low life expectancy among rough sleepers.

Figure 3 graphically represents the difference in attendance rates among rough sleepers and the general population. For most rough sleepers the rate of attendance is between 3-7 fold higher than for the general population. The difference in rates between rough sleeper groups and the general population were highest among 30-59 age groups. The smallest difference in rates between the rough sleeper group and the general population group was seen in the 80 years and over age group.

Figure 2: Total cost of services for rough sleeping population, split by hospital service, January 2010 and June 2012 (for matched rough sleepers)

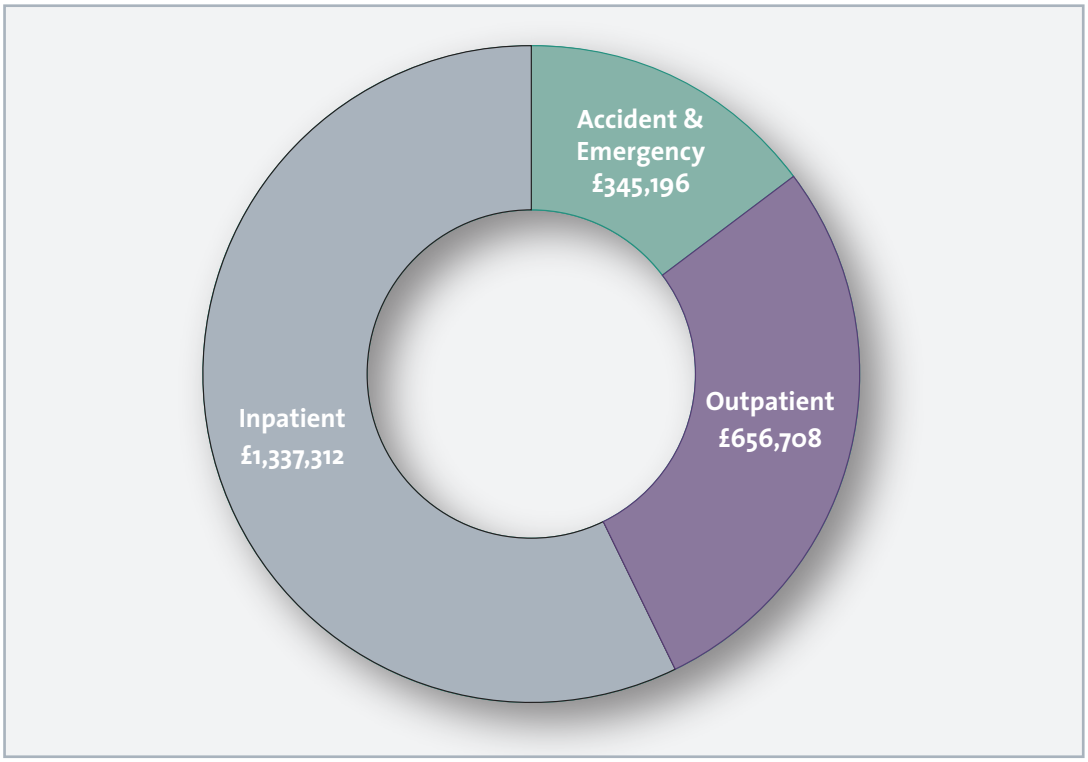


Figure 3: Rate of A&E attendances for matched rough sleepers and general INWL population, from January 2010 to June 2012 (by age)

Figures 4 and 5 show the numbers of rough sleepers with outpatient appointments, and the rates per 1,000 population by gender. Generally, when analysed by age and gender, all rough sleeper population groups have high rates of outpatient appointments compared with the general population. The general pattern was for the rate of patients who had outpatient hospital appointments to increase with age, with some exceptions, notably the under 20 age group.

Figure 4: Rate of rough sleeper patients who had outpatient appointments for matched female rough sleepers, by age, January 2010 to June 2012

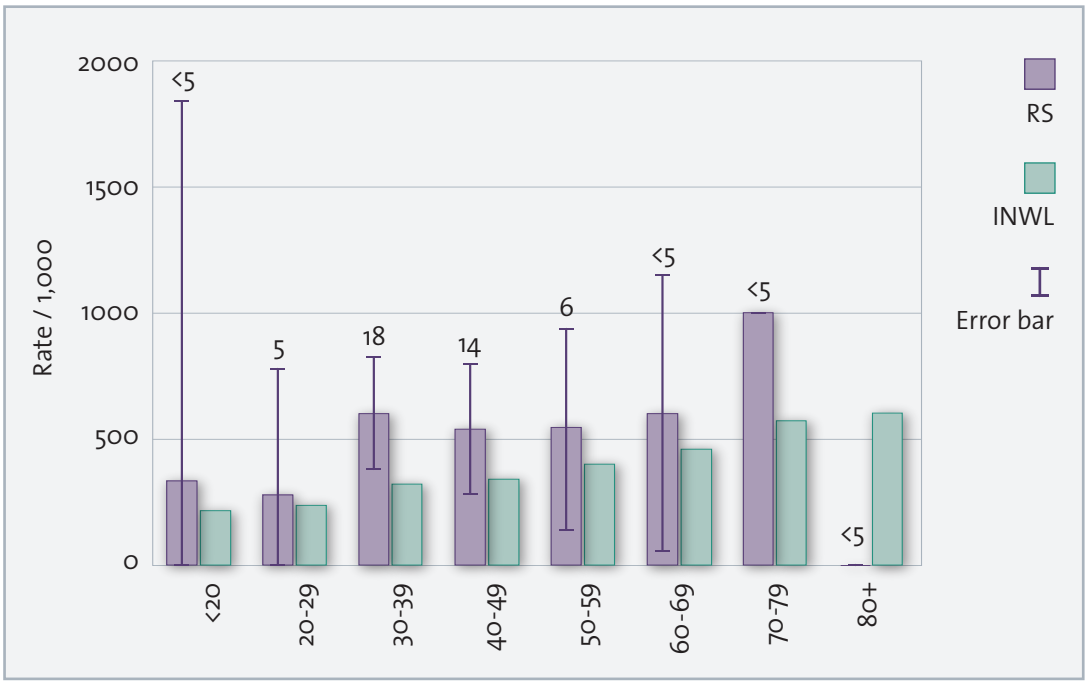


Figure 5: Number and rate of rough sleeper patients who had outpatient appointments for matched male rough sleepers, by age, January 2010 to June 2012

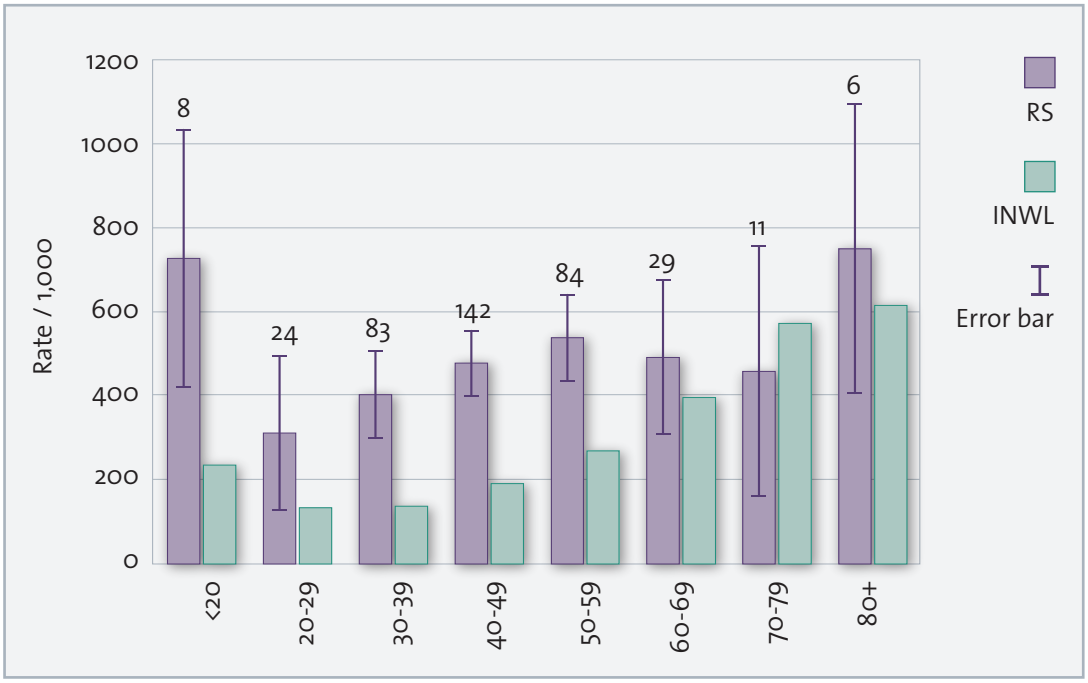


Figure 6 describes 'did not attend' (DNA) outpatient appointments. The rate for those patients who did not attend hospital outpatient appointments was 1,043 per 1,000 rough sleepers while 'did not attend' (DNA) rates in the general population were 160 per 1,000 INWL population. This shows nearly seven times higher DNA rates among the rough sleepers, compared with the general population.

Figure 6: Rate of outpatient appointments by matched rough sleepers and general population, by attendance, January 2010 to June 2012 (number of RS above bar)

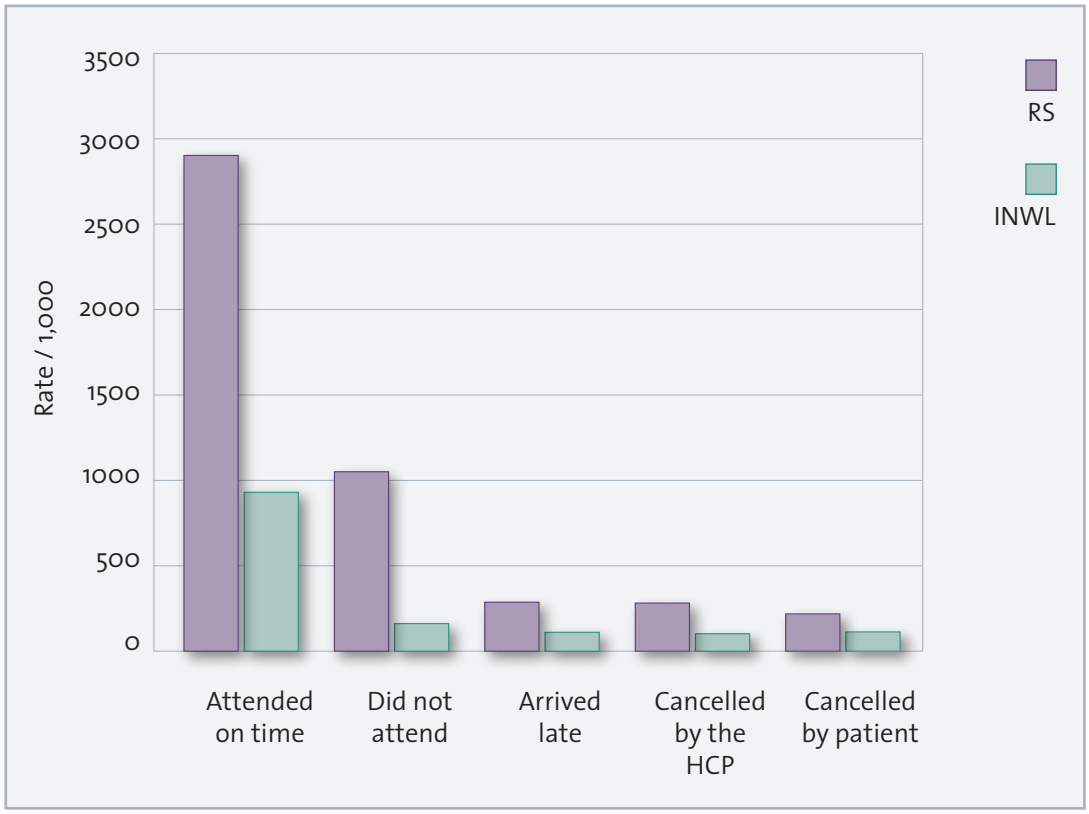


Table 1 shows the number of outpatient appointments for rough sleepers by treatment function specialty. The main reason for outpatient appointments for these patients was mental illnesses (1163 appointments). Furthermore, a high number of trauma and orthopaedics, hepatology and ophthalmology related outpatient appointments were observed for this group of patients.

Table 1: Top 20 outpatient appointments per patient for matched rough sleepers, by treatment function specialty, January 2010 to June 2012

Treatment function Specialty	Number of patients	Number of outpatient attendances	Appointments per patient
TRAUMA & ORTHOPAEDICS	88	321	3.6
ADULT MENTAL ILLNESS	79	1163	14.7
GENERAL SURGERY	59	187	3.2
HEPATOLOGY	48	204	4.3
OPHTHALMOLOGY	40	213	5.3
PLASTIC SURGERY	37	118	3.2
RESPIRATORY MEDICINE	34	130	3.8
UROLOGY	32	107	3.3

DERMATOLOGY	31	125	4
PHYSIOTHERAPY	20	120	6
RHEUMATOLOGY	15	85	5.7
VASCULAR SURGERY	13	108	8.3
GYNAECOLOGY	13	69	5.3
ENDOCRINOLOGY	11	46	4.2
OCCUPATIONAL THERAPY	10	50	5
CLINICAL HAEMATOLOGY	8	75	9.4
CHILD and ADOLESCENT PSYCHIATRY	8	38	4.8
OLD AGE PSYCHIATRY	7	53	7.6
DIABETIC MEDICINE	6	39	6.5
OBSTETRICS	6	27	4.5

Figures 7 and 8 show the numbers and rates per 1,000 population of rough sleeper patients, by age and gender, for patients that had admissions. The 294 rough sleepers who were admitted accounted for 802 hospital admissions during the period of January 2010 to June 2012. The number of rough sleepers admitted to hospitals was lower than the general population among patients in the over 60 age groups. The number of rough sleepers admitted to hospital is high among women aged 20-59 years, compared with the general population of women.

Figure 7: Rate of patients admitted to hospital for matched female rough sleepers and general female population, by age, January 2010 to June 2012 (numbers of RS above bar)

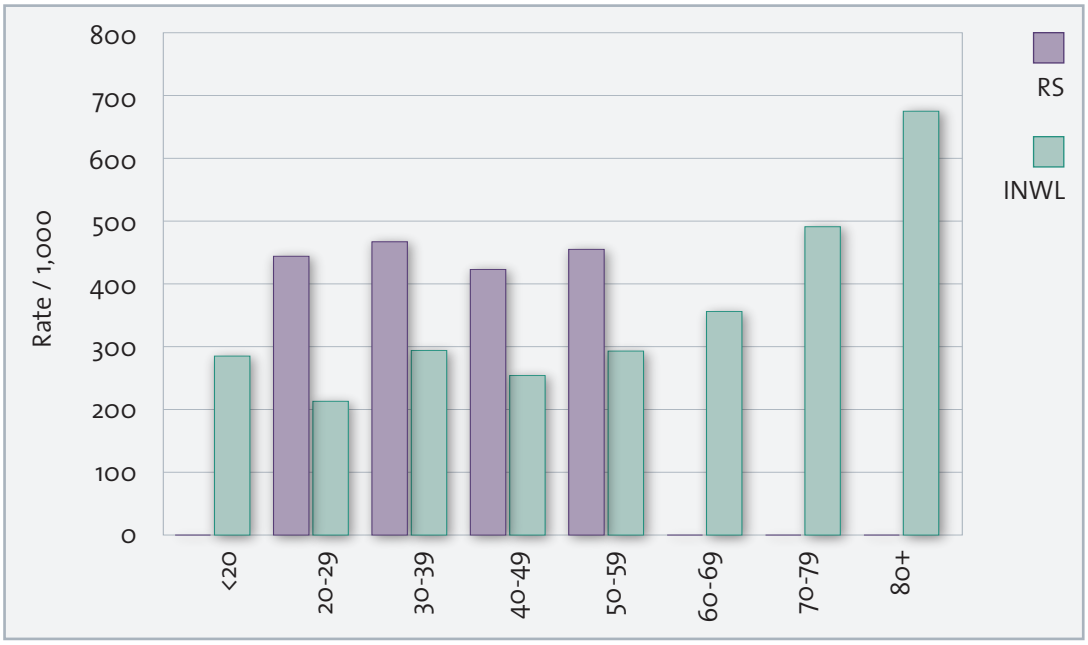


Figure 8: Rate of patients admitted to hospital for matched male rough sleeper and general male population, by age, January 2010 to June 2012 (numbers of RS above bar)

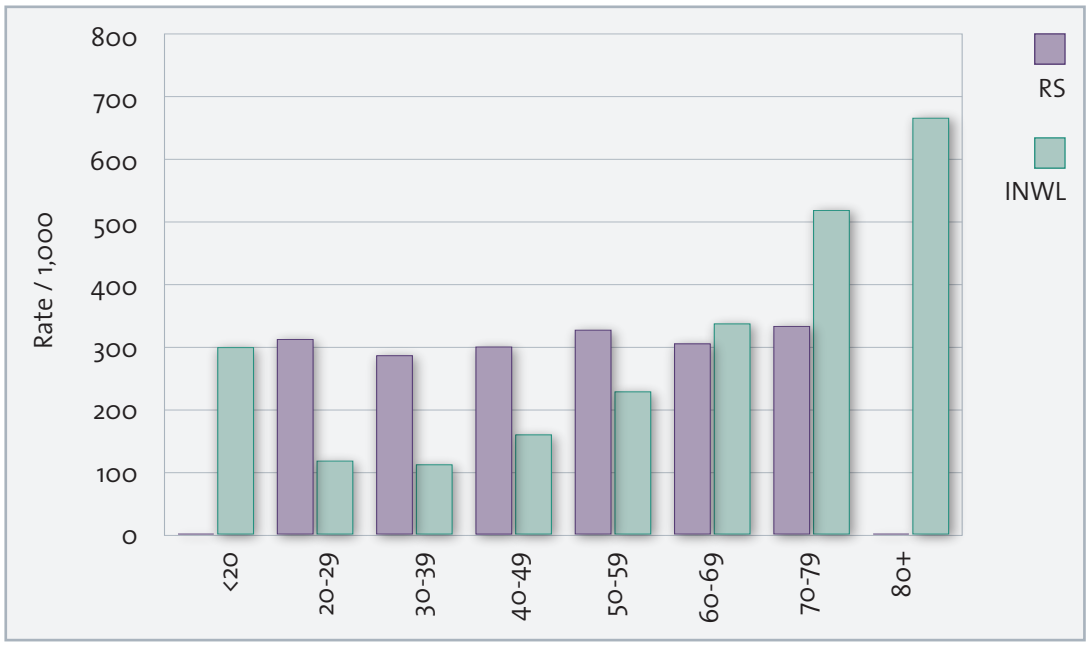


Table 2 shows the numbers and rates of hospital admissions per 1,000 population by method of admission (elective or emergency), for rough sleepers and the general INWL population. There were a high number of emergency and low number of elective admissions for rough sleeper population when compared with the general population, for whom the opposite is true. The ideal is for care to be planned (ie elective) as far as possible; managed elective care being less expensive than an emergency admission.

Table 2: Hospital admissions for rough sleepers and INWL general population, January 2010 to June 2012 (aggregated), by admission method (summary of table 17)

Admission Method	Rates of admissions per 1000 rough sleepers per year	Rates of admissions per 1000 INWL general population per year
Elective	61	111
Emergency	163	47

Table 3 shows the number of hospital admissions of rough sleepers by ICD-10 primary diagnosis chapter. The three commonest diagnosis chapters were mental and behavioural disorders (this includes alcohol and drug related admissions), injury, poisoning, and certain other external causes and unclassified signs and symptoms.

Table 3: Number of hospital admissions for matched rough sleepers, by ICD-10 primary diagnosis chapter, January 2010 to June 2012

Primary diagnosis chapter	Admissions	Patients	Admissions per patient
Mental and behavioural disorders	159	42	4
Injury, poisoning and certain other external causes	136	59	2
Symptoms and signs not elsewhere classified	104	36	3
Diseases of the digestive system	96	40	2
Diseases of the skin	52	20	3
Diseases of the musculoskeletal system	41	18	2
Diseases of the respiratory system	39	16	2
Diseases of the nervous system	32	10	3
Diseases of the circulatory system	32	15	2
Cancers	14	*	*
Diseases of the eye	14	7	2
Benign neoplasms or diseases of the blood	13	*	*
External causes	13	8	2
Diseases of the genitourinary system	9	*	*
Pregnancy, childbirth and the puerperium	8	5	2
Infectious and parasitic diseases	7	*	*

The length of stay for rough sleepers was slightly longer than for the general population. Table 4 shows that the average length of stay for rough sleepers was around 5.8 days, while the average length of stay for the general population was 2.8 days.

Table 4: Length of stay for matched rough sleepers and general population, January 2010 to June 2012

Length of stay	Proportions for rough sleepers	Proportions for general population
<1	51.2%	62.4%
1 day	14.1%	13.8%
2 days	7.5%	6.6%
3-4 days	10.8%	6.5%
5-7 days	7.5%	4.1%
8- 14 days	5.6%	3.4%
15- 30 days	3.3%	2.1%
Over 30 days	0.0%	1.1%

Table 5 shows that of the 933 rough sleepers, 294 patients were admitted to hospital. Out of those admitted from January 2010 to June 2012, 57.5% were admitted with one ICD-10 diagnosis chapter while 23.8% were admitted with two ICD-10 chapters recorded (compared with 18.6% in general population). 18.7% of rough sleeper patients admitted to hospital had three or more types of disease (compared with 7.9% of the general INWL population).

Table 5: Co-morbidities amongst matched rough sleepers and the general population, January 2010 to June 2012

Hospital admissions with co-morbidities, 2010 - 2011	Rough sleepers	General population
Admitted with only one ICD-10 disease category	57.5%	73.5%
Admitted with two ICD-10 disease category	23.8%	18.6%
Admitted with three + ICD-10 disease category	18.7%	7.9%

3: Improving healthcare for rough sleepers

Summary

- Greater access to health services needs to be enabled, supporting rough sleepers in accessing services, reduce barriers, and bringing services to rough sleepers.
- Commissioners need to work across agencies and with other commissioners to develop models of care for rough sleepers, working across professional and clinical boundaries.

3.1 Reducing barriers to accessing healthcare

As identified in the qualitative study, there are examples of practice which could enhance access to health services and improve health outcomes:

- health services removing barriers to access and enhancing patient experiences
- using homelessness support services to enhance access to health services
- taking services to where homeless people are
- services coming together to improve joint working

In primary care, rough sleepers can face barriers to registering with their local GP, but this doesn't have to be the case. A doctor for the homeless explains his surgery's approach to registering new patients:

> *'You are entitled, as a GP to require people to demonstrate their identity. The law is silent and the regulations are pretty silent as to how you do that. [...] As far as we're concerned, people are who they say they are, unless we have reason to think differently, and if you are standing here right in front of me and you say you're NFA [no fixed abode], then you are NFA in Westminster.'*

And despite being a mainstream practice, the manager of another medical centre takes a similar approach:

> *'We don't ask for proof of address: I just don't see the need for it. Why would someone come and tell you they live somewhere when they don't? It's unnecessary, and also passports and things like that. I think: we're not the immigration service, we're the health service. [...] Our job is to provide healthcare to people and we want to make that as accessible as possible.'*

Homelessness support services could be used to promote a wide spread campaign with rough sleepers to encourage them to register with a GP.

Health services can remove barriers to access and enhance patient experiences by taking the service to homeless people using outreach programmes, hostel in reach, and bringing services into day centres. As one Westminster based GP said:

> *'We need to be as concerned with the people who do not attend the service as the people who do, cause often the ones who are not attending us have the greater need.'*

Both targeted homelessness services and generic health providers can enhance access to their services, and improve health outcomes, by developing their knowledge of service pathways and working together.

Examples of practice that can support rough sleepers to access appropriate health services

Enabling access

- Specialist homeless GPs
- GPs registering people without the need for proof of identity
- Local accommodation projects which have a health focus
- Accompaniment to appointments, eg Groundswell peer health advocates
- Open referral system to secondary healthcare, eg UCL Pathway team

Bringing services to the patient

- Day centres where health services are brought in
- Outreach e.g. outreach team that are accompanied by a mental health social worker and in nurses from GP practices going out with the homeless outreach teams
- Hostel in-reach
- One stop shops, eg a supported accommodation projects offering regular 'health MOT' sessions

Working across service and organisational boundaries

- Find and treat tuberculosis services
- Dual diagnosis outreach worker

3.2 Developing effective interventions

Overall there is a lack of good quality research, particularly randomised controlled trials (RCTs), involving homeless people. However, the literature review did identify evidence for a number of interventions that are effective in tackling the health needs of homeless people. Key findings from the literature review are summarised in the table below.

Mental illness	There is some evidence to support assertive outreach programmes and case management[3,13,14]. Personality disorders - there is no evidence for interventions specifically targeting homeless people BUT the broader evidence base suggests: ▶ Insufficient evidence for either psychological or pharmacological treatments for antisocial personality disorder[15,16]. ▶ Some evidence for psychotherapies for borderline personality disorder although the evidence base is weak. The strongest evidence is for Dialectical Behaviour Therapy[17].
Substance misuse	Services that pursue harm reduction or minimisation engage most effectively[18]. Case management usually results in better health outcomes than usual care[16]. There is evidence that housing is effective in reducing substance misuse, relapses and associated health service use[19]. Drug dependence – there is evidence for safe opiate medication substitute prescribing, medically supervised injecting centres, hepatitis A, B and tetanus immunization, safer injecting advice; and access to needle exchange programmes[3]. Alcohol dependence – there is evidence for support programmes to aid personal motivation[3]. Community matron models may reduce acute service demand among alcoholic homeless clients and improve quality of life[8]. Dual diagnosis – there is no evidence for interventions specifically targeting homeless people BUT the broader evidence base suggests there is strong evidence for an integrated approach which combines both mental health and substance abuse treatments. This may include pharmacological treatment, intensive case management, motivational interviewing, individual and group psychotherapy and family participation[20,21,22,23].
Infectious disease	There is evidence for vaccination schedules, needle exchange programmes, medically supervised injecting centres, washing and laundry facilities, podiatry interventions, insecticide for bedding in shelters[3].
Sexual health	There is limited evidence to inform targeted health promotion interventions, although informal programmes to promote sexual health can lead to lasting health gain[24]. There is evidence to support case management for homeless people with HIV[21].

Brain injury	There is no evidence for interventions specifically targeting homeless population BUT the broader evidence base suggests[26]: ▶ Those with mild brain injury make a good recovery with provision of appropriate information. ▶ For moderate to severe injury there is strong evidence of benefit from multidisciplinary rehabilitation. More intensive programmes are associated with earlier functional gains, and outpatient therapy could help to sustain early gains.
Housing	There is some evidence that housing should be provided as part of an integrated model[21]. Housing is particularly important for safe discharge from hospital.

3.3 Models of service delivery

'Particularly in London [...] the system has set itself up in this... adversarial approach, in which the name of the game is to find reasons why this person isn't our responsibility [...] The system rewards turning people away. Any system which is soft and accepts patients which aren't strictly its responsibility, risks being overwhelmed.'

- Healthcare professional

Healthcare services can operate within rigid boundaries – geographical, cultural, organisational, systemic – and therefore risk excluding homeless people from accessing the healthcare and support they require.

Models of care have been developed to remove those boundaries in order to provide a better system of care for rough sleepers. A selection of these models were identified in the literature and are described below.

The Department of Health described four models of care for specialist homelessness healthcare[14]:

1 Mainstream practices providing services for homeless

A GP from a mainstream practice holds regular sessions for homeless people in a drop-in centre or sees them in his/her own surgery. May not register patients and no 24/7 provision.

2 Outreach team of specialist homelessness nurses

An outreach team of specialist nurses provide advocacy and support, dress wounds etc and refer to other health services including dedicated GP clinics. Unlikely to register patients and no 24/7 provision.

3 Full primary care specialist homelessness team

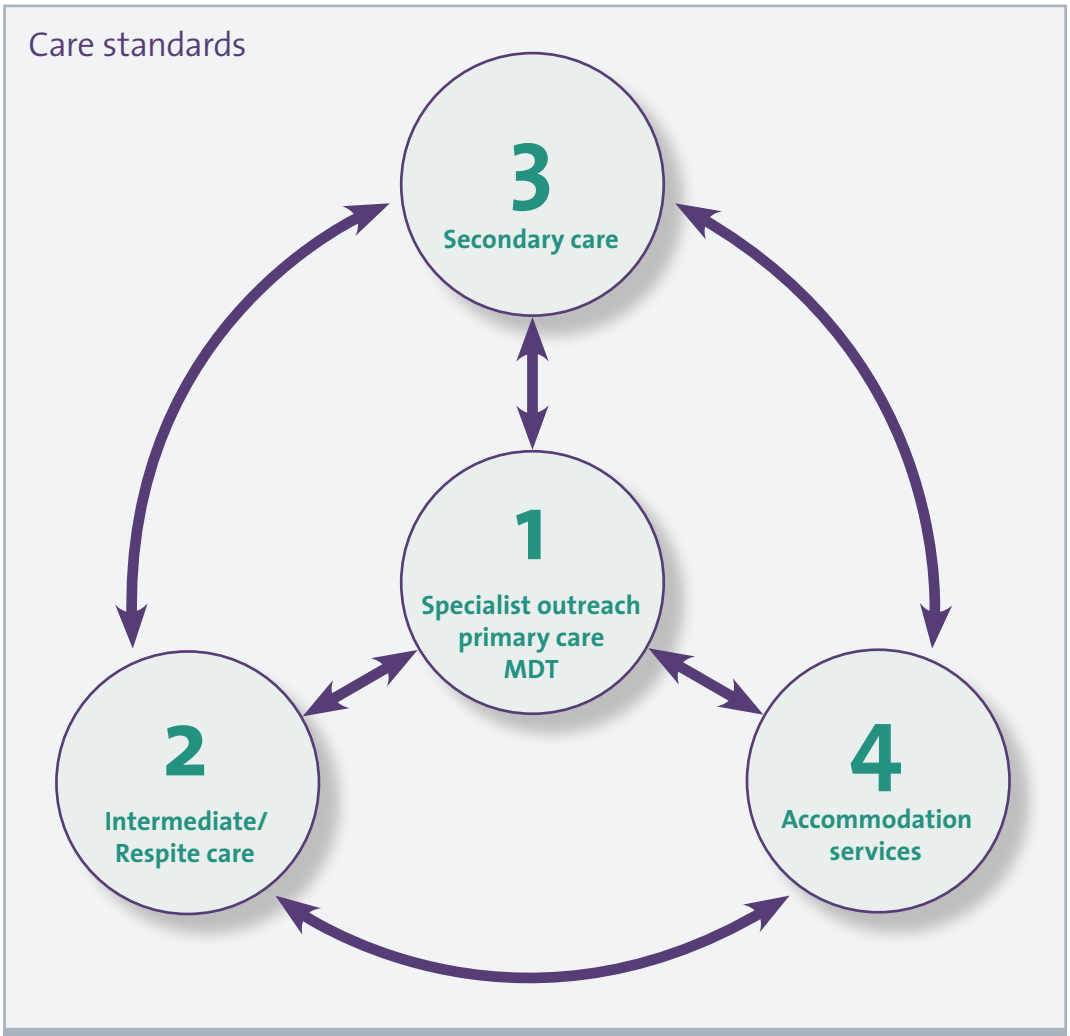
A team of specialist GPs, nurses and other services (CPN, podiatry, substance misuse specialists) provide dedicated and specialist care. Co-located with a hostel / drop-in centre. Usually register patients and provide 24/7 cover.

4 Fully-coordinated primary and secondary care

A team of specialists spanning primary and secondary care provide an integrated service including: specialist primary care, out-of-reach services, intermediate care beds and in-reach services to acute beds.

Models 1 and 2 are appropriate for all localities with homeless populations. Model 3 is a full primary care specialist homelessness team which can tailor the service to meet health needs and overcome access issues. Model 4 is a fully integrated model.

The integrated approach is recommended in the London Pathway, a model developed for rough sleepers in secondary care[2].



Key

1 Primary care led multidisciplinary team (MDT) providing service linkage and case management. MDT case management requires a named patient advocate to assess needs and ensure access to a package of care by linking health, housing, social care and voluntary sector provided services.

2 Intermediate/respite health and social care to:

a) avert unnecessary secondary care admission

b) prevent inappropriate hospital discharge and emergency re-admission

c) organise onward care and resettlement

3 Inpatient and outpatient care.

4 Statutory and third sector residential support services.

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Notes