

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

Annex

February 2013

Authors:

Literature review

Colin Brodie

Data analysis

Gayan Perera, Sinan Rabee

Qualitative research

Jane Jones, Broadway



Part 1: Literature review

1. About this review	7
2. Introduction	9
3. Health needs of homeless people	11
4. Use of services by homeless people	13
5. Cost of healthcare	15
6. Effectiveness of interventions and service delivery	16
7. Models of delivery	23
Appendix	27

Part 2: Data analysis

Introduction	34
Background	34
Comparison of total CHAIN population and those patients matched with NHS data	35
Summary of NHS cost and activity for rough sleepers in INWL, using matched NHS data	40
A&E data analysis	44
Outpatient data analysis	52
Inpatient hospital admissions analysis	60
Conclusion	72
Source information	73

Part 3: Qualitative research

Executive summary	75
1. Introduction and methodology	80
2. The health needs of current and former rough sleepers in Inner North West London	81
3. Barriers to accessing health services	91
4. Enabling access and getting the most out of services	112
5. Discharge and move-on from services	134
6. Final reflections	144

PART ONE

Literature review

Colin Brodie

1. About this review

This literature review is intended to support the report “Rough sleepers: health and healthcare”, a health needs assessment of homeless people living in inner London, sponsored by the Department of Health and undertaken by the Public Health Intelligence team at NHS North West London (Hammersmith & Fulham, Kensington and Chelsea, and Westminster) in collaboration with Broadway, the London based homelessness charity.

1.1. Scope

This literature review is intended to be a rapid summary of the best available research evidence and as such should not be seen to take the place of a full systematic review. The review draws on the following categories of material:

1. evidence summaries and reviews
2. primary research literature
3. key policy documents and grey literature

1.2. Key questions

The remit for the literature review was to identify research and grey literature relevant to the objectives of the study, and are arranged under the following headings:

1. Health needs of homeless people
2. Use of services by homeless people
3. Cost of healthcare
4. Effectiveness of interventions and service delivery
5. Models of delivery

Clearly the health needs assessment process will address these objectives in detail, but the purpose of this review is to identify what the literature can tell us.

1.3. Methodology

The literature review will not be a systematic review, but will follow a robust process and provide a summary and synthesis of the key evidence on the topic.

For sources searched and search strategies please see the appendix. Papers were selected for inclusion or exclusion according to the criteria below.

Inclusion criteria	Research literature with a focus on: <ul style="list-style-type: none">▶ the healthcare needs of homeless people▶ population and demographics of the homeless population▶ use of healthcare services by homeless people▶ healthcare service costs and cost effectiveness▶ effectiveness of interventions and services aimed at homeless clients▶ models of service delivery for homeless people The review will largely be limited to UK research, but will include reviews of the international literature.
	Evidence published since 2002 (last 10 years). Earlier evidence may be incorporated when included in evidence summaries.
	English language only.

1.4 Quality assessment

The articles and grey literature cited in this review have not been fully critically appraised. The full text of the studies listed in this review have not all been accessed and in some cases summaries have been taken from either abstracts or from the narrative reviews. The studies chosen for this review have been chosen by a single reviewer. Commissioners are advised to read the primary research.

2. Introduction

Homeless people experience poorer levels of general physical and mental health than the general population, and there is a substantial international evidence base which documents multiple morbidities^{1,2,3,4}. Research largely finds the average age of death of a homeless person as between 40-42 years of age^{2,4,5} with the life expectancy for 'rough sleepers' 40.5 years compared to the UK national average of 74 for men and 79 for women⁶. Crisis identified the average age of death for homeless people in England as 47 compared to 77 for the general population⁷.

Chronic homelessness is also an associated marker for tri-morbidity, complex health needs and premature death^{2,4}. Tri-morbidity is the combination of physical ill-health with mental ill-health and drug or alcohol misuse. Many homeless people die from treatable medical conditions, HIV, liver and other gastro-intestinal disease, respiratory disease, and consequences of drug and alcohol dependence.

Homelessness is a particular issue in London with half of England's rough sleepers located in London and over a third of no fixed abode hospital admissions occurring in the NHS London area. During 2009/2010 there were 47,093 people using Supporting People funded hostel places in England, and rough sleeping in London increased by 30% over the five years to 2009/10⁵. There is evidence that an increasing proportion of rough sleepers in London are from Central and Eastern European countries⁴. 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 needs⁸.

The causes for homelessness are complex and multi-factorial, including significant emotional and /or physical trauma in childhood, poor familial relationships, unemployment, lack of qualifications, substance misuse, mental health illness, debt and poverty, or institutionalisation^{3,5}.

Research by Professor Barry McCormick, has shown that homeless people attend A&E six times as often as the housed population, are admitted four times as often and stay three times as long⁹. A homeless drug user admitted to hospital is seven times more likely to die over the next five years than a housed drug user admitted with the same medical problem⁵.

This literature highlights a number of issues concerning research with the homeless population, particularly around research into effective interventions:

- ▶ There is a lack of good quality studies.
- ▶ Studies have small sample sizes, and therefore lack statistical power.
- ▶ Follow-up is a problem and so procedures for tracking participants is critical.
- ▶ The majority of controlled studies have focussed on mental health and substance misuse in single adults.
- ▶ There is a particular lack of studies on interventions for runaway youth and homeless families/children.
- ▶ Future researchers should consider the inclusion of usual care groups as a

control/comparison.

- ▶ Some interventions may be effective even though they have not been evaluated in homeless subjects.
- ▶ Health and social care policy interventions may have an impact on the health of this group, but these have rarely been evaluated in a controlled study.

The review is arranged into headings appropriate to the objectives of the needs assessment, although some themes have been developed according to the nature of the evidence identified during the review process.

3. Health needs of homeless people

Homeless people, particularly rough sleepers, have a higher rate of serious morbidity compared to the general population³. A national audit of the health and wellbeing of homeless people found that eight out of 10 clients had one or more physical health need and over half had a long term need (56% compared to 29% in the general population)¹. Seven out of 10 clients had one or more mental health need, a rate over twice as great as the general population, and over half the clients used one or more type of drug. The audit also highlighted the high rate of smoking among homeless clients, and the poor diets many have.

Wright and Tompkins report the most common health needs of homeless people as drug dependence, alcohol dependence or mental ill-health, and dual diagnosis³. Polydrug use is common, smoking prevalence can be as high as 80%, and active tuberculosis is reported to be between 1.6-6.8%. There is also a high prevalence of sexually transmitted diseases (including HIV). Homeless people are nine times more likely to commit suicide, three times more likely to die as a result of a traffic accident, and twice as likely to suffer from infections⁷.

Below is a summary of the range of health problems experienced by homeless populations, as described by the authors:

Diseases found among homeless people:

1. drug dependence syndrome
2. alcohol dependency syndrome
3. mental ill-health, including personality disorders and suicidal behaviour
4. physical trauma, including injury, foot trauma and dental caries
5. adverse effects of illicit drugs, including heroin related death, alcohol misuse, and psychosocial ill-health
6. complications of injecting illicit drugs, including blood borne infections and tetanus
7. infections, including hepatitis B & C and HIV
8. inflammatory skin conditions
9. skin infestations, including scabies
10. respiratory illness, including pneumonia and influenza

John and Law categorise the health needs of homeless people as:

- ▶ Biological (eg trauma, infestation, foot problems, sexual health, infections, dental disease, emphysema and asthma, gastrointestinal reflux disease, dermatological conditions, cardiac disease).
- ▶ Psycho-social (eg mental health illness, self-harm, psychological stress, drug and alcohol misuse).
- ▶ Sexual health (eg safe sex behaviour, sexual abuse and exploitation, sex workers)¹⁰.

Hicyilmaz and Robinson cite a definition of multiple needs from the European Federation National Organisations Working with the Homeless, where homeless people have at least three of the following:

1. physical health problem
2. mental health problem
3. substance misuse problem
4. vulnerability because of age
5. personality disorder
6. offending behaviour (previous contact with criminal justice system)
7. borderline learning difficulties
8. disability
9. challenging behaviour¹¹

A service evaluation of a homeless intermediate care pilot project found the following rates of morbidity among the 34 homeless clients included in the project¹².

Condition	Prevalence
HIV	23.5%
Past hepatitis B	34%
Past or active hepatitis C	84%
Drug dependency	83%
Alcohol dependency	74%
Mental health problems	87.5%
Documented past suicide attempt	71%
COPD/asthma	44%
Liver cirrhosis	45.5%
Past or Active tuberculosis	15.2%
Past or Active syphilis	11.8%

Common referrals made during the project were to liver services, HIV services, chest clinics, neurology, pain management, tissue viability, the local homeless community mental health team, psychology, dentistry, social work, occupational therapy, physiotherapy, palliative care and counselling services.

4. Use of services by homeless people

Homeless people present a high demand on acute NHS services with recent evidence that homeless people attend A&E six times as often as the housed population, are admitted four times as often and stay three times as long^{4,13}. Research by Homeless Link found that in the previous six months, four in 10 of the homeless people involved in its audit had been to A&E at least once and three in 10 had been admitted to hospital¹. Homeless people use hospital services at a disproportionate rate to the general population.

Homeless people face a range of barriers to accessing mainstream health services. These may be organisational and administrative barriers, such as inflexible appointment systems or the need for an address to register with a GP. There are also attitudinal barriers, such as discrimination by health professionals. Homeless people may also be reluctant to seek health care because of a fear of being stigmatized or because their own health is not their priority^{10,14}.

The Department of Health report *Inclusion health: improving primary care for socially excluded people* identifies a number of common barriers to access as displayed in the illustration overleaf⁹.

Common barriers to access



Barriers to accessing mainstream services are further described in *Healthcare for Single Homeless People*:

- ▶ Mainstream GP surgeries may require proof of address for registration.
- ▶ Homeless people generally have poor engagement skills and chaotic lifestyles which makes it difficult for them to book and keep appointments.
- ▶ Some will not seek assistance until their health is critical, as health needs are often surpassed by other, more immediate needs¹³.

Homeless people have identified a number of barriers to accessing services including stigma, discrimination (individual or organisational), no continuity of care, difficulty accessing drug and alcohol services, lack of knowledge of entitlement to services, and financial cost¹¹.

Despite a recognised high level of need for oral health care among homeless people, a survey of staff working in homeless dentistry in the UK found that service use was low and instead homeless people used A&E services¹⁵. There is some very limited evidence that a targeted dental service (a mixture of a fixed site and outreach clinics) may promote uptake of dental care among this population group¹⁶.

5. Cost of healthcare

The Department of Health Office of the Chief Analyst combined hospital episode statistics for those classified as no fixed abode, with data from six specialist homelessness GP practices, and found that the homeless population consumes about four times more acute hospital services than the general population, costing at least £85 million per year¹³.

It is clear that homeless people access services in an inefficient and costly way and that 'homelessness is more expensive to society than the costs of solving the problem'¹⁷.

There is very little evidence on the cost effectiveness of interventions or services delivered to homeless people. Only two UK studies analysing the cost of services for the homeless population were identified in the course of this literature review. A report on a pilot project for personalised budgets was also identified.

One study compared screening for tuberculosis among new entrants to the UK in three different settings: a hospital based clinic, general practice, and centres for the homeless¹⁸. Although not exclusively targeting homeless clients, this study found that costs for screening an individual in a homeless hostel was £13.17, compared to £1.26 (general practice) and £96.36 (hospital based clinic). The cost per person screened per case of tuberculosis prevented was £23.00 (homeless hostel) compared with £6.32 (general practice) and £10.00 (hospital based clinic). The authors conclude that screening for tuberculosis in primary care is feasible and could replace hospital screening of new arrivals for those registered with a GP.

In an economic evaluation of a homeless intermediate care pilot project, found that the number of hospital admissions to the hostel running the pilot had dropped 77% relative to 2008, and the number of accident and emergency (A&E) attendances had dropped 52%⁵². Hospital 'did not attends' (DNAs) were 22% lower. The secondary care usage data was compared with four other local hostels, which did not share this trend. There was also some evidence that health outcomes improved as a result of this nurse-led intermediate care pilot.

The cost benefit analysis found that the pilot was cost neutral. The cost of secondary care usage from the hostel was £168,000 in 2008, compared with £160,000 in 2009 incorporating the cost of reduced secondary care usage and the cost of the project. US evidence has shown that medical respite care can provide a reduction in hospital admissions and consequently cost savings^{20,21}.

A pilot project for personalised budgets for long-term rough sleepers cost £4,437 per person in the first year compared to £3,120 for standard outreach care²². However, many of this small group of entrenched rough sleepers had received outreach care previously without improving outcomes, and it was predicted that the participants would require less intensive support from the pilot project coordinator (the bulk of the cost) as time went on.

6. Effectiveness of interventions and service delivery

6.1 Overview

The paucity of trials involving homeless people is highlighted in a number of reviews, in particular the lack of good quality studies^{3,23,24}.

Despite this limited evidence base, Hwang et al identified some evidence that coordinated treatment programmes (case management) for homeless adults with mental illness or substance abuse usually resulted in better health outcomes than usual care, and concluded that healthcare for the homeless should be provided through such programmes where possible²⁴. Surprisingly, the authors found no evidence that supported or subsidised housing had a consistent effect on physical or mental health, or substance use.

Fitzpatrick-Lewis sought to update this earlier review, with an additional focus on the effect of interventions on housing status²³. The authors identified many of the same issues as Hwang et al with regard to the methodological quality of studies for homeless people, however, there was new evidence that provision of housing as an intervention can be effective for improving health as well as housing status²⁴. Provision of housing was associated with a decrease in substance use, in relapses from substance use, and in health service use, and increased housing tenure. The review reinforced the evidence for case management and, adding to the earlier review, reported that case management appears to be an effective intervention for homeless people with HIV.

The authors concluded that housing should be provided as part of an integrated model in which other supportive services are provided on site.

Wright and Tompkins examined the international literature and found:

- ▶ Effective interventions for drug dependence include oral opiate maintenance therapy, hepatitis A, B and tetanus immunisation, safer injecting advice, and access to needle exchange programmes.
- ▶ Some evidence for assertive outreach programmes for those with mental ill health.
- ▶ Evidence for supportive programmes to aid those with motivation to address alcohol dependence.
- ▶ Informal programmes to promote sexual health can lead to lasting health gain³.

There is some emerging evidence that personalised budgets can be an effective way of moving long-term and entrenched rough sleepers into accommodation²². The broader impact included greater engagement with services, improvements in physical and mental health, lifestyle, and a reduction in alcohol use.

6.2 Mental illness

There is some evidence that assertive community treatment programmes with active case management can lead to fewer inpatient days, fewer A&E visits, more days in community housing, more outpatient visits, and significantly greater improvements in symptoms, life satisfaction and perceived health status³. Similar findings for intensive case management are reported in systematic reviews^{23, 24}.

Coldwell and Bender found that assertive community treatment demonstrated a greater reduction in homelessness and a greater improvement in psychiatric symptom severity compared with standard case management treatments²⁵.

A briefing from the Mental Health Network highlights the issue of access to mental health services for homeless people²⁶. The network recommends improving staff awareness, delivering services differently, and effective joint working with partners as key solutions. The briefing also supports assertive outreach programmes, the psychologically informed environments approach to providing a therapeutic environment, and improving access to psychological therapies.

Killaspy found that those admitted to a designated ward for the homeless with mental illness showed a greater improvement in engagement compared to a control group after follow up. There was no difference in housing stability²⁷.

6.2.1 Personality disorders

There is evidence that personality disorders are highly prevalent in the homeless population and that this can result in them falling through the net of mental health and social care services^{28,29}. Research suggests that 60-70% of the homeless population meet the criteria for personality or post-traumatic stress disorders compared to 5-13% of the general population^{30,31}.

Although not specifically examining the homeless population, a number of Cochrane reviews have assessed the evidence for pharmacological and psychological interventions for a number of personality disorders.

Two of these reviews found insufficient evidence for either psychological or pharmacological interventions for antisocial personality disorder^{32,33}. There was some evidence that three psychological interventions (contingency management with standard maintenance; CBT with standard maintenance; 'Driving Whilst Intoxicated' programme plus incarceration) did have significant improvements on substance misuse outcomes³².

A Cochrane review found that pharmacological interventions yielded no promising results for the core symptoms for borderline personality disorder (BPD) – feelings of emptiness, identity disturbance and abandonment – and that total BPD severity was not significantly influenced by any drug³⁴. However, there were indications of some

beneficial effects with second-generation antipsychotics, mood stabilisers, and dietary supplementation by omega-3 fatty acids (although these are mostly based on single study effect estimates). Antidepressants may be helpful in the presence of comorbid conditions.

A similar review of psychosocial interventions reports some beneficial effects for both comprehensive psychotherapies (where there is a one to one interaction between professional and patient) as well as non-comprehensive psychotherapeutic interventions (where there is no one to one work) for BPD³⁵. The strongest evidence is for Dialectical Behaviour Therapy. However, again there is a lack of a robust evidence base.

A survey in Glasgow reported on the high value that service users placed on good relationships with staff, with contributing factors including substantial investment in services, sufficient time to work with people, knowledge of trauma and the causes of homelessness, and non-judgemental staff³⁶. The development of trauma services, including both counselling and non-counselling responses, should be a central part of an overall response to the needs of this group.

The authors also highlight the need for high levels of support during periods of transition, such as following a prison sentence or during a move to more independent accommodation.

6.3 Substance misuse

The relationship between homelessness and substance misuse is complex with strong evidence of a mutually reinforcing relationship between these two social problems (ie homelessness increases the risk of substance misuse, while entering into substance misuse also increases the risk of becoming homeless)³⁷. Recent research has tended to focus on all forms of substance misuse, rather than dealing solely with either alcohol or drug misuse. Consequently, substance misuse as a whole has been considered for the purposes of this review, drawing out some of the messages from research on alcohol and drug dependence where possible.

An extensive review commissioned by the Scottish Government examined the effectiveness of a range of substance misuse services in order to draw on international best practice³⁷. Services that pursued harm reduction or harm minimisation policies were found to be able to engage with homeless people with a substance misuse problem more effectively. There was limited success for services that aimed solely at promoting abstinence among this population group, as many clients would cease contact before treatment was complete or would avoid these services altogether.

The review makes a number of recommendations based on their assessment of service design and effectiveness:

- ▶ Realistic service outcomes need to be set, these will be higher for some service users than others.
- ▶ Harm reduction/harm minimisation models appear to meet with more success, though it needs to be borne in mind that their goals are more limited than those which aim for abstinence.
- ▶ The evidence base suggests a need for a mixture of services, which accepts that

harm reduction and semi-independent living may be the only realistic goals but which can be stepped up to abstinence and totally independent living if appropriate.

- ▶ Longitudinal monitoring of service outcomes should be undertaken where possible.
- ▶ The evidence base suggests that service interventions may need to go on for some time, creating a need for a secure funding base.
- ▶ Modifications of generic services may be the best option in areas where numbers of homeless people with substance misuse are low.

One of the key messages of the review is that the pursuit of abstinence, independent living and paid work for all homeless people with substance misuse may not be a realistic goal, as many are highly vulnerable and may need long term service intervention which may preclude independent living and secure paid work. Hence the need for a flexible service model allowing for a harm reduction approach or the capacity to pursue abstinence as appropriate.

There is mixed evidence for the effectiveness of case management on substance misuse. However, interventions that included post-detoxification stabilisation, abstinence-contingent work therapy, or an intensive residential treatment programme, all showed significantly greater reductions in substance use than the usual care groups^{23,24}. The provision of housing (as part of case management) is associated with decreased substance use and relapses from periods of substance abstinence and, in particular, abstinence-contingent housing appears to provide greater impact on sustained abstinence than non-abstinence-contingent housing²³.

6.3.1 Alcohol dependence

Wright and Tompkins reported that recovery from alcohol dependence appears to be strongly associated with personal motivation and a supportive intervention programme³. Personal motivation for recovery, rather than programme related factors, were most influential in determining outcomes. Successful outcomes were predicted by personal lifestyle factors which included lower recent and lifetime substance use, fewer prior treatment episodes, more stable housing at baseline, fewer incarcerations, and less social isolation.

There is some evidence that a community matron model reduces acute service demand and improves quality of life in alcoholic homeless clients¹². The study measured acute service demand (A&E attendance and inpatient admissions) and quality of life scores in six homeless clients following the introduction of a community matron model. The findings suggest that improved health outcomes can be achieved, but further work is required to examine whether these changes are sustainable, and if a wider range of health outcomes should be measured.

6.3.2 Drug dependence

Safe opiate medication substitute prescribing is now a cornerstone of the management of heroin dependence, although there is only an established evidence base for either buprenorphine or methadone maintenance medication which has

demonstrated reduced crime and reduced drug use³. There is insufficient evidence for heroin prescription as first line treatment.

These findings are supported by Dunn who describes a methadone prescribing service set up in a hostel in Camden³⁸. Thirty clients received treatment using this outreach model and the study found significant reduction in heroin use and the frequency of injecting. The outreach clinic offers a potential model for delivering services to homeless people with substance misuse problems.

Wright and Tompkins found that there is limited UK-based research evaluating the impact of health promotion approaches to drug users³. However, international research has demonstrated that medically supervised injecting centres reduce the incidence of drug-related death; halt the increase in reported hepatitis B or C infections; reduce injecting related-risk behaviour; increase the likelihood of starting treatment for drug dependence; reduce the prevalence of discarded syringes in public places; do not increase the number of theft and robbery incidents in the area; and increase acceptance of the centres by both businesses and residents. There is a case that homeless drug users could be a priority group for medically supervised injecting centres.

6.3.3 Dual diagnosis

Estimates of the prevalence of dual diagnosis among the homeless population vary between 10-50%²⁶. There is a lack of evidence for models of service delivery and interventions specifically for homeless people with dual diagnosis, and so some of the broader dual diagnosis literature has been included on the basis that some conclusions may be drawn for the homeless population.

In 2002 the Department of Health acknowledged that mental health and substance misuse services had evolved separately, and that few services existed to address the needs of those who had both substance and alcohol misuse issues in conjunction with a mental health problem³⁹. Consequently, patients have fallen between services and have not received the care and treatment required.

The strongest evidence points to an integrated model which combines both mental health and substance abuse treatments concurrently^{39,40,41,42}. Strategies commonly used include a combination of pharmacological treatment, intensive case management, motivational interviewing, individual and group psychotherapy, and family participation, although a Cochrane review of psychosocial interventions found no compelling evidence to support any one psychosocial treatment over another^{42,43}.

Georgeson reports on the Matrix Model implemented in Bristol and reports that implementation of an integrated model requires creation of a formal care pathway for dual diagnosed patients⁴⁰. The author's key recommendation is that professionals co-locate in each other's agencies, adopting an assertive outreach approach to working with dual diagnosis and complex-needs clients.

An evaluation of dual diagnosis community psychiatric nurses working within community mental health teams found an increase in the detection of comorbidity, improved staff perceptions of working with patients that misuse substances, and clinical and functional improvements in patients over two years⁴⁴. Karper et al found that a care coordinator was a relatively low intensity but promising intervention for homeless people with dual diagnosis⁴⁵.

In Richmond a new service was developed for people with dual diagnosis⁴⁶. The

model comprised three components: a link worker from the community drug and alcohol team who works with individual mental health teams; staff training in dual diagnosis; and a protocol for joint working of patients by both mental health and substance misuse teams. Referral pathways between teams have been improved, and the service has been considered a success by patients and staff.

6.4 Infectious disease

A number of primary prevention interventions are effective in reducing infectious disease prevalence:

- ▶ vaccination schedules against tetanus, influenza, pneumococcus, diphtheria, hepatitis A and B
- ▶ needle exchange programmes
- ▶ medically supervised injecting centres for drug users
- ▶ washing and laundry facilities
- ▶ podiatry interventions to provide adapted shoes or cut toe nails
- ▶ insecticide application to bedding in shelters³

There is some evidence that tuberculosis link workers can enable the integration of health and social care, thereby mitigating some of the social risk factors that complicate treatment for marginalised groups such as homeless clients⁴⁷.

Monetary incentives can also improve adherence rates for attendance at assessment and treatment of latent tuberculosis²⁴.

6.5 Sexual health

Despite a high prevalence of sexually transmitted diseases including HIV among such populations, there is limited evidence to inform best practice for targeted sexual health promotion interventions among homeless people³.

Common findings are that interventions which seek to effect attitudinal and behavioural change through interactive methods such as role-play, video games and group work, lead to a lasting reduction in both risk from drugs and sexual activity. Further research is required to evaluate interventions targeting differing sub-populations of homeless people.

6.6 Brain Injury

There is evidence that the rates of traumatic brain injury (TBI) are higher in the homeless people than the general population. A UK study found 48% of homeless participants reported a history of TBI compared to 21% of the control group⁴⁸. 90%

of the homeless participants indicated they had sustained their first TBI before they were homeless, and the authors conclude that sustaining a TBI may be a risk factor for homelessness.

Research from Canada indicates similar findings with a 53% lifetime prevalence for TBI, and 70% of the respondents experiencing their first TBI before they became homeless²⁴.

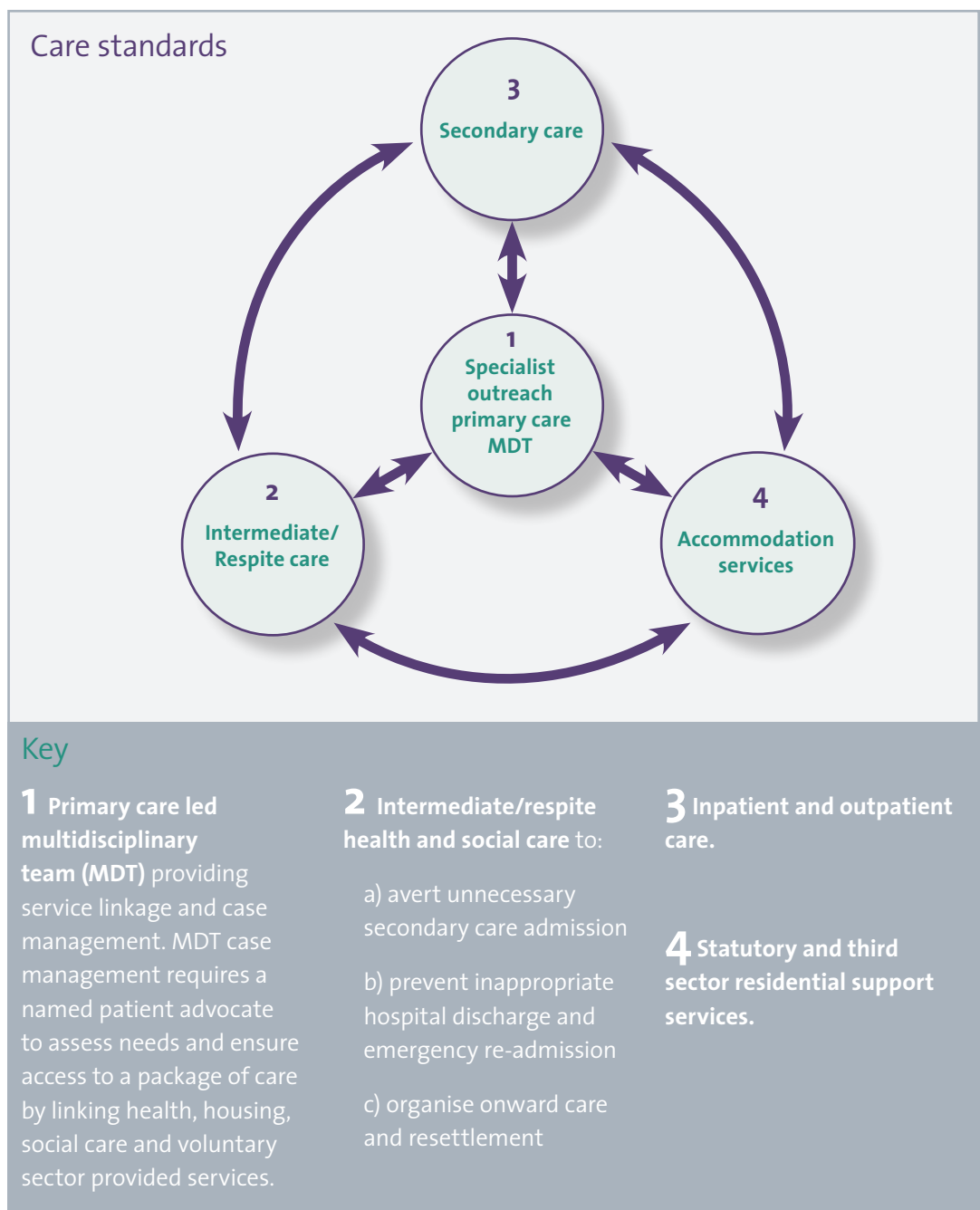
Although not specifically investigating the homeless population, a Cochrane review of multidisciplinary rehabilitation for acquired brain injury (ABI) found strong evidence suggesting that most patients with mild brain injury made a good recovery with provision of appropriate information, without additional specific intervention⁴⁹. For moderate to severe injury, there was 'strong evidence' of benefit from formal intervention. For patients with moderate to severe ABI already in rehabilitation, there was strong evidence that more intensive programmes are associated with earlier functional gains, and 'moderate evidence' that continued outpatient therapy could help to sustain gains made in early post-acute rehabilitation. There was 'limited evidence' that specialist in-patient rehabilitation and specialist multi-disciplinary community rehabilitation may provide additional functional gains.

As problems following ABI vary, the authors conclude that different interventions and combinations of interventions are required to suit the needs of patients with different problems. Patients discharged from in-patient rehabilitation should have access to out-patient or community-based services appropriate to their needs.

7. Models of delivery

Although published research on models of service delivery for homeless people is limited, the literature review identified a number of potential models. These are described briefly below.

The Faculty of Homeless Health and London Pathway have produced a set of standards for planning, commissioning and providing health care for homeless people and other excluded groups⁵. This integrated approach is illustrated in the diagram below:



The London Pathway is a model of healthcare developed for single homeless people and rough sleepers in secondary care⁵⁹. Core services offered by the model include hospital ward rounds; homeless health nurse practitioners; care navigators; sanctuary; needs assessment and start up support; and accreditation, professional support and training.

This forms the basis of a model implemented at University College London Hospital⁶. The model is shown below and incorporates a number of the London Pathway services.

Overview of UCLH approach to homeless health services

OBJECTIVE 1: THINK HOMELESS!

Check housing status for all patients on admission. If homeless, in a hostel, temporary or insecure housing, refer to the Homeless Healthcare Nurse Practitioner.

OBJECTIVE 2: HOMELESS TEAM COORDINATE CARE

Patient seen by Homeless Healthcare Nurse Practitioner, visited by the Homeless Ward Round, needs assessed and Homeless Care Plan started.

OBJECTIVE 3: CARE PLAN MEETING

Complex needs cases referred to weekly Homeless Paper Ward Round for multi-agency Care Plan and Sanctuary assessment.

OBJECTIVE 4: COMMUNITY SUPPORT

Care Navigator Team and patient plan community support and consider Sanctuary placement (if ongoing medical needs, 2nd admission in 12 months, or complex case).

OBJECTIVE 5: SANCTUARY

Tri-morbid and complex needs treated in psychologically-informed environment. Relationships built with Care Navigators, aiming for brief period of stabilisation and then independent living.

OBJECTIVE 6: HOUSING FIRST

After stabilisation in Sanctuary, patient moves directly to independent permanent housing (privately rented or in housing association) with access to clinically-led multi-agency Care Navigator support.

OBJECTIVE 7: INDEPENDENCE

Care Navigator Team and patient work toward independence and meaningful activities such as Streetscape, working and paying taxes. For those with long-term care or support needs, links are made with local services.

An evaluation compared a cohort of patients managed with this model with a previous cohort. The results found that 10 times as many patients (35% compared with 3.5%) left hospital with a multi-agency care plan, and that continuity of care and compliance with care plan was increased. The number of homeless patients with official documentation required for assistance with housing, finding a GP, and entering community methadone plans also increased. The patient experience is also reported as improving. The average length of stay fell by 3.2 days, from 12.7 to 9.5 days.

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 readmissions⁵¹. Essential criteria for a successful model have been identified as: strategic buy-in, information sharing; training, joint working, and community-based support. An agreed process between the hospital team, local authority, and wider voluntary sector is required.

Although the existing UK evidence base for intermediate care focusses on older people, it may provide a suitable environment for homeless people to access the healthcare they need⁵². There is some evidence that a nurse-led intermediate care service can reduce hospital admission, A&E attendances and improve health outcomes⁵². There is some US evidence that suggests that intermediate (respite) care reduces hospital admissions and provides cost savings^{20,21}.

The report *Healthcare for Single Homeless People* describes four models for specialist homelessness primary care, see below¹³. These range from mainstream and outreach services to the fully integrated primary and secondary care model.

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 likely to be appropriate for localities with small 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.

In their review of healthcare for the homeless, Wright and Tompkins identified two models of primary care delivery: either mainstream general practice with a GP with Special Interest, or a specialised general practice that only registers homeless people³. The review concludes that barriers to provision and multi-agency working need to be addressed, and that ‘accessible and available primary health care is a pre-requisite for effective health interventions’.

Nyiri & Eling suggest that a specialist clinic for asylum seekers and refugees can help treat urgent conditions, facilitate access to NHS services, prevent further illness, and reduce inappropriate use of acute services while integrating patients into mainstream general practice⁵³.

Examples of local good practice across London are described in *Overview of health services for rough sleepers in London: report of evidence gathering and stakeholder engagement*⁵⁴. These include services which address access issues, projects managing demand for acute services, outreach and screening, partnerships with third sector providers, involving clients, and integrating services.

(a) Sources searched

Databases

Cochrane Library (www.thecochranelibrary.com)

MEDLINE

HMIC

Websites

NHS Evidence (www.evidence.nhs.uk)

NICE (www.nice.org.uk)

Research papers and grey literature submitted by the Project Steering Group

(b) Medline literature search strategy

(Note that this informed the strategy when searching other sources)

MEDLINE; exp POPULATION/; 88503 results.

MEDLINE; (population adj5 size).ti,ab; 10556 results.

MEDLINE; exp DEMOGRAPHY/; 842560 results.

MEDLINE; demograph*.ti,ab; 128366 results.

MEDLINE; exp PREVALENCE/; 157948 results.

MEDLINE; prevalence.ti,ab; 313287 results.

MEDLINE; homeless*.ti,ab; 5621 results.

MEDLINE; (rough adj4 sleep*).ti,ab; 27 results.

MEDLINE; exp HOMELESS PERSONS/; 5598 results.

MEDLINE; 1 OR 2 OR 3 OR 4 OR 5 OR 6; 1144786 results.

MEDLINE; 7 OR 8 OR 9; 7356 results.

MEDLINE; 10 AND 11; 3047 results.

MEDLINE; HOMELESS PERSONS/sn [sn=Statistics & Numerical Data]; 1198 results.

MEDLINE; 12 OR 13; 3442 results.

MEDLINE; 14 [Limit to: Publication Year 2002-2012 and English Language]; 1672 results.

MEDLINE; London.af; 346695 results.

MEDLINE; 15 AND 16 [Limit to: Publication Year 2002-2012 and English Language]; 75 results.

MEDLINE; COMMUNITY HEALTH SERVICES/ut [ut=Utilization]; 1375 results.

MEDLINE; PRIMARY HEALTH CARE/ut [ut=Utilization]; 1961 results.

MEDLINE; FAMILY PRACTICE/ut [ut=Utilization]; 84 results.

MEDLINE; (“primary care” OR “general practi*” OR GP OR dentist OR dental OR pharmac* OR optician*).ti,ab; 702515 results.

MEDLINE; (use* OR using OR usage OR utili* OR uptake).ti,ab; 5957844 results.

MEDLINE; 21 AND 24; 320465 results.

MEDLINE; 18 OR 19 OR 20 OR 25; 322653 results.

MEDLINE; exp HOMELESS PERSONS/; 5598 results.

MEDLINE; (rough adj4 sleep*).ti,ab; 27 results.

MEDLINE; homeless*.ti,ab; 5621 results.

MEDLINE; 27 OR 28 OR 29; 7356 results.

MEDLINE; 26 AND 30; 232 results.

MEDLINE; 31 [Limit to: Publication Year 2002-2012 and English Language]; 148 results.

MEDLINE; (“secondary care” OR “secondary health care” OR “secondary healthcare”).ti,ab; 2941 results.

MEDLINE; (“acute care” OR hospital*).ti,ab; 719933 results.

MEDLINE; EMERGENCY MEDICAL SERVICES/ut [ut=Utilization]; 1256 results.

MEDLINE; HEALTH SERVICES/ut [ut=Utilization]; 5599 results.

MEDLINE; (use* OR using OR usage OR utili* OR uptake).ti,ab; 5957844 results.

MEDLINE; 33 OR 34; 721814 results.

MEDLINE; 37 AND 38; 294569 results.

MEDLINE; 35 OR 36 OR 39; 299709 results.

MEDLINE; 30 AND 40; 546 results.

MEDLINE; 41 [Limit to: Publication Year 2002-2012 and English Language]; 286 results.

MEDLINE; “cost effectiv*”.ti,ab; 63060 results.

MEDLINE; exp ECONOMICS/; 453699 results.

MEDLINE; “economic evaluation”.ti,ab; 4198 results.

MEDLINE; (“cost benefit” OR “cost analysis”).ti,ab; 9619 results.

MEDLINE; 43 OR 44 OR 45 OR 46; 492476 results.

MEDLINE; exp HOMELESS PERSONS/; 5598 results.

MEDLINE; (rough adj4 sleep*).ti,ab; 27 results.

MEDLINE; homeless*.ti,ab; 5621 results.

MEDLINE; 48 OR 49 OR 50; 7356 results.

MEDLINE; 47 AND 51; 688 results.

MEDLINE; 52 [Limit to: Publication Year 2002-2012 and English Language]; 256 results.

MEDLINE; 27 AND 36; 71 results.

MEDLINE; 54 [Limit to: Publication Year 2002-2012 and English Language]; 37 results.

(c) References

- 1 Homeless Link (2010) The health and wellbeing of people who are homeless: evidence from a national audit. London: Homeless Link
- 2 Queen’s Nursing Institute (2008) Guidance resource: clinical assessment guidelines for single homeless adults. London: Queen’s Nursing Institute
- 3 Wright N. M. and Tompkins C.N. (2006). How can health services effectively meet the health needs of homeless people? *British Journal of General Practice* 56(525): 286-293
- 4 Three Boroughs Homeless Team (2008) Homeless health care: commissioning services for single homeless adults in Lambeth, Southwark and Lewisham
- 5 Hewett N. (2011). Standards for commissioners and service providers. Version1.0. London: Faculty of Homeless Health
- 6 Porter M. and Shand J. (2011) University of London College Hospital Trust: Homeless Care; Harvard Business School/UCL Partners ‘case’ paper presented at ‘Value in Healthcare Delivery’, London, June 2011
- 7 Crisis (2011) Homelessness: A silent killer. A research briefing on mortality amongst homeless people
- 8 Nyiri P. & Eling J. (2012). A specialist clinic for destitute asylum seekers and refugees in London. *British Journal of General Practice* 62(604):599-600
- 9 Department of Health (2010) Inclusion health: improving primary care for socially excluded people. London: Department of Health
- 10 John W. and Law K. (2011). Addressing the health needs of the homeless. *British Journal of Community Nursing* 16(3): 134-139

- 11 Hicyilmaz M. and Robinson E. (2008) Review of the needs assessment of clients served by the Three Boroughs Primary Health Care Team. Final Draft Report
- 12 Dorney-Smith S. (2011). Nurse-led homeless intermediate care: an economic evaluation. *British Journal of Nursing* 20(18): 1193-1197
- 13 Department of Health Office of the Chief Analyst (2010) Healthcare for Single Homeless People. London: Department of Health
- 14 McColl K., Pickworth S., & Raymond I (2006). Project: London--supporting vulnerable populations. *BMJ* 332(7533): 115-117
- 15 Hill K. B., and Rimington D. (2011). Investigation of the oral health needs for homeless people in specialist units in London, Cardiff, Glasgow and Birmingham. *Primary Health Care Research & Development* 12(2): 135-144
- 16 Daly B., Newton J.T., & Batchelor P. (2010) Patterns of dental service use among homeless people using a targeted service. *Journal of Public Health Dentistry* 70(1): 45-51
- 17 Ritchie C (2010). Supported accommodation commissioning plan: rough sleepers and single homeless. London: Lambeth Adults and Community Services
- 18 Bothamley, G. H., J. P. Rowan, et al. (2002). Screening for tuberculosis: the port of arrival scheme compared with screening in general practice and the homeless. *Thorax* 57(1): 45-49
- 19 Dorney-Smith S. (2007). Piloting the community matron model with alcoholic homeless clients. *British Journal of Community Nursing* 12(12): 546, 548-551
- 20 Buchanan D., Doblin B., Sai T., and Garcia P. (2006) The effects of respite care for homeless patients: a cohort study. *American Journal of Public Health* 96(7):1278-1281
- 21 National Health Care for the Homeless Council (2010) Medical respite care: demonstrated cost savings. Nashville: National Health Care for the Homeless Council
- 22 Hough J. and Rice B. (2010) Providing personalised support to rough sleepers: An evaluation of the City of London pilot. York: Joseph Rowntree Foundation
- 23 Fitzpatrick-Lewis D., Ganann R., Krishnaratne S., Ciliska D., Kouyoumdjian F., Hwang S. (2011) Effectiveness of interventions to improve the health and housing status of homeless people: a rapid systematic review. *BMC Public Health* 11: 638
- 24 Hwang S., Tolomiczenko G., Kouyoumdjian F., & Garner R. (2005). Interventions to improve the health of the homeless: a systematic review. *American Journal of Preventive Medicine* 29(4): 311-319
- 25 Coldwell C.M. and Bender W.S. (2007). The effectiveness of assertive community treatment for homeless populations with severe mental illness: a meta-analysis. *American Journal of Psychiatry* 164(3): 393-399

- 26 Mental Health Network (2012) Mental health and homelessness: planning and delivering mental health services for homeless people. Briefing 235. London: NHS Confederation
- 27 Killaspy H. (2004). Treating the homeless mentally ill: does a designated inpatient facility improve outcome? *Journal of Mental Health* 26(6): 593-599
- 28 Bordas C.S. (2009). Personality disorders in homeless people. *International Journal of Psychology & Psychological Therapy* 9(2), 275-283
- 29 Campbell J. (2006). Homelessness and containment--A psychotherapy project with homeless people and workers in the homeless field. *Psychoanalytic Psychotherapy* 20(3), 157-174
- 30 Fazel S., Khosla V., Doll H., & Geddes J. (2008) The prevalence of mental disorders among the homeless in Western countries: Systematic review and meta-regression analysis. *PLoS Med* 5(12): e225
- 31 Maguire N., Johnson R., Vostanis P., Keats H., & Remington R.E. (2009) Homelessness and Complex Trauma: A review of the literature. Southampton
- 32 Gibbon S., Duggan C., Stoffers J., Huband N., Vollm B. A., Ferriter M., & Lieb K. (2010). Psychological interventions for antisocial personality disorder. *Cochrane Database of Systematic Reviews*
- 33 Khalifa N., Duggan C., Stoffers J., Huband N., Vollm B. A., Ferriter M., & Lieb K. (2010). Pharmacological interventions for antisocial personality disorder. *Cochrane Database of Systematic Reviews*
- 34 Stoffers J.M., Völlm B.A., Rucker G., Timmer A., Huband N., & Lieb K. (2010). Pharmacological interventions for borderline personality disorder. *Cochrane Database of Systematic Reviews*
- 35 Stoffers J.M., Völlm B.A., Rucker G., Timmer A., Huband N., & Lieb K. (2012). Psychological therapies for people with borderline personality disorder. *Cochrane Database of Systematic Reviews*
- 36 Ferguson I., Petrie M., & Stalker K. (2007). With them all the way : how can services better meet the needs of homeless people with severe mental distress and behavioural difficulties? *Mental Health Today* 2, 8-31
- 37 Pleace, N (2008). Effective services for substance misuse and homelessness in Scotland: evidence from an international review. Edinburgh: Scottish Government Social Research
- 38 Dunn J. (2006). Setting up a methadone maintenance clinic in a hostel in London's West End. *Psychiatric Bulletin* 30(9): 337-339
- 39 Dennis, S. (2009) Commissioning Services for Users with Dual Diagnosis, in *Dual Diagnosis: Practice in Context* (eds P. Phillips, O. McKeown and T. Sandford), Wiley-Blackwell, Oxford, UK
- 40 Georgeson, B. (2009). The Matrix Model of dual diagnosis service delivery.

- 41 Kandel Y. (2007). Treatment program for dual-diagnosis substance abusers. *Archives of Psychiatry and Psychotherapy* 9(1-2), 61-67
- 42 Tsuang J. and Fong T. W. (2004). Treatment of patients with schizophrenia and substance abuse disorders. *Current Pharmaceutical Design*, 10(18): 2249-2261
- 43 Cleary M., Hunt G. E., Matheson S.L., Siegfried N., & Walter G. (2008). Psychosocial interventions for people with both severe mental illness and substance misuse. *Cochrane Database of Systematic Reviews*
- 44 Griffin S. (2008). A 'dual diagnosis' community psychiatric nurse service in Lanarkshire : service innovation. *Psychiatric Bulletin* 32(4), 139-142
- 45 Karper L., Kaufmann M., Millspaugh G., Vega E., & Stern G. (2008). Coordination of care for homeless individuals with comorbid severe mental disorders and substance-related disorders. *Journal of Dual Diagnosis* 4(2)
- 46 Whicher E.V. and Abou-Saleh T. (2009). Service development: developing a service for people with dual diagnosis. *Mental Health and Substance Use: Dual Diagnosis* 2(3): 226-234
- 47 Craig G.M., Booth H., Hall J., Story A., Hayward A., Goodburn A., & Zumla A. (2008). Establishing a new service role in tuberculosis care: the tuberculosis link worker. *Journal of Advanced Nursing* 61(4): 413-424
- 48 Oddy M., Moir JF., Fortescue D., & Chadwick S (2012). The prevalence of traumatic brain injury in the homeless community in a UK city. *Brain Injury* 26(9): 1058-1064
- 49 Turner-Stokes L., Disler P.B., Nair A., & Wade D.T. (2005) Multi-disciplinary rehabilitation for acquired brain injury in adults of working age. *Cochrane Database of Systematic Reviews*
- 50 London Pathway <http://www.londonpathway.org.uk/index.php/about/> (accessed 17 July 2012)
- 51 Department of Health (2012) Improving hospital admission and discharge for people who are homeless. London: Department of Health
- 52 Lane R (2005). The road to recovery. A feasibility study into homeless intermediate care. Homeless Intermediate Care Steering Group
- 53 Nyiri P. & Eling J. (2012). A specialist clinic for destitute asylum seekers and refugees in London. *British Journal of General Practice* 62(604):599-600
- 54 Regional Public Health Group for London (2010) Overview of health services for rough sleepers in London: report of evidence gathering and stakeholder engagement

PART TWO
Data analysis

Gayan Perera, Sinan Rabee

Introduction

Background

The health of rough sleepers in the inner North West London (INWL) area – Hammersmith and Fulham, Kensington and Chelsea, and Westminster – has been highlighted as an issue.

Aims

This report aims to describe and analyse the health needs of rough sleepers in INWL, and their impact on health care services, with particular reference to usage and cost.

Methods

A group of individuals confirmed to be rough sleepers was identified from the CHAIN (Combined Homelessness and Information Network) system for matching to NHS general practice registered data. CHAIN is a database, commissioned and funded by the Greater London Authority (GLA) and managed by Broadway, which 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.

The underlying base for the group was defined as those people who had been seen rough sleeping by outreach teams, or were hostel residents, in 9 London boroughs between January 2010 and December 2011. These were: Westminster, Lambeth, City of London, Kensington & Chelsea, Hammersmith & Fulham, Hackney, Tower Hamlets, Camden and Southwark. This group was then further narrowed down to a total of 3450, by including only those who had been seen rough sleeping at least three times, and in at least two separate quarters. Apart from this, the contacts could happen at any time over the period.

Data matching process

For the rough sleepers identified in the CHAIN database, we then matched first name, surname, and date of birth with NHS general practice registered population records (EXETER) for INWL. Data matching was carried out in Excel. Initially, data from CHAIN including first name, surname and date of birth was matched with NHS data using an automated data matching processes. After this, an analyst went through all the records to check the accuracy of the matched data. Where records did not match, these were checked to see if it was because of spelling mistakes. A second manual matching process was independently carried out by a senior public health analyst. Both analysts discussed and resolved any disagreements about valid matches.

Limitations of matching process include the fact that those people who rough sleep are thought to use multiple names, and some of them do not have an NHS number. Further, some people who sleep rough in one area may access health services in another part of the country. Those patients who do not have an NHS number cannot be linked to patient records (and so to hospital outpatient, inpatient and A&E

databases). Therefore, those who did not have any NHS numbers were excluded in the analysis. This paper describes the healthcare utilisation of rough sleepers known to have NHS numbers. This is not the entire rough sleeper population who access health services.

Out of 3450 rough sleepers – of which 2989 were primarily sleeping in the three INWL boroughs – 933 (31% of people seen rough sleeping in INWL) were registered with a GP in one of the INWL PCTs.

To help understand the disease patterns and demographics of the rough sleeping population, and to quantify the demand to health services during January 2010 and June 2012, we analysed A&E, hospital admission and hospital outpatient data for the 933 individuals identified as rough sleepers. These 933 patients were known to be rough sleeping at points during 1 January 2010 and 31 December 2011. However, we do not know if they were still rough sleeping after 31 December 2011. Therefore, we decided to analyse the hospital data during this period, defining it as our main study period. During the post rough sleeping period (from 1 January 2012 to June 2012), we are not certain that those people had been rough sleeping. For instance, some may have moved to permanent houses. However, the post rough sleeping period analysis is useful for investigating the longer term effects of rough sleeping.

Comparison of total CHAIN population and those patients matched with NHS data

Table 1: Description of matched (933) and un-matched (2517) rough sleeper patients who had contacts with hospitals, by age group (2010 – 2011)

Age band	No. of people NOT matched with NHS data	No. of people matched with NHS data	All people
<20	11 (0%)	3 (0.3%)	14
20-29	250 (10%)	79 (8%)	329
30-39	736 (29%)	237 (25%)	973
40-49	861 (34%)	350 (38%)	1211
50-59	483 (19%)	178 (19%)	661
60-69	135 (5%)	66 (7%)	201
70-79	35 (1%)	16 (2%)	51
80 and over	<5 (0.1%)	<5 (0.1%)	7
Unknown	<5 (0.1%)	<5 (0.1%)	<5
Grand Total	2517 (100%)	933 (100%)	3450

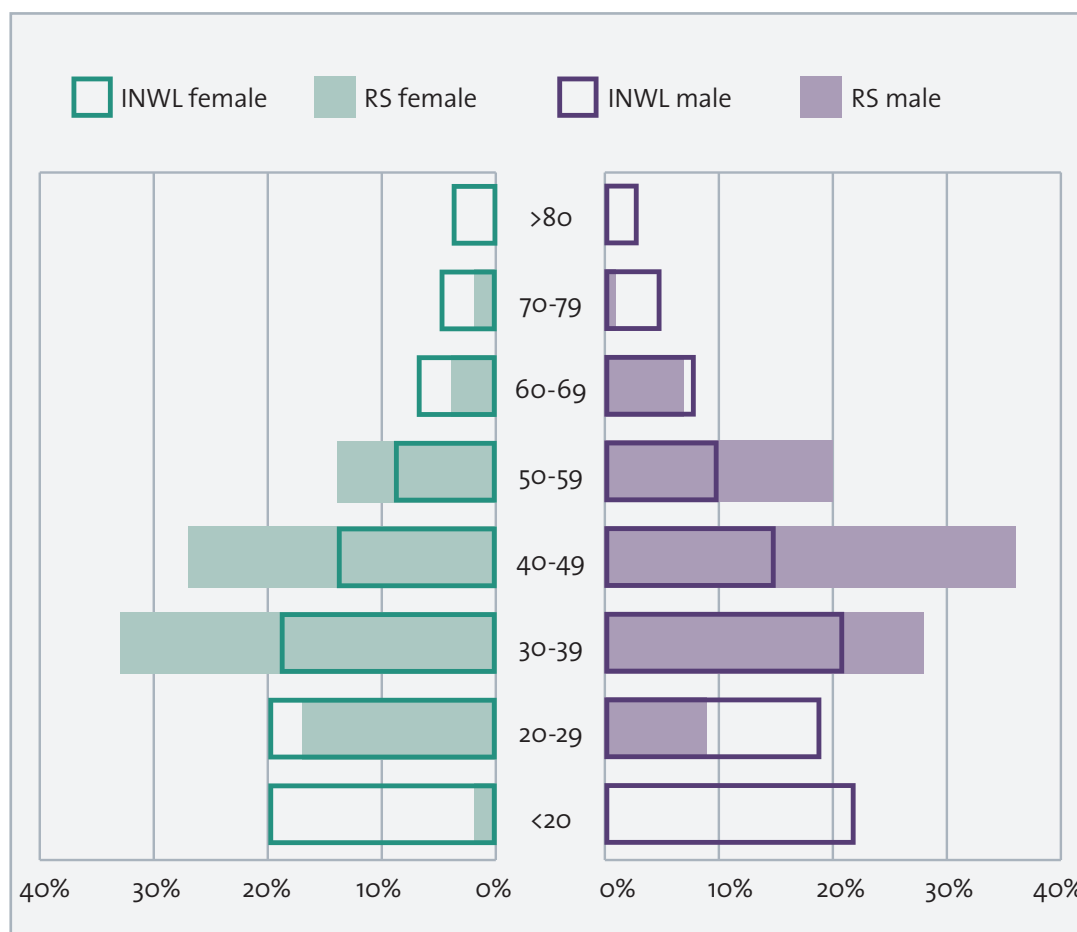
There were 3450 rough sleepers identified through the CHAIN data. The table above shows the age distribution for the individuals for whom it was possible to match records with NHS data (total n=933). For the remaining 2518 rough sleepers, there were no matching NHS records. Within both categories (NHS data matched and no NHS data matched), the highest proportion of rough sleepers were in the 40-49 years age band.

Table 2: Description of matched (933) and un-matched (2517) rough sleeper patients who had contacts with hospitals, by gender (2010 – 2011)

Gender	No. of people NOT matched with NHS data	No. of people matched with NHS data	All people
Female	263 (10%)	99 (11%)	363
Male	2254 (90%)	834 (89%)	3087
Persons	2517 (100%)	933 (100%)	3450

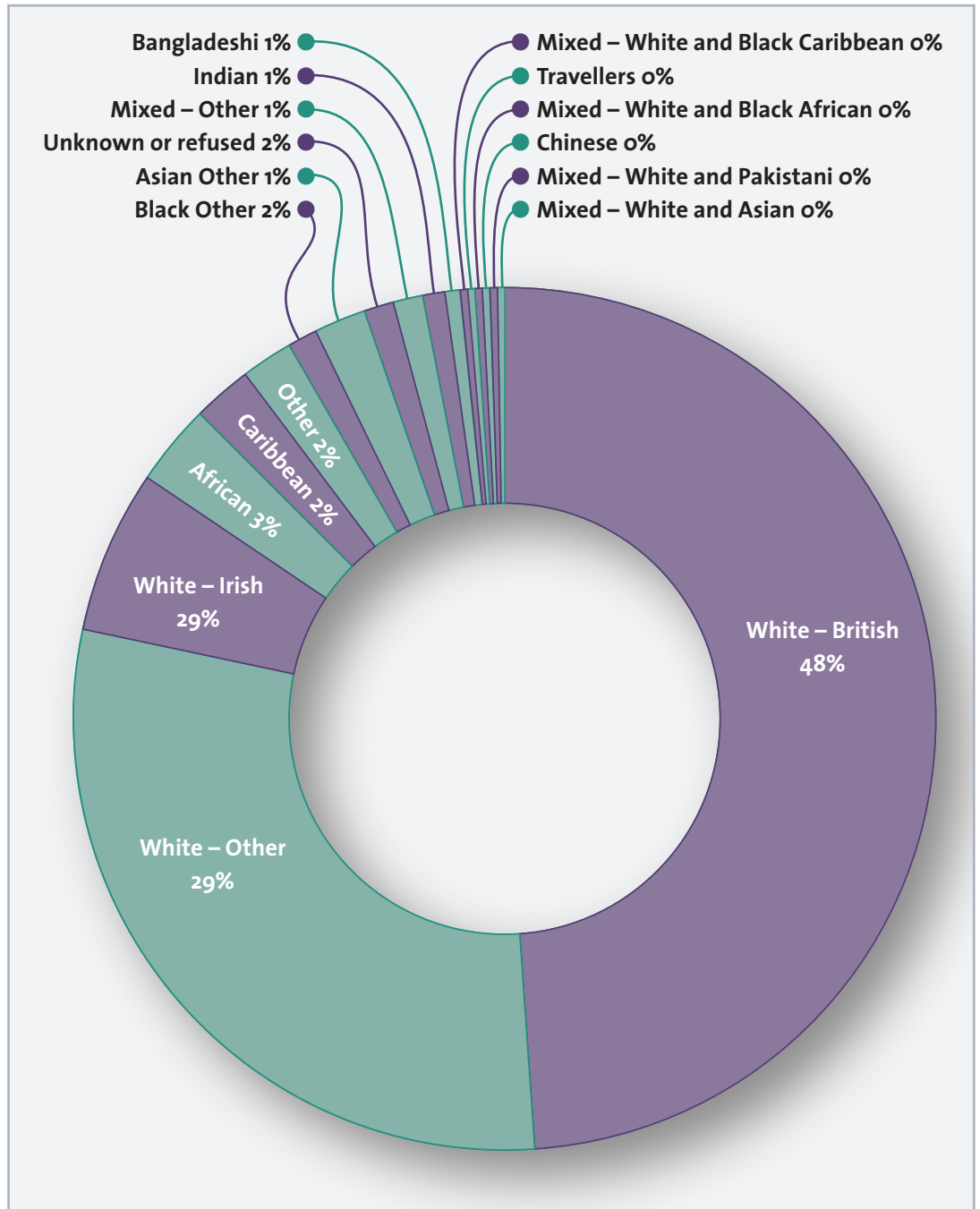
Of the 3,450 rough sleepers in the INWL area, 3087 were males. 834 of them had NHS records matching to them. Of the 362 female rough sleepers, 99 could be matched to their NHS records.

Figure 1: Population pyramid for all 3,450 rough sleepers identified by CHAIN (2010 - 2011)



There are more rough sleepers in the 30-59 age groups, compared with the general population.

Figure 2: Proportion (%) of 3450 rough sleepers identified (CHAIN data) by ethnicity (2010 – 2011)



48% of rough sleepers were white British, and 29% white – other, a high proportion.

Table 3: Description of matched (933) and un-matched (2517) rough sleeper patients who had contacts with hospitals, by ethnicity (2010 – 2011)

Ethnicity	No of people NOT matched with NHS data	No of people matched with NHS data
White - British	1080 (43%)	576 (62%)
White - Other	835 (33%)	163 (17%)
White - Irish	138 (5%)	80 (9%)
Black (African and Caribbean)	191 (8%)	64 (7%)
Asian (Indian, Bangladeshi, Pakistani and Asian other)	85 (3%)	11 (1%)
Mixed	55 (2%)	18 (2%)
Other including travellers and Chinese	83 (3%)	12 (1%)
Refused or unknown	51 (2%)	9 (1%)

Generally, apparent differences between those total patients from CHAIN and those 27% of CHAIN patients matched with NHS data may not be significant except for between white population sub groups. The major observable difference was seen among the white British patients that are over represented in the NHS matched data compared with the total CHAIN population. On the other hand, there is under representation among the white other group in the matched NHS data. It is likely that many white other population groups do not have a NHS number, hence there is a low proportion of the white other group in the matched group.

Table 4: Description of the 2517 rough sleepers and 933 rough sleeper registered patients who had contacts with hospitals by country of birth (2010 – 2011)

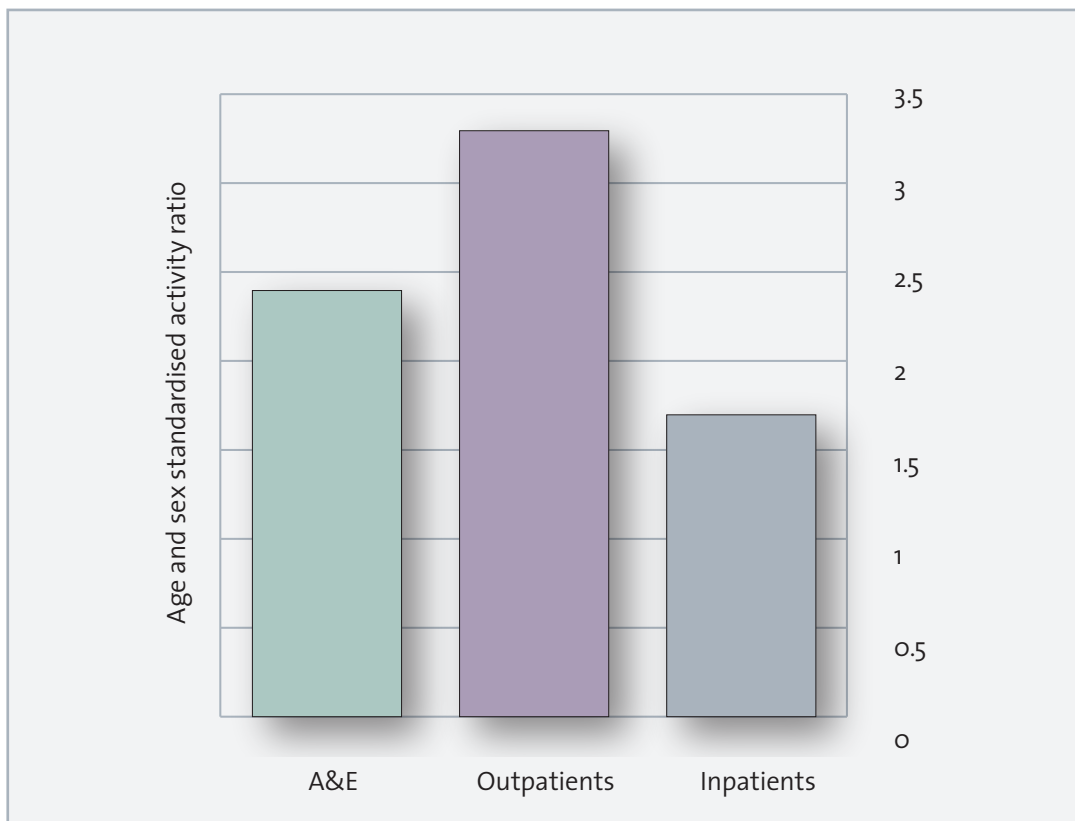
Country of birth	No of people not matched with NHS data	No of people matched with NHS data	All people
UK	1181 (49%)	658 (72%)	1839
Poland	278 (12%)	39 (6%)	317
Unknown	340 (14%)	88 (9%)	258
Ireland (Republic of)	81 (4%)	42 (6%)	123
Lithuania	88 (4%)	11 (2%)	99
Romania	88 (3%)	10 (1%)	98
Portugal	48 (2%)	12 (2%)	60
Czech Republic	42 (2%)	14 (2%)	56
Latvia	47 (2%)	8 (1%)	55
Slovakia	42 (2%)	8 (1%)	50
Italy	31 (2%)	10 (1%)	41
Hungary	34 (1%)	5 (1%)	39
France	32 (1%)	5 (1%)	37
Germany	25 (1%)	<5 (0%)	*
Eritrea	15 (1%)	6 (1%)	21
68 other countries	145 (6%)	<5 (0%)	*
Grand Total	2517 (100%)	933 (100%)	3450

As demonstrated in tables 1-4, there are few significant differences in age or demographics between those matched and not matched. However, there is large proportion of white British population among matched data, while there is low proportion of white other groups in the data which were matched with NHS data.

It seems that many of the rough sleepers who were born outside the UK do not have a NHS number and hence, cannot be matched with NHS data, notably those who were born in Eastern European countries, such as Poland, Lithuania and Romania.

Summary of NHS cost and activity for rough sleepers in INWL, using matched NHS data

Figure 3: Indirectly age and sex standardised A&E, outpatient and inpatient activity ratios for matched rough sleepers between January 2010 to December 2011, compared with INWL general population



An age and sex standardised activity ratio of 1.0 indicates that the rough sleeper population matches the INWL general population average. A ratio greater than 1.0 demonstrates observed activity among rough sleepers higher than the expected number in the INWL average rate for each age and gender groups. For all three types of hospital activities, the ratio is significantly higher than the INWL average with greatest impact on outpatient activity. Indirect standardisation is used as it is an appropriate measure when dealing with small numerators. Note that the ratios should not be compared against each other: they are comparisons with the general population.

Figure 4: Venn diagram of services use by matched rough sleepers

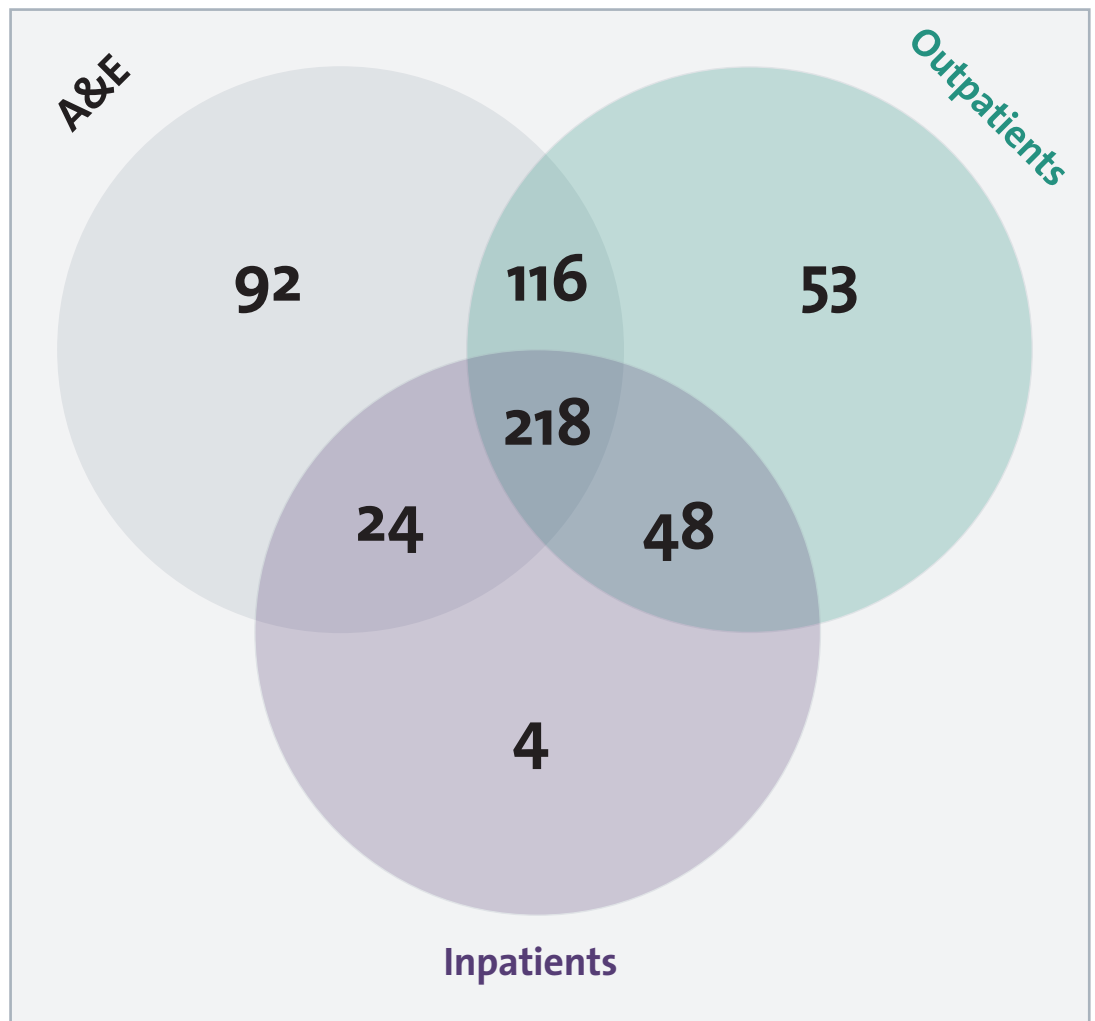


Figure 4 is a Venn diagram of service use by rough sleepers (for whom the NHS number is known), and shows that a large proportion of users were engaged in all three services (218). It is worth noting that 395 patients with known NHS numbers do not fit this diagram, but we cannot assume that they did not use hospital services. This is because rough sleepers do not always use their NHS registered names and therefore cannot always be tracked to their NHS activity.

Table 5: Trends hospital activity for matched rough sleepers during the study period and post-study period (count of activity)

	2010 Jan- 2011 Dec	2012 Jan- 2012 June
A&E	913	1745
Outpatient	1341	1912
Inpatient	282	482
All activity	2536	4139

There is a 7 fold increase in annual activity from January 2012 to June 2012 period compared with the 2010-2011 annual rate.

Table 6: Number and cost of matched rough sleeper patients by acute hospital services, January 2010 to June 2012

Type of hospital activity	No. of patients	Count of activity	Total cost for rough sleepers	Cost per unit of activity	Cost per patient
A&E	450	3272	£345,196	£105.50	£767.10
Outpatient (OP)	435	4413	£656,708	£148.81	£1,509.67
Inpatient	294	802	£1,337,312	£1,667.47	£4,548.68

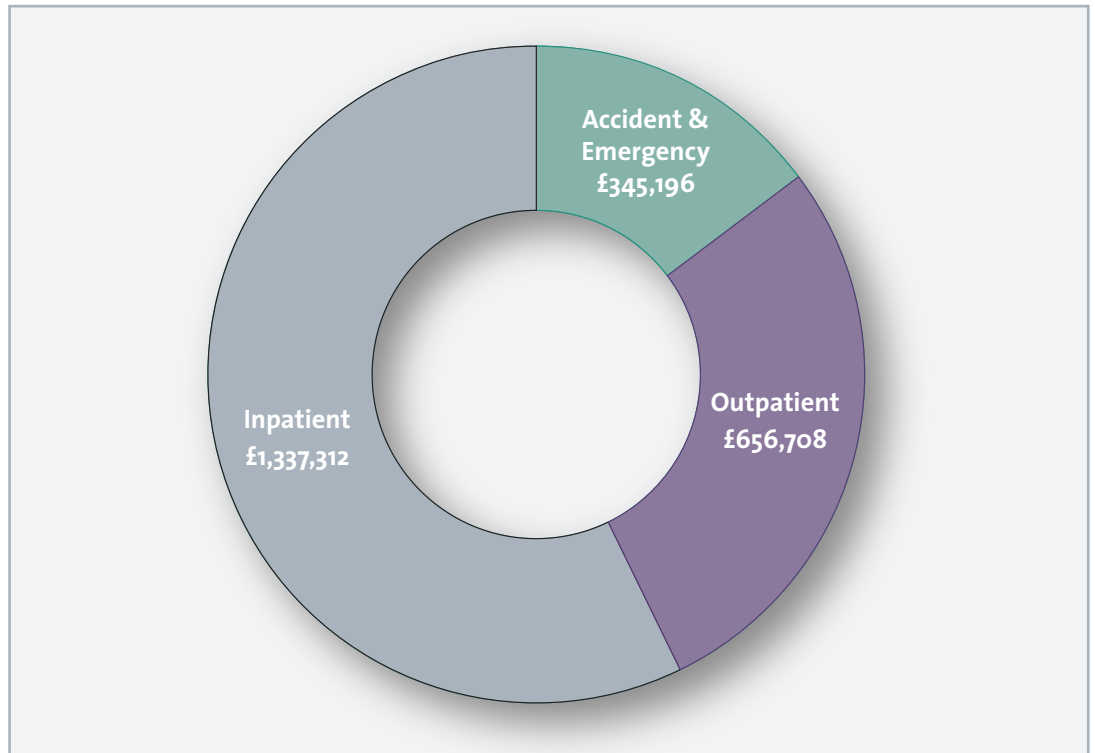
Total hospital cost for those 933 rough sleepers from January 2010 to June 2012 was £2,339,216. Over £1.3 million was spent on inpatient admissions during this period.

Table 7: Estimated excess cost of rough sleeping per year, for health services, January 2010 to June 2012, for matched rough sleepers

Hospital service type	Total cost for rough sleepers	Cost per head of rough sleeper population	INWL cost per head of population	Excess cost per rough sleeper	Total excess cost
A&E	£345,196	£148	£36	£112	£104,490
Outpatients	£656,708	£282	£240	£42	£38,763
Inpatient	£1,337,312	£573	£316	£257	£240,097
Total excess cost of rough sleeping for 933 patients per year					£1,228,118

The excess cost for the 933 matched patients was £1,228,118. Assuming that the 2989 INWL rough sleepers had the same hospital activity as those 933 patients who had matched data, we can estimate the total excess cost of rough sleeping in INWL to be £1,228,118 per year.

Figure 5: Total cost of services for rough sleeping population, split by hospital service, January 2010 and June 2012 (for 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 4). The following sections of analysis show hospital use by the rough sleeper community in INWL for A&E services, inpatient and outpatients services.

A&E data analysis

Figure 6: Rate of patients attending A&E for matched rough sleepers and general population (INWL), January 2010 to June 2012 (with 95 % confidence intervals)

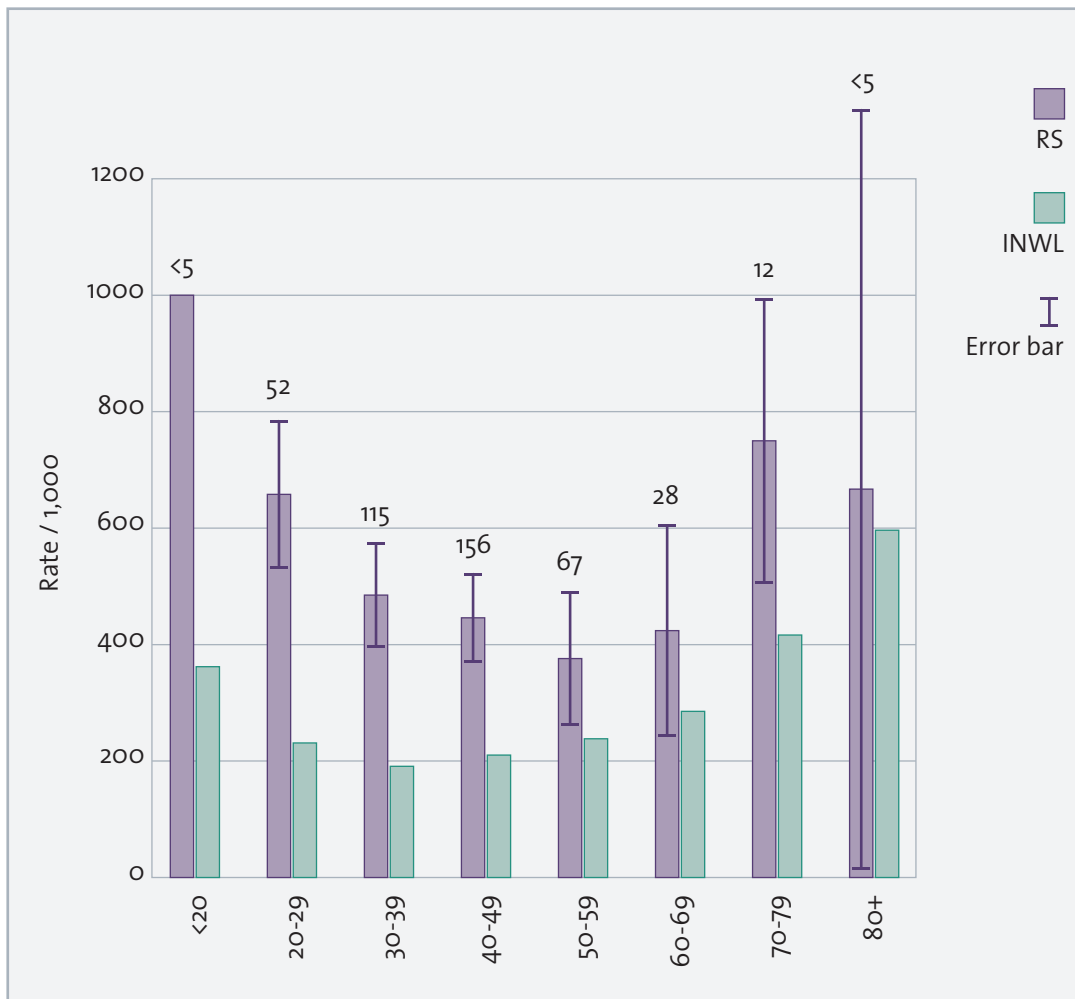


Figure 6 shows the number of rough sleepers who attended A&E services. In terms of crude numbers, the highest activity was seen among rough sleepers aged 40-49 years of age. The rate per 1,000 rough sleepers for A&E admissions, when compared with admissions for the general INWL population, shows higher rates of attendance across all age groups among rough sleepers. Most of those patients were between 30-49 years old. However, as a rate, rough sleepers of all age groups have a high A&E attendance rate compared with the general population, with the highest being the under 20 and 70-79 age groups.

Table 8: Frequency of A&E attendance for matched rough sleepers between January 2010 and June 2012

Frequency of attendance	2010 Jan to 2011 Dec	2012 Jan to 2012 Sept
Once	111	124
Two to five times	131	117
Six to ten times	36	24
Eleven to twenty times	18	12
Over 20 times	15	8

Table 8 shows the frequency of attendance at A&E. There were two people who attended A&E over 100 times during the 2010 and 2011 main study period. 21% of patients attended more than five times.

Table 9: A&E attendance for matched rough sleepers and INWL general population, by service accessed

Place of A&E attendance	Count of attendance for rough sleepers		Rate per 1000 per year for rough sleepers		Rate per 1000 per year for INWL general population		Ratio of attendance rates for rough sleepers and general population	
	Jan '10- Dec '11	Jan '12- Jun '12	Jan '10- Dec '11	Jan '12- Jun '12	Jan '10- Dec '11	Jan '12- Jun '12	Jan '10- Dec '11	Jan '12- Jun '12
A&E attendance to acute hospital	1588	1077	851	2309	128	168	6.6	13.7
Urgent care and Walk-in centre attendance	116	144	62	309	6	23	10.3	13.4
Total	1704	1221	913	2617	135	191	6.8	13.7

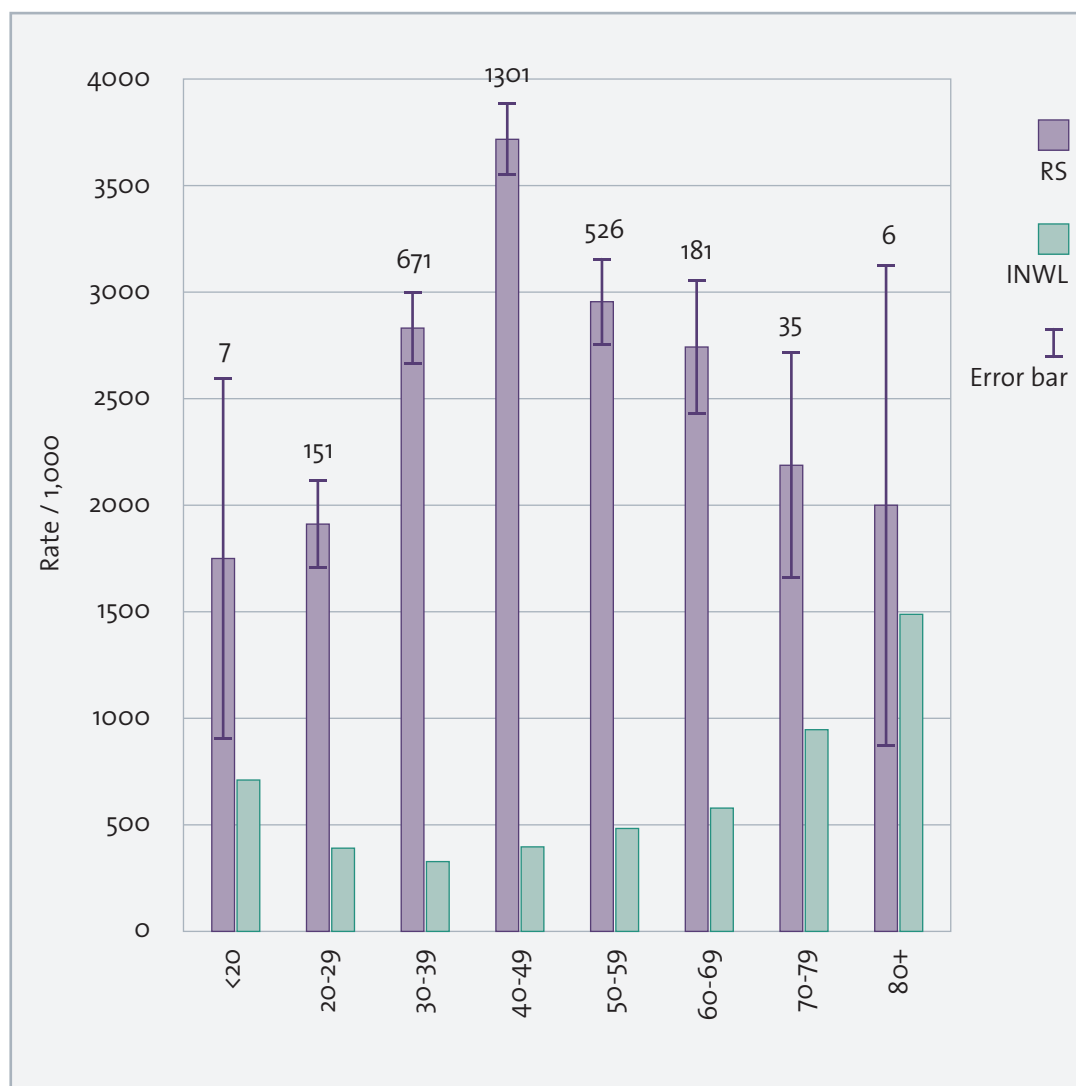
INWL PCTs provide emergency medical services via urgent care centres, walk-in centres and by acute trust A&Es. Most homeless individuals attended the acute trust A&E department, rather than urgent care or walk-in centres. Furthermore, rough sleeper groups have a nearly seven fold A&E attendance at hospitals when compared with the general population.

The cohort of homeless population identified for the purpose of this analysis was defined as those patients who were seen rough sleeping more than twice during the calendar years 2010 and 2011. It is possible that individuals who were homeless during the year 2011 may not have been homeless before the timeframe or after the

timeframe. Table 8 also analysed the data for those who were rough sleeping after that two year period.

The rate of A&E attendance among the rough sleeper community increased by nearly two fold after December 2011, from 913 per 1,000 population to 1,745 per 1,000 population. The majority of these attendances were to the A&E department of an acute hospital, with only a few attendances recorded at urgent care centres. The figures for the general INWL population also show an increase in admissions after the end of 2011, however, the magnitude is much smaller than that for rough sleepers (an increase from 135 per 1,000, to 191 per 1,000 as oppose to an increase from 913 per 1,000 to 1,745 per 1,000). The main reasons for increasing A&E activity in INWL are likely to be different to those for rough sleepers: for example, older patients with co-morbidities may make a greater contribution to A&E attendance amongst the INWL general population. Furthermore there is increase in childhood hospital admissions in the INWL general population during this period.

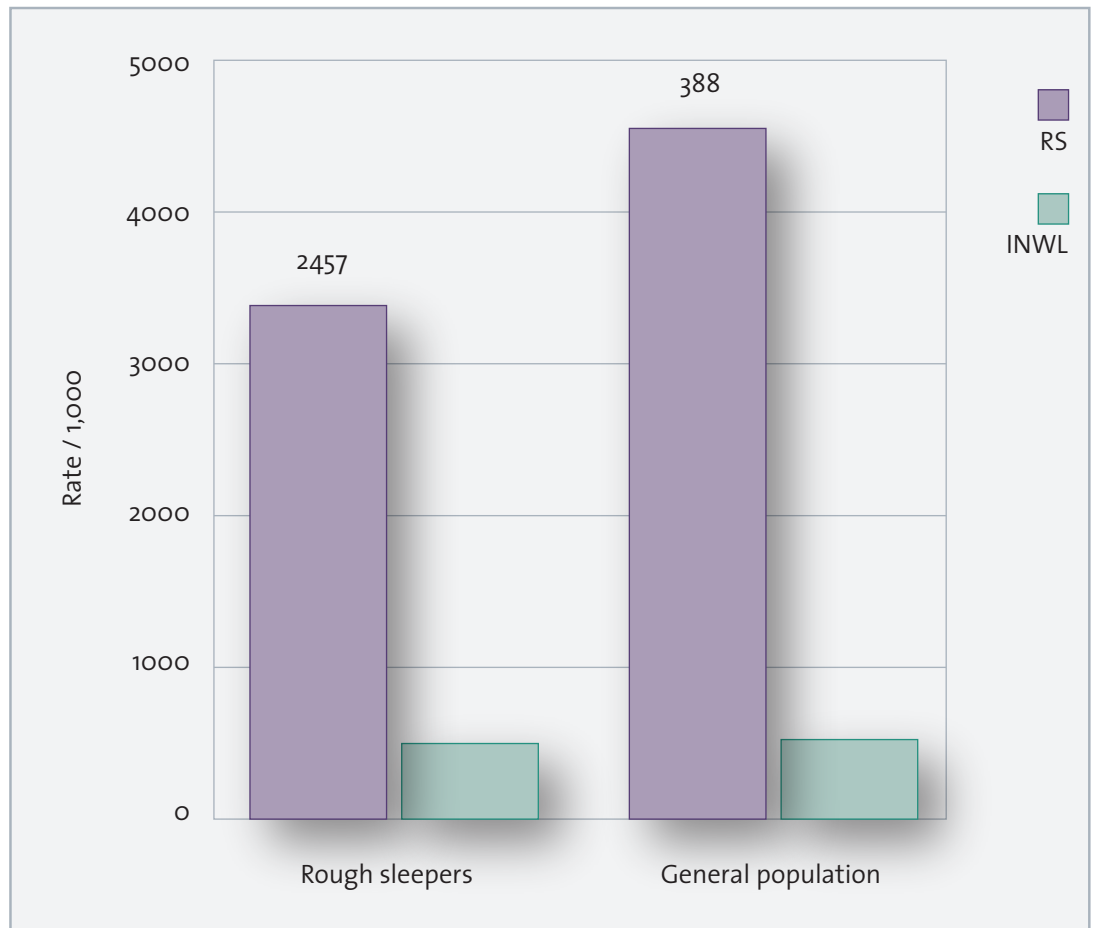
Figure 7: Rate of A&E attendances for matched rough sleepers and general INWL population, from January 2010 to June 2012, by age (with 95 % confidence intervals)



When data from January 2010 to June 2012 were reviewed, the 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 7 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 8: Rate of A&E attendances for matched rough sleepers and general population from January 2010 to June 2012 by gender



The figure above shows the number and rates of A&E attendance for rough sleepers by gender, compared with the general population. The female A&E attendance rate is nine times higher than the general population. The male A&E attendance rate is seven times higher than the general population.

Figure 9: Rate of A&E attendances as a proportion of attendance category, for matched rough sleepers and the general population, January 2010 to June 2012

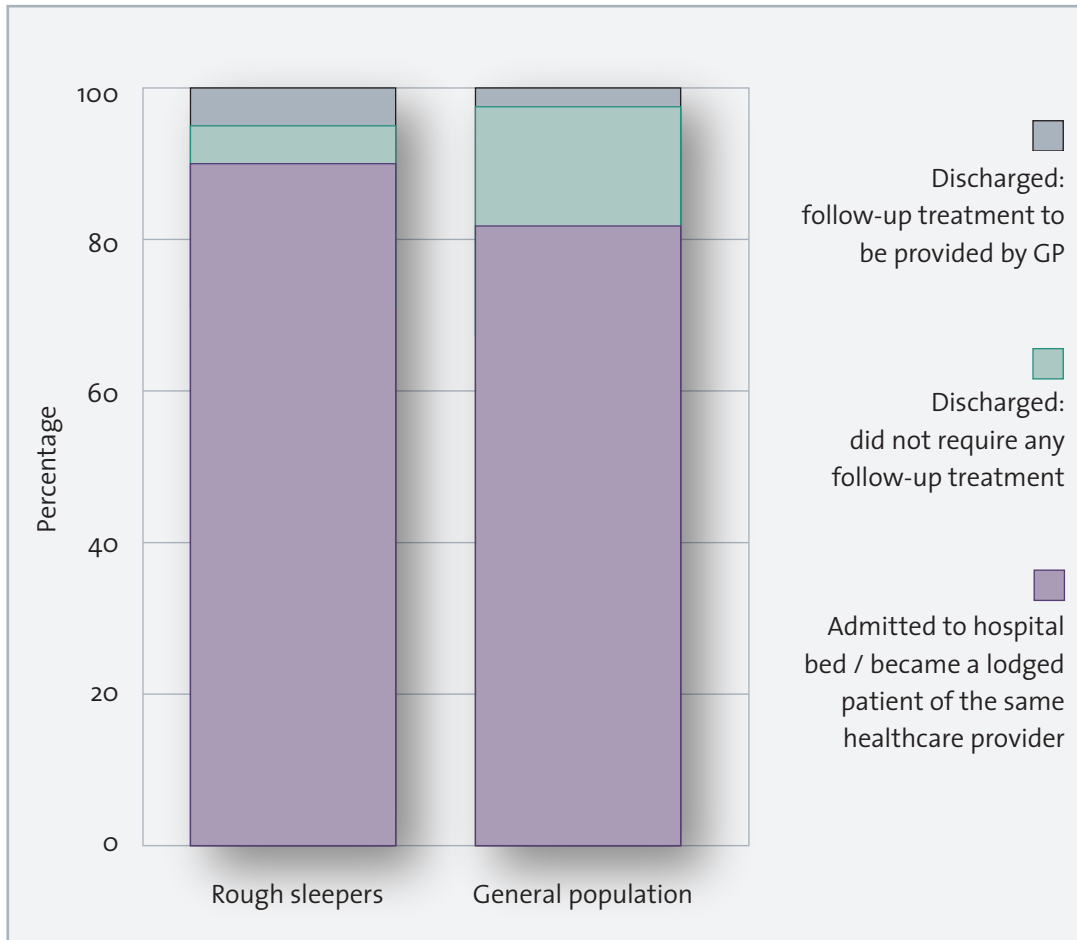


Figure 9 graphically represents the outcome of A&E attendance in terms of admission to hospital or discharge. Of the rough sleepers who attended A&E, 90% were admitted for inpatient care, while only 82% were admitted in the general population.

Figure 10: Rate of A&E attendance for matched rough sleepers and the general population, by commissioner PCT, April 2009 to June 2012 (number of RS above bar)



Out of the rough sleepers in INWL, two in three patients had their healthcare services commissioned by Westminster, but were not necessarily rough sleeping in the Westminster area. Attendance rates were also highest among Westminster rough sleeper patients.

Figure 10 graphically represents the difference in the A&E admission rates of the three PCTs, Hammersmith and Fulham, Kensington and Chelsea, and Westminster, for rough sleepers and the general population. The lowest rate of 3,006 per 1,000 population was observed for Kensington and Chelsea while the highest rate of 3,768 per 1,000 population was observed for Westminster PCT.

Table 10: Top 10 providers by count of A&E attendances for matched rough sleepers, January 2010 to June 2012

Provider name	Number of attendances	Number of patients	Attendance per patient
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	1010	310	3.3
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	965	343	2.8
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	332	159	2.1
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	280	128	2.2
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	82	19	4.3
ROYAL FREE HAMPSTEAD NHS TRUST	54	20	2.7
HEART OF ENGLAND NHS FOUNDATION TRUST	51	*	<5
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	47	*	<5
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	40	14	2.9
NORTH WEST LONDON HOSPITALS NHS TRUST	37	18	2.1

*denotes figures under 5

A large number of patients attended Guy's and St. Thomas's Hospital A&E department. Most of the patients who attended A&E had been to Imperial College Health Care NHS Trust, which includes the St. Mary's, Charing Cross, and Hammersmith Hospital sites.

Table 11: Number of A&E attendances for matched rough sleepers, by Clinical Commissioning Group, January 2010 to June 2012

CCG	Jan 2010 and Dec 2011	Jan 2012 to Jun 2012
Central London CCG	914	776
West London CCG	331	216
H&F CCG	327	190

Local authorities will have social care responsibilities, while Clinical Commissioning Groups (CCGs) will hold the healthcare responsibilities for rough sleepers, from April 2013. Therefore, the table above shows the A&E attendances for rough sleepers by the CCG of the GP practice. During the timeframe of the review, January 2010 to June 2012, the highest numbers of admissions were for rough sleepers registered with practices of the Central London CCG (Westminster).

Table 12: Number of A&E attendances for matched rough sleepers by GP practice, January 2010 to June 2012

GP practice name	Number of attendances	GP practice population	Rate per 1,000
The Dr Hickey Surgery	1249	1387	900.5
Scarsdale Medical Centre	248	5380	46.1
Hammersmith Surgery	188	9764	19.3
Lisson Grove Centre	111	7570	14.7
Millbank Medical Centre	95	6242	15.2
The Westbourne Green Surgery	93	3860	24.1
Great Chapel Street Medical Centre	85	231	368.0
The Bush Doctors	77	12109	6.4
Brook Green Medical Centre	67	11904	5.6
The Good Practice	61	3389	18
Harrow Road Health	58	4,229	13.7
The Pembridge Villas Surgery	45	9606	4.7
The Surgery (Dasgupta)	33	3468	9.5
North End Medical Centre	31	16554	1.9

The Dr Hickey Surgery, which serves homeless people in Westminster, had the highest number of patients who attended A&E. Other GP practices with high numbers of A&E attendances were Scarsdale Medical Centre, Hammersmith Surgery and the Lisson Grove Centre.

Outpatient data analysis

Figure 11: Number and rate of rough sleeper patients who had outpatient appointments for matched female rough sleepers, by age, January 2010 to June 2012 (with 95 % confidence intervals) (numbers of RS above the bar)

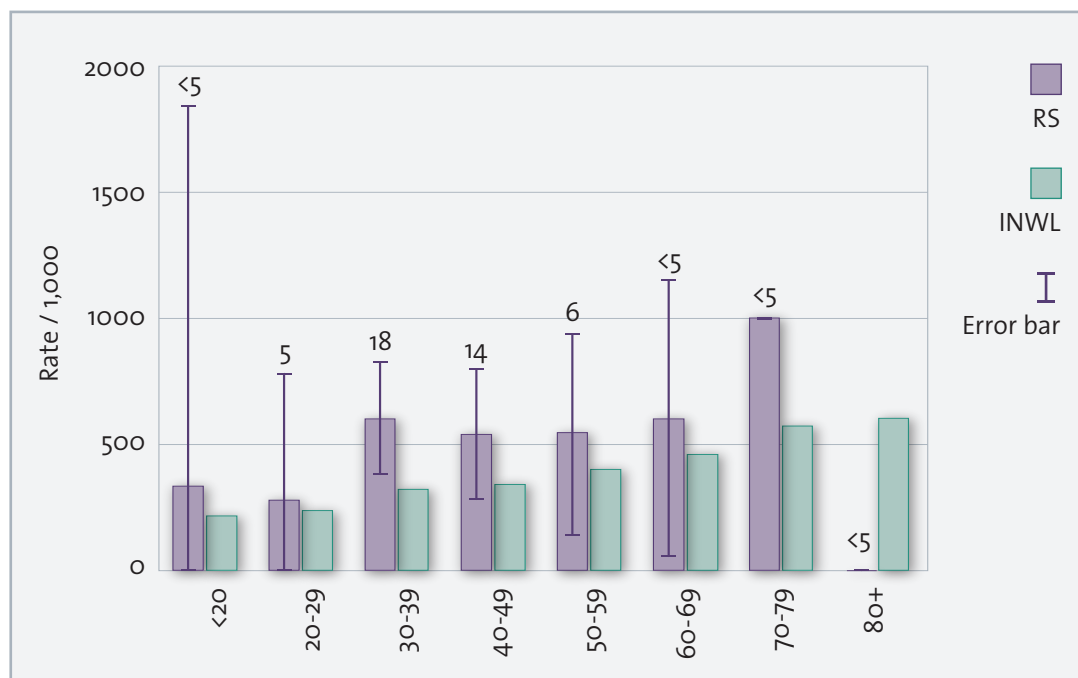
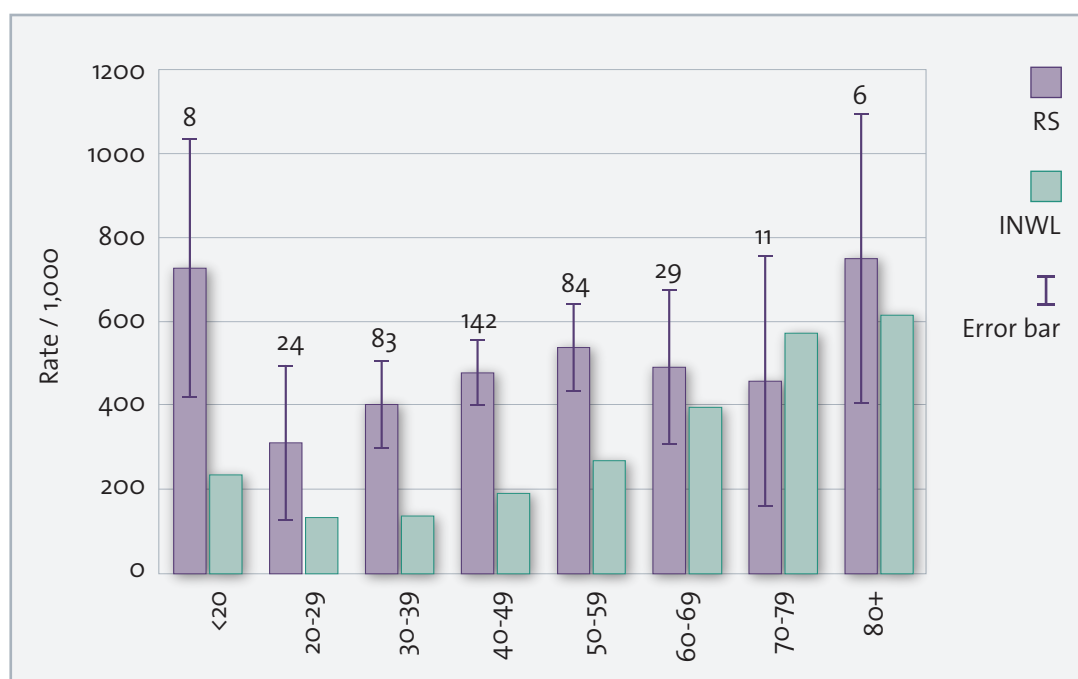


Figure 12: Number and rate of rough sleeper patients who had outpatient appointments for matched male rough sleepers, by age, January 2010 to June 2012 (with 95 % confidence intervals) (numbers of RS above the bar)



Figures 11 and 12 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 13: Rate of outpatient appointments for matched female rough sleepers and general population, by age, January 2010 to June 2012 (with 95 % confidence intervals) (numbers of RS above bar)

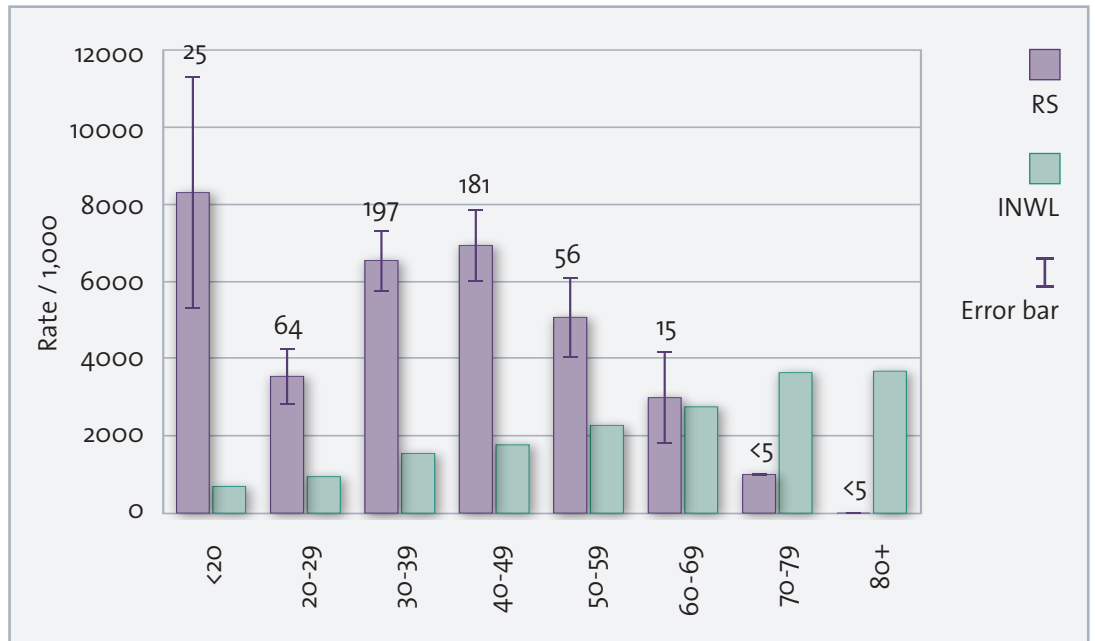
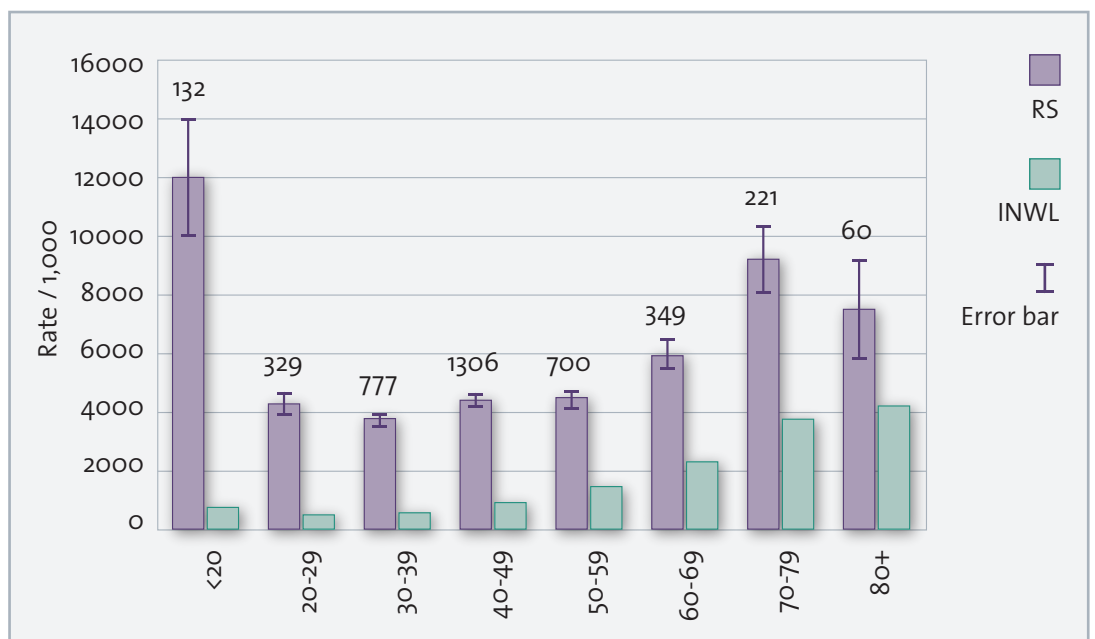
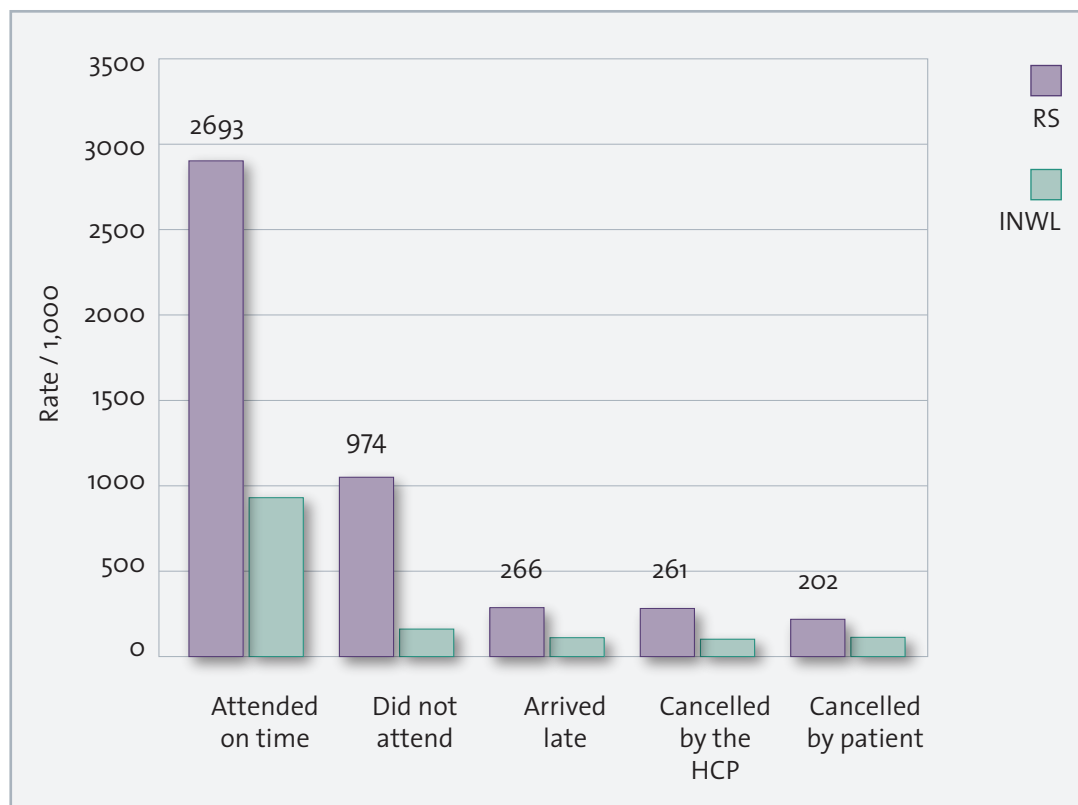


Figure 14: Rate of outpatient appointments for matched male rough sleepers and general population by age, January 2010 to June 2012 (with 95 % confidence intervals) (numbers of RS above bar)



Figures 13 and 14 show the rate and number of outpatient appointments by gender and age for rough sleepers. By age band, the number is highest among males for those aged between 40-49 years and among females for those aged between 30-39 years. The rate per 1,000 female rough sleepers is higher than for males, which means that even though the population size is smaller their individual usage of outpatient care is higher than that for males. For both sexes, rough sleepers attend significantly higher rates of outpatient appointments per 1,000 population.

Figure 15: Rate of outpatient appointments by matched rough sleepers and general population, by attendance, January 2010 to June 2012 (number of RS above bar)



The graph above 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 16: Rate of outpatient appointments for matched rough sleepers and general population, by type of attendance, January 2010 to June 2012 (numbers of RS above bar)

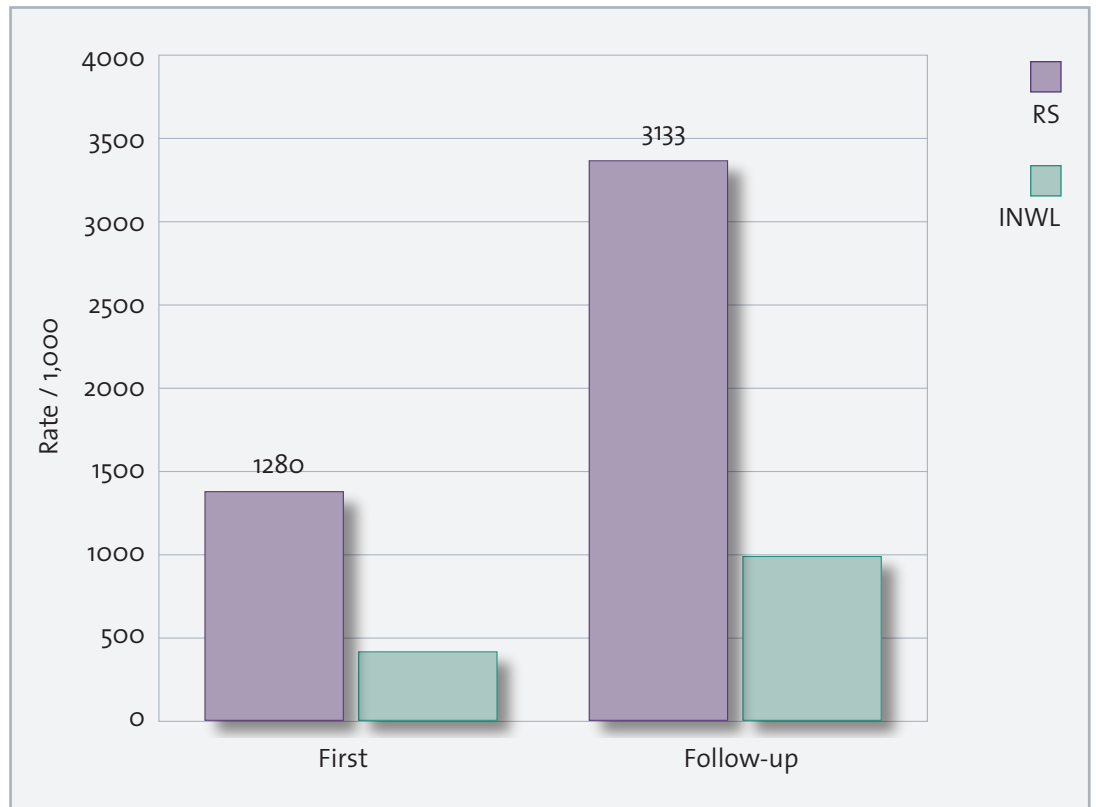


Figure 16 shows the numbers and rates of outpatient appointments per 1,000 population by type of attendance. There is no significant difference between the ratio of first to follow-up outpatient appointments between rough sleepers and the general population (1:2.4). However, outpatient first and follow-up attendance rates among rough sleepers were around three times higher compared with the general population.

Table 13: Number and rate of outpatient appointments for matched rough sleepers, by period of analysis

Period	Number of appointments	Rate per 1,000 per year
January 2010 to December 2011	2876	1541.3
From January 2012 to June 2012	1537	3294.7
January 2010 to June 2012	4413	1892.0

Table 13 shows outpatient appointments by period of analysis, with the highest rate being for the six month period from January 2012 to June 2012 (calculated as an annual rate). Some of the patients may have settled back in homes during this time. According to the definition of the dataset, those patients were known to be rough sleeping, through having had contacts with CHAIN, during the January 2010 to December 2011 period only.

Table 14: Number of hospital outpatient appointments for matched rough sleepers, by provider, January 2010 to June 2012

Provider	Number of appointments
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	1514
CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	1433
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	799
GUY'S AND ST THOMAS' NHS TRUST	330
EALING HOSPITAL	32
BARTS AND THE LONDON NHS TRUST	27
ROYAL FREE HAMPSTEAD NHS TRUST	23
KING'S COLLEGE HOSPITAL (DENMARK HILL)	22
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	21

Table 14 shows the provider trusts where rough sleepers received outpatient care. Most of the patients had outpatient appointments with either Imperial College Healthcare NHS Trust or CNWL mental health trust. This highlights mental health as a serious issue amongst rough sleeping populations. Furthermore appointments for tertiary hospitals such as Moorfields Eye Hospital highlights Ophthalmology are an issue with rough sleepers.

Figure 17: Rate of outpatient appointments for matched rough sleepers and general population, by commissioner PCT, January 2010 to June 2012 (numbers of RS above bar)

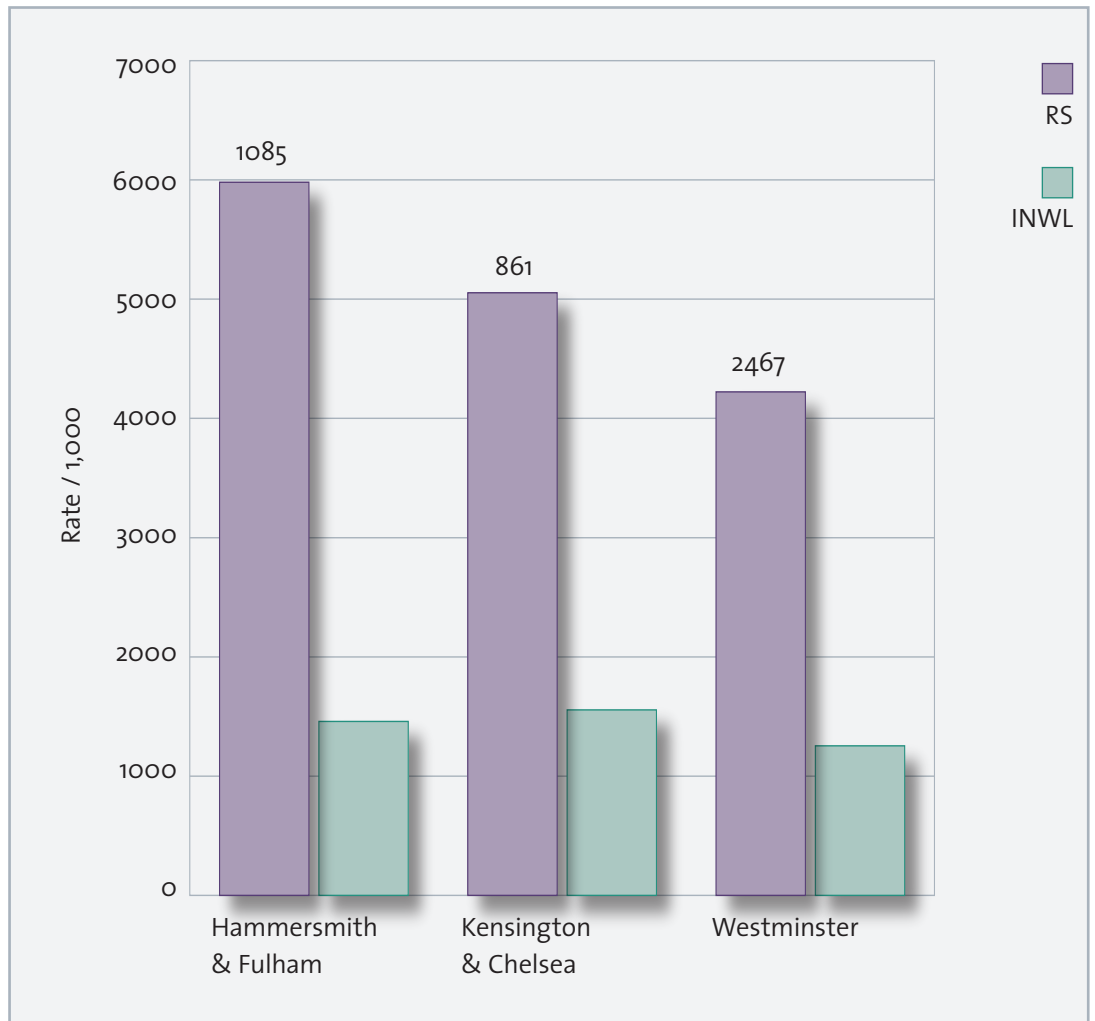


Figure 17 shows the numbers and rates per 1,000 population for rough sleepers and the general population of INWL, by PCT. The outpatient appointment rate was high among Hammersmith & Fulham PCT registered patients, compared with the other two PCTs' patients.

Table 15: Number and rate of hospital outpatient appointments for matched rough sleepers, by GP practice, January 2010 to June 2012 (aggregated)

GP practice	Number of appointments	Practice population	Rate /1,000
THE DOCTOR HICKEY SURGERY	1107	1387	798
GREAT CHAPEL STREET MEDICAL CENTRE	156	231	675
THE GOOD PRACTICE	203	3,389	60
DR DANDAPAT & PARTNERS	137	3,606	38
THE OLD OAK SURGERY	132	3,862	34
THE WESTBOURNE GREEN SURGERY	129	3,860	33
FLUXMAN HARROW ROAD HEALTH CENTRE	114	4,229	27
THE PEMBRIDGE VILLAS SURGERY	205	9,606	21
THE SURGERY, 82 LILLIE ROAD	60	3,401	18
MILLBANK MEDICAL CENTRE	110	6,242	18
ELGIN CLINIC	82	5,025	16
SOHO SQUARE GENERAL PRACTICE	64	4,019	16
SHIRLAND ROAD MEDICAL CENTRE	58	3,643	16
THE BUSH DOCTORS	162	12,109	13
BROOK GREEN MEDICAL CENTRE	148	11,904	12
NAGARAJAN QUEENS PARK HEALTH CENTRE	40	3,232	12
THE FORELAND MEDICAL CENTRE	44	4,002	11
LISSON GROVE HEALTH CENTRE	78	7,570	10
NEW ELGIN PRACTICE	47	4,762	10
THE GARWAY MEDICAL PRACTICE	45	4,665	10
STANHOPE MEWS SURGERY	87	9,095	10
VICTORIA MEDICAL CENTRE	109	12,355	9
THE LILYVILLE SURGERY	67	8,165	8
RICHFORD GATE MEDICAL CENTRE	79	10,271	8
PADDINGTON GREEN HEALTH CENTRE	44	8,506	5
HAMMERSMITH SURGERY	40	9,764	4

Table 15 shows the number of rough sleepers receiving outpatient appointments by GP practice. The Dr Hickey Surgery in South Westminster, which serves mainly for the homeless population, had the highest number of outpatient appointments during this period.

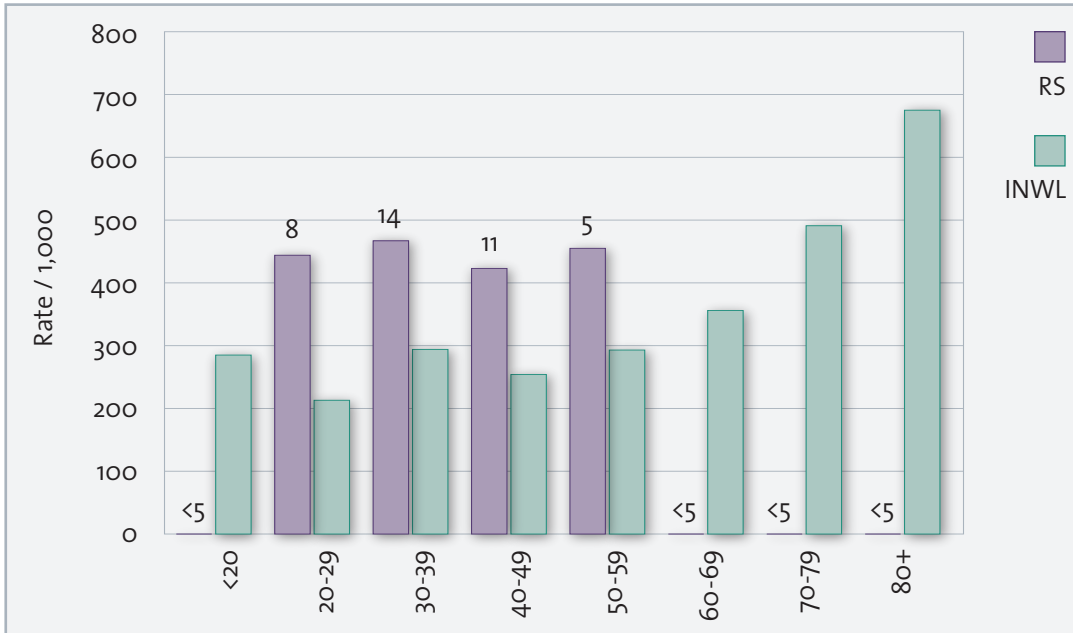
Table 16: Top 20 outpatient appointments per patient for matched rough sleepers, by treatment function specialty, January 2010 to June 2012

Treatment function Specialty	Number of patients	Number of outpatient attendances	Appts per patients
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

Table 16 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.

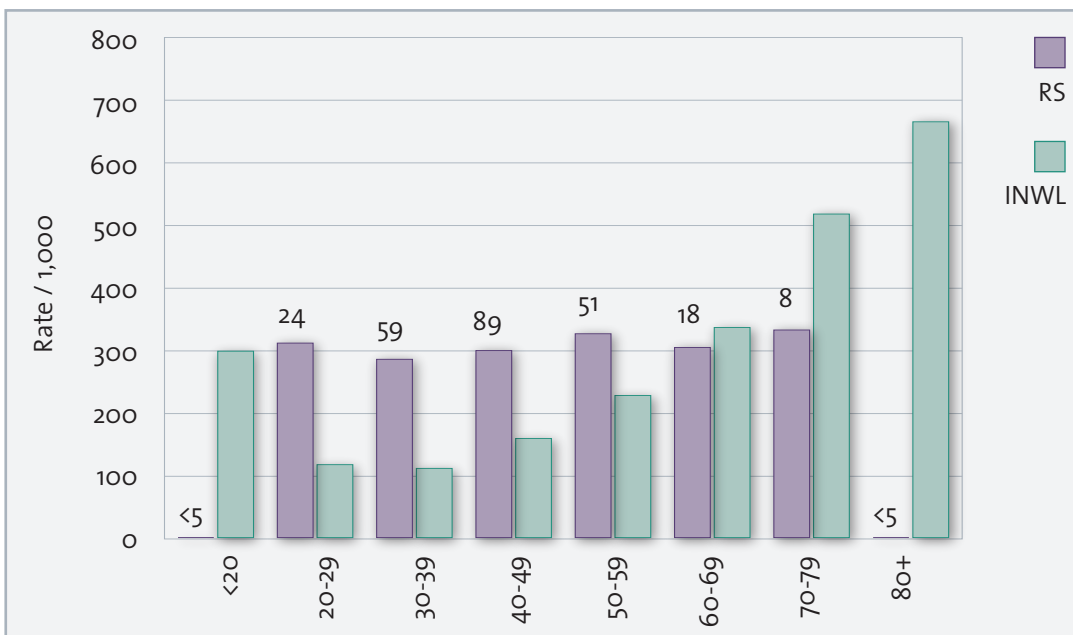
Inpatient hospital admissions analysis

Figure 18: 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)



The number of rough sleepers admitted to hospital is high among women aged 20-59 years, compared with the general population.

Figure 19: 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)



Figures 18 and 19 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.

Figure 20: Rate of hospital admissions for matched female rough sleepers and general female population, by age, January 2010 to June 2012 (number of RS above bar)

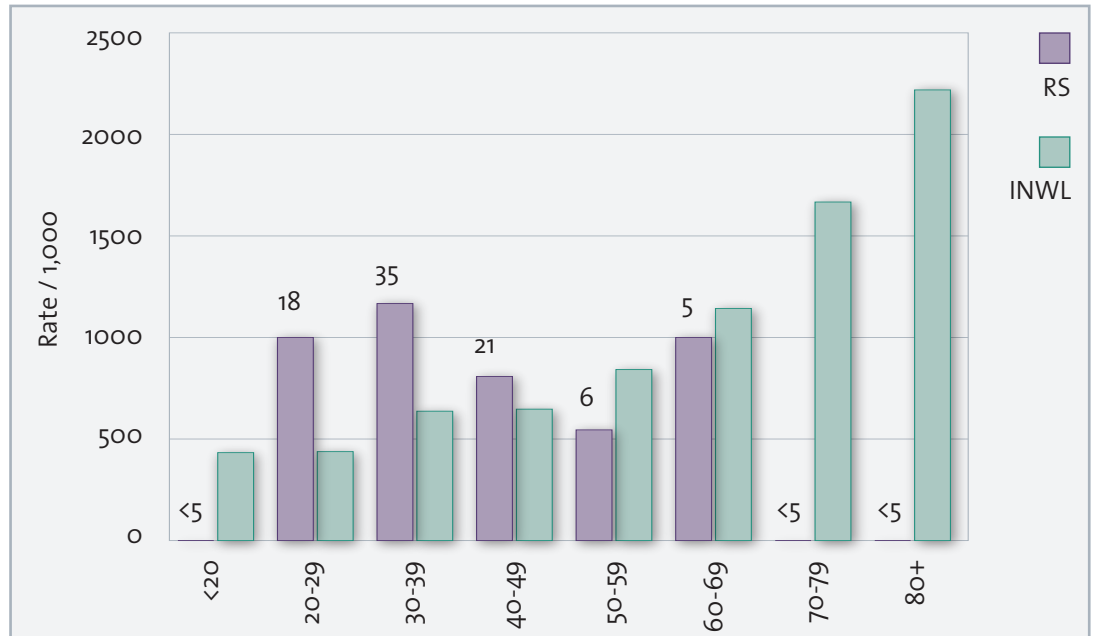
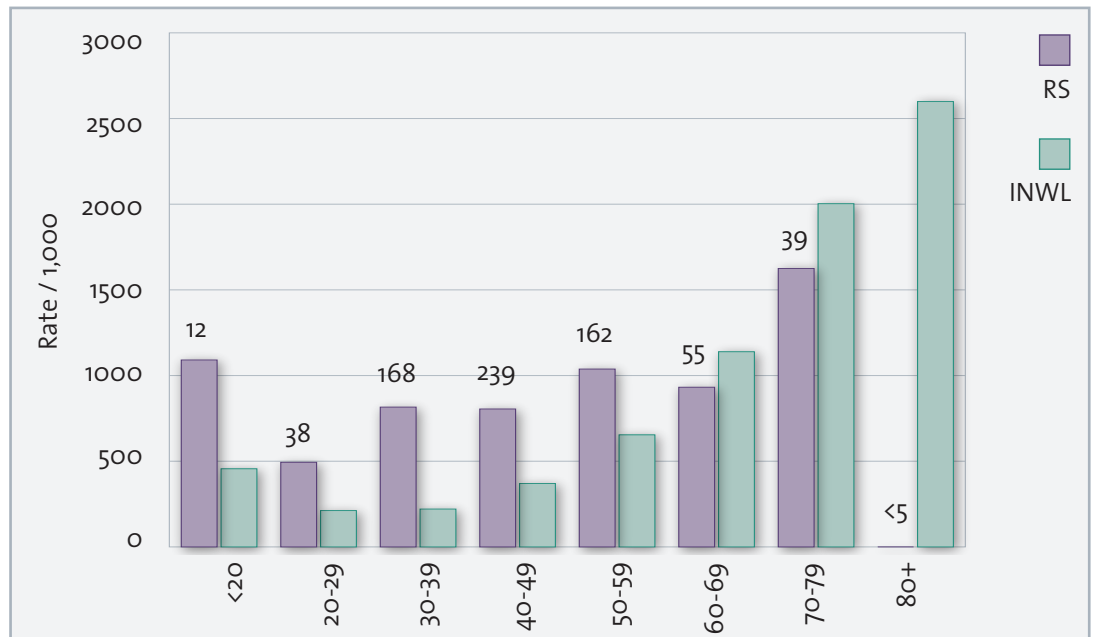


Figure 21: Rate of hospital admissions for matched male rough sleepers and general male population, by age, January 2010 to June 2012 (number of RS above bar)



Figures 20 and 21 show the rates of hospital admissions by age and gender. The rate of hospital admissions was lower than for the general population among rough sleepers aged 60 years and above. Most of the male age groups, from less than 20 to 50-59, have high admissions rates compared with general population.

Figure 22: Rate of hospital admissions for matched rough sleepers and general population, by ethnicity, January 2010 to June 2012 (numbers of RS above bar)

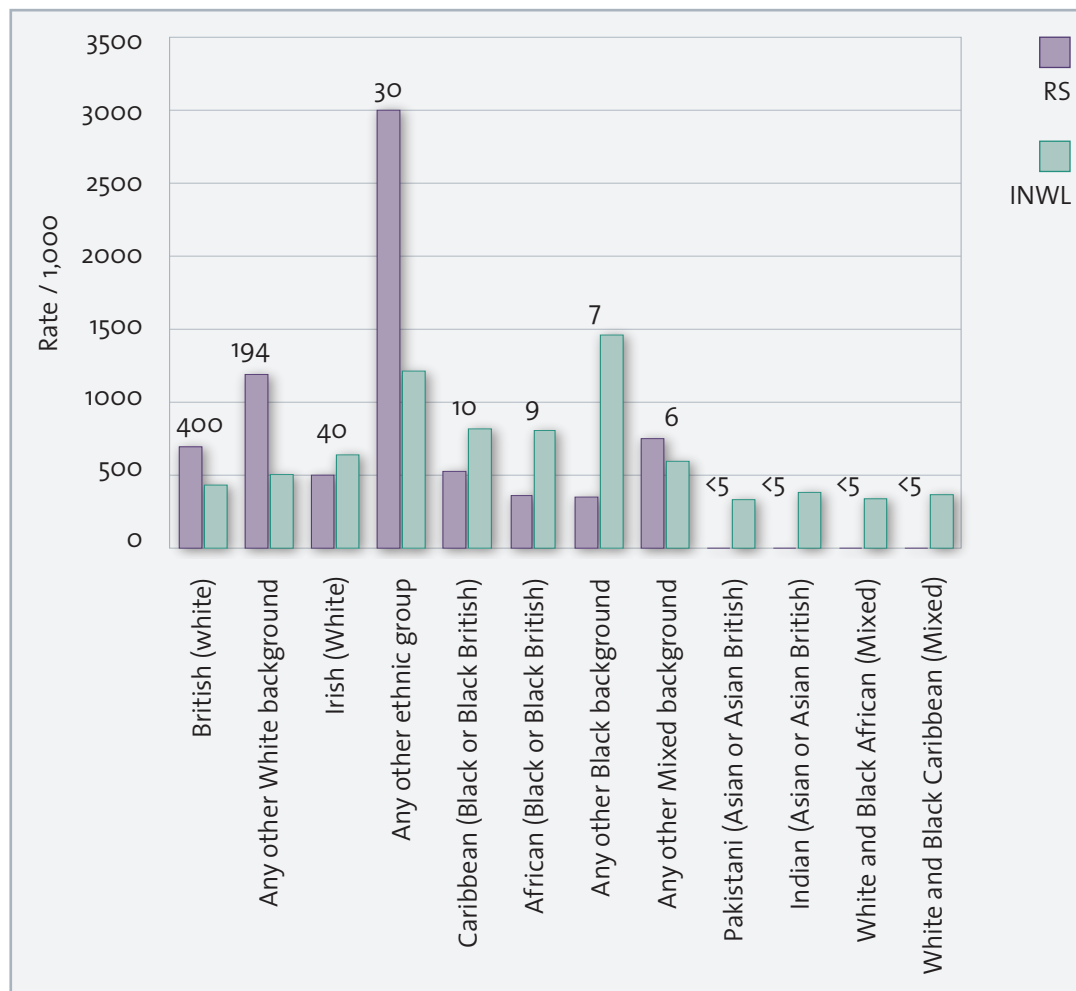


Figure 22 shows the numbers and rates of admission per 1,000 population of admissions by ethnicity. In terms of ethnicity, any other ethnic group and any other white background (which includes the Eastern European group) had high rates of hospital admissions compared with the general population. However, all black ethnic groups from the rough sleeper cohort had lower hospital admissions compared with the general population rates.

Table 17: Numbers and rates of hospital admissions for matched rough sleepers and general population, by method of admission (elective or emergency)

Admission method	Number of admissions for rough sleepers	Rates of admissions per 1000: rough sleepers	Rate of admissions per 1000: INWL general population
Elective: booked	59	63	111
Elective: from waiting list	72	77	126
Elective: planned	39	42	96
Emergency: other means, including patients who arrive via the A&E department of another healthcare provider	34	36	8
Emergency: via Accident and Emergency (A&E)	563	603	171
Emergency: via Bed Bureau	6	6	1
Emergency: via GP	6	6	6
Other	23	24	12

Table 18: 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 19: Hospital admissions for rough sleepers, January 2010 to June 2012 (aggregated), by admission method, cost and length of stay

Method of admission	Number of patients	Cost	Length of stay
Elective	191	£247,200	57
Emergency	27	£1,060,959	426

Tables 17-19 show 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.

Table 20: Number and rate of hospital admissions for matched rough sleeping cohort, by period: “during” and “after”, January 2010 to June 2012

Period	Number of Rough sleepers admitted to hospital	Rates of admissions per 1000 rough sleepers per year	Rate per 1000 in the INWL general population per year
January 2010 to December 2011	529	282	200
January to June 2012	273	585	172

Table 20 shows the number of hospital admissions by period after and during the period used to identify the rough sleeping cohort. The rough sleeper cohort was defined as those patients who had contacts with CHAIN during 2010 and 2011. However, according to the data, the rate of hospital admissions was highest during 2012, after the cohort defined period. During this period, some of the rough sleepers are expected to have settled in new homes.

Table 21: Number of inpatient hospital admissions for matched rough sleepers, by hospital care provider, January 2010 to June 2012

Provider	Number of admissions
GUY’S AND ST THOMAS’ NHS FOUNDATION TRUST	223
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	260
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	103
CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	62
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	55
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	9
KING’S COLLEGE HOSPITAL NHS FOUNDATION TRUST	9
NORTH WEST LONDON HOSPITALS NHS TRUST	7
CAMDEN AND ISLINGTON MENTAL HEALTH AND SOCIAL CARE TRUST	5
ST GEORGE’S HEALTHCARE NHS TRUST	5
BARTS AND THE LONDON NHS TRUST	5
OTHER PROVIDERS	59

Table 21 shows the number of inpatient hospital admissions of rough sleepers by provider trust. Most of the rough sleepers in INWL were admitted to Guy’s and St. Thomas’ NHS Foundation Trust and Imperial College Healthcare NHS Trust.

Figure 23: Rate of inpatient admissions for matched rough sleepers and general population, by commissioner PCT, January 2010 to June 2012 (95% confidence intervals) (numbers of RS above bar)



Figure 23 shows the numbers and rates per 1,000 population of inpatient admissions of rough sleepers by commissioner PCT. Rates of hospital admissions were high among Kensington and Chelsea GP registered patients compared with the other two PCTs among the general population. For the rough sleeper population, rates were highest in Westminster.

Table 22: Number of inpatient admissions for matched rough sleepers, by Clinical Commissioning Group

CCG	During 2010 and 2011	After 2011
Central London CCG	322	158
West London CCG	116	64
H&F CCG	91	51

Table 22 shows the number of inpatient admissions of rough sleepers by Clinical Commissioning Group. Overall, the greatest numbers of rough sleepers with hospital admissions were registered with GP practices of the Central London CCG (Westminster).

Table 23: Number of inpatient admissions for matched rough sleepers, by practice, January 2010 to June 2012

GP practice name	Total
The Dr Hickey Surgery	314
Great Chapel Street Medical Centre	40
Brook Green Medical Centre	31
The Westbourne Green Surgery	29
The Surgery	28
The Bush Doctors	28
Lisson Grove Centre	22
Scarsdale Medical Centre	19
The Good Practice	18
Millbank Medical Centre	18
The Pembridge Villas Surgery	17
Harrow Road Health	15
Old Oak Surgery	11
Victoria Medical Centre	10
Other INWL practices	202

The numbers of admissions to hospital were highest in two Central London CCG practices (The Dr Hickey Surgery and Great Chapel Street Medical Centre). These two practices mainly serve homeless communities in Inner North West London.

Table 24: Number of hospital admissions for matched rough sleepers, by treatment function specialty, January 2010 to June 2012

Treatment function specialty	Number of Admissions	Number of Patients	Admission per patient
ACCIDENT & EMERGENCY	287	83	3
GENERAL MEDICINE	147	59	2
ADULT MENTAL ILLNESS	77	28	3
GASTROENTEROLOGY	52	23	2
TRAUMA & ORTHOPAEDICS	43	19	2
GENERAL SURGERY	33	15	2
UROLOGY	15	5	3
PLASTIC SURGERY	15	8	2
CARDIOLOGY	12	8	2
OBSTETRICS	10	5	2
ENT	10	8	1
ORAL SURGERY	9	5	2
GERIATRIC MEDICINE	8	*	*
ENDOCRINOLOGY	7	*	*
OPHTHALMOLOGY	7	*	*
HEPATOLOGY	6	*	*
NEUROSURGERY	6	*	*
MEDICAL ONCOLOGY	5	*	*
PAEDIATRICS	5	*	*
OTHER SPECIALTIES	48	*	*

Table 24 shows the number of hospital admissions of rough sleepers by treatment function specialty. The three treatment function specialities with the highest numbers of admissions were A&E, general medicine and adult mental illness. Out of 77 adult mental illnesses admissions, 62 (81%) were admitted to Central North West London NHS Foundation Trust.

Information on diagnosis of inpatient admissions is very well recorded in NHS data. An international classification system (ICD-10 diagnosis) is used to diagnose the conditions of patients. ICD-10 diagnosis is divided into four levels. The simplest and highest level is called an ICD-10 chapter. There are 16 ICD-10 chapters, with each chapter then further divided into two digit, three digit and four digit descriptions. Four digit descriptions provide the exact full medical condition.

Table 25: 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	*	*
Unknown diagnosis	33	9	3

Table 25 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 26: Number of inpatient hospital admissions for matched rough sleepers, by ICD-10 primary diagnosis 4 digit description, January 2010 to June 2012

Primary diagnosis 4 digit description	Admissions
Mental & behavioural disorders due to use of alcohol: acute intoxication	46
Mental and behavioural disorders due to use of alcohol: withdrawal state	41
Chest pain, unspecified	22
Cellulitis of other parts of limb	19
Unspecified injury of head	19
Paranoid schizophrenia	15
Other and unspecified convulsions	13
Epilepsy, unspecified	12
Lobar pneumonia, unspecified	12
Cutaneous abscess, furuncle and carbuncle of limb	10
Chronic lymphocytic leukaemia	9
Syncope and collapse	9
Non-infective gastroenteritis and colitis, unspecified	8
Generalized idiopathic epilepsy and epileptic syndromes	7
Pneumonia, unspecified	7
Dental caries, unspecified	7
Gastritis, unspecified	7
Gastrointestinal haemorrhage, unspecified	7
Other and unspecified abdominal pain	7
Open wound of other parts of head	7
Schizophrenia, unspecified	6
Alcoholic cirrhosis of liver	6
Ulcer of lower limb, not elsewhere classified	6
Headache	6
Other chest pain	6
Poisoning by Heroin	6
Anaemia, unspecified	5
Men & behav dis multiple/psychoact drug: unsp men & behav di	5
Mental disorder, not otherwise specified	5
Alcoholic liver disease, unspecified	5
Haematemesis	5
Ascites	5
Other 4 digit diagnoses	452

Table 26 shows the number of inpatient hospital admissions of rough sleepers by ICD-10 primary diagnosis 4 digit description. The three commonest four digit descriptions were mental & behavioural disorders due to use of alcohol: acute intoxication; mental and behavioural disorders due to use of alcohol: withdrawal state; or blank entry.

Table 27: 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%

The length of stay for rough sleepers was slightly longer than for the general population. 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 27).

Table 28: Mean length of stay for hospital admissions for matched rough sleepers and general population, by age, January 2010 to June 2012

Age band	Rough sleepers	General population
<20	3.1	1.03
20-29	7.9	1.64
30-39	7.5	2
40-49	5.19	1.25
50-59	4.2	1.63
60-69	5.31	2.23
70-79	3.03	3.63
80+	10	9

The mean length of stay is higher for rough sleepers for most age groups except in the older population (70 years and above) where the length of stay appears to be similar to that of the general population.

Table 29: 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%

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).

Conclusion

The analysis has provided a description of the homeless population of INWL. Key findings from this report are that rough sleepers in INWL utilise healthcare more frequently than the general population:

- ▶ Rates of A&E attendances among rough sleepers are approximately seven times higher compared with the general population.
- ▶ Numbers of hospital outpatient appointment did not attends are seven times higher compared with the general population.
- ▶ Rough sleepers required much higher rates of emergency (as supposed to elective) admissions than the general population (73% rough sleepers, while 30% in the general population).
- ▶ Mean length of stay at hospital for those rough sleepers is three days higher compared with the general population.
- ▶ Rough sleeper population has over double the number of patients with three ICD-10 categories at admission (18.7% rough sleepers, while 7.9% in the general population)
- ▶ Rates of all forms of hospital usage appear to increase over time within the same cohort.

Source Information

Data sources used throughout:

- ▶ Broadway: CHAIN database

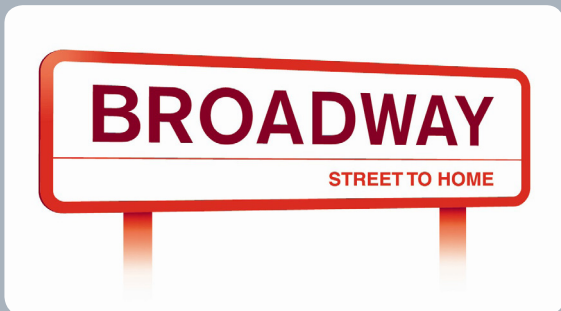


- ▶ Secondary Uses Service (SUS), via INWL Business Intelligence Unit: inpatient, outpatient and accident & emergency tables
- ▶ EXETER: GP registered population data

PART THREE

Qualitative research

Jane Jones, Broadway



Executive summary

The research

Broadway's Research Team was commissioned by the Inner North West London Primary Care Trust to conduct a qualitative study of the health needs of current and former rough sleepers in the area and identify to what extent health services are meeting their needs.

Preliminary interviews were conducted with seven commissioners and the Director of Public Health in order to identify their priorities and concerns.

The findings presented in this report are derived from in-depth interviews with:

- ▶ Twenty-two current and former rough sleepers.
- ▶ A peer volunteer.
- ▶ Seventeen health professionals and service providers.

The health needs of current and former rough sleepers

'I've had [arthritis] for years but when I was sleeping rough, sleeping on the concrete, it must've made it worse because I only walk so far and collapse down.'
– rough sleeper

Out of the twenty-two current and former rough sleepers interviewed, the following health needs were reported:

Health need	Present	Past
Physical	18	-
Mental	14	5
Alcohol misuse	9	7
Drug misuse	11	2
Tri-morbidity*	9	8

* Tri-morbidity: co-existing physical and mental health and substance misuse problems.

Interviewees identified certain experiences that contributed to their ill-health and / or vulnerability to homelessness:

- ▶ Childhood abuse.
- ▶ Traumatic experiences.
- ▶ Domestic violence and abuse.
- ▶ Relationship breakdown.
- ▶ Bereavement.
- ▶ Difficulties at work and job loss.

Some spoke of how homelessness contributed to a decline in their health by:

- ▶ Aggravating existing conditions.
- ▶ Making them vulnerable to infection.
- ▶ Causing sleep-deprivation which impacted upon their mental health.

Access to health services

The current and former rough sleepers interviewed reported contact with the following services:

- ▶ General Practices (twenty-one of the twenty-two people interviewed).
- ▶ Dentists (sixteen people).
- ▶ Accident and emergency departments (thirteen people).
- ▶ Hospitals- other (seven people).
- ▶ Drug and alcohol services (nine people).
- ▶ Mental health services (eleven people).
- ▶ Homelessness services (twenty-two people).

It should be noted that this information is self-reported and (because of the relatively small number of people interviewed) should not be taken as representative of homeless people's use of services in the area.

Barriers to accessing health services

'I think when you go to a normal doctor they do look down on you [...] I think they are a bit worried in case I give them something. [...] It was just the way they were talking, looking, sitting away from me.'

– rough sleeper

Interviewees identified a number of barriers to accessing health services:

- ▶ Not feeling ready to address health concerns whilst dealing with more immediate concerns as a rough sleeper.
- ▶ Deliberate neglect of health as a form of self-harm.
- ▶ Fear and denial of ill-health preventing people from seeking treatment.
- ▶ Embarrassment and low self-esteem, or difficulty communicating health needs, preventing people from seeking treatment.
- ▶ Negative perceptions of services can exist for a number of reasons, including: fear of 'officials' and clinical settings, the denial of services, experiences of stigma, or negative experiences of treatment (for example of mental health medication and of giving or receiving blood).
- ▶ Lack of access to information about health services and lack of referrals to those services.
- ▶ Exclusion from services on account of being unable to demonstrate a local connection or because local authority departments or local services dispute responsibility for their care.
- ▶ Exclusion from services because of clinical boundaries around dual diagnosis or co-existing substance misuse problems.
- ▶ Delayed access to services due to long waiting times and the 'testing' of homeless people for reliability.
- ▶ Negative experiences of homelessness services that can impact upon health and deter access, such as bullying and harassment by other service users and chaotic hostel environments

Interviewees suggest that additional barriers may be faced by certain sub-groups of current and former rough sleepers, including:

- ▶ People with personality disorder.
- ▶ Migrants and speakers of other languages, including Central Eastern Europeans.

Enhancing access to health services and improving patient experiences

'We've got a client who never engaged in health services: never. But now, because of his relationship with one of the Groundswell peers, he barely says 'no' to an appointment.'

– project worker

Interviewees identified a number of practices that health services can adopt to remove barriers to access and improve patient experiences:

- ▶ Taking health services to the patient via day centres, medically-trained staff on outreach shifts and in-reach into hostels.
- ▶ A 'one-stop-shop' approach to delivering healthcare: addressing all of a patient's health needs when they do access the service (which may require the allocation of additional time).
- ▶ Additional support from GPs, such as directly booking hospital appointments.
- ▶ Services working across geographical and clinical boundaries that can limit access, for example by delivering dual diagnosis treatment through joint working across services, or pan-London healthcare initiatives.
- ▶ Open referral systems (e.g. accepting self-referrals).
- ▶ The removal of obstacles to GP registration.
- ▶ Training to remove stigma towards or lack of understanding of the needs of rough sleepers among medical staff.

Interviewees said that homelessness support services can take the following action to enhance access to health services:

- ▶ Enable people to move off the street.
- ▶ Offer support and encouragement to access health services.
- ▶ Adopt a strong health focus within homelessness support services.
- ▶ Accompany people to health appointments or arrange peer support.

Finally, interviewees suggested several ways in which homelessness support agencies can improve client experiences of their own services and thereby enhance access to healthcare:

- ▶ Create therapeutic environments built upon healthy relationships.
- ▶ Ensure staff are well-supported (especially when dealing with personality disorder).
- ▶ Encourage service-user ownership and control over the service and their care, for example via opportunities for feedback, the use of peer support and 'co-production'.
- ▶ Adopt a holistic approach towards promoting individual wellbeing, considering

factors such as meaningful use of time and positive social networks.

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, with the patient's explicit consent.

Discharge and move-on from services

'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.'

– former rough sleeper on discharge from mental health unit

Interviewees raised a number of concerns around hospital discharge, including:

- ▶ Early discharge before the patient feels their health needs have been fully met.
- ▶ Self-discharge resulting from a failure to meet the patient's needs, particularly around opiate-dependency.
- ▶ Discharge to the street either because homelessness is not identified or hospital staff do not make the necessary referrals following the disclosure of homelessness.
- ▶ Poor communication between hospitals and GPs or homelessness support providers upon discharge.
- ▶ Discharge without clothing or transport.

One interviewee with no recourse to public funds said that he was discharged from hospital to the street more quickly when he was unable to provide a national insurance number.

Interviewees suggested that hospital discharge could be improved for current and former rough sleepers by:

- ▶ The provision of respite accommodation with adequate healthcare.
- ▶ A system of care coordination for every homeless person to ensure that all their health and social care needs have been fully addressed.

Several interviewees also expressed concern regarding move-on from supported accommodation. They suggested that a poorly-managed move-on could be detrimental to a person's wellbeing, as could feeling 'trapped' in unsuitable accommodation.

Finally, interviewees said that, in some cases, the transition away from specialist homelessness health services is too abrupt and can cause deterioration in health.

1. Introduction and methodology

Broadway was commissioned by the Inner North West London Primary Care Trust to conduct research into the health needs of current and former rough sleepers in Kensington and Chelsea, Hammersmith and Fulham and Westminster.

Our research focused on physical and mental health and substance misuse. It aimed to explore:

- ▶ What are the barriers to current and former rough sleepers accessing healthcare services and receiving effective healthcare and how can these be overcome?
- ▶ Where are there gaps in healthcare pathways for current and former rough sleepers?
- ▶ Which healthcare services effectively meet the needs of current and former rough sleepers and why?
- ▶ How far, and under which circumstances, can this group's needs be met by generic health services and how far are specialist services for homeless people necessary?
- ▶ How can healthcare service provision for current and former rough sleepers be improved?

The research was shaped by initial interviews with seven commissioners and the Director of Public Health from Inner North West London, who identified various priorities and concerns.

Subsequently, we conducted in-depth interviews with:

- ▶ Twenty-two current and former rough sleepers from across the three boroughs: They included seven current and fifteen former rough sleepers. Ten interviews were conducted in Westminster, seven in Kensington and Chelsea, and five in Hammersmith and Fulham.
- ▶ One formerly homeless peer volunteer.
- ▶ Seventeen health professionals and other service providers in the three boroughs.

This piece of research forms part of a broader study conducted by the Inner North West London Primary Care Trust, including:

- ▶ A review of the existing literature relating to the health needs and service use of current and former rough sleepers, as well as the effectiveness of specific interventions and models of service delivery aimed at homeless people.
- ▶ A statistical analysis of rough sleeper data (from the Combined Homelessness and Information Network, CHAIN), cross referenced with NHS data, which illustrates some patterns in the use of health services by a cohort of 933 current and former rough sleepers.

2. The health needs of current and former rough sleepers in Inner North West London

Key points

- ▶ Eighteen of the twenty-two participants had current physical health problems, including injuries, blood-borne viruses, respiratory ailments, impaired liver and kidney function, cancer and heart disease, epilepsy, skin and foot complaints, injecting injuries, gum disease and tooth decay.
- ▶ Fourteen people had a current mental health issue, and an additional five people a former mental health issue, including depression, self-harm and suicidal thoughts, anxiety, personality disorder and schizophrenia.
- ▶ Sixteen people had a current or former problem with alcohol, and thirteen people had a current or former problem with drugs. Six people were currently using both alcohol and drugs.
- ▶ Several people had a dual diagnosis (a concurrent substance and mental health issue) and several had 'tri-morbidity' (co-existing physical and mental health and substance misuse problems). Several described their substance misuse as a form of self-medication for underlying mental health problems.
- ▶ Key life events and experiences that precipitated participants' homelessness and declining health included childhood abuse, traumatic experiences, domestic violence, relationship breakdown, bereavement, and the loss of employment or work-related pressures.
- ▶ Rough sleeping had had a detrimental impact upon many participants' health. It aggravated existing conditions (such as asthma or arthritis); led to the development of new health conditions (such as TB); and made people more vulnerable to infection. Sleep deprivation affected people's mental health and drugs and alcohol were often used as a way of coping on the streets.

2.1 Health needs

This section outlines the physical and mental health and substance misuse issues of the twenty-two current and former rough sleepers from Inner North West London who participated in this study.

2.1.1 Physical health

Eighteen out of the twenty-two current and former rough sleepers who participated in the study reported having at least one current physical health problem. These included the following: injuries (to the head, back, hand, foot or leg); blood-borne viruses, such as Human Immunodeficiency Virus (HIV) and Hepatitis C; respiratory ailments, such as asthma and tuberculosis (TB); impaired liver and kidney function; cancer and heart disease; epilepsy; skin and foot complaints; injecting injuries; gum disease and tooth decay. Three interviewees were also awaiting medical examinations for unexplained dizzy spells, tremors and vomiting blood, respectively.

Many individuals had more than one physical ailment, including long-term conditions. For example, Ruth (pseudonyms are used throughout this report), who started to suffer with severe indigestion as a rough sleeper and had been vomiting blood, also had asthma and at seventeen had been diagnosed with an under-active thyroid. Others had experienced a sequence of related physical health problems, such as Daniel who developed a hernia after an operation for appendicitis or George, who eventually had to have a toe amputated after he developed antibiotic-resistant osteomyelitis from an untreated fracture.

There are certain ailments which participants considered to be inter-related, for example, Richard's HIV meant that his immune system was low and he was particularly susceptible to contracting TB, whilst Ryzard explained that his liver has been damaged by the aggressive course of treatment he had undergone to cure him of TB.

2.1.2 Mental health

Mental ill-health was also highly prevalent: Fourteen of the people interviewed stated that they were experiencing a current mental health problem, with a further five referring to a problem in the past. The most commonly reported condition was depression (ten cases clearly identified), varying from milder symptoms to one diagnosis of severe depression:

'They're what I call the black moods. [...] At times it feels like the whole of myself is just shutting down.'

– Alistair

Two people reported having made repeated suicide attempts and a further two disclosed having suicidal thoughts. Five spoke of self-harm that, in some cases, was so severe it required hospitalisation.

One interviewee reported that she had been diagnosed with personality disorder and schizophrenia, but was not sure if she agreed with the diagnosis. Another reported contact with mental health services and being prescribed anti-psychotic medication, but did not disclose a diagnosis. Two interviewees described feeling 'paranoid'; three specifically referred to 'anxiety'.

2.1.3 Substance misuse

Nine people said that they currently have a problem with alcohol and a further seven reported having had an alcohol problem in the past. Interviewees spoke of different drinking patterns, from Rita who 'binged' occasionally since she started sleeping on the street, to Richard who consumed seven or eight cans of Super Skol each day and Tom who regularly consumed two large bottles of vodka a day, until he managed to detox. Some of the interviewees described ongoing symptoms of alcohol dependency:

'Waking up with fits and throwing up and all of that: it used to be once a week [...] and now it's a guaranteed thing: I get up in the morning and it's like oh shit it's the morning here we go... fits [...] I don't want to drink when I wake up [...] so you leave it as long as you can and you start getting fits and the only thing that's going to sort it out is having a drink, so fuck it.'

– Dave

Eleven people identified a current drug problem and two reported having had a drug problem in the past. Again, people spoke of different patterns and preferences, for example, Omar, who is now on a subutex script, was using £300 to £400-worth of heroin at the peak of his addiction, whereas Ryan spends about £20 every three or four days on cannabis and has used a variety of stimulants, such as cocaine, ecstasy and speed.

Six of the interviewees reported that they were still using both alcohol and drugs. For example, Matthew said he had been smoking heroin on a daily basis for the last three or four months, whilst taking a methadone script and bingeing periodically on alcohol. Mark said that he was drinking ten to fifteen cans a day and used ecstasy, cocaine, crack cocaine and LSD.

2.1.4 Tri-morbidity and dual diagnosis

As part of this research, issues of 'tri-morbidity', i.e. co-existing physical and mental health and substance misuse problems were considered. Nine people reported all three types of health problems and a further eight reported having had all three in the past. Such conditions often interact and, at times, interviewees identify a clear relationship between different aspects of their ill-health.

Many of the interviewees make a clear connection between their substance misuse and mental health issues. One person in the sample said that he suffered from paranoia and anxiety as a result of his heavy cocaine and alcohol use. However

more people described their substance misuse as a form of self-medication for underlying mental health problems. For example, when Charlotte, who self-harms and has suicidal thoughts, was asked if her drug-use was related to how she is feeling, she replied *'If it weren't for this (drug) I would be probably six feet under by now'*, indicating that she uses drugs as a form of self-medication for mental distress.

Similarly, George's case illustrates how poor physical health can impact upon mental health and substance misuse. He had been prescribed oxycodone 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.'

Meanwhile, a number of other interviewees talked about how their substance misuse had impacted upon their physical health. This happened in various ways, from the immediate results of intoxication such as Ryzard who fell off a bench and broke his shoulder, to the more long term effects of substance misuse such as alcohol-related liver damage, in Tom's case. Moreover, Matthew described how an episode of deliberate self harm (riding his bicycle into a bus and breaking his ribs) was also preceded by drinking alcohol, without which he considers it probably would not have occurred.

2.2 Health and homelessness: the links

Interviewees described key life events and experiences that precipitated their homelessness and declining health, including childhood abuse, traumatic experiences, domestic violence, relationship breakdown, bereavement, and the loss of employment or work-related pressures. Others also discussed the many ways in which rough sleeping has had a detrimental impact upon their health. Each of these issues will be explored in further detail within this section.

2.2.1 Childhood abuse

Out of the twenty two current and former rough sleepers interviewed, four people explicitly referred to childhood abuse. For example, Omar, who spent much of his teenage years in and out of children's homes, first started using heroin when he ran away from home:

'I started using when I was 13, 14. I ran away from home because of an arranged marriage. I was supposed to get married at 14, but I ran away.'

Likewise, Luke, who started using heroin at 15 and is being treated for depression, described growing up in an abusive household:

'My old man's an alcoholic- used to beat me mum around all over the place, so I just had to grow up too quick, you know what I mean? I had to shield all my sisters from all that.'

He feels that there is a clear connection between the abuse he suffered as a child and the problems he has experienced since:

'I grew up hating my family [...] I'd really like them to know that the way I am, is partly because of them.'

It is possible that other interviewees had similar childhood experiences but chose not to divulge this information.

For many, the young age at which their substance misuse problems began is testimony to the unhappy nature of their childhood. In addition to those identified above, another three reported that they began using heroin between 11 and 16 years of age. Furthermore, Mark, who is currently consuming 10-15 cans of super strength lager a day, first began drinking alcohol when he was just five years old.

2.2.2 Traumatic experiences

In addition to abuse and neglect, two of the interviewees also identified a specific traumatic experience which they say played a significant role in the problems they developed later in life. Luke, mentioned in the previous section, also suffered a violent mugging as a teenager:

'I got mugged down in (location) when I was a kid, 17, [...] I got battered. I was in an induced coma for a while: my head swelled up and that... and they shattered my knee: I've got pins in my knee, broken ribs, punctured lung, broken ankle, broken wrist. That's it. And six months in traction.'

As a result of the emotional trauma caused by this incident, he reported that everything started 'spiralling out of control':

'There's a knock-on effect from all of that [...] you walk about and just hate everything, hate everyone.'

It was at this time that he developed what he refers to as 'a bit of a habit' and started using heroin regularly.

Meanwhile, Jenny, who suffered a serious head injury as a teenager, speculated that the physical trauma may be one of the underlying causes of her diagnosis with schizophrenia and personality disorder later in life:

'When I was 16 I had a horse-riding accident: I had a very bad head injury [...] I had amnesia afterwards and I had to re-learn everything, it was awful. In terms of diagnosing mental illness and all the rest of it maybe it is more physically controlled than I thought: maybe I damaged myself more badly than we had originally feared.'

2.2.3 Domestic violence and abuse

Jenny, mentioned above, also strongly maintained that her mental health and

substance misuse problems were caused largely through long-term exposure to abusive relationships as an adult:

'It wasn't something that was naturally there- it was something that developed over the years: a way of behaving, pretending to everyone else that I am OK, when I am not OK.'

She was first diagnosed in 1985, when she had a crisis after an 'exceptionally bad relationship':

'I couldn't bear it anymore, I went crazy: crying, yelling and crying. It was so bad because he was just systematically picking away at me all the time. I'd come home and he'd start shouting at me or beating me up or some horrible thing like that. I couldn't take it any more. That was the first time I have been mentally ill and it was because of some guy using me to fulfil his needs whilst evidently hating my guts.'

Another interviewee, Ruth, described bingeing on alcohol and taking an overdose in a suicide attempt after suffering sexual harassment and bullying at the hands of her peers. She is currently sleeping rough. She had to leave her previous accommodation because her sister's partner was threatening her with physical violence.

Similarly, Chris is now sleeping on the streets of London after he had to leave his previous tenancy in another area to escape from a situation where he was being exploited by some new 'friends' who were buying him drinks and giving him money in return for 'favours' that involved delivering drugs.

2.2.4 Relationship breakdown

Nine out of the twenty two interviewees cited relationship breakdown as a key factor in their experiences of homelessness and associated health problems, although these issues occur at different points for different people. For James, the substance misuse problems came first. When he developed an addiction to cocaine, his relationships began to suffer as a result:

'I had a decent girlfriend [...] but I just pushed it away [...] I stole money off my mum and they weren't speaking to me; my family up north basically disowned me.'

Meanwhile, for Dave, the 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!'

Likewise, Chris's problems began when he fell out with his family: he moved away from his hometown after a big argument with his dad and ended up sleeping on the streets. He was later housed, but his father passed away soon afterwards and his sisters hold him responsible for what happened. Consequently, he found himself drinking *'morning, noon and night': 'I was that pissed off with things'*:

2.2.5 Bereavement

The issue of bereavement was apparent in ten of the interviews and for four people it was a central theme that was inextricably linked to their poor mental health.

Matthew, who has severe mental health problems, explained that he has had eight deaths in his family in eight years. He lost his mother at Christmas and his father at New Year; two weeks later his uncle died and then a cousin the week after that. He describes the impact this had on him as follows:

'I went numb when my mum died. I was at (hostel) at the time and I just lost it. I was riding my bike into cars and cracked four ribs. I'd been drinking but I did it on purpose. It wasn't just the one time: I was riding into cars and winding up with black eyes. I went deep into myself.'

Similarly, Ryan struggled to cope when his father passed away:

'In 2007 my father died of full-blown cancer and I hit the bottle, I slashed my wrists, I've overdosed and I was about a year sleeping rough.'

A further two interviewees reported suffering severe mental health crises after losing their young sons. Dennis describes the day he found out that his son had died:

'I just blew up like a volcano, started smashing out at anything and everything: I smashed four phone boxes, lucky I didn't take it out on somebody otherwise I'd be in for manslaughter now. I just freaked out.'

He feels that to this day he still has 'a little bit of a mental health problem' as a result of the bereavement and he is being prescribed anti-psychotic medication. Meanwhile, Alistair has been diagnosed with severe depression following his loss:

'I didn't realise what was happening to me [...] the tiredness was showing on me, I weren't washing, I stopped shaving [...] sometimes you think, what the hell, is it worth it?'

2.2.6 Employment

Having spoken to mental health professionals, Alistair now believes that work also played a key role in the emergence of his current mental health problems, which only manifested themselves fully when he became redundant:

'They say it was down to work, the loss of my son; trying to do everything but still living out on the streets. [...] They seem to think that because I've been working I've been using that, without realising it, to kind of take my mind off it: use it as an escape route, so I hadn't really faced the reality of what's happening.'

Meanwhile, other interviewees spoke about negative experiences around frustrated career ambitions and job loss, which had a detrimental impact upon their health and wellbeing. Matthew, for example, played professional football in his twenties until a serious injury stunted his career and he began dabbling in drugs.

Similarly, Tom moved to the UK from Slovakia several years ago to obtain employment. He was working for some time, until one day he was attacked and suffered severe damage to a tendon in his hand, which left him with restricted movement. Consequently, he lost his job and his home and began drinking heavily as his mental health deteriorated.

On the contrary, Barry, who considers himself to be in generally good health and regularly enjoys paid employment, describes developing a stress-related condition following problems in one particular job, which left him feeling as if he had no choice but to resign:

'Most of my problem after working nights was the stress. Basically your stomach gets in a twist and you need to get rid of that twist and that takes time. You can't be off work for stress unless you take pills from the doctor and I wouldn't take pills from the doctor.'

In one case there was a complex interplay between employment as both a trigger for and a facilitator of substance misuse, as well as substance misuse ultimately impacting upon the individual's ability to maintain their employment: James's dependency upon cocaine and alcohol escalated during the years he spent working in a high-pressure sales environment, to the point that he was eventually dismissed:

'As I earned more money in the job I was doing, because I was in sales, I earned more money and had a lot more disposable income, I gradually got more of a habit: this is over a ten year period [...] and then it all come on top and I was doing it at work and then I just couldn't...'

2.2.7 Homelessness and deteriorating health

James was also one of twelve interviewees who talked about how the experience of homelessness had a negative impact upon their health and wellbeing. In his case, his asthma, a pre-existing health condition, was aggravated by sleeping on the streets. Similarly, Ryan described the impact of sleeping rough upon his arthritis:

'I've had this for years but when I was sleeping rough, sleeping on the concrete, it must've made it worse because I only walk so far and collapse down.'

Other interviewees spoke of being particularly vulnerable to infection while they were sleeping on the streets. For example, Daniel struggled with wound care after an operation on his appendix because he was sleeping rough:

'I felt all funny, I felt all ill and where the wound was [...] I thought this feels all wet here: there's all this green stuff coming out of my wound [...]. It didn't help me in a way because I was prone to infection then, with dirty streets.'

Dennis's story

'I moved out of my wife's flat years ago, 14 or 15 years ago, and was on the street, having a good time and a bad time, depending on the weather. [...] They finally got me accommodation because I was in a pretty bad state, like a cat that had been through the hedge. I had a fungal infection, I had dysentery, I'd eaten out of dustbins. [...] When I was sleeping rough I built a little shelter. [...] One night I was sleeping there and I felt something crawling up my leg and thought what the hell is this? [...] It turned out to be a rat and it bit the end of my penis. [...] It was terrible but I started laughing because I can't imagine being in the position to tell anyone what happened. [...] It got to the point where I was covering myself with crap and there was nowhere to clean up: no-one would have me into their pubs and clubs: no, no, fuck off, we can't have you in here- go jump into the Thames. I was getting it from all corners. Try walking into a shop covered in shit.'

Another issue that was mentioned by several interviewees was the impact of sleep deprivation upon their health and wellbeing. 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.'

Other interviewees talked about the widespread availability of drugs and alcohol on the street as a further obstacle to maintaining good health. Ryan reflected bluntly:

'When I was homeless around here in 2009 I was drinking a lot, smoking a lot: it's the only thing to do when you're on the streets.'

Dave, mentioned previously, started using heroin to cope with life on the streets; Tom talks about deliberately having to isolate himself from his social group whilst living on the street in order to regain control over his drinking and Ryzard contracted TB from drinking alcohol out of a cup which he shared with friends.

Finally, there were two women within the sample who talked about living in situations that posed a risk to their health in order to avoid sleeping out on the streets. Clare, who was in recovery from a dependency upon heroin spanning decades, was sent against her will to live in a hostel with chaotic drug users, where her progress faltered. Meanwhile, Jenny described staying with men who were abusive to her because she had nowhere else to go:

'I had to ask guys to help me and I really do not like doing that, love, really do not like doing that because I know that when guys help women sometimes they get a little bit nasty because you're dependent on them.'

3. Barriers to accessing health services

Key points

- ▶ Participants had used a range of services, including GPs (mainstream and specialist homelessness services), dentists, accident and emergency departments, hospital out-patient and in-patient services, drug and alcohol services, mental health services, and homelessness services.

Barriers to access

- ▶ Barriers to accessing health services included:
- ▶ Not seeking help for health needs, for reasons including: a lack of motivation to access health services because of the need to focus on day-to-day survival as a rough sleeper; the neglect of health needs as a form of self-harm; fear and denial of ill health; a different experience of pain; difficulty in expressing what is wrong; embarrassment and low self-esteem and negative perceptions of services. People's negative perceptions of services included experiences of stigma; the denial of services; fear of 'officials' and clinical settings; negative experiences of treatment and of bullying and harassment or chaotic hostel environments.
- ▶ Lack of access to information about services, leading to limited referrals.
- ▶ Non-inclusive services, including the restrictions of geographical, departmental and clinical boundaries: Geographical boundaries could mean that homeless people were refused services because they were unable to demonstrate a local connection; departmental boundaries could mean that even those with a local connection were denied services as different local authority departments disputed responsibility for their care; clinical boundaries could mean that homeless people, in particular those with a dual diagnosis, were denied access to mental health services; and also that people with co-existing substance misuse problems found it difficult to access treatment.
- ▶ Women, Central and Eastern Europeans, and people who have a personality disorder can face specific barriers to accessing services.
- ▶ Several participants had experienced extensive delays in treatment, in particular, for hospital treatment and psychotherapy, resulting in a detrimental impact on their wellbeing.

This section outlines the services used by participants and the barriers to accessing health services, including not seeking help for health needs; a lack of access to information and referrals; and non inclusive services.

3.1 Services used

General Practices

Out of the twenty two current and former rough sleepers interviewed, all but one of them was registered with a GP. Those in Westminster attended GPs set up specifically for homeless people, whereas those in Kensington and Chelsea and Hammersmith and Fulham attended a variety of mainstream practices.

Most people visited their GP on a regular basis; usually to collect prescriptions or obtain the relevant paperwork to maintain their benefit payments. When asked how often they had visited their GP over the last two years, six people replied fortnightly or more, five people replied at least monthly but less than fortnightly and a further eight people had visited their GP less than monthly.

Dentists

Out of the twenty two interviewees, thirteen people were registered with a dentist, although only seven of them reported having used their dentist in the last two years. A further three people had seen a dentist in the last two years but were not permanently registered.

Accident and Emergency departments

Interviewees were also asked whether they had attended A&E in the last two years. Out of the twenty one people who responded, thirteen had been at least once. Out of these thirteen, four people had been once; two had been twice, five had been three times and another had been four times. One person did not specify.

Hospital out-patient

Some of the interviewees reported going to hospital over the last two years via non-emergency routes for out-patient appointments, for example, George goes for yearly injections at the Pain Management Service at St. Mary's for the trapped nerve in his back and Omar, Tom and Richard have attended the Chelsea and Westminster Hospital to discuss Hepatitis C treatment, access physiotherapy and attend appointments at the specialist HIV clinic, respectively.

Hospital in-patient

Five people mentioned being kept in as hospital in-patients after emergency admissions for TB, appendicitis, self-harm, and a hernia operation.

Drug and alcohol services

Seven people are currently linked in with drug and alcohol services. In Hammersmith

and Fulham people access the Community Drug and Alcohol Service (CDAS) and Oasis and in Kensington and Chelsea they use the Community Assessment and Primary Service (CAPS) and Blenheim Community Drug Project. In Westminster, interviewees reported collecting their heroin-substitute scripts from The Cardinal Hume Surgery and one person had previously attended a thirteen-week structured recovery programme at Turning Point. In addition to this, one person reported attending regular Alcoholics Anonymous (AA) meetings and another had attended AA and Narcotics Anonymous in the past.

Mental health services

Eleven people reported having had some contact with mental health services and five people were currently linked in with a psychiatrist or Community Psychiatric Nurse (CPN). Two people said they had been sectioned under the Mental Health Act in the past.

Homelessness services

All of the interviewees in this study had ongoing contact with at least one support provider for homeless people. Thirteen people were living in supported accommodation and the remaining eleven were accessing day centres for rough sleepers. People used the day centres for a variety of health reasons, including the use of washing and laundry facilities; the provision of free or low-cost food and drink; in order to access alternative therapies such as acupuncture, reflexology and relaxation classes, or mainstream services such as doctors, nurses, podiatrists, dentists and opticians offered from the premises. All of the hostel-based clients in Kensington and Chelsea reported having accessed the peripatetic nurse.

3.2 Not seeking help for health needs

Some of the barriers to accessing health services are self-imposed and relate to the individual's situation as a current or former rough sleeper and associated issues.

3.2.1 Rough sleeping as a barrier to accessing health services

A number of interviewees described neglecting their health whilst sleeping rough:

'It took me about three years to try and do something [seek help for Hepatitis C] because I was still on the street, in and out of prison.'

– Omar

'I have to be literally, nearly dying before I go into hospital.'

– Richard

When Luke moved into accommodation, he thought: *'I'm off the street now, come on!'* and started to address his health needs, but while he was rough sleeping it was impossible: *'It's too chaotic out there.'*

One of the doctors interviewed believed that rough sleepers are, likewise, unlikely to be in a position to address the psychological trauma which may underlie mental health issues:

'Often the person might not feel ready for it (therapy) when they are homeless or temporarily housed: they just don't feel they can relax yet.'

3.2.2 The neglect of health needs as self-harm

A number of people said that they not only neglected their health needs whilst on the streets, but would, at times, knowingly jeopardize their health. Several associated this with depression and self-harm. For Dave: *'things happen that make you stop caring [about your health]'*; and Ryzard recalled a time when he was drinking out of a cup which he shared with friends when one of them began to cough up blood, yet he carried on drinking; two days later he was hospitalised with TB. Likewise, Luke looked back upon his pattern of drug use and withdrawal in the following way:

'I just thought with depression, it [drug use and withdrawal] was part of self-harm [...] 'cos you just don't feel anything, so if you are actually feeling something, even really in pain, at least you are feeling something.'

Other interviewees discussed how depression prevented them from accessing health services. For example, Omar was attending Alcoholics Anonymous (AA) and Narcotics Anonymous, which he found enjoyable and beneficial, until he became depressed eighteen months ago and stopped attending.

During initial interviews with commissioners, concerns were raised regarding the difficulty of successfully treating leg ulcers among rough sleepers. None of the rough sleepers interviewed identified leg ulcers as a key health issue (although this does not necessarily mean that nobody had experienced the problem). Two doctors for the homeless offered some interesting reflections on the topic that could easily apply to other areas:

'You sense they almost don't want them [their ulcers] to heal [...]. It's sort of part of their view of themselves as rotting or incomplete or unwhole, whatever, dirty, something like that. You know, there is something about the psyche of someone in that situation and I think it can be very difficult to get that treatment if they are unwilling to come.'

'I always feel like we are working against quite a lot of internalised societal attitudes ... I think quite often our patients have [internalised] society's distaste for them'

3.2.3 Fear and denial of ill-health

Several interviewees reported that they care very much about their health and it is the fear of bad news that has prevented them from approaching health services. Referring to the time when she almost went blind through untreated diabetes whilst living on the streets, Clare explained:

'You know there is something wrong but you are frightened and don't want to know what it is: it's denial.'

Dave, who was recently treated for cancer, described a similar attitude:

'For a long time I just thought 'I'm alright, there's nothing wrong with me' and you don't really think about those sort of things. And then as I started thinking about it I admitted to myself: "come on, all the things I've done through my life, you're bound to have some problems with your health", so I started to listen to the doctors a bit. But I do find that if I don't listen to the doctors I live a happier life... they stick so much stuff in your head!'

Other interviewees are still avoiding seeking help for certain health concerns. Matthew confided that his foot had been swollen and painful for some time now, to the extent that he had to wear one shoe larger than the other, but he had not told anyone because he was scared that it might be arthritis.

James, who failed to attend hospital for tests regarding a pain in his chest, offered an insight into why such matters may be a particular source of anxiety for those who are rough sleeping or insecurely housed and often dealing with multiple issues:

'If there is something wrong with me I want to be in the right frame of mind [...]. I don't need this. I've got no money, no cigarettes, nothing and then they might tell me I have a dodgy heart.'

3.2.4 Embarrassment, low self-esteem and difficulty communicating health needs

Some conditions may be hard to describe because of their complexity, others may be embarrassing to people. One interviewee said that he was embarrassed going to the dentist *'because I've hardly got any teeth in my mouth.'*

Another described how hard it can be to express a mental health need:

'I think communication is a big one (barrier) because sometimes people say what's wrong? What's the matter with you? And sometimes you can't really explain because you can't even really tell yourself: you just know that you're hurting inside and something's wrong, but sometimes it's really hard to find a way of expressing it to somebody, so you act it out in some way, either through alcohol or drugs or violence, whatever.'

– former rough sleeper

3.2.5 Negative perceptions of services

Many people interviewed expressed negative perceptions of health services, and several of the professionals interviewed for this research acknowledged that such perceptions are often born out of experience.

Experiences of stigma

A number of people described experiencing stigma from health professionals, and professionals interviewed also agreed that stigma towards homeless people does exist:

'I think when you go to a normal doctor they do look down on you [...]. I think they are a bit worried in case I give them something. [...] It was just the way they were talking, looking, sitting away from me.'

– Ryan

'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

One of the most common scenarios described involves GPs making assumptions that certain individuals will try to obtain unnecessary medication from them, because of their situation. For example, Clare made an official complaint and received an apology from her GP after the following conversation took place:

'I had one doctor, when I was living at (hostel) and I went over there because 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?'

Luke, who has had similar experiences, says he is now reluctant to ask for painkillers:

'They see your situation and they think: Hold on, he's a junkie, alcohol dependent and he's coming in here asking for pain relief!'

On the other hand, there are some individuals who may make excessive use of health services, such as their GP, because of an underlying mental health condition. For example, Dependent Personality Disorder is described as 'a pervasive and excessive need to be taken care of'¹ and therefore people with such traits may regularly seek unnecessary treatment. However, one interviewee from a Personality Disorder Service whose remit includes the prevention of 'GP pestering' expressed concern that these individuals may be met with a dismissive attitude even when they present with genuine health concerns.

¹ Psychology Today Diagnosis Dictionary: Dependent Personality Disorder
<http://www.psychologytoday.com/conditions/dependent-personality-disorder> (last updated: 07/21/2008).

Interviewees express a sense that the health needs of this group may not be attended to with the same level or urgency as those of the general population. Richard complained that people perceived as ‘junkies’ are made to wait until last for their medication at some chemists and one service provider suggested that Accident and Emergency Departments may leave the ‘problematic person’ to last.

This was perhaps the case with Daniel, who was removed from hospital by the police because ‘*the consultant didn’t like how I approached him and told him what I thought about the system.*’ At the time he was suffering from a surgical hernia caused by an operation he had undergone at the hospital three days previously. He had to seek advocacy from a homeless support provider before this medical need was addressed.

The information provided by interviewees suggests there is a need to change attitudes among some medical staff so that current and former rough sleepers are able to access the healthcare they require.

For one professional the fundamental problem is that ‘*things have been watered down*’ due to a gradual decline of standards in the NHS:

‘I’ve seen that the attitudes and respect have gone down. I think people are less respectful, and it shocks me: even from the top down and that worries me. [...] They haven’t got time. [...] If you look at the statistics of A&E attendance, in ten years it’s doubling; it’s trebling. [...] So when people come in that are more problematic and chaotic, obviously they have to draw the line and say I can’t deal with that behaviour at the moment here.’

Denial of services

A number of both rough sleepers and professionals interviewed described homeless people being refused access to services:

‘The reluctance of our patients to engage, I think quite frequently reflects multiple experiences of rejection [from services].’

– Doctor

‘There was one (rough sleeper) who kept persistently complaining about a problem with breathing from his nose and the doctor referred him to hospital so he went to see an ENT [Ear Nose and Throat] consultant and the ENT consultant saw him and said right, this guy needs an operation, but I’m not going to offer him one because I don’t know if he’ll turn up.’

– Practice Manager

Fear of ‘officials’ and clinical settings

A number of interviewees said that they did not like ‘officials’. In particular, there was a great deal of anxiety around mental health services among interviewees. For example, Charlotte ran out of a hospital appointment when a psychiatrist was mentioned, and Matthew fled after spotting ‘*men in white coats*’, fearing that he would be sectioned.

Other interviewees had outright phobias of certain clinical settings and practitioners, which prevented them from accessing the services they need:

'I have been to the [dentist's] waiting room three or four times! [but never made it into the chair]'

'As soon as they tell me that they've got to pull [a tooth] out, that's it: I'm gone.'

It may be important to think about the 'image' or 'branding' of a service, as this can also serve as a barrier to access. For example, Charlotte said she was much more willing to engage with her local drug service when it changed its name to 'Oasis', from 'Druglink,' which she found stigmatising.

3.2.6 Negative experiences of treatment and services

Other interviewees discuss negative perceptions and experiences of homelessness support services, which may pose a barrier to future engagement and have a knock-on effect upon their health. The key problems identified were bullying and harassment by other service users and chaotic environments in some hostels. Likewise several interviewees spoke about negative experiences of medical treatment, in particular with regard to medication-based treatment for mental ill-health and giving or receiving blood and transfusions as an intravenous drug user. Each of these issues will be discussed in this section.

Medication for mental health

Three people reported having bad experiences with medication for their mental health. For example, Chris spent three years taking ineffective anti-depressants: a situation which he believes could have been averted by medical staff listening more closely to him.

Meanwhile, Ruth suffered an adverse reaction to her anti-depressants which she holds responsible for a recent suicide attempt. She didn't want to go on the medication in the first place but says that she was persuaded to do so by her doctor. Ruth finds talking to a counsellor much more beneficial and highlights the importance of access to talking therapies rather than just prescription medication for mental ill health.

Finally, Dennis described the devastating impact of taking anti-psychotic medication upon his wellbeing:

'The medication is murdering me [...]. When I get out of bed in the morning I feel like I'm fighting just to stay alive.'

Shaking with the tremors, which he thinks are most likely caused by the medication, Dennis has been suffering 'a little bit of a mental health problem' brought on by the loss of his young son the previous year: 'How would somebody feel after losing a member of (their family)? Pretty shitty.' He wondered whether a bit of 'cheering up' would do him more good.

Blood tests and transfusions

The other common theme of complaint was regarding negative experiences of having blood taken and receiving transfusions in hospital. Several interviewees report that injecting drug users frequently have veins so damaged that it is very difficult to extract blood and failed attempts by medical staff to do so can be very painful. For example, a nurse once stuck a needle into one of Dennis's arteries, which he describes as akin to *'being hit over the head with a cricket bat.'*

One supported accommodation worker said that clients often complain to her about bruising caused by nurses unsuccessfully 'digging for blood,' and she was even aware of cases where the patient has been told to find a vein themselves.

A nurse said that she struggles at times to find a vein in such patients and that it is very important that hospitals have specially trained staff who are able to take blood from, or deliver transfusions to, patients whose veins have been damaged through drug use without causing them unnecessary distress.

In the box below, a service provider speaks of the impact which this problem can have on people.

Taking blood and giving transfusions to intravenous drug users:
'Digging for blood'

This client self-discharged, he said I've had enough - I'm not going to be used as a pin cushion anymore. He pulled it out actually. He was having a transfusion and it was just going everywhere: it wasn't going into his vein because his vein was collapsed. But he said there's no point going there: you have to go to the jugular, cos he's an IV (intravenous) drug user, he hasn't got any veins. So he ended up self discharging and he was in need of this blood and he came back here. [...] He withdrew from the support and he just locked himself in his room. He said 'I just want to die. I won't go back to hospital.'

– Worker at a supported accommodation project

Bullying and harassment

Three rough sleepers spoke about bullying and harassment within services. Ruth had been very distressed as a result of ill-treatment by other clients at the day centre she was attending:

'One of them was sexually harassing me and I kept turning him down so he's got everyone else on the bandwagon, but I don't think they realise why. [...] I'm the only gay female in (day centre) so they think it's a challenge. [...] All the people I used to talk to look at me and start laughing at me or they whisper all the time, or they turn their back.'

She reports that the situation escalated as a result of inaction by staff to the point where, the previous week, she had attempted to commit suicide:

'Over the last few weeks I seem to have a black cloud over me which I can't shift [...] because of what's going on and people not dealing with it and sorting it out.'

Bullying can also take the form of exploitation: Omar was aware of people in his hostel getting bullied into requesting additional prescription medication from their GP in order to support others' substance misuse.

Meanwhile Jenny, who has suffered a history of abuse, struggled to feel at ease living in a hostel environment because of conflicts between residents. She says she recently had to call the police after finding herself caught up in an argument. Moreover, she reports that the situation was even worse in previous accommodation where she did not have her own room: she reached the point where she was fearful to fall asleep because she suspected that other residents were injecting her with drugs in her sleep.

Chaotic hostels

A number of former rough sleepers described improvements in their health since entering supported accommodation and some made positive comments about their current hostel being better than others where they had lived previously.

However, several interviewees talked about the difficulties of thriving in 'chaotic' hostel environments. For Greg his accommodation was having a direct impact upon his substance misuse:

'Cos I'm in here... not to blame it on here, but sometimes you might be a bit stressed out... [...] I'll smoke marijuana now and then... one or two a night.'

Meanwhile, Callum was adamant that he would not be able to successfully address his mental health issues until moving on from his current accommodation:

'It's like living on the set of Thriller: the place is full of zombies who only come out at night.'

He described one incident where someone came into the hostel screaming and brandishing a hammer. He says that when he reported his concerns to staff they did not appear to take him seriously.

Sam had grave concerns around the enforcement of hostel health and safety rules, alleging that staff had been known to 'turn a blind eye' to drug use on the premises for a certain client.

3.3 Lack of access to information and referrals

A number of interviewees described the difficulty of accessing timely information as a rough sleeper. For example Dennis, a rough sleeper who suffered from incontinence and a skin condition, was not aware that he could access washing facilities at a day centre.

All of the current and former rough sleepers interviewed in this study are now linked in with some form of support service. However, many recall a time when they lacked such support. For example, three of the interviewees spoke about how it was not until they came into contact with the criminal justice system that they were linked into the appropriate services. Clare, who successfully completed a Drug Rehabilitation Requirement (DRR) two years ago and is now abstinent of heroin for the first time in thirty two years, said:

'It is hard to get involved with services unless you are committing crime. It actually took me to get arrested and get a DRR.'

The consequences of not being linked into health services in a timely manner can be severe. One health professional in Kensington and Chelsea is confident that such referrals save lives:

'If I hadn't been here then I don't think they would be either. They would've died.'

However, contact with a support provider is not necessarily a guarantee that an individual will be referred to the appropriate services. A member of staff at a specialist mental health service was concerned that support workers can sometimes act as gatekeepers and refrain from referring their clients to the service:

'Probably one of the biggest problems is [...] you will either have people who think these people can't be helped, homeless or otherwise: what's the bloody point? [...] Alternatively, when we go out to hostels, they are quite keen on referring to us but they are quite sceptical as to whether their client will maintain attendance, will commit to the service. I think there is an element of they may be keen but they don't want to put us out. [...] We say, let us be the judge of that.'

A final issue for consideration identified during the interview process is that support staff may be inclined to refer all current and former rough sleepers to specialist homeless services, where these exist, even if this is not necessarily the most appropriate option for the individual concerned. The Cardinal Hume surgery, for example, has been set up especially to attend to those people who are homeless and may have difficulty accessing a mainstream GP because of the nature of their health problems. They operate on a walk-in basis because many of their patients struggle to keep appointments and they offer a methadone prescribing service for those with substance misuse problems. However, Ruth, a Westminster-based rough sleeper with no drug-use issues and a conscientious attitude towards attending health appointments, was also referred to this practice, and although she praised their work, she finds her weekly appointments quite an ordeal:

'It's like walking into a methadone clinic [...], everyone is on something. The first time I went there I just cried [...]. Every week it's a dread.'

Ruth has difficulty forming relationships and trusting new people, so is reluctant to move on despite the problems because *'it's better the devil you know.'*

3.4 Systemic barriers

Several interviewees described difficulties with non-inclusive services. Firstly, they said homeless people as a group sometimes do not have their needs met by generic health services. Secondly, they said sub-groups of homeless people can find it particularly hard to get their specific health needs met: such as women, people with personality disorder and migrants.

3.4.1 Geographical boundaries

Interviewees suggest that many healthcare services operate within rigid boundaries and therefore risk excluding vulnerable people from accessing the healthcare and support they require. One of these boundaries is geographical: A couple of interviewees talk about being turned away from services because they could not prove their local connection. A healthcare professional said that it is not uncommon for surgeries to refuse to register people without proof of identity and address:

'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.'

Meanwhile, Ryan reports that he was turned away from a Westminster day centre because he was told he had lost his local connection after living in a different city for a couple of years and both Chris and Ruth were concerned for other rough sleepers who they see turned away because they are linked in with other day centres and are only permitted to access one service. One doctor says his patients regularly tell him *'I went to the (day centre) and they turned me away because I've only been seen rough sleeping once.'* He goes on:

'You can spend hundreds of thousands saving a drug user's life but then what? Who will accept responsibility? Hospital in-reach has been cut and which borough will take them?'

– doctor

He went on to explain that they are currently caring for a cognitively impaired man who has been in hospital unnecessarily for a month while two local authorities dispute who is responsible for him.

3.4.2 Departmental boundaries

A number of participants report a lack of co-ordination between different departments of the same local authority that are keen to protect their budget. For example, 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.'

A healthcare professional said:

'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.'

A number of healthcare professionals expressed concern about the impact of recent changes in funding on healthcare provision for homeless people, for example the loss of ring-fencing on substance misuse funding, and cuts to the NHS budget:

'If you take a thousand beds out of the North West London economy [...] that's going to make it much more difficult for people to access secondary care, and always the people who are most likely to be disadvantaged in that regard are homeless people.'

3.4.3 Clinical boundaries

Many of the interviewees highlighted key clinical boundaries that have prevented them, or those they work with, from accessing the support or treatment they require.

Dual diagnosis

The barriers to accessing mental health services for people with substance misuse problems are well documented,² and this is an issue of great concern for several of the interviewees who participated in this study.

Mark, who is a dependent drinker and is diagnosed with depression, says he had a referral for counselling made by his Community Psychiatric Nurse (CPN) rejected. His homelessness service tried to arrange for him to see their counsellor, but he is still awaiting a decision.

² For example, Sian Rees (2009) *Mental Ill Health in the Adult Single Homeless Population: A Review of the Literature*. Crisis. London

Dual diagnosis and access to mental health services: 'Now what?'

A project worker at a hostel for serially excluded rough sleepers reports that he spent hours of keywork time encouraging a client with dual diagnosis to access desperately needed bereavement counselling after a series of close family members passed away:

'He's having visual hallucinations in his room, he's talking to his mum who's dead in his room [...]. It's worse when he is using [...] but it's apparent all the time [...] so there is a mental health need there.'

The client finally agreed, only to be immediately rejected by both mental health services and an independent counselling service, on grounds of his substance misuse.

'Now what?' the project worker asked.

'They talk about people slipping through nets. The problem is there is no net: any kind of dual diagnosis and they [mental health services] will not engage with the client.'

A number of health and homelessness professionals who work closely with current and former rough sleepers expressed their frustration because they feel their opinions are not taken into account when mental health services are evaluating whether a person's apparent mental health condition is caused by their substance misuse:

'Where we get frustrated, as a service, is that our experience is always disregarded. We can say to mental health services we have known [the individual] for two years, we have seen them straight, we've seen them sober, we've seen them stoned and we've seen them pranged and there is something psychotic with this person. [...] The unfortunate thing with mental health services is that they have only ever seen someone when they are in crisis and they have never seen them when they're well. We constantly have this problem.'

– hostel manager

The case study opposite gives an example of one man who was reported to have received an ineffective mental health crisis intervention, and the impact this had upon him.

Ineffective mental health crisis intervention: ‘He was in real torment’

A supported accommodation manager described difficulties in working with the mental health crisis team when one client was in need:

‘We had a problem recently with somebody we had worked with for two years [...] who has been very well and very engaging, but who had not been taking his medication and then he lost complete control and it was sad to see for him because he was in a very worrying state.

From this very amiable guy who staff had laughed and joked with for years...He was in real torment.

His pre-cons were that he would assault members of the public [...] when he got psychotic and wasn’t taking medication.

At this stage the poor guy just completely lost control and that evening [...] the pharmacist kindly brought his prescription round to us, at which point the guy jumped on him and battered him on the street and left him bleeding.

We’d had the crisis team out four or five times and they’d done nothing and we had said to them we’ve known this guy all this length of time and he is not well and his pre-cons [previous convictions] are that he will assault members of the public and we got no support whatsoever.’

Co-existing substance misuse problems

Clinical boundaries can also pose problems for individuals with co-existing substance misuse problems. Dave, a dependent drinker on a methadone script living in Kensington and Chelsea, says he has to travel all the way to the Cardinal Hume surgery in Westminster because he cannot access treatment at the local prescribing service because of their rules around alcohol use:

‘You’ve got to realise you’re dealing with people who might have more than one addiction, as I was at the time, and if you are going to breathalyse me of course I’m going to have alcohol come out because that’s what I have to do in the morning to stabilise, so I can function and I can go to these meetings and things [...]. I could go there, but the indignity of throwing up down the street all the time, getting there, maybe even throwing up in the doctor’s surgery and everything, is not great is it?’

A doctor at a different practice said that one of the main reasons they don’t offer a methadone prescribing service at their practice is because the new opiate prescribing contract is ‘terribly prescriptive’:

‘You can only prescribe X, Y and Z and no extra beyond that and you mustn’t [prescribe to] people with co-existing alcohol problems and this problem and that problem and so on. That would immediately eliminate the vast majority of the people that we see here.’

Mental health services

Interviewees report that current and former rough sleepers can have difficulty accessing mental health services, regardless of whether they have dual diagnosis. One professional said that there is a very fragmented psychiatry service in Westminster which inevitably means a significant amount of people slip through the gaps:

'We have three different sets of psychiatrists that our folk might possibly be able to get to see. One is the normal, mainstream, as was CMHT [Community Mental Health Team]: the patch based psychiatry service. The second set are the Joint Homelessness Team, who are funded by the local authority. Then there's the third lot which are substance misuse psychiatrists who have no natural connection to the other two. Now the difficulty is that the three lots are not very keen on talking to each other.'

When trying to make a referral for a rough sleeper with no substance misuse problems he reports that the following occurs:

"the substance misuse psychiatrist is not appropriate; the mainstream service says the he does not come under their remit because he does not have an address and the Joint Homeless Team (JHT) say that they cannot take him because their remit is for rough sleepers who are not engaging with services and the referral has come via a GP. Moreover, he says the JHT will only really take a person on if they are 'sectionable.'"

This issue of the threshold for accessing mental health services was also raised by a professional at a hospital, who said that due to the difficulties of organising follow-up treatment with rough sleepers, psychiatric services probably consider it 'futile' to take anybody on, unless they can section them.

Another healthcare professional thought that the focus of mental health services was skewed towards people with severe and enduring mental health needs, rather than those whose issues may be more transient in nature; leaving many people without psychiatric support.

Another feared that this situation will continue to worsen in light of recent government spending cuts and the loss of hospital beds:

'This is why they won't diagnose people: they have really cut back so much in mental health, they are frightened to make diagnoses, because then they are accountable for doing something.'

The manager of a personality disorder service commented that as a direct result of cutbacks to other services, such as mental health units, he had witnessed a deluge of often inappropriate referrals to his service because people were panicking and thinking 'we need to place them somewhere'. He worried that this could negatively impact upon the outcomes achieved by the service.

He said that the high costs of effective treatment, such as Dialectical Behaviour Therapy (DBT), for personality disorder make it more difficult for people to access them:

‘Cost is a major thing. On psychiatric wards (there is) a heavy emphasis on people with depression, manic depression, schizophrenia, schizo-affective disorder, OCD. A lot of those diagnoses rely heavily on anti-psychotics, mood stabilisers, anti-depressants, benzodiazepines. Why? Because it is cheap. If you have to have somebody who is going through lots and lots of therapy it’s time consuming, it’s blooming expensive and if somebody gets half way through and decides to drop out, you’ve spent all that money and all that time, seemingly for nothing.’

3.4.4 Access for marginalised groups

Interviewees report that certain sub-groups of homeless people can find it hard to get their specific health needs met, including women, people with a personality disorder, and some migrants, such as the large cohort of rough sleepers from Central and Eastern European countries.

Women

The commissioners interviewed at the beginning of this study said that it is important to consider whether homeless women face particular barriers to accessing services. A member of staff at St. Mungo’s who is involved in the Rebuilding Shattered Lives Campaign³ explained that women can be put off from attending male-dominated services and that, unfortunately, there are increasingly few women-only services available as a result of cuts over recent years. In her experience, women are more likely to have childcare responsibilities which prevent them from attending health appointments and those who are involved in prostitution may have sleeping patterns that are not conducive to accessing services.

A number of interviewees made comments about gender considerations in the delivery of services, based upon their experiences. Charlotte, who implies that she has experienced abuse in the past, said that it is important to her to have a female keyworker. However, she has been allocated a male worker and feels that she cannot speak to him.

Due to the limited information collected, it is not possible to draw broader conclusions about women’s health needs and barriers to access from this study and there is a need for further research to assess how far their needs are being met.

People with personality disorder

It is estimated that up to sixty percent of people accessing services for current and former rough sleepers have a personality disorder.⁴ During the preliminary interviews for this study commissioners expressed concern that a large number

³ This 18 month campaign aims to raise awareness of women’s homelessness, to showcase good practice and innovation and, ultimately, to improve services and policy for the future: <http://rebuildingshatteredlives.org/>

⁴ University of Southampton (2012) Psychologically informed services for homeless people: Good Practice Guide

of homeless people do not appear to be in receipt of effective treatment for their personality disorder. Consequently, researchers took steps to interview participants with personality disorder in order to ascertain why this may be the case. However, it proved a challenge to find homeless people who accepted having personality disorder and one professional who reported working extensively with this group said that it is largely due to the disempowering nature of the term currently used to describe the condition:

'People won't engage with a disempowering label [...] one of the last things that people are going to hang onto is their own personality and to have a label attached that tells you that the one thing you do have, when you have no other possessions, is disordered: there has been a lot of campaigning done to re-label it complex trauma.'

During the interviews with current and former rough sleepers, the two people who said that they had a PD diagnosis were asked for feedback on this issue. Jenny, who is not sure that the diagnosis is correct, says that *'complex trauma'* would be *'more accurate.'*

Another former rough sleeper, who has had a very positive experience of PD services and now delivers Knowledge and Understanding Framework (KUF) PD-awareness training to medical professionals, said that even though he never had a problem with the diagnosis because it was properly explained to him, *'it could be better worded.'*

Interviewees also report that the cost of personality disorder treatment (dialectical behaviour therapy, DBT) can be prohibitive and one homelessness worker said the Community Mental Health Team's attitude is *'there's nothing we can do so we're not going to work with them,'* alluding to the belief that PD is *'untreatable.'* However, since 2003 the government has taken the approach that treatment can be effective and created a number of programmes⁵.

Central and Eastern Europeans

Interviewees suggest that another group that may face particular difficulties in accessing services are the growing number of rough sleepers from Central and Eastern European (CEE) countries⁶. 44% of rough sleepers in Hammersmith and Fulham are from CEE countries; 29% in Kensington and Chelsea; and 34% in Westminster.⁷

⁵ Department of Health (2003) Personality Disorder: no longer a diagnosis of exclusion.

⁶ EU expansion in 2004 and 2007 enabled people from the following countries to come to the UK to work: Poland, Lithuania, Estonia, Latvia, Slovenia, Slovakia, Hungary, the Czech Republic, Romania and Bulgaria. These are referred to as Central and Eastern European (CEE) countries in this report.

⁷ CHAIN Annual Reports for Hammersmith and Fulham, Kensington and Chelsea and Westminster 1st April 2011 to 31st March 2012.

To begin, there may be a language barrier. For example, an outreach worker said *'that client group in particular struggle, I think, to access health services'* and described a scenario encountered by the team:

'[A staff member] phoned up to make an appointment for somebody this week and she said do I need to come? I can interpret. They said no, no, we have our own: we use language line. She said when this guy turned up they were like, "no we can't talk to you".'

However, language does not appear to be the only barrier to Central and Eastern European rough sleepers accessing the necessary health services. Professionals who work with CEE rough sleepers say that it is difficult to maintain the health gains achieved through accessing primary care, when they often cannot access secondary care, housing or benefits such as ESA. This leads to a situation in which it can seem futile to address health needs:

'We don't tend to put our clients through detox; the CEE clients, because they go straight back to the street. If they've got no recourse to funds, there is no accommodation. [...] What we've found is people will go to detox, do really well, be really successful and then come back to the street and within two or three days it starts all over again.'

– day centre manager

Ryzard, who spent many years sleeping rough, would drink six litres of cider a day, as well as vodka and beer and he was admitted to hospital seven times for alcohol-related seizures. He never tried to access detox or reduce his drinking because he said that it was simply not possible on the street.

It was not until Ryzard became seriously ill with TB that he was placed in short-term supported accommodation provided by a charitable organisation for A10 nationals with no recourse to public funds. His new keyworker explained that many people in Ryzard's situation could access further treatment by filling in a HC2 form: they support all their clients to access healthcare in this way.

Ryzard had not heard of the HC2 form before: his keyworker suspects that its existence is not widely publicised for financial reasons.

One GP pointed out that it can also be important to provide medication for patients with no recourse to public funds for public safety reasons. He gave an example of a Latvian, who had been diagnosed with schizophrenia after killing somebody, who requested the anti-psychotic drug risperdal. Upon questioning him, the GP found that he had been *'losing his temper and hitting things'* and that two people he lived with in a squat had guns. This gave him serious cause for concern that he could become a danger to others, so he provided him with medication from a small supply that he had stockpiled for patients without access to prescription medication. He expressed disbelief that there is no standard medical provision for such individuals.

Evidently, the CEE nationals discussed in this section are not the only individuals who may face linguistic, cultural or legal barriers to accessing the health services they require, even though they are by far the most numerous sub-group of rough sleepers.

For example, a day centre manager in Hammersmith and Fulham, also mentioned that they have some contact with rough sleepers from the Horn of Africa, who can

face particular barriers in accessing mental health services:

'In our experience, they don't accept mental health conditions: they have very traditional views of that, maybe they think that they are possessed and they resort to very traditional ways for treating that. [...] Also, the problem is that if someone is displaying this, the community will tend to isolate them.'

These are but a few examples of a much wider issue. One professional said:

'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.'

3.5 Delays in accessing services

The importance of timely access to services was discussed by a significant number of interviewees, in particular in relation to hospital treatment and psychotherapy. Several people had experienced extensive delays for treatment, resulting in a detrimental impact on their wellbeing. For example, George says that he had to wait for eighteen months before he was able to access desperately needed facet joint injections from the Pain Management Service in St. Mary's Hospital. He was *'in agony'*, to the extent that he started smoking heroin for pain relief.

Omar, whose Hepatitis C makes him feel very ill, says:

'I've been waiting nearly a year to get my treatment. There was the old treatment... the new one's come out now and they want me to start on the new one and I have to wait to get funding to get it: that's what the wait's for. I can't believe it.'

His keyworker believed that the delay is, at least in part, down to her client being *'tested'* for reliability and commitment. A doctor for the homeless acknowledged that *'they inevitably test them out.'*

Moreover, another of the doctor's key concerns was the long delays he faced when trying to secure psychotherapy for his patients:

'The services for people with severe trauma are overloaded and waiting times are months and months: people are normally moved on before their turn ever comes up.'

During another interview, rough sleeper, Chris, described some worrying, unexplained symptoms:

'When I'm walking down the road or standing doing the toilet, it just comes on. It's like everything starts spinning and you start to sweat and you get this horrible taste like blood. [...] I've not had it this bad as what I'm getting lately.'

He's been to see his GP who referred him to hospital, but his appointment is over a month away. Similarly, Ruth has been vomiting blood on a regular basis; sometimes as often as four or five times a day, but still she has to wait another month for her hospital scan.

Finally, an outreach worker pointed out that some services have unhelpful opening hours that do not facilitate timely access:

'You can't just pitch up on the off-chance: it's a limitation. I think a lot of services are designed like that with not really rough sleepers in mind. Even the drug and alcohol services in our borough, which are excellent [...] for your first assessment you can only turn up on a Monday, Wednesday and Friday between 9am and 10.30 am [...]. If you're rough sleeping you haven't got an alarm clock and you're using drugs, even if you're desperate to get off them [...] it just makes it harder: much, much harder.'

4. Enabling access and getting the most out of services

Key points

Interviewees report that health services can take the following action to remove barriers to access and enhance patient experiences:

- ▶ Take the service to the patient via in-reach at day centres and hostels and by accompanying outreach staff.
- ▶ Take full advantage of opportunities for engagement by offering a one-stop-shop for healthcare; addressing all of the patient's needs in a holistic manner when contact is made.
- ▶ Deliver additional services at GP surgeries to facilitate access.
- ▶ Ensure that patients are allocated sufficient time. Local assets include GPs able to offer extensive initial assessments and longer, flexible appointments.
- ▶ Work across traditional clinical and geographical boundaries, for example, by delivering dual diagnosis or pan-London treatment.
- ▶ Operate open referral systems or, in the case of GPs, register patients regardless of ability to provide proof of identity and address.
- ▶ Offer staff training (for example delivered by homelessness services), and create staff roles within the services with a specialist remit for meeting the needs of homeless people, to help overcome the issue of stigma and discrimination.

Homelessness support services are said to be able to enhance access to health services by:

- ▶ Supporting people to move off the street.
- ▶ Offering support and encouragement to boost people's self-esteem and challenge any negative views of services.
- ▶ Keeping services health-focused by recruiting medically-trained staff; holding regular health-related events, such as screening; nominating a health champion and discussing health matters at staff and resident meetings.
- ▶ Accompanying clients to appointments or arranging peer support.

Four key ways in which specialist homelessness services can promote health and wellbeing within their own services were also identified:

- ▶ Create therapeutic environments based upon healthy relationships and promote positivity using tools such as 'appreciative enquiry.'
- ▶ Ensure staff are well-supported (especially when dealing with personality disorder).
- ▶ Encourage service-user ownership and control over the service and their care, via opportunities for feedback, the use of peer support and 'co-production.'
- ▶ Adopt a holistic approach towards promoting individual wellbeing, considering factors such as meaningful use of time and positive social networks.

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, with the patient's explicit consent.

As well as identifying some of the barriers faced by current and former rough sleepers, participants in this study also highlighted many examples of local assets and positive practice which they feel enhance access to health services and improve health outcomes. This chapter, which will outline these points, is divided into four sections: how health services can remove barriers to access and enhance patient experiences; how homelessness support services can enhance access to health services; how specialist homelessness support services can promote health and wellbeing within their own services and how all services can improve joint working.

4.1 How health services can remove barriers to access and enhance patient experiences

Health services can remove barriers to access and enhance patient experiences by taking the service to the patient; offering a one-stop-shop approach to the delivery of healthcare; working across traditional geographical and clinical boundaries; operating open referral systems; training healthcare staff to overcome stigma; removing obstacles to GP registration and taking action to address specific problems around mental health treatment and taking blood from intravenous drug users.

4.1.1 Taking services to the patient

Day centres

A number of interviewees spoke positively about their experiences of accessing healthcare via day centres. For example, Barry has received a number of alternative therapies at his day centre: relaxation classes, acupuncture, homeopathy, reflexology and Indian head massages. He feels he has gained a lot from them:

'I'd recommend the acupuncture to anybody. It takes you back to where you used to be when life was good.'

Ruth also accessed acupuncture at her day centre, which she described as 'fantastic' and she was given three weeks of homeopathy which she found helped her cope with anxiety. Moreover, she has weekly appointments with the day centre counsellor who she describes as 'the only person I can really trust.'

Alistair also benefited from mental health in-reach at his day centre: he was unaware that he was suffering from severe depression until it was identified by the psychiatric nurse. He is now linked in with the appropriate services and getting the necessary medication.

Daniel, whose difficulties dealing with surgical wounds as a rough sleeper were described in section two, was also very grateful that the day centre nurse was available to assist him:

'They used to do it every day for me in St. Martin's. It was good they had the services 'cos they could put sterile pads where the wound was, so they helped me out a lot.'

The manager of a medical centre says that they used to deliver their service, one day a week, from the local day centre. However, since the PCT-run practice has been taken over by a private company they are no longer permitted to attend:

'The ideals changed significantly, from being an NHS practice which doesn't have any focus on profit [...] it was all about one hundred percent health care. Now we are owned by a private company whose sole purpose is to make profit.'

Despite the limitations of delivering healthcare away from their well-equipped practice, he notes that the success of the in-reach was evident from the subsequent drop in homeless patients attending the service.

Outreach

Another way of taking health services to the patient is via outreach. When asked what improvements he would like to see in the delivery of healthcare to the homeless, Alistair, a rough sleeper whose mental health has been in decline over an extended period of time, replied:

'Perhaps in the evenings, if they had someone with medical experience, probably psychiatric experience... [...] It's alright having someone come up and say "are you alright" and invariably you say "yes" and off you go. They need someone with expertise to see there is something actually wrong [...] to go out with the outreach workers, once or twice a week: that might save some lives'

In Kensington and Chelsea the outreach team is accompanied by a mental health social worker who can conduct mental health assessments if necessary. An outreach worker said that this is a valuable resource and, because they form part of the outreach team, she believes they have a greater understanding of rough sleepers' mental health needs than generic mental health services. The team is also accompanied by a peripatetic nurse, but she struggles to find a place to take patients for treatment. She often takes them back to a hostel medical room when she is in the south of the borough, but she is in need of a medically equipped room in the north.

In Westminster, a doctor from a homelessness practice reported that nurses from the service go out with the outreach team and, although the interventions they can perform in the street are limited, they have been able to offer assessment and advice and draw people back into the surgery.

Hostel in-reach

Interviewees also reported that bringing health services to the patient via in-reach can be effective. For example, one nurse, who regularly spends time attending to patients at Kensington and Chelsea supported accommodation, says this gives her the opportunity to build a rapport with the clients and help repair their often shaken trust in medical professionals, so that they can integrate back into mainstream services.

Likewise, a Westminster-based GP for the homeless visits five different supported accommodation projects on a monthly basis for *'advertising as much as anything else'* with the conviction that:

'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.'

However, other interviewees noted that many GPs are still reluctant to attend to patients in hostels, so this is an area where considerable improvements could still be made.

As part of his role as Health Champion, a project worker within a Hammersmith and Fullham supported accommodation project says he has made significant advances

in setting up health in-reach within his service, which he considers to be the best way of getting a chaotic and entrenched client group engaged with health services:

'We've had the Hep C Trust come in, TB van, podiatrist, My Time Active (who work with clients on the lower level of health, like BMI, weight, eating better), the district nurse, GPs, the nurse from the local GP. These clients have accessed health services for the first time after being here for three years. When the nurse came in, one client saw a nurse for the first time in five years: if you come here they'll engage with you.'

Seven months in, he reports that the health benefits are already apparent:

'We've got a lot of new diagnoses: [...] we've got a TB diagnosis, an HIV diagnosis, a Hep C diagnosis. [...] Now they are all treated, they are all engaged with medication, services, so life expectancy has increased.'

A client from the service who was also interviewed had noticed a marked increase in health in-reach over recent months. Another former rough sleeper said he would like to receive as much treatment as possible via in-reach because he just hates hospitals.

4.1.2 One stop shops and the delivery of additional services via GPs

Interviewees suggest that another solution could be to deliver additional health services via a person's GP. For example, one GP for the homeless remarks that they have started offering Pabrinex injections to people who are alcohol dependent because research shows that they help to protect against long-term damage. He would like this to be rolled out more widely, because he says it would have significant health benefits, but many GPs are apprehensive due to a misconception about the risks involved.

He is also interested in delivering Hepatitis C treatment from the surgery, having heard that this is being trialed in a practice in Watford. This could potentially help to ease the long delays faced by people such as Omar, who has been waiting for almost a year for his hospital-based Hepatitis C treatment. It would even be possible to deliver such a course of treatment via hostel in-reach, although this would need significant funding.

The important thing, he says, is to offer a 'one stop shop' approach to healthcare:

'If we've got a patient here, let's do as much as we can between us while their concentration lasts: [...] so they'll come to me for a sick note and I'll go through their history and we say, oh right, you need some immunisations, and what about some blood tests? We can do this, then go and see the nurse and do that. You're quite depressed and you've got an alcohol problem, why don't you go and see Dave and have a chat with him?'

GPs can also ensure that successful hospital referrals are made by using the ‘choose and book’ system to directly make an appointment and eliminate the risk of lost correspondence resulting in a non-attendance:

‘It’s really helpful to be able to say: OK Johnny, you want to get your Hep C sorted out. OK, Dr. xxx will see you at ten o’clock on Monday 11th September. We’ll go on the TFL website and here is the bus that will get you there in time to keep that appointment.’

A one-stop-shop approach can also be combined with taking health services to the patient. For example, the manager of a supported accommodation project who runs health MOT days says that they seize every opportunity for engaging with people around their health:

‘Ninety percent of the effort in trying to get someone to do something is in the engagement with them, so to get someone on the TB van, most of the effort is engagement with the person, so it’s a lost opportunity not to engage them then in other health support needs.’

– Project manager

4.1.3 Providing time

In order to deliver a one stop shop approach and deal holistically with a patient’s health needs, interviewees point out that services need to have sufficient time at their disposal. As discussed in section two, current and former rough sleepers are likely to have considerably more complex health needs than the general population and allowances must be made accordingly. The interviewees who participated in this study provided examples of best and worst practice.

Chris has experienced depression for ten years and has attempted suicide three times during this period. He said he finds talking about his problems very therapeutic and, for the most part, manages his illness by speaking regularly to staff at the day centre he attends. However, there may be occasions when this is not possible and this is when he can take a turn for the worse:

‘If nobody talks to me I can go down to nothing and that’s when I feel like taking tablets.’

For Chris, the key to delivering a quality service is sufficient time to listen to the patient. He has had both positive and negative experiences over the years:

‘I was seeing a counselor in (town) once a week, but this guy was useless. [...] He asked me about four questions. I was filling a form in at the same time. He just stared at the wall and give me a question. You answer it and you’re still filling the form in and then he’d ask you another question. So I went outside and the doctor asked ‘how did you get on? I said I feel worse now than when I went in.’

However, after just one session he was impressed with his new Community Psychiatric Nurse:

'(Name) was different and she asked me all questions. [...] She wanted to know my whole life story.'

Having listened to him, she was able to identify that his current depression medication is not working; something he had suspected all along. He has been taking it for three years.

Likewise, Chris is full of praise for a doctor from a local hospital who helped him during a recent mental health crisis:

'The doctor came in and I just sat there for about an hour and a half just talking to him, asking how I'm feeling and all that. After that... I just needed to get things off my chest: I felt OK. [...] They've told me, any time you feel like that and you're alone, just come back and speak to somebody.'

Chris appears able to talk fairly openly with any receptive professional, but he finds face-to-face contact is necessary and, for this reason, he doesn't find help-lines useful.

Other people may find it considerably more difficult discussing their problems with an unfamiliar professional and it may also be necessary to dedicate time, over a period of weeks or months, to building up enough trust for a therapeutic relationship to work effectively. For Ruth, her monthly appointments with a Community Psychiatric Nurse have been insufficient for her to build up the necessary rapport that would allow her to benefit from the sessions.

Two of the GPs interviewed during the course of this study, also identified having sufficient time to deal effectively with the health needs of current and former rough sleepers as essential to achieving positive outcomes. On one hand, the specialist homeless practice operates at lower patient numbers and therefore spends more time per patient than other GP practices. On the other hand, the Practice Manager of a mainstream service with a reputation for working well with rough sleepers, said that they operate at an advantage because their standard appointments are slightly longer than most:

'Our baseline appointment has always been fifteen minutes, where as ninety-nine percent of surgeries in the UK run on ten minutes, so that extra five minutes is fifty percent more time and one of the doctors who worked here actually said: that extra five minutes is like an hour [...] for the first time in my career patients are getting up to leave before me saying sorry your time's up.'

This practice also offers a forty-five minute session to all new homeless patients in which they are fully screened in accordance with an established protocol that identifies the most prevalent health problems among this population.

It seems that not all services spend sufficient time to deliver such a comprehensive service. Daniel attributed the poor quality of his care in hospital regarding a surgical hernia (described previously), in large part to the staff team appearing *'tired and overstretched'*.

For an A&E professional interviewed, time is the main limitation in delivering effective treatment to homeless patients:

'The environment is not conducive because it's so busy in A&E and they need time and we don't always have the time to give them, so that's probably the biggest issue down here for us.'

Meanwhile, at the other end of the scale, an accommodation-based nurse reported that she is able to complete a full assessment of each individual's physical and mental health and substance misuse. As a result, she says she is able to take a preventative approach and deal with problems, on site, before they deteriorate to the point of requiring hospitalisation. Resident, James, illustrated this by saying that the nurse spent sufficient time with him to notice that he was relying too heavily upon his asthma pump and took steps to *'wean him off it'* before the misuse of this medication caused his condition to worsen.

4.1.4 Working across traditional boundaries

Health services can also enhance access to healthcare for rough sleepers by working across the traditional clinical and geographical boundaries described in the previous section. Interviewees identified a couple of local assets which demonstrate how such barriers can be overcome.

Dual diagnosis

Hammersmith and Fulham's Service Development Officer reported that her key objective at present is to address problems experienced by people with dual diagnosis in accessing mental health services, described in section three.

She says that she has been sitting in on weekly rounds at the Avonmore psychiatric ward and raising awareness among staff about how to develop care plans with the eighty percent of their patients who have substance misuse issues. Consequently, she reports that patients with dual diagnosis are now linked in with substance misuse services upon their release and the whole process is care-managed.

Furthermore, she reports that she has set up a six-weekly, Hammersmith and Fulham, Dual Diagnosis governance meeting to bring together all of the relevant services and identify how practice can be improved.

She has also organised a rolling programme of mental health assessment referral training, delivered by Avonmore staff to hostel workers, to improve the quality of referrals and increase their chance of success.

Finally, she has commissioned a new Dual Diagnosis Outreach Worker to help hostel staff to work effectively with those people whose needs are still not being met. The post offers a mixture of guidance, training and clinical supervision and acts as an intermediary between support providers and mental health services.

One Hammersmith and Fulham project worker interviewed said he had noticed a significant improvement at the supported accommodation project where he works, since the creation of the Dual Diagnosis Outreach Worker role:

'It's a support. For me it's more important than any other role. [Working with people who have dual diagnosis] is improving: already it's one hundred times better than it was.'

Find and Treat Project

Meanwhile, the Find and Treat Project is working across local authority boundaries as a mobile team of health specialists dedicated to the early identification and successful treatment of TB among hard-to-reach groups, such as homeless people and drug and alcohol users, throughout London.

A representative of the project reports that they have been independently evaluated as cost-effective in the British Medical Journal and are looking into possibilities for expansion, both geographically (covering the whole of England) and in terms of the service delivered.⁸ He described the current, limited focus on TB as a *'missed opportunity'* and wants to deliver *'a full platform of diagnostics and treatment' including Hepatitis B, C and HIV, as well as offering immunisation.*⁹

In line with the project manager's comments that engagement with the patient is *'ninety percent of the effort'*, the Find and Treat Project representative believes *'if a person is willing to come on the van to get screened for TB, they are willing to get screened for anything'*.

Furthermore, he reports that Find and Treat have teamed up with Groundswell to reach across linguistic divides and they currently have two Central and Eastern European peers assisting them to reach out to non English-speaking rough sleepers.

4.1.5 Open referral systems

Another way that services can make themselves more accessible is by having an open referral system. For example, an interviewee from the University College Hospital London Pathway team, say they will approach anyone who might be homeless, regardless of whether they have identified themselves as such. Similarly, the manager of a Westminster-based personality disorder service says that they are happy to accept self-referrals, regardless of whether a person has a formal diagnosis:

⁸ British Medical Journal (2011) Dedicated outreach service for hard to reach patients with tuberculosis in London: observational study and economic evaluation 343:d5376

⁹ Please refer to <http://www.niis.org.uk/> for more information

'About sixty percent have a formal diagnosis of some sort of PD, [...] thirty to forty percent, at any given time, have personality disorder traits, personality issues, that chances are if they were put before a psychiatrist, would be diagnosed. One thing that we do differently to other people is that people can self-refer. [...] Probably, I would say a good fifty percent, possibly more, of our cases are self-referred.'

4.1.6 Training healthcare staff to overcome stigma

The interviewees who participated in this study suggested that stigma among healthcare professionals can pose a significant barrier to homeless patients accessing the healthcare they require, as discussed in section three.

One homelessness worker identified that staff training is the key to addressing stigma in health services and suggested that much more extensive work needs to be done on the issue. He would like to see all nurses being required to undertake a placement within homelessness services so that they can learn to work effectively with *'not so easy'* patients.

Some positive work is already being done. A hospital healthcare professional reports that the relationship they have developed with homeless health organisation Groundswell has been very valuable in raising awareness among hospital staff about rough sleepers and how best to assist them:

'We've learnt a lot from Groundswell: we've learnt that a lot of them actually carry mobile phones [...] and most of them have quite routinised behaviour and sleep in the same place [...] so they can be actually located quite often. [...] One of the flaws in our system is that our joined up working is very poor, so we don't know what the services are for homeless people in the community. We don't know where to go very often. But Groundswell has been pretty good on that.'

Furthermore, a member of staff from Groundswell delivers training on a six-monthly basis to coincide with each new influx of junior doctors, so that the benefits are ongoing. Similarly, another interviewee identified the Alcohol Liaison nurse at their local hospital as an important asset, because he is experienced in working with homeless patients and is able to provide training to junior doctors, although she is concerned that the hospital may not always take full advantage of this resource.

One healthcare professional also suggested that a basic handbook with guidance on how to work with homeless people would be a valuable tool for all of those medical staff who do not have access to such training, given that it is not widely available at present.

Whilst such small initiatives can contribute to a general improvement in the delivery of healthcare to homeless people, the above healthcare professional ultimately aspires to a comprehensive system of care coordination for all homeless and vulnerably housed patients, such as the Pathway team at University College Hospital, which she believes would have a truly transformative potential.

4.1.7 Removing obstacles to GP registration

As discussed in section three, it is reported that homeless people can face barriers to registering with their local GP. However, two of the healthcare professionals interviewed for this study also referred to the efforts made at their respective practices to dismantle barriers to access. 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.'

For this doctor one of his priorities would be a widespread registration campaign amongst rough sleepers because he says that they are significantly less likely to be registered than hostel dwellers.

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.'

4.2 How homelessness support services can enhance access to health services

4.2.1 Supporting people to move off the streets

Many of the barriers to addressing health needs identified in section three, as well as the causes of health issues discussed in section two, were related to sleeping rough. There is a general consensus among interviewees that supporting people to move off the streets is an important first step in helping them to address their health needs. Several former rough sleepers reported a marked improvement in their health since they were housed, even before access to health services was considered. For example, Dennis, who developed a skin condition through poor personal hygiene while he was living on the street, now has unrestricted access to shower and laundry facilities and Mark, whose diet was very poor, said that his health improved as soon as he was housed: *'at least you know you've got two meals a day.'*

4.2.2 Support and encouragement

As discussed in section three, failing to address health needs can be related to low-self esteem, self-harm and negative perceptions of services. Interviewees report that support services can play a key role in building people's self esteem and challenging

the negative feelings that prevent them from taking a proactive approach to their health:

'A lot of people feel looked down upon, feel undeserving, feel disrespected and have a negative opinion of themselves. It's about challenging this: 'You are the same as me. This is just a bad step in your life, but tomorrow's another day.' [...] It's a group that need respect, understanding and a little bit of empathy and a little bit of time and I find just giving them a little bit of that, you get so much more back.'
Nurse

Several of the interviewees talked about what it is that makes a good keyworker. Richard was particularly full of praise for his keyworker, Sandra:¹⁰

'Sandra is pure gold: she's the best person I've worked with ever. [...] I'm always totally honest with her. [...] I feel comfortable with Sandra. I'd say she knows me properly. [...] That's what makes a good keyworker: if you can trust them. [...] I feel I can talk to Sandra about anything.'

Mark said that it is very important for a keyworker to be persistent because people can change their minds and decide to accept help. He speaks about his first contact with people offering support when he was living on the street:

'I couldn't be bothered, wouldn't be bothered: I didn't even want to talk to the outreach team when they first came round.'

Even now, he joked, he keeps trying to convince his keyworker that he does not need her *'but she doesn't listen.'*

Similarly, for Dave if it wasn't for *'hassle'* from staff, he would not have sought treatment for the cancerous growth on his back.

4.2.3 A health focus within homelessness services

However, good keyworkers alone are not sufficient. In order to achieve positive health outcomes, interviewees stress that it is important for whole services to operate in a health-focused manner. For example, for the manager of a supported accommodation project, health *'forms the foundation'* of their service:

'We particularly target health needs as a way of enabling somebody to move forward: it's the priority here, we're not going to get anything else done with people while they have severe and enduring health problems.'

He says that by an accident of recruitment, they have a lead worker on health who comes from a clinical background as a nurse and that she has been good at navigating the system and establishing pathways because *'she can speak their language.'* In future he says he will intentionally recruit for nurses.

¹⁰ Name changed to protect interviewee's anonymity

In addition to this, he says that screening is a service priority and they hold a twice yearly 'health MOT'. Subsequently, he reports that they have successfully supported clients through treatment for Hepatitis C, TB and HIV. The manager said he makes it clear that there is an expectation that clients will address their health needs and if they do not do so, his staff are prepared to issue them with warnings for breach of their support contract.

Similarly, in his role as 'Health Champion' a project worker said he had introduced some key changes to make his service more health-focused:

'At the residents' meeting we discuss health services, what they can access, what they can't. Now we have a section in the team meeting where I talk about health, new services that I've found.'

Moreover, he emphasised that it is about generating a culture shift in which staff and clients alike are positive about addressing health needs:

'Straight away it was apparent that our clients were not going to appointments: they're too chaotic, they're either too drunk or they have taboos and anxieties about going to health services. It was almost accepted that this is the client group and that's what happens, but I was like, no: it's not working so it has to change.'

However, other interviewees report that limited resources can restrict the role that homelessness services can play in promoting health. For example:

'For outreach teams, particularly around health, quite often it's just about fire-fighting. If someone hasn't got a GP we'll always encourage them: try and get them to register, for sure. But then it's kind of like they've done that, box ticked, but we don't necessarily follow that up.' Outreach worker

4.2.4 Accompaniment to appointments

For some current or former rough sleepers, who may be mistrustful of services or apprehensive about receiving a diagnosis or undergoing treatment, interviewees suggest that it can be helpful to be accompanied to health appointments by a member of staff. For example, Richard appreciated the support of a trusted worker who accompanied him when he received his HIV diagnosis and Dave said he was reconsidering his refusal to attend a residential detox after a preliminary visit to the service with his keyworker.

The manager of the health-focused supported accommodation project described above, said that they have the advantage of being well-staffed and therefore, keyworkers are available to accompany clients to medical appointments. Other projects, however, do not have the same resources and are frequently unable to accompany clients to appointments. One hostel enlisted the support of Groundswell, who run a peer health advocate scheme that provides ex-homeless volunteers to accompany hostel clients to health appointments, and they are impressed with the results:

‘We’ve got a client who never engaged in health services, never. But now, because of his relationship with one of the Groundswell peers, he barely says ‘no’ to an appointment. He goes to them all with Groundswell, because he has such a good relationship with [his peer advocate].’

Groundswell’s Project Coordinator reported that their peers have managed to increase attendance of health appointments to 87 percent.

4.3 How specialist homelessness services can promote health and wellbeing in their own services

Interviewees spoke about how homelessness support services can promote health and wellbeing in their own services by creating therapeutic environments built upon healthy relationships; ensuring that staff are well supported; encouraging service-user ownership and control and adopting a holistic approach to promoting individual wellbeing. Each of these themes will be discussed in the following section.

4.3.1 Creating therapeutic environments built upon healthy relationships

A specialist GP working with homeless people defined homelessness as follows:

‘Homelessness, as much as anything else, is a disease of relationships.’

During interviews with current and former rough sleepers, they talked about how ‘diseased’ relationships can infiltrate support services for the homeless, in the form of bullying and harassment and chaotic hostel environments, and cause further detriment to their clients’ health, as described in section three. A number of service providers reported that they were alert to this risk and had taken preventative action within their services.

Recently published guidance on Psychologically Informed Environments (PIEs)¹¹ reports that the high numbers of current and former rough sleepers with personality disorder are inclined to exhibit problematic drug use, have difficulty managing their emotions and exhibit anti-social or aggressive behaviour, among other problems. Consequently, the guidance states that it is of uttermost importance that these services operate within a ‘therapeutic framework’, based upon positive relationships, which enables individuals to change negative behaviour patterns.

Despite the shortcomings of some chaotic hostel environments outlined in the previous section, several interviewees also gave examples of what’s working well in this area. The same GP who described homelessness as ‘a disease of social

¹¹ University of Southampton (2012) Psychologically informed services for homeless people: Good Practice Guide.

relationships' claims that the 'unique selling point of his service' is the ability to develop 'longitudinal relationships:'

'It's only then that you begin to develop relationships of trust that enable them to believe that your medicine might be worth taking.'

Similarly, several interviewees acknowledged that positive relationships form the foundation of successful treatment. For example, after two years Charlotte is beginning to trust her drug worker and feel like she might be able to 'tell her things.' However, such relationships must be cultivated with great care and consistency: one interviewee described how an indiscretion on the part of his doctor undermined the trusting relationship that they had built up over the years:

'She said, "I hope you haven't come for any sleeping tablets 'cause you won't get any." I said "I've not asked for anything, but I think I do need something because an hour and a half sleep in three days isn't really adequate." And I said, "What do you suggest?" And she said, "I suggest that you deal with your substance misuse." This was in the waiting room, which upset me a little bit. I wouldn't have minded if she'd pulled me to one side but, you know. And I just said to her, "I'm very surprised that you... I thought you were much more professional than that," and I just left the surgery, 'cause I was upset.'

In addition to building trust, one manager of a supported accommodation project described their use of an 'appreciative enquiry' approach towards developing a therapeutic environment. The idea is to focus exclusively on people's strengths and opportunities, rather than threats and weaknesses, signalling a move away from risk-led support-planning:

'So rather than saying "tell us what the problem is," you would focus on some of the strengths: [...] you'll get groups of people together and we'll put a question like "tell us about a time that you helped a friend" and then people begin to focus upon what's good and what they're strong at: not look constantly at what they are weak at and where the threats have occurred.'

4.3.2 Supported staff

The same manager talked about the fundamental importance of having a 'good, resilient staff team' when working with individuals who have challenging behaviour:

'The nature of personality disorder is often creating those gaps in a team and exploiting those gaps, but when the team stands firm and nobody gives in and works and supports together, then eventually you can break through.'

He said that they have one resident who arrived having been excluded from all the other services in the area. His behaviour was very challenging for the first couple of months, but now he is no trouble at all because 'he's worked everybody out and realised there's no gaps.'

In order to achieve such results, he said his experienced staff team has taken full advantage of the support offered by the Waterview Centre, a specialist personality disorder service in the borough. The manager reported that although the Waterview

does not tend to engage directly with rough sleepers they have been very forthcoming with support sessions and case conferencing. Furthermore, a few staff members have been on Cognitive Behavioural Therapy (CBT)¹² training in recent years, which they say was very helpful.

Another interviewee who accessed dialectical behaviour therapy for Personality Disorder at the Forensic Intensive Psychological Treatment Service (FIPTS) in Lambeth, believed that he received a high-quality service because the staff were well supported:

‘They themselves actually did some of the therapy that we did (and) were mentored by other colleagues. [...] Because they were heavily supported, that then meant that they could give their best to us, [...] so I am a big advocate of staff getting lots and lots of support, not them just being left by management: “Oh get on with it! What’s the matter with you?” because I know from my own experience just how demanding people with that disorder can be.’

4.3.3 Service user ownership and control

A couple of the interviewees described feeling, or having felt, sensations of powerlessness in their relationship with a support provider.

‘I was invited to an engagement meeting with staff, but it just felt like I was being black mailed. [...] I don’t engage with keywork. It pisses me off that he (worker) only wants to do keywork when it suits him.’

Supported accommodation resident

During this study, several interviewees talked about the importance of current and former rough sleepers having a sense of ownership and control over the services that they access on a regular basis. In the above scenario, offering a more flexible, client-centred approach to keywork could perhaps remedy this person’s reluctance to engage. However, interviewees reported that the ways in which service-user empowerment can be achieved are manifold, as outlined below.

Feedback

On a basic level, one GP surgery for homeless people set up a patient involvement group, where patients gave feedback about their experiences of the services and changes were made as a result: for example, to increase patient confidentiality at the reception desk. Similarly, the clients of one support provider were taking part in a survey which will be used to map their health needs and make improvements to service-delivery.

Peer support

At the other end of the scale, one interviewee had taken support-delivery into her own hands and offered peer-support to people who were dealing with problems similar to her own such as depression, self-harm and bereavement after the loss of a child. Donna, who runs a Facebook page and a helpline, finds it therapeutic to help others: *‘it helps me in a way.’*

¹² Cognitive behavioural therapy (CBT) is a talking therapy that can help you manage your problems by changing the way you think and behave (NHS definition)

Whilst seen by many as a valuable resource, comments made by another interviewee highlight the risks implicit in the delivery of peer support: On one hand, he said the peer support group he attends for people who have had problems with alcohol misuse is ‘one big family’ and an opportunity ‘to put a bit back in,’ but on the other hand he swore he would never attend Alcoholics Anonymous or Narcotics Anonymous because:

‘I don’t want some ex-user telling me, cos in (day centre) they tried to do it, but they’re hypocrites: you had one of them that used to be sprawled outside with a needle hanging out of his arm and now he’s working for them!’

Likewise, another interviewee completely disengaged with his local Community Alcohol Support Service, after attending his first meeting with peers who he felt were ‘a lot of hypocrites’ who talked about abstinence then went straight to the pub.

Co-production

In addition to offering peer support, Donna has become involved in a ‘co-production’ initiative within her supported accommodation project.

She said that she previously had some disempowering experiences with services, such as being put into accommodation that she knew was not suitable during her recovery from heroin-use and experiencing a relapse:

‘I had to go through all that to prove that I was right and I knew what was best for me.’

For Donna people who have had problems with drugs or alcohol are sometimes ‘treated like idiots’ and this is what motivated her to stand up for herself and get involved in co-production.

She described co-production as ‘people who live within the services, making it better for other people.’

At first, she said that she was a bit sceptical as to whether change was really possible, but having attended initial meetings she was convinced that the former rough sleeper who ran the sessions was committed to making a real difference to service delivery by handing power back to the clients:

‘I really like him, he’s a good guy, he’s helping people a lot. [...] It’s about the clients, not about the staff. Once people realise that things will change... [...] I think he’s made that possible.’

Asked what key message she would like to send to commissioners, Donna stated:

‘People need to be able to have their say.’

Peer health advocates

Another initiative that puts former rough sleepers in control is Groundswell’s Peer Health Advocate Scheme. The Project Coordinator said that his organisation had led the way ‘by allowing homeless people to be part of the solution.’

As well as improving access to health services for rough sleepers and supported accommodation residents, as described in the previous section, he said it also offers the volunteers an opportunity to build a new life after homelessness. At the time of the interview, seven ex-volunteers had progressed onto paid employment, including three of the original peer advocates who are now employed as part-time project assistants by Groundswell and another who has been taken on as a full-time Care Navigator by the Pathway Team at University College Hospital, London.

A professional from Pathway explained that he would like to see a system set up whereby every homeless person is allocated a Care Coordinator. He envisages that each hospital could have a GP-led team of Care Coordinators from a clinical background, supported by paid Care Navigators, with personal experience of homelessness.

4.3.4 Adopting a holistic approach to promoting individual wellbeing

Many interviewees reported that the services that work closely with current and former rough sleepers can support people to achieve better health outcomes by taking a holistic approach to promoting their wellbeing. When asked about what they believe has helped them to improve their health or would help them to improve their health in the future, many of the current and former rough sleepers interviewed identified the importance of using their time in a meaningful way and developing positive social relationships.

Meaningful use of time

Specifically, several interviewees said that staying busy was a good way of limiting their substance misuse. For example, Mark is aware that there is a strong connection between unstructured time, his depression and his alcohol consumption:

‘My main (trigger) is boredom. I suppose everyone says that. Because then I start to think a lot and if I think a lot, I drink.’

Interestingly, Richard, who felt he is in good mental health, noted a similar pattern with his drug use:

‘I need to find things that are going to keep me occupied; keep my mind occupied so I don’t feel I want to go out and use.’

Dave, whose substance misuse is worse when he has nothing to do, struggles more now he is in supported accommodation than he did as a rough sleeper:

‘On the street you have to keep going to stay alive [...]. In here I’ve heard so many blokes saying, what are we supposed to do all day?’

He suggested that the hostel should offer more activities. As a musician he would like them to buy a drum kit because he thinks the residents would find playing therapeutic and he would enjoy giving classes:

‘It would fill the gap and give me something I have to do.’

Fellow resident, Mark, explained that the hostel does provide clients with a small budget to spend on activities, such as cookery. Nevertheless, James would like more to be available; although he does acknowledge that the take-up is often poor when they do organise activities.

Evidently, accommodation-based activities are just one way of staying busy. Other interviewees participate in paid work, volunteering and educational or leisure activities and affirm that these have had a positive impact upon their health and general wellbeing.

For example, Ryan, who has slept rough, on and off, for many years, has taken drugs because he felt that *'there is nothing else to do.'* However, now he is volunteering for a charity as a van driver, delivering food to rough sleepers in Central London:

'I think voluntary work guards against depression. [...] Sometimes I think, is life worth living? But I wake up the next morning and I've got things to do.'

Similarly, for a number of people paid work had played a positive role in their lives. Luke finds he drinks more when he is not working:

'I've always worked from an early age: I was working on market stalls and that when I was a kid. I don't that until I was 17 and then I got my first proper job when I got my national insurance number and everything. I carried on working all the way through.'

Likewise, Jenny has a long history of paid employment, which she considers beneficial for her mental health:

'I used to do a lot of full-time work including road sweeper; post office night porter; the catering trade- about 30, 35 years on and off in the catering trade- surveyor's assistant; painter and decorator for four and a half years [...] it's as well that I work because I don't have babies: it's as well that I have something to do.'

Making friends

Participating in work or activities also gives people the opportunity to make friends: another key factor that interviewees identified as being important to their health. When asked what he needed to be healthy, Tom replied that the most important things were housing, a job, money and friends. He had difficulty establishing a positive social network after he left his family behind when he moved to the UK. Although he initially made friends they were all heavy drinkers and when he decided to address his alcohol misuse he had to isolate himself from them as well.

Dennis, who is being prescribed strong medication for his mental health, said that what he really needed was *'some friendship with somebody and not being completely isolated.'* Despondently, he described one failed attempt to strike up a conversation:

'I tried to talk to somebody in Tesco's and he nearly bit my head off just talking about chocolate... I said: Have you tried Galaxy? And what business is it of yours? Mind your own business! [He replied]'

On other occasions he had been driven to more extreme behaviour out of the desperate need for human contact:

I'd found a bottle of whiskey in a dustbin: proper whiskey. I said, "right, I'm having this" and nicked it. I saw two policeman walking up the road. I'd finished off just about this much and I poured it all over myself, rubbed it in with my hands and said "arrest me." They looked at me and went "Are you mad?" I said, "no, not exactly, I just want a bit of conversation."

Dennis would like more drop-in sessions to be made available, such as arts and crafts, where he could meet some people.

4.4 Collaboration between services

Many interviewees spoke of the importance of effective collaboration between all health and support services. They discussed the benefits of information-sharing, whilst respecting patient confidentiality and also key roles that have helped to develop staff knowledge of service pathways and facilitate joint working.

4.4.1 Information-sharing and confidentiality

A few interviewees described how the patient experience could be improved by services working together more effectively. One of the key concerns was that, when they fail to do this, people can end up having to re-tell traumatic stories over and over again to different service providers. One homelessness professional considered that it was 'almost a form of abuse' to ask people to constantly talk about painful memories and regrets and that this could even put people off accessing services altogether.

To address this he suggested there should be one full assessment of all of a person's needs, which is completed once and shared among the relevant professionals. He gave the example of the Common Health Assessment Tool (CHAT) which has been rolled out in various services that work with rough sleepers across Hammersmith and Fulham and is to be introduced in Westminster this year.

However, a professional who works with the CHAT in Hammersmith and Fulham warned that its effectiveness as a tool depends upon how thorough workers are when completing the form. Furthermore, she said it needs to be reviewed at least annually to update and measure progress, but this does not always happen.

Some interviewees expressed concern that confidentiality can be another major barrier to effective joint working and patients must always give their consent before any information can be shared, where as another nurse said that it hadn't posed a problem:

'They trust me because I don't breach their confidentiality: if they tell me not to say something, I won't say anything. I've not had anyone say that they've never wanted me to work on their behalf.'

– Nurse

Comments made by one hostel resident illustrated the importance of obtaining very clear and explicit consent from patients about information-sharing. Craig stopped engaging with a health worker because he believed that there was a breach of confidentiality:

'I don't really get on with her to tell you the truth [...] I felt she was telling my GP things that he didn't need to know. [...] I haven't spoken to her since: anything I do I go deal with myself.'

Sometimes clients do withhold their consent for information-sharing and staff reported that this can be a major barrier to joint working. For example, one professional said that her clients frequently lie to doctors about their alcohol use in order to obtain medication that should not be taken with alcohol. This presents a problem for staff, who then have to manage the overdose risk. Another hostel worker identified a particularly shocking case:

'We had a very difficult client [...] who was being scripted from everywhere; literally everywhere, and again no joint working between us and these services, so we weren't aware of it. They weren't aware of it because there was no joint working between that service and these other services she was being scripted from. She had a hold-all full of medication. She had something like fifty three overdoses in two years, until she came here and then we were like 'something's not right,' looked into it, monitored her and how much medication she was taking, then contacted local services saying have you got a client called this registered there? [...] She was going to White City, she was going to Greenford...[...] we had to take control. We went to the GP and said this is what is happening. The GP was really helpful and contacted all these other services and basically had to stop her getting scripted for any medication anywhere.'

Effective case-management would have led to much earlier identification of this issue and re-occurrence could have been avoided. However, the compartmentalised delivery of care meant that it took a long time before the full picture became evident and the problem could be addressed.

4.4.2 Developing knowledge of service pathways and developing joint working

A number of interviewees talked about the importance building up resources and staff knowledge in order to deliver a better service to their clients. Within Hammersmith and Fulham, interviewees identified two roles that help facilitate joint working between health and support services and share information: the Health and Homelessness Project (HHP) Coordinator, who works at the Broadway Centre, and the Service Development Officer, employed by the local authority. They have proven to be important resources for local support providers, according to an interviewee from a local project.

The Hammersmith and Fulham Supporting People Team originally contracted a Service Development Officer in 2009 to build the capacity of staff working with people who have substance misuse and offending issues, which brought her into close contact with supported accommodation staff:

'I set up the Practitioners' forum so we could get all the frontline workers together to talk about the challenges, identify gaps in practice, so that we could look at what training's needed [...]. It was through that work that it was identified that there was a lot of need within the hostels and actually there was a real kind of hunger for more information, more training and more support.'

Over the two years that followed the officer said her role was to ensure that hostel staff were provided with the appropriate training and held a number of forums to strengthen joint-working relationships across the borough. She stated that a November 2011 Supporting People audit found that the confidence of front-line workers had significantly increased as a result.

Similarly, the HHP Coordinator explained how she developed a live directory of health services in the borough, chaired regular Health Action Group meetings in which representatives from a variety of services have the opportunity to liaise and share information, and delivered a comprehensive programme of both staff and client health-related training.

Within Kensington and Chelsea, a specialist nurse for the homeless said she also works to strengthen joint-working relationships and deliver client and staff training as a part of her very versatile role:

'I go to a nurse forum, liaisons with CAPS [Community Assessment and Primary Service for drug users], A&E. I educate the staff in the hostels, [run] group sessions. I gave a seminar to the [hostel] clients on AIDS day, I do awareness sessions, open forums. I'll give a talk whenever they want me to give a talk. I go to [hostel] staff meetings and I'll explain it all to them, or if I can't I'll bring someone else in.'

For a staff member at a supported accommodation project where this nurse works the recent case-conference she set up regarding a particularly chaotic client was extremely valuable:

'It's like hitting your head against a brick wall because you're really trying with this client, but we've been trying now for two years and his A&E attendance is still sky high and he's still not faring very well, so bringing everyone together: certain suggestions were made in that meeting where I was like "oh, OK I wasn't aware of that service, but maybe that's worth exploring" [...]. I think it offers reassurance for staff as well [...] because it's not just your problem.'

5: Discharge and move-on from services

Key points

- ▶ Hospital discharge is an area of weakness when it comes to meeting the needs of homeless people. Key issues raised during this study were: 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; and discharge without clothing or transport.
- ▶ Hospital staff interviewed said that there was a need for care coordination, improved communication and a dedicated budget to meet basic expenses for clothes and transport for people leaving hospital to overcome these issues.
- ▶ Remaining in homelessness accommodation when they were ready to move on could be detrimental to people's health. Likewise, the transition from supported accommodation to independent living could be difficult for people and they were particularly at risk when specialist health services for homeless people withdrew their support after they were housed. Homeless people with health needs may need support during and after they move on in order to prevent their health regressing.

The final part of rough sleepers' journeys through services can have a significant impact on their future health. This section will explore their experiences around discharge from hospital and move-on from supported accommodation and specialist health services.

5.1 Hospital discharge

Most discussions with interviewees relating to the experience of leaving services were focused upon hospital discharge. This is known to be an area of health service provision that is particularly weak when it comes to meeting the needs of homeless people.¹³ The key issues raised during this study were: 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; lack of resources to cover basic expenses; and the need for care coordination. Each of these issues, in turn, will be discussed in the following section.

¹³ Homeless Link (2012) Improving Hospital Admission and Discharge for People who are Homeless.

5.1.1 Early discharge before health needs are fully met

Experiences

Clare's story (see box below) is an example of early discharge; in her case, from a hospital mental health unit before she was ready.

Case management and continuity of care: Clare's story

Clare was discharged after she was hospitalised following an incident of self-harm. She was left in a hotel to dress her own wound, with no follow-up support or healthcare:

I used to self harm. I needed more help. They had me there [in hospital] for about two weeks after I done that (indicating to large scar on her arm). I nearly died when I done that. I wanted to stay there. () I was quite distressed and 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.

I was homeless and then they put me in a hotel. () They were going to put me on the street and I was like 'I'm not leaving' and it was only down to one nurse that said you can't put her out on the street.

They didn't follow it up, which I thought was disgraceful. () I was in the hotel with no support for six months. I think people just get lost.

A nurse said that early discharge is a real problem and often leads to people who are experiencing mental health problems getting arrested. She described an incident where a client from a supported accommodation project where she worked was sectioned under the Mental Health Act after experiencing a crisis and threatening staff and residents with a broken glass. He was moved around six different places in six weeks and nobody would take him on so he ended up being discharged back to the same accommodation. Following another altercation the police were called and he had to wait under police surveillance until another mental health bed became available. For the Deputy Manager of the project concerned the solution is clear:

'More money into mental health () to give more beds back, because some seriously ill people are being discharged too quickly.'

A professional working in a hospital paints a similar picture of the hospital system in general:

'It seems like a solution for the hospital rather than the patient: it's designed to get them out of hospital so we can use the bed again.'

The case of a patient with no recourse to public funds

This situation seems to be particularly severe in the case of patients with no recourse to public funds. Ryzard, a rough sleeper from Poland, was admitted to hospital several times for alcohol-related seizures. Each time he was just provided with medication and a drip then rapidly discharged because he had no national insurance number. At

one point, when he felt particularly weak, he presented at hospital with a friend's national insurance number: this time the treatment was much more thorough and he was kept in for six days, before being discharged to a Bed and Breakfast, rather than to the street.

Self-discharge

There are also a number of patients who self-discharge before their treatment is complete. Some of the rough sleepers interviewed had self-discharged from hospital: Ruth walked out after being left on a trolley for four hours by staff with a 'cup of tea fixes everything' attitude, after she had tried to commit suicide by overdose. Dennis left hospital in his nightgown because he felt 'suffocated' and Ryan self-discharged because he felt ignored by staff who were only attending to his immediate needs following an overdose, and dismissed his complaints of joint pain: the reason he took too many tablets in the first place.

A nurse reported that a common reason for self-discharge is the inability of hospitals to adequately care for opiate-dependent patients who are not already on heroin-substitute medication.

Managing opiate-dependency in hospitals:

'Let down and disrespected'

Healthcare staff told the story of one client who was addicted to heroin but was refused methadone in hospital and, as a result, self-discharged early.

He went in with suspected DVT [Deep Vein Thrombosis]: his leg was completely... twice the size, hot to touch, [he was] really in a lot of pain with it. () He had done six or seven hours and he was saying to the doctor 'please I need some methadone or something. I'm not scripted, but I am physically withdrawing: I am sick.'

I went up there and I tried to negotiate and I got as far as [drug service] and they were saying 'yes, put him on this.' () The consultant said 'no.'

This poor guy then had to go out onto the street () in order to get some drugs to subdue his withdrawal. () He wanted to stay and sort his health issues out; he felt that bad, but they wouldn't support him with his methadone withdrawal. () This poor guy has got such a thing about people letting him down in hospital and he's right: he has been let down and disrespected as a homeless person.

If you think about it, he is going in with suspected DVT and what he is actually being forced to do () is go and buy illicit drugs and then further groin inject, which is what is causing the suspected DVT.

5.1.2 Discharge to the street

Experiences

Ryzard, the Polish rough sleeper described above, said that hospital staff were fully aware that they were discharging him to the street upon the first few occasions that he presented at hospital. This is not uncommon. Daniel (see box below) also reports being discharged to the street.

Discharge from hospital to the street: Daniel's story

Interviewer: 'They knew you were of no fixed abode and they still discharged you?'

Daniel: 'Yeah, they still discharged me, straight onto the street.'

'You've got nowhere to go. I had an operation for my appendix, so it's a deep operation, and [they were] throwing me out onto the street after two days.'

'It didn't help me because I was prone to infection on the dirty streets. () I was in [day centre] and I felt all funny: I felt all ill. Where the wound was () there's all this green stuff coming out.'

The difficulties

It is possible that in some cases staff are not aware of a patient's housing status. A nurse says that people will not disclose this information upon admittance to hospital because they fear that it will attract stigma. However, according to another professional the question is often not even asked. This could be because some doctors do not consider housing to be within their remit, as suggested by one hospital nurse, or it could be because they would not know what to do with this information anyway. For a GP working within the University College Hospital Pathway team now that they have system in place it is worth posing the question, but *'before, if there wasn't a service, why open that can of worms.'*

'It is against our ethos to just kick them back out onto the street but that's what happens.'

Hospital worker

For this professional without training or resources she tries to prevent this from occurring by sign-posting people to services that might be able to help such as the housing office or a local homelessness charity:

'At present we are not really sure when we direct people () we're not really sure what kind of service they are going to get and whether they are actually going to get the help they need.'

Meanwhile, an A&E-based nurse said that the discharge team at her hospital does try to arrange temporary accommodation for homeless patients upon discharge. However, she considered this to be little more than *'a sticking plaster on what's really a big wound.'*

Despite reporting success in improving the experiences of homeless patients and

preventing inappropriate discharge, a doctor from the Pathway team acknowledges that finding suitable move-on accommodation is no easy task. He estimated that only one third of all the patients they see have a local connection and may therefore be entitled to local authority housing.

Respite

In order to address the bottleneck effect caused by homeless patients who have no suitable accommodation to return to upon discharge, the Pathway team have proposed a new 'respite' model of care:

'Pathway medical respite centres will offer short term and convalescent beds to homeless patients fit to leave hospital, where the patient would benefit from a further period of health-led care and support'

A number of other interviewees were in favour of such a service, describing it as 'a no-brainer' and saying that investment in respite centres would produce an overall saving for the NHS.

5.1.3 Poor communication upon discharge

In the meantime, the experiences of homeless patients at the point of discharge could be improved by increasing communication between hospitals and other key services involved in their care.

Communication with GPs

One GP complained that communication from hospitals can be very poor:

'It's not infrequent that patients will say, "I was in the hospital the other day and they said this and that and gave me some white pills to take" and () you scabble around trying to get this information out of the hospital.'

He continued by saying that an A&E department will often write out a letter after the patient has left to a 'Dear Doctor Unknown' and then presumably put it in the bin because there is nowhere to send it:

'The CCG, PCT or whatever has paid for that A&E attendance () and in the end it's useless because the information doesn't go anywhere and the patient can't remember and they lost the prescription anyway, or they didn't wait for it or all of those tests that were done, that X-ray that was taken, those bloods, that opinion...'

He said that while he understands that it can be difficult for hospitals if a patient does not have a GP or know their name, the process could easily be made more effective by simply giving the patient a letter, or discharge summary in their hand when they leave hospital. Similarly, another professional suggested that homeless patients could be provided with memory sticks to store such data.

On the other hand, an A&E-based nurse pointed out that GPs can be unreceptive to communication. She said that even when a GP is sent a letter regarding their patient's

hospital visit and advised that follow-up treatment is required, they are unlikely to pursue this unless the patient is sufficiently proactive to make an appointment themselves. Clearly, there are exceptions to the rule and the practice manager of one medical centre talked about the importance of following up hospital correspondence to ensure that patients are getting good quality treatment. However, when this is not the case, the nurse said that collaborating with peer health advocacy organisation, Groundswell, has helped to address the gap:

'One of the things that has really helped has been the Groundswell project. It's been able to link people up with a GP: that's really been helpful. We can alert Groundswell that this person doesn't have a GP and we sent them out on antibiotics, we're really worried that they're not going to take them or they're not going to come for an appointment. They link up with GP practices in the borough that actually take homeless patients.'

Communication with support workers

Another area of poor communication is between hospitals and support workers. Accommodation-based support providers report that hospital staff inappropriately discharge patients to their care without consulting them. A project worker complained that it puts a lot of pressure on staff who are not medically trained, when a person who is still acutely ill returns to the project, forcing them to pick up the pieces left by bad practice elsewhere.

However, one hospital worker explained that they are not able to contact a patient's support worker unless the individual concerned provides the relevant information and their consent. Another says that there is often a misunderstanding on the part of support workers who over-estimate the capacity of hospitals to retain patients once the person decides to leave.

By going out and visiting local hostels, a hospital-based nurse has been able to challenge these perceptions and has also gained a clearer understanding of the limited capacity of supported accommodation projects to offer any form of follow-up medical care. It is only through opening the channels of communication that they have learned to work more effectively together.

Communication with outreach workers

In the case of rough sleepers, as opposed to supported housing tenants, it is advisable for hospitals to liaise with their local outreach team who can help them to find suitable accommodation for a patient upon discharge. However, this needs to be done ahead of time and one outreach worker said that they are regularly contacted as the patient is discharged; at which point there is often little they can do. In her experience it is only when a person is sectioned under the Mental Health Act that discharge tends to be adequately planned.

At the University College Hospital the Pathway Team have set a target for all homeless patients to be referred to them within two days of their admittance to hospital, in order to begin the process of discharge planning. Although there will be occasions when this may not be possible (for example, if the patient is unconscious), the target is successfully met in seventy to eighty percent of cases. Other hospitals could aspire to similar standards with regards to timely referral of rough sleepers to an outreach team.

5.1.4 Discharge without clothing or transport

Upon discharge from hospital, homeless people may also be faced with even more immediate concerns. Dave found himself walking down the street in a hospital-issued backless gown, after his clothes were cut off by medical staff following his admission with a head injury.

A&E staff from two different hospitals told of a shortage of basic resources for their most vulnerable patients. In the absence of a dedicated budget staff do their best to ensure that homeless patients are adequately clothed:

'We bring old clothes in and we've got a cupboard with old clothes because sometimes we have to bathe them and put them in clean clothes.'

The situation with money to pay for transport is similar. One nurse described being discouraged from using expensive hospital transport but there is no budget for taxis and often the patient is penniless. A similar solution is attempted:

'Occasionally what we do is we have a little box that we collect a little change in that we find around.'

Both nurses (and, it can be assumed, their patients) would appreciate a designated budget for such expenses.

5.1.5 The need for care coordination

The overriding desire of both nurses is for a system of care coordination to be established so that each homeless person can have their case managed by a named individual from admission, through to discharge and beyond.

At the moment, neither nurse is aware of the existence of a clear protocol for dealing with homeless patients, in their respective hospitals.

'There is a discharge team in the hospital that I am not part of and I am not entirely sure how they work with homeless [people], but my understanding and experience is that they don't manage too well.'

It is by an accident of recruitment alone that she is able to offer some assistance:

'I worked for a few years with homeless people. () I've got a lot of experience around housing and homeless people, but that's not my job.'

She described her work as *'problem-solving,'* whereas a Care Coordinator could offer a much more strategic and proactive approach.

Likewise, for her colleague from another large hospital the task of attending to homeless patients requires *'energy and dedication,'* which she is not able to offer because it is only a small part of her role. What is needed is a specialist role to be created, but the initiative must *'come from the top:'*

'My experience in the health service has always been that unless you have

executive buy-in, you are going to fight such a massive battle, to your own detriment most of the time. () The commissioners just need to say to the Execs, NHS London: we want this resolved.'

5.2 Move-on from supported accommodation

The other key area of concern regarding moving on from services was the transition from supported accommodation to independent living. This can be a source of great anxiety for two main reasons: firstly, because those who do move on sometimes find that the process is poorly managed, and secondly, because for many there is a sense of being 'trapped' without avenues for progression. Each of these issues will be explored in the following section.

5.2.1 Poorly managed move-on

One GP for the homeless was concerned that people were regularly moved on from supported accommodation without sufficient preparation:

'I think a lot of failures occur because people are put out into housing too soon and they can't cope with it: they're not prepared enough. () They can't put up with the loneliness; they're not very good at cooking or budgeting; or you've got the next door drug addicts who immediately come and knock on the door.'

Omar struggled when he moved into his own place and his health deteriorated as a result:

'I was just left to myself and I found it really hard. I did alright for two years, Miss, but slowly, slowly I just went downhill and that's when the Hep C kicked in.'

The situation could have been different had he received some on-going support:

'I would've loved to have some help: probably I wouldn't be here now. I had a nice flat and all. () You are supposed to get a bit of aftercare and I didn't get that. (They should've) come to see me every month.'

In contrast, another interviewee, who had made a remarkable recovery from his mental health illness, now lives happily in his own accommodation. He was 'guided and prepared' through the move-on process, rather than just 'thrown out.'

5.2.2 Feeling trapped

A couple of interviewees described feeling trapped and frustrated in their current supported accommodation. Adam was angry that he has been 'referred' for move-on, but nothing actually materialises. This has caused him to feel resentful towards staff who 'don't follow through' on their promises. Already suffering from severe mental health problems, Adam believed he would not be able to address the problems while

he is living in his current accommodation, where he is deeply unhappy.

Meanwhile, for Jason, the stress generated by his housing situation serves as a trigger for drug use. He turns his anger towards the local authority and people that arrive from outside the area who are competition for social housing. He accepted that those with dependents have a greater need for housing than he does but he needs to see some kind of *'light at the end of the tunnel.'*

Jason wanted the council to reserve a small quota of social housing for single men who address their health issues and do well in supported accommodation, because at the moment *'there is no clear path of getting out of here'* and this makes him feel de-motivated:

'They say if you engage... that's the key word "engage," then it looks good on your case and you might be able to get somewhere, and then you do that and there's fuck all there and it bugs you, because you are doing everything they ask you to do and sometimes you don't get the reward.'

5.3 Moving on from specialist homeless services

The process of migrating away from specialist services for rough sleepers is not always as smooth as it could be and this can cause the patient's health to decline.

Chris was linked in with two specialist homeless services during a previous episode of sleeping rough: a GP and a Community Psychiatric Nurse (CPN). However, contact with both services was abruptly severed once he was housed.

'I had a CPN from the homeless section and when I moved into my flat, they kept me going for a couple of weeks and then had to break the connection 'cause I wasn't homeless anymore. I went downhill slowly.'

The GP did not even give him a couple of weeks to find a new doctor: he was immediately removed from their register and was unable to obtain repeat prescriptions for his anti-depressants as a result. He would have liked them to keep him on, just until he *'got sorted.'*

One GP for the homeless said that *'it all goes horribly wrong very quickly'* if such transitions are not managed with care:

'If you're on a methadone script and you've got mental health issues and your flat comes up in Walthamstow, the thing not to do is say: we are going to break all of your relationships and you're going to have to make them all anew in Walthamstow and you've got three days to do it.'

At his surgery they take the following approach:

'First of all, get your flat; second, get some furniture; third, find your job centre; fourth, find your chemist and just do it one step at a time and we'll still be here prescribing your methadone () and then you'll probably move your prescriber last.'

During initial interviews with commissioners, concerns were raised about the ability of former rough sleepers to progress from specialist to mainstream services once they were housed. Likewise, one outreach worker said that people do not want to move on from the Westminster-based practice. However, the GP disagreed:

'People tend to auto-triage themselves when they get better () and that happens in a pretty natural way.'

They sign-post anyone who is ready onto an appropriate mainstream practice.

For one hostel-based nurse, specialist health services for the homeless, such as her own, play a key role in rebuilding people's trust in health services and linking them back into the mainstream:

'The model of care that I follow is to introduce them into normal primary care, so my main aim is to bridge this attitude that they have towards going to see GPs: they're scared to do that. I bring them to their GP and then () between the two of us, we nurture them and we build up their confidence and then they trust us.'

Consequently, people generalise those positive experiences and are more willing to engage with other mainstream GPs.

6. Final reflections

6.1 Challenging context

The context of this research is a period of reductions in government spending in areas which, the evidence so far suggests, are likely to disproportionately affect homeless people. Resources for rough sleepers specifically are impacted by changes in local structures. For example, some commissioners and service providers expressed concern regarding the removal of the post of Homeless Health lead within the tri-borough Vulnerable Adults team which aimed to ensure clarity and coordination in addressing the needs of this group. The broader policy context will also impact on the health of rough sleepers. For example, access to housing and benefits that are key to health may be affected by upcoming welfare reform.

6.2 Local assets and suggested improvements

Whilst it was not within the scope of this piece of research to fully evaluate effective practice in the delivery of healthcare to current and former rough sleepers, there were some consistent messages from those interviewed regarding positive local assets and suggested improvements that may warrant further consideration and exploration.

6.2.1 Care coordination and joint working

A common theme highlighted by the service providers interviewed for this study, is the need for effective care coordination and case management to enable current and former rough sleepers to successfully navigate health and support services throughout their journeys from the street towards the fulfilment of all their health and social care needs. This function could be performed by a *'lead professional'* responsible for overseeing the care provided and facilitating effective joint working between all relevant agencies. The professional that assumes this role could be determined on a case by case basis, depending upon the individual's needs and pattern of service use.

Three hospital-based interviewees suggested that a medically-trained care coordination team within each hospital would be an ideal way of picking up those who have fallen through the gaps in the system and ensuring that their needs are addressed in a holistic manner before they move on from the service in a planned and supported way. Such a system is already in place at the University College Hospital, London (Pathway for Homeless Patients) and was identified by an interviewee from a different hospital as a local asset to emulate.

Both she and a representative of the Pathway team express the view that although

financial and resource constraints may be cited as a barrier to providing coordinated services, a view needs to be adopted which recognises that leaving needs unmet is, in the long term, more costly than addressing them within a culture of preventative services.

In addition to care coordination, interviewees also identified a number of local assets which they believe have been successful in improving health outcomes for rough sleepers by facilitating joint working. These include (but are not limited to):

- ▶ The Service Development Officer post in Hammersmith and Fulham aimed at unblocking health pathways and developing the capacity of support staff.
- ▶ The Homeless Health Project in Hammersmith and Fulham, which has produced a comprehensive directory of services; set up a health action group offering opportunities for networking and liaison and provided health related training for rough sleepers and support staff.
- ▶ Medically trained staff working within support services such as the peripatetic nurse in Kensington and Chelsea; the recently commissioned dual diagnosis worker in Hammersmith and Fulham and outreach nurses in Westminster.

6.2.2 General strategies for enhancing access to health services for current and former rough sleepers

Participants in this study identified a number of practices in their local areas which they believe have enhanced access to health services for current and former rough sleepers.

Improving patient experience through staff training

Some of the rough sleepers who participated in this study reported negative experiences as a result of staff not being equipped to meet their needs. However, interviewees also affirmed that patient experiences of the health system can be significantly improved through training for health professionals, delivered by specialist staff, homeless organisations or peer advocates. One hospital-based interviewee said that the training her staff received from homeless health organisation, Groundswell, was a valuable asset to their work.

Boosting patient confidence through peer support

Other interviewees say that the emergence of a commitment to peer support has proven successful; boosting appointment attendance among individuals who were previously reluctant to engage with health services. In particular, one project worker identifies Groundswell's peer health advocates as a local asset. Moreover, a representative from the organisation affirms that this peer support approach to improving health outcomes empowers homeless people by recognising their ability to form part of the solution to the problem of poor health outcomes for this group.

Taking the service to the patient to build bridges

The effectiveness of taking health services to rough sleepers has also been highlighted by various participants in the study, whether via in-reach to hostels and day centres or the accompaniment of outreach teams by medical professionals. For example, one project worker says that a number of his clients have received life-saving diagnoses and treatment as a result of health in-reach.

Maximising impact by offering a one-stop shop approach

Specialist homeless health services report that a 'one-stop-shop' approach is an effective method of delivering healthcare to homeless patients. The idea is to maximise the impact of every contact by offering a broad range of medical interventions. Examples include GP practices with onsite mental health and substance misuse workers, as well as proposals by the Find and Treat Project to amplify the range of immunisation, screening and treatment they are able to offer to rough sleepers.

Reaching out to minority groups of rough sleepers

Interviewees note that certain sub-groups of rough sleepers require the implementation of additional measures to ensure they do not develop life-limiting and costly health complications. They state that services need to be accessible to speakers of other languages, particularly those from Central and Eastern European countries who represent a large cohort of rough sleepers. Furthermore, individuals with no recourse to public funds must be supported to access treatment by completing an HC2 form.

6.2.3 Local asset checklist by service type

Interviewees identified a number of local assets which they feel enhance the capacity of specific health and homelessness services to meet the needs of current and former rough sleepers. Based upon their experiences, they also suggested some further improvements which they believe could be made. These will be outlined in the service-specific checklists below:

General Practitioners

- ▶ Provision of a full initial health assessment for all homeless patients.
- ▶ Availability of flexible/extended appointments, when necessary.
- ▶ Capacity to participate in in-reach/out-reach activities.
- ▶ Use of 'Choose and Book' to facilitate referrals for homeless patients
- ▶ Availability of treatments such as Pabrinex injections and Hepatitis C medication via GP practices.
- ▶ Registration of any patient from within practice boundaries, regardless of whether they are able to produce proof of address or identification.
- ▶ Willingness on the part of GPs to carry out home visits to hostel-based patients.

Hospitals

- ▶ A clear protocol for identifying rough sleepers and fully addressing their needs, including accommodation upon discharge.
- ▶ Staff with specialist training, available in all hospitals, to take blood and give transfusions to people whose veins have been damaged by intravenous drug use.
- ▶ A named care coordinator for all homeless patients.

Specialist homeless health services

- ▶ Delivery of a holistic and flexible service to meet the needs of rough sleepers.
- ▶ Role building up trust in health professionals and linking patients into mainstream provision.
- ▶ Overseeing continuity of care during the transitional period between homelessness and settled accommodation by keeping people on until they are linked in with the necessary mainstream services and offering the support they need to do this.

Mental health services

- ▶ Provision of talking therapies, such as counselling for depression and dialectical behaviour therapy for people with a diagnosis of personality disorder.
- ▶ Well-supported staff teams.
- ▶ Close liaison with support providers when assessing an individual experiencing mental distress.
- ▶ Not excluding any person with mental health problems from accessing mental health services on the grounds of substance misuse.
- ▶ Services with clear and comprehensive remits, which do not exclude anyone.
- ▶ An emphasis on preventative work, such as extended contact with a Community Psychiatric Nurse, in order to prevent heavy use of crisis intervention services.
- ▶ Sensitivity when using the term 'personality disorder' by adopting an alternative term such as 'complex trauma'.

Homelessness support services

- ▶ Building self-esteem and challenging negative self-perceptions through therapeutic relationships and tools such as 'appreciative enquiry'.
- ▶ Facilitating contact with health services by liaising with health professionals, setting up in-reach and accompanying clients to appointments or arranging peer support.
- ▶ Taking a holistic approach to promoting individual wellbeing by promoting involvement in meaningful activities and the establishment of a positive social network.
- ▶ Nominating a health lead or champion to ensure services are health-focussed.
- ▶ Encouraging service user ownership and control over the service.
- ▶ Offering personalised support options.

- ▶ Clear rules against bullying and drug use that are strictly enforced by all members of staff.
- ▶ Supporting former rough sleepers during the transition to independent accommodation: ensuring that they are ready, accommodation is appropriate and follow-up care is provided.
- ▶ Adequate training and support for staff working with people who have personality disorder.

6.3 Recommendations for further research

Fruitful avenues for further research include, but are not limited to:

- ▶ An exploration of models of care coordination for current and former rough sleepers, with a view to producing a best practice model.
- ▶ A study of current and former rough sleepers with personality disorder to determine the best way to facilitate access to effective treatment.
- ▶ A study to capture the experiences of rough sleepers in London with no recourse to public funds, with a particular focus on those from Central Eastern European backgrounds.
- ▶ A study of the specific health needs of women and how far these are met locally.
- ▶ An evaluation of peer support initiatives, with a view to investing further in this work.

