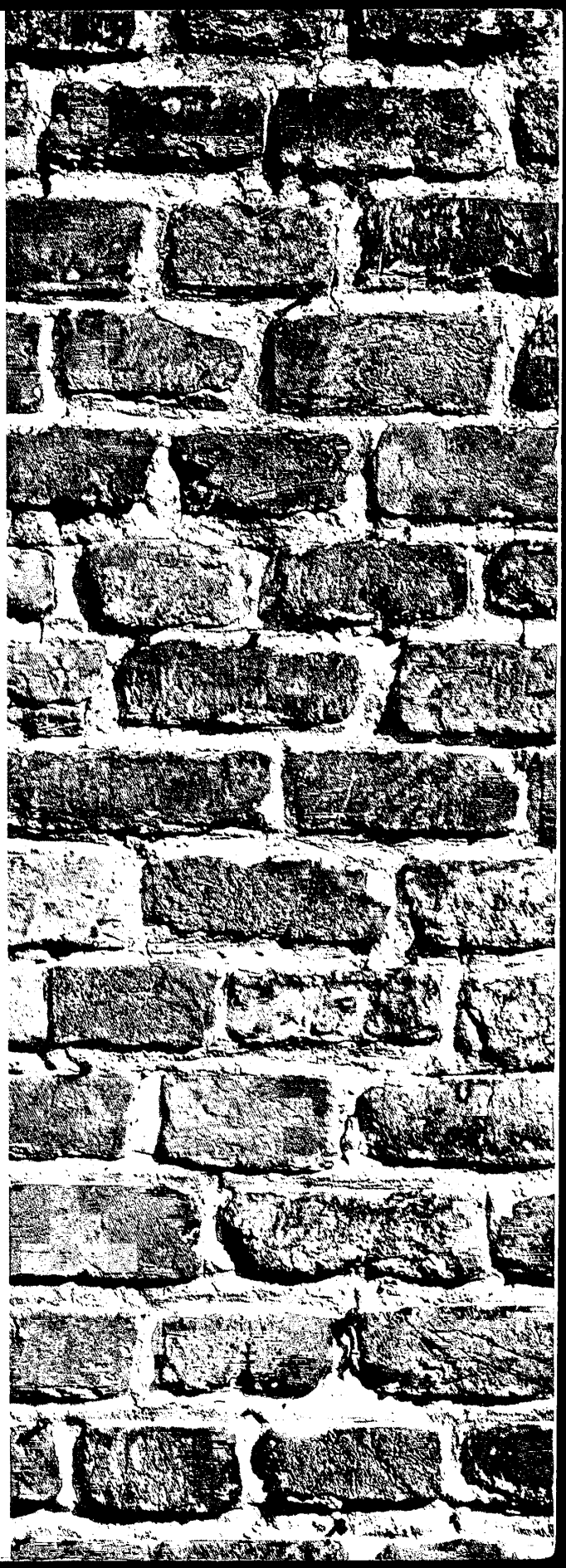
King's Fund

Health & Homelessness in London

A review

Nicholas Pleace
Deborah Quilgars



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Preface

In May 1995, the Centre for Housing Policy (CHP) at the University of York was commissioned by the King Edward's Hospital Fund for London to review health and homelessness in the capital. The central aims of the Review, as listed in the original research brief, were as follows:

(i) to strengthen the knowledge base of the Grants Committee with an up-to-date survey of needs and activity in relation to the health needs of homeless people and their access to services in London;

(ii) to develop an overview of funding resources available to support work on health and homelessness issues;

(iii) to clarify the Fund's strategic funding role, and to identify priorities for future King's Fund grantmaking activity in relation to access to health services by homeless people.

The scope of the Review was to include the gathering of demographic information on homeless people in London and information on their health status. In addition, the Review was to examine existing provision and highlight key issues arising from the current situation. The Review was also designed to identify gaps in provision and to map the activity of funding organisations.

The research team at CHP adopted several methods in order to fulfil these objectives. The methods used reflected the time that was available for the study (five months) and the available funds for the research, which placed constraints on the time that the research team could spend in London.

The first stage of the research was a national and international literature search on health and homelessness in general, and in the UK and London in particular. Several bibliographical databases, including those managed by the NHS Centre for Reviews and Dissemination, which is also based at the University, were employed for this stage of the study, and considerable use was also made of health-specific sites on the World Wide Web. The second stage of the Review involved the collection of as much of the available statistical information on homelessness in London as possible. Once these data were collected, they were analysed to generate as much information as possible on the number and characteristics of homeless people in London.

The third stage of the Review was the collection of information on the activity of health service providers and funders that worked in providing health care to homeless people in London. This element of the Review, in itself, proved to be a major exercise. Much of the statutory sector, including health authorities, family health service authorities, health commissions and London boroughs, were contacted and extensive contact was also made with charitable and voluntary sector organisations. In total, 177 organisations were identified as having a possible role in health care provision for homeless people and were contacted. An unusually high response rate to this request for information (46.5 per cent) was achieved.

Following the third stage of the Review, the research team organised and conducted a series of 36 interviews with professionals. Some 30 telephone interviews, five face-to-face interviews and one group discussion were conducted with staff from a wide range of homelessness and health organisations. These included providers of direct health services to homeless people, funders of services and policy experts in the field. Staff working in specialist outreach teams, medical centres and day centres were also interviewed, along with some staff working as providers in the mainstream NHS. Funders and policy experts from both the statutory and voluntary sector were included in the interviews. While the staff interviews were being conducted, the research team arranged a series of five group discussions with homeless people in London. The groups ranged in size from four to eight people, with 32 individuals being interviewed in total. One group was made up of nine young people (three female); another was made up of homeless people who were refugees (three female); another contained seven people who are sleeping rough and other homeless people (one female); the others were both smaller groups (three and four people, one female), and were made up of homeless people of varying ages and circumstances.

The first chapter of the Review presents demographic information on homelessness in London during the last quarter of 1994. The second chapter describes the health status of homeless people in London. Chapter 3 is concerned with the experience of homeless people using the mainstream health service in London, and Chapter 4 describes the specialist health services available to homeless people in London. Chapter 5 presents the views of professionals and homeless people on mainstream and specialist health services. Chapter 6 discusses the planned changes in the homelessness legislation and summarises the Review's findings on health and homelessness in London. The report ends by presenting recommendations for policy and practice developments in health services for homeless people.

Nicholas Pleace
Deborah Quilgars

Acknowledgements

The Review would not have been possible without the cooperation of a large number of organisations. The research team is grateful for the assistance of all the funding bodies, health commissions, Family Health Service Authorities, District Health Authorities, London boroughs, and voluntary and charitable organisations that responded to requests for information. In addition, the research team would like to thank the staff in the public, voluntary and private sectors who gave up their time to be interviewed for the study.

The research team is also grateful for the assistance of all those homeless people who gave up their time to be interviewed. The research team would like to give special thanks to the staff and volunteers working at the London Connection Day Centre, Great Chapel Medical Centre, The Passage Day Centre, The Cardinal Hume Medical Centre and the East African Refugee Group for arranging the group interviews with homeless people and for supplying venues.

Within the University of York, the research team would like to thank the Social Policy Research Unit, the NHS Centre for Reviews and Dissemination, and the social section of the Library for the use of their bibliographic resources.

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Executive summary

Homelessness in London

The numbers of homeless people in London

1.1 A distinction is drawn between statutorily and non-statutorily homeless people in the UK. *Statutorily homeless households*, following assessment by a local authority (borough in the case of London), qualify for permanent rehousing in council or housing association housing. The homeless households that qualify for assistance include people with dependent children, women who are pregnant and single people who are 'vulnerable', in that they cannot be expected to fend for themselves. In London (and the rest of the UK), statutorily homeless households often have to wait for permanent social housing to become available. While statutorily homeless people are waiting in temporary accommodation (such as leased accommodation, hostels, and bed and breakfast hotels) for their permanent homes, they are still regarded as homeless.

1.2 Homeless people who do not qualify for assistance under the homelessness legislation are generally single people without children who are not deemed to be 'vulnerable' under the terms of the legislation. These homeless people are usually referred to as *single homeless people*. Most single homeless people live in short-term accommodation such as hostels and bed and breakfast hotels, but a substantial minority live on the streets. People who live for some or all of the time on the street are usually referred to as *people who are sleeping rough*.

1.3 It is estimated that the homeless population of London was just under 106,000 during the last quarter of 1994. This is only a broad estimate, because available data on homelessness in London are *generally poor*. Information on statutory homelessness is confined to households, no data are released on the ethnicity of households, and data are not collected on the size, age and gender of homeless households. Data on people living in hostels, night shelters and short-stay hostels are limited, and information on certain groups, such as single homeless people from ethnic minorities and homeless asylum seekers and refugees, is practically non-existent.

1.4 The majority of homeless people in London (estimated at 71 per cent, 76,000 people) were statutorily homeless households awaiting rehousing in temporary accommodation. The remaining households were mainly non-statutorily single homeless people who

were mainly living in various forms of hostel, using night shelters, sleeping rough and squatting. The number of people who are sleeping rough has fallen in recent years because of major Government programmes, the Rough Sleepers' Initiative (RSI) and the Homeless Mentally Ill Initiative (HMII), both of which have been shown to have significantly helped reduce rough sleeping in London.

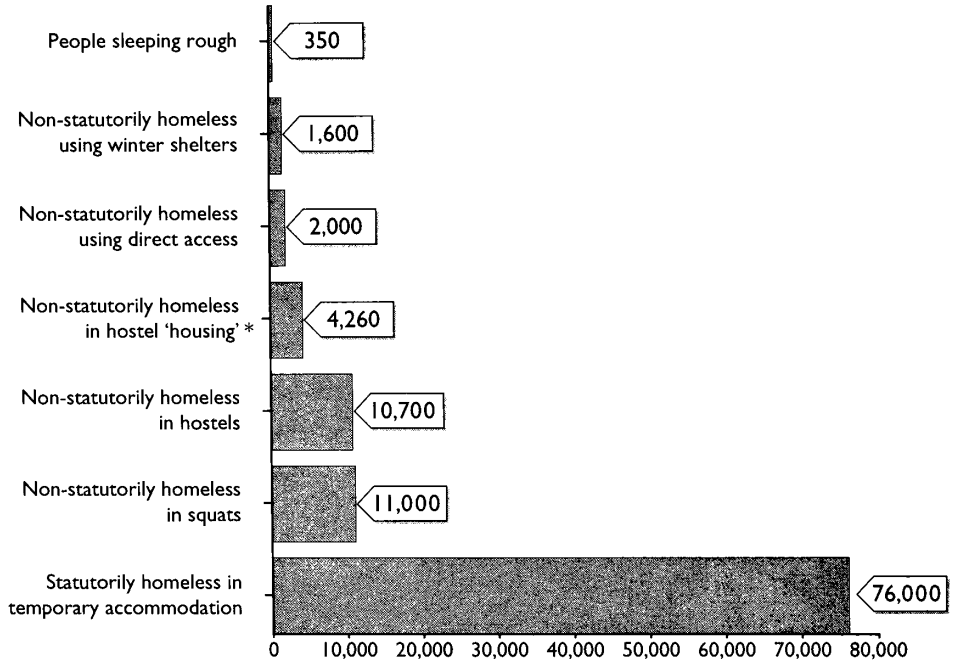

Figure 1 Estimated homeless population of London in the last quarter of 1994

* Non-statutorily homeless using hostel 'housing' schemes. Some hostels in London provide what is effectively permanent or semi-permanent *housing* to homeless people. However, these schemes do not generally offer the security of a tenancy and individuals living within them are still homeless.

Sources: CHP estimates of statutory homelessness based on Department of the Environment (1994, PIE Returns) data. The Homeless Network. Construction Industry Relief and Assistance for the Single Homeless (CRASH). London Hostels Resource Centre. Health Action for Homeless People.

The geographical distribution of homelessness in London

1.5 Non-statutory homelessness, particularly people who were sleeping rough, was concentrated in inner London.[1] Statutory homelessness was more evenly divided between inner and outer London, with 43 per cent (estimated at 33,000 people) of statutorily homeless households in the 13 inner London boroughs and 57 per cent (estimated at 43,000 people) in the 20 outer London boroughs. The level of statutorily homeless households on *average* per inner London borough was estimated at 2,500 people, compared with 2,100 people per outer London borough.

The characteristics of homeless people in London

1.6 It is known that most of the homeless people who are sleeping rough on a regular basis are white, male and middle-aged. Data on the people using night shelters and direct access hostels suggest that they have similar characteristics to people sleeping rough. Among homeless people living in other forms of hostel there is a significant Black and Asian population and a greater representation of women and young people.

1.7 Since homeless people from ethnic minorities are, based on current evidence, more likely to be sharing unwillingly with friends or relations in overcrowded or poor accommodation, they are often in the group of homeless people about which little is known. It can be surmised, based on data on people entering the UK collected by the Home Office, that most homeless people who are asylum seekers or refugees are probably young and male, because the great majority of refugees and asylum seekers are also young and male.

1.8 Data on the ethnicity of homeless families accepted as statutorily homeless are not available (because they are not currently released by the Department of the Environment), and data on household composition, age and gender are not generally collected. Past studies of statutory homelessness in London indicate that the largest groups are lone women in their mid-twenties with young children and couples with children. Most statutorily homeless people also tend to be young (under 30) and unemployed. About 50 per cent of statutorily homeless households in London are white, 20 per cent are Black and 20 per cent are Asian, the remainder of people coming from

---

1. Inner London is defined by the Department of the Environment as including: Camden, the City of London Corporation, Greenwich, Hackney, Hammersmith and Fulham, Islington, Kensington and Chelsea, Lambeth, Lewisham, Southwark, Tower Hamlets, Wandsworth and Westminster.

other ethnic groups (homeless households from ethnic minorities *tend* to be larger than white households). Single homeless people represent about a third of all statutorily homeless acceptances across London, the proportion increasing in some inner London boroughs.

1.9 It is generally accepted that, in order to reduce the risks to health that homelessness represents, the problem of homelessness itself must be addressed. Many homeless people have support or social needs in addition to their housing and medical needs. *There is a requirement for agencies providing housing, health services and support services to cooperate in providing a 'package' of services to many homeless families and single homeless people to end their homelessness and address their health problems.*

Health and homelessness in London

1.10 The exact relationship between health and homelessness is unclear. This is because some health problems, particularly mental health problems, *may* sometimes predate or even lead to homelessness as well as being caused or exacerbated by experiencing homelessness. In addition, studies that compare the health of homeless people with other populations that have poor health status (such as people on low incomes) are relatively rare.

1.11 People who are homeless face an increased risk of contracting *infectious disease* because they often live in overcrowded, cold, damp and insanitary conditions and have low incomes that limit the use of heating systems or mean that their diet is poor.

1.12 People who are homeless face an increased risk of *mental health problems*. Homeless people are often subject to massive stress because of the factors that made them homeless (such as escaping violence or abuse, or the loss of a family home due to mortgage arrears) or because of the experience of homelessness itself (such as parents confined to one small room with young children for prolonged periods).

1.13 People who are homeless face an increased risk of *physical health problems.* Poor diet, stress, cold, damp, along with inadequate sanitation and food storage or preparation facilities, all increase the risk of physical health problems. For example, prolonged exposure to cold puts strain on the heart, and high stress is associated with a raised incidence of cardiovascular disease and cancers. There is also an increased risk of trauma (physical damage) because of an increased risk of violence to some single homeless people, and an increased risk of accidents among homeless children in

temporary accommodation because of limited play space and poor safety (for example, there might be nowhere to place a kettle except on the floor).

1.14 *Homeless families* in London are likely to experience health problems associated with cramped conditions if they are in certain forms of temporary accommodation, although use of bed and breakfast hotels for temporarily housing homeless families has declined very considerably since the late 1980s. *Homeless children* are reported as showing behavioural disturbance, depression, disturbed sleep, bed-wetting, toilet-training problems and violent mood swings. There are also concerns about general mental and physical development. A high level of accidents and physical damage resulting from the use of force by parents has been found among homeless children. Parents within homeless families are often subject to stress, isolation, boredom and loneliness. Low incomes can lead to inadequate diet and the sometimes cramped conditions in temporary accommodation generates an increased prevalence of infection.

1.15 *Single homeless people* in London have higher than average levels of certain health problems. Particular areas of concern are the prevalence of tuberculosis among single homeless people in London and the very high levels of mental health problems. There are concerns about the level of HIV and hepatitis infection among *young single homeless people* who fairly frequently (but by no means always) use drugs intravenously or work in the sex industry.

1.16 *People who are sleeping rough* in London have a health status that is far worse than that of the general population. Work on the average lifespan of people who sleep on the streets in London has indicated that many men who sleep rough only live until their mid- to late forties. The prevalences of infection, physical disease and, particularly, mental health problems are very high. Some estimates suggest a prevalence of serious mental health problems of 9–26 per cent, compared with a level of 0.5–2 per cent in the general population. There is evidence of a high level of alcohol use among people who are sleeping rough, often existing in combination with a mental health problem. In broad terms, the severity of health problems among this group of people is likely to be higher than other single homeless people, and they are more likely to have multiple health problems.

Homeless people and mainstream health services in London

1.17 The fieldwork for the Review and the literature review showed that considerable problems existed for homeless people trying to use mainstream health services in London. There were five reasons for this.

(i) *Stereotypes and prejudice.* This affects some categories of homeless people more than others. People sleeping rough, in particular, are sometimes treated badly or refused access when trying to use NHS services in London. Homeless people are consequently reluctant to use some NHS services or may not use them until disease has become debilitating or painful.

(ii) *The geographical decentralisation of the NHS.* Many homeless people are relatively mobile, although often not by choice. The NHS in London operates more or less entirely on the basis of geographical decentralisation. This makes it difficult for homeless people to ensure continuity of care and to maintain contact with health services. This problem could be exacerbated by the low incomes of homeless people, which can prohibit them travelling to services.

(iii) *Procedures within the NHS.* Geographical decentralisation means that access to services is organised according to where one lives and many administrative systems, particularly those in GP surgeries, work on the basis of someone having a permanent address. Staff are also generally not trained to meet and understand the needs and special requirements of some homeless people. Much of the NHS is therefore *not designed* to allow for the needs of homeless people.

(iv) *The social marginalisation of some homeless people.* Some homeless people, particularly single homeless people and people sleeping rough, lack social skills, find it difficult to cope with authority and cannot express themselves easily. Some evidence suggests that factors such as a high level of sub-literacy or illiteracy among homeless people make it difficult for them to deal with bureaucracy and difficult for them to complain.

(v) *Relative scarcity.* Recent evidence, including from within Government itself, indicates problems with regard to sufficient access to GP services, acute beds, mental health services and related services, such as the ambulance service, for all of the population of London. It is important to consider the additional problems that homeless people may face in getting access to and using health services in the light of this situation.

Primary care

1.18 *Registration with GPs* can be particularly difficult for homeless people in London. Evidence on homeless families' access to permanent registration with GPs is quite

limited, but it generally assumed that the absence of a permanent address and the tendency for this group of homeless people to be moved between areas makes registration difficult. With regard to single homeless people, there is strong evidence of quite severe problems; studies in London have suggested that registration for people who are sleeping rough and people from ethnic minorities who are homeless can be particularly difficult, and that upwards of 40 per cent of people who are sleeping rough can be unregistered. The fieldwork for the Review suggested that particular problems existed with registration, and with the behaviour of GP services towards patients, with regard to *homeless people who were refugees or asylum seekers* and *homeless people who were dependent on drugs or alcohol.*

1.19 Data on *community health services* and homeless people in London are very limited. There have been no studies that have examined the use that homeless people make of non-GP primary care services. It is generally assumed that access to those community health services that are normally accessed via a GP (such as community nursing) is poor for homeless people, because they have difficulty in using a GP service in the first instance. Problems are also presumed to exist with regard to access to dentists, opticians and services such as chiropody, and many specialist health services for homeless people in London provide these health services in addition to GPs. Some of the barriers that homeless people experience (see 1.17) may be present when they try to use community health services based in health centres, but there are currently no data to confirm or refute this possibility.

Secondary (acute) care

1.20 Access to Accident and Emergency (A&E) departments may be problematic for some homeless people in London, such as certain people who are sleeping rough or using alcohol, and homeless people who are from ethnic minorities, asylum seekers or refugees. Homeless people are generally thought to use A&E departments because they cannot get access to GPs, but this is not necessarily the case in London. There is some evidence that homeless people often present to A&E departments with health problems that are sufficiently great to *require* their attendance at hospital. Data on the use of inpatient facilities indicate a high level of usage by homeless people, but few problems in getting these services or with regard to treatment were found by the Review. There is a general concern about the adequacy of discharge arrangements for homeless people from all forms of hospital (including psychiatric units) in London.

Health services for homeless people in London

1.21 Initiatives designed to improve access to primary care services remained relatively rare; although several schemes involving health visitors or link workers who helped homeless people get access to GP and other services were in place, they were on a restricted scale. Most provision of primary care for homeless people was in the form of dedicated medical centres and medical teams attached to day centre provision. These services were concentrated in inner London, particularly Westminster. In addition, there were a number of travelling teams of health care professionals, most notably those funded under the HMII by Government for homeless people with a mental health problem. There was little evidence of modification in hospital services to allow for homeless people, although some examples of small-scale projects were found.

1.22 Several examples of community care planning for homeless people were found, but these were small in scale and only one example of full joint commissioning for homeless people is being planned. There was little planning or service delivery involving housing, health, social services and the voluntary sector for homeless people in London.

The activity of funders

1.23 Specialist services for homeless people that were provided by health commissions, health authorities or family health service authorities were quite frequently funded via Section 56 finance or LIZ (London Initiative Zone) funds. Section 56 finance was established under the 1977 NHS Act and gives the Department of Health powers to fund services designed to address the needs of non-statutorily homeless single people. Much of the funding provided under Section 56 ceased in March 1996. LIZ finance followed the Tomlinson Report and is linked to a five-year development plan for London. In addition, Trusts and purchasing authorities also used general funds to provide health services for homeless people. The provision of medical services by the voluntary sector in London is funded by contributions from charities, private companies, London boroughs and bodies such as the London Boroughs' Grants Unit.

Chapter 1

Homelessness in London

Introduction

Measuring homelessness is difficult, because of the lack of consensus about when a person or a household should be regarded as homeless, and because the data that are available on homelessness are often limited. This first chapter begins with a very brief discussion of different definitions of homelessness and then moves on to describe the working definition that was used for this study. The second part of the chapter describes some of the problems and issues that arise in trying to measure homelessness, and then uses all the data on London that the research team could gather to produce estimates for Greater London, health authority areas and the individual boroughs. The final part of the chapter examines the data that are available on the characteristics of homeless people in London.

Different definitions of homelessness

In England, the legal definition of homelessness is contained in the Code of Guidance to the 1985 Housing Act:

> *Someone is homeless if there is no accommodation in England, Wales or Scotland which that person can reasonably occupy together with anyone else who normally lives with them as a member of their family or in circumstances in which it is reasonable for that person to do.*
>
> *(Department of the Environment, 1992, para 5.2)*

Current debate and argument about homelessness can be described as focusing around what the legal definition actually means when it refers to accommodation that someone can 'reasonably occupy'. Some argue that those living in conditions that are overcrowded should be regarded as homeless, while others argue that people in this situation are experiencing overcrowding, but that this is not the same thing as homelessness. Similar arguments exist over the point at which poor physical conditions in a dwelling should be seen as making the occupants effectively homeless.

The situation is made more complex because arguments also exist about which homeless people can be seen as *legitimately in need of assistance* from the State and which homeless people have *no right to such assistance* and should be expected to address the causes and consequences of their homelessness themselves. These arguments revolve around which homeless people should be assisted by the State (if any), whether or not existing access to State assistance is adequate, and whether those homeless people who are currently expected to fend for themselves actually require assistance.

Homeless people who receive help from the State are generally described as 'statutorily' homeless, while those who do not are generally referred to as 'single homeless people', because the great majority of homeless people who do not qualify for assistance are single.

People who are regarded as statutorily homeless are individuals and households who have a right to be rehoused by local authority housing departments because they are homeless and in *priority need* under the terms of the 1985 Housing Act. The 1985 Housing Act obliges local authorities to provide permanent housing, either directly or by referral to other agencies such as housing associations, to homeless people who fall into the following groups:

- those who are pregnant, or live in a household with someone who is pregnant;
- those who live in a household that contains one or more dependent children;
- those who live in a household that contains a person who is 'vulnerable' under the terms of the Code of Guidance to the 1985 Housing Act. This includes:
  - people who find it difficult to fend for themselves due to old age;
  - people with learning difficulties;
  - people with a mental health problem;
  - disabled people;
  - people who are vulnerable for other 'special reasons'; this includes children and women escaping violence and abuse, people escaping racial abuse, and young people who are considered to be at risk – some local authorities interpret this duty as including people with dependencies on drugs or alcohol, certain categories of ex-offender and people with terminal or life-threatening illnesses such as HIV.

An individual, couple or family that falls into one of these groups must also demonstrate that they are not intentionally homeless because they have deliberately done something, or failed to do something, that caused their homelessness. It must also be clear that they have not left

accommodation that it was reasonable for them to continue to occupy, and they must demonstrate, under most circumstances, a local connection. Once accepted, a household has *priority access to permanent accommodation* and will be housed in a council or housing association home as soon as a suitable one becomes available.

Council housing and housing association housing are both under pressure because of limited supply in the face of high demand. Recent research into council housing lettings showed that new tenants, who were allocated housing through the waiting list, had waited an average of 1.9 years to receive a home (Prescott-Clarke *et al.*, 1994, para 5.7.1). Statutorily homeless people should not, in theory, have to wait anything like this long for a home because acceptance under the homelessness legislation means that they bypass the waiting list and are allocated permanent housing as soon as it becomes available. In practice, the demands on council and housing association housing are such that most statutorily homeless households, including families, have to wait at least several months for a suitable permanent house or flat to become available. The amount of time spent by homeless families who were awaiting permanent accommodation in bed and breakfast hotels was the subject of much media attention in London in the mid- to late 1980s.

The pressures of demand on council housing and housing association housing are widely viewed as resulting in local authority housing departments interpreting the guidance to the 1985 Housing Act in quite a narrow way, in order to minimise the pressure on their stock (Niner, 1989; Anderson, 1994; Butler *et al.*, 1994). It can be argued that the area in which local authorities have the most room for discretion is in the definition of a 'vulnerable' household, since the actual or imminent presence of a child is not open to interpretation. The result is that most of the homeless people housed under the 1985 Housing Act are part of households containing children or a pregnant woman,[1] while access to State assistance by other homeless people may sometimes be restricted. In addition, local authorities can in theory use strict definitions of intentionality and the requirement for a local connection to restrict access to assistance. Decisions under the homelessness legislation are sometimes contested in the courts by people who have applied for assistance under the 1985 Housing Act.

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1. Contrary to the assertions of tabloid newspapers on the subject, there is no evidence that young women get pregnant to gain access to council and housing association housing under the homelessness legislation. A quick examination of Department of the Environment figures on statutory homelessness shows that only 11 per cent of homeless acceptances in 1994 (average over the last five years: 12 per cent) were because a household member was pregnant, and this figure *included families and couples*, as well as lone women.

At the time of writing the homelessness legislation is about to be replaced with a new Act. The replacement legislation is not expected to alter the criteria for acceptance as statutorily homeless, but it will end the *priority* access to permanent accommodation that homeless people have under the 1985 Housing Act. Under the law change, statutorily homeless households will have the right to suitable temporary accommodation for 12 months, but will only be allocated permanent accommodation via the waiting list (i.e. they will have to wait for a permanent housing association or council tenancy with all the non-homeless households that require them). The possible impact of the replacement of the homelessness legislation on health and homelessness in London is discussed in Chapter 6.

People who are homeless and are not judged as falling into the categories of priority need in the Code of Guidance to the 1985 Housing Act are essentially single people without dependent children and some couples without children. The proportion of single people within this group means that they are usually referred to as single homeless people. Although people in this group may not be 'vulnerable' under the terms of the legislation, the evidence is that it contains many people with health care and support needs (Craig and Timms, 1992; Dant and Deacon, 1989; Vincent *et al.*, 1993; Anderson *et al.*, 1993). Many organisations, such as CHAR, CRISIS and Shelter, argue that the provision of housing and other services for this group should be a priority.

The debate about homelessness therefore centres on two areas. First, there are the arguments surrounding the point at which someone can legitimately be called homeless, as opposed to badly or inappropriately housed. Second, there are the arguments surrounding which homeless people should be given assistance by the State to end their homelessness, which is essentially a debate about the circumstances in which someone should take responsibility for ending their own homelessness and the circumstances in which they should be helped.

The definitions of homelessness that are currently in existence are, at least to some extent, based on ideological views about the conditions in which people should be expected to be responsible for their own lives. Any definition that is produced is consequently unlikely to be universally accepted.

Defining homelessness

In a recent study, the Royal College of Physicians (1994, pp. 1–2) noted the problems in defining homelessness but suggested that it was possible for working definitions to be

produced that could be used to study the relationship between homelessness and health. The study suggested that homelessness could be subdivided into three broad groups.

> **Group I.** This group includes statutorily homeless people, mainly families with children and pregnant women. The RCP describes this group as representing the 'official' homeless in the UK.
>
> **Group II.** This group is made up of hostel dwellers and people sleeping rough. It is largely composed of homeless men who are not statutorily homeless or included in official statistics (unlike group I).
>
> **Group III.** This group is made up of other groups with inadequate housing and refers to all the people in the UK with *significant* housing need. This is defined as including both 'potential' and 'concealed' households, i.e. people who wish to leave their current shared accommodation and live somewhere else. The RCP notes that there are no data on this group of sufficient quality to estimate either its size or its needs (Royal College of Physicians, 1994, p. 17).

This classification is clear and it accurately reflects the availability of data. It is also realistic in its assertion that very little can be said about the health care needs of a large section of the homeless population, group III, because data do not exist on this group of homeless people (it can be added that there is also little agreement as to who should be included in this group, which makes any data collection almost impossible). However, there are two important limitations to this classification that mean that it needs to be modified in order to examine the relationship between homelessness and health in London.

The first of these limitations is the relationship between group I and group II. While it is generally the case that single homeless people are not often accepted as homeless under the 1985 Housing Act and thus enter 'group II' in suburban and rural areas, this is *not* the case in urban areas of the UK. Many larger urban authorities accept relatively high numbers of single homeless people as statutorily homeless, including many London boroughs. Department of the Environment data covering homelessness 'acceptances'[2] during 1994 show that, across London as a whole, just under a third of acceptances were 'vulnerable' households (average 29 per cent, median 27 per cent). Data from 1991/92, the last occasion on which they were

2. Households that are accepted as homeless under the 1985 Housing Act. These data are drawn from the 1994 P1E Returns for London, published as Department of the Environment Information Bulletins every quarter.

collected, indicate that approximately 70 per cent of the 'vulnerable' homelessness acceptances in London are single people.[3] In other words, single homeless people accepted for rehousing under the homelessness legislation because they are 'vulnerable' can be broadly estimated as representing approximately 20 per cent of *all the statutorily homeless households in London* (about 5,250 people over the course of 1994). In inner London, the proportion of single homeless people accepted as statutorily homeless can be estimated at 22 per cent of all acceptances (2,900 single homeless people during 1994), and in outer London it can be estimated at 19 per cent of all acceptances (2,300 single homeless people during 1994).

In short, the generalisation that 'group I', which this report will refer to as *statutorily homeless people*, is mainly composed of families and pregnant women is less true of London than it is of the non-urban areas of England. It is very important to consider the differences in the needs of homeless families and single homeless people, but these groups cannot be separated from one another on the basis of the homelessness legislation because too many single homeless people are accepted as homeless in London.

The second limitation is in relation to the Royal College of Physicians categorising almost all single homeless people as belonging to only one group, the non-statutorily homeless 'group II'. This is inappropriate for two reasons. First, substantial numbers of single homeless people are housed under the homelessness legislation in London, and second, the classification makes no distinction between single homeless people living in some form of accommodation, such as hostels, and people sleeping rough.

Recent research suggests that 'group II' is an unsuitable classification to use in studying the impact of homelessness on health, since the health status of homeless people appears to deteriorate as their housing conditions worsen. Anderson *et al.* (1993) and Bines (1994) have demonstrated that the health of people who are sleeping rough on the streets is worse than that of single homeless people staying in hostels and bed and breakfast hotels in the UK. International studies[4] have also shown that the health of people who are living on the street is markedly worse than any other section of modern industrial societies. Since people who are sleeping rough represent the extremes of homelessness, and have the most pronounced health problems, they are discussed separately in the Review.

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3. 1991/92 Housing Investment Programme (HIP) Returns from local authorities collected by the Department of the Environment.

4. See Chapter 2.

The definitions of homelessness used in this study

The following definitions of homelessness will therefore be used for the purposes of this study:

- *statutorily homeless people* who have been accepted as homeless under the 1985 Housing Act, but who have not yet been permanently housed (people housed in hostels, bed and breakfast and other temporary accommodation by local authorities while awaiting permanent housing);
- *non-statutorily homeless people* staying in hostels, night shelters, resettlement units and other temporary accommodation who have not been accepted as statutorily homeless;
- *people sleeping rough* (living outside) on a regular and irregular basis.

This definition excludes concealed households and the other groups defined as belonging to 'group III' by the Royal College of Physicians study. Part of the reason for this exclusion is simply that data do not exist that can be used to provide any reliable information on this group, which led the Royal College of Physicians (1994) to exclude them from their own recent analysis of health and homelessness in the UK. As noted above, it is not possible to measure 'group III' homelessness (sometimes called 'hidden' homelessness) because agreement does not exist about what it is that should be measured, or, indeed, whether there is anything to measure in the first place.

Within each of these three broad categories (statutorily homeless people, non-statutorily homeless people and people sleeping rough), the health care needs and characteristics of the following sub-groups are considered separately:

- homeless families (including lone parents and homeless children);
- single homeless people.

Where data are available, the health care needs and characteristics of homeless people from ethnic minorities, young people, children, older people and women are also examined under each of the three broad categories of homelessness. The amount of data available mean that in several sections of the Review it has not been possible to provide information in any detail about differences between age groups, gender and ethnic background.

The number of homeless people in London in 1994

Problems of measurement

The official data that are available on homelessness in the UK are limited to households that are accepted as statutorily homeless. Little official information is available on non-statutory homelessness, apart from the results of occasional exercises like the rough sleeper count in the 1991 Census. This means that it is necessary to rely on estimates and academic studies when trying to determine the non-statutorily homeless population of London.

While data are collected on statutory homelessness, which cover the activities of local authorities and housing associations under the 1985 Housing Act, these are confined to information on *households* rather than individuals. This focus on households in the official data on statutory homelessness means that the actual number of homeless people rehoused by local authorities and housing associations is much higher than the recorded number of 'acceptances' of households in the published Department of the Environment figures. In the last year for which figures were available (1992), the 143,000 homeless acceptances under the 1985 Housing Act actually represented more than 400,000 homeless individuals (Standing Conference on Public Health, 1994, p. 18). In short, it is not possible with the information currently available to do anything other than estimate what the statutorily homeless population of London is. It is also impossible to do anything other than estimate its composition in terms of gender and ethnic origin, because the individual characteristics of the members of homeless households are not recorded.

As well as the other problems associated with the Department of the Environment figures on homelessness, there is also the practice of moving statutorily homeless households across boroughs to temporary accommodation. Certain areas, such as Bayswater, with its relative concentration of bed and breakfast hotels, saw an influx of statutorily homeless people from several boroughs in the mid- to late 1980s. This was because those boroughs without sufficient temporary accommodation to house homeless people awaiting permanent rehousing moved them to those areas where temporary accommodation was available. Acceptance under the 1985 Housing Act by a borough guarantees a permanent home in that borough, but not that a statutorily homeless household will be temporarily accommodated within that *same* borough while awaiting a permanent home.

Since the relative decline in the use of bed and breakfast hotels,[5] it is not certain whether the movement of statutorily homeless households still happens to quite the same extent that it once did, when the effect was a concentration of statutorily homeless people in bed and breakfast hotels in central London (Scheuer *et al.*, 1991). However, the research that has examined the use of private sector leasing (PSL)[6] shows that as much as 52 per cent of PSL temporary accommodation in London is provided outside the placing borough (London Research Centre, 1991). This indicates that very substantial numbers of statutorily homeless people are awaiting accommodation at least some distance from the borough in which they applied for assistance and in which they will eventually be rehoused.

The official statistics on statutory homelessness only record where a household is accepted, not where it is temporarily housed. In short, while there is information about where statutorily homeless households in London are accepted as homeless and where they will be eventually rehoused, data on the distribution of the statutorily homeless population of London in temporary accommodation are limited.

The complexity of estimating homelessness in London is exacerbated by the nature of homelessness. Homelessness is not, for the great majority of homeless people, a fixed state. It is assumed that the majority of families and one-parent households that are rehoused under the current homelessness legislation stay permanently rehoused, although problems are known to exist with some single statutorily homeless people who are sometimes unable to manage living in an independent tenancy and become homeless again (Pleace, 1995). There is also some evidence that people may move in and out of the non-statutorily homeless population (Anderson *et al.*, 1993).

The homeless population of London is therefore in a constant state of flux. At any given time, many people are leaving it permanently, some are rejoining it after a period in housing, and a considerable number are joining it for the first time. Thus, *the number of people who experience homelessness during a year in London is much greater than the number who are homeless at any one point in time*. This constant shifting and changing mean that it will never be possible to estimate the homeless population of London very accurately, because it quite literally changes from one day to the next.

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5. See Chapter 2.

6. PSL refers to various arrangements by which local authorities make use of private rented sector housing stock.

The temporary and sometimes episodic nature of homelessness has another effect. As some homeless people leave the homeless population of London they are, in effect, replaced by individuals and households who have either become homeless for the first time or who are returning to a state of homelessness after being temporarily housed. This means that while the homeless population at any one point might be 50,000 or 100,000 individuals, providing housing and other necessary services for all those people will not address the problem of homelessness. In crude terms, for every homeless person that is housed, another one will be 'generated' by the economic, social and housing supply factors that are generally accepted as 'causing' homelessness.[7] This point can be illustrated by examining statutory homelessness in London over the last ten years (see Figure 2).

Although a few families, and perhaps quite significant numbers of single homeless people, who are rehoused under the homelessness legislation return to being homeless, most remain housed. Bearing this point in mind, an examination of Figure 2 shows that *newly* statutorily homeless households and households re-entering homelessness have been appearing in London at a rate of between 25,000 and 37,000 every year since 1984 (the number of acceptances fell in 1993 and 1994).

In summary, the data on homelessness in London are at best limited and the homeless population is a moving target. Even assuming the data on homelessness in London were very good, accurate measurement would still not be possible because of the numbers of homeless people leaving and joining the homeless population at any point in time. Elements of the population are semi-permanent, as people may be homeless in hostels or on the streets (for example) for many years, but a huge element (statutorily homeless households) is largely transitory, only experiencing homelessness for several months.

In addition to these problems, there is the question of definition that has already been discussed. Different estimates of homelessness in London are generally based around different definitions of homelessness, which leads to wide variation in the figures that are produced.

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7. It is not the purpose of the Review to examine the arguments about the causes of homelessness, since it is primarily concerned with its effects. Arguments continue about the extent to which homelessness is caused by housing supply, relationship breakdown, social change, macroeconomic change resulting from the structural changes in capitalism as forms of production alter, Government policy, and the characteristics of people who become homeless (particularly with regard to single homeless people). As yet, no one explanation has been generally accepted.

According to various definitions of homelessness and the estimates that have been produced using them, the homeless population of London ranges between tens of thousands to well over a hundred thousand at any one point.

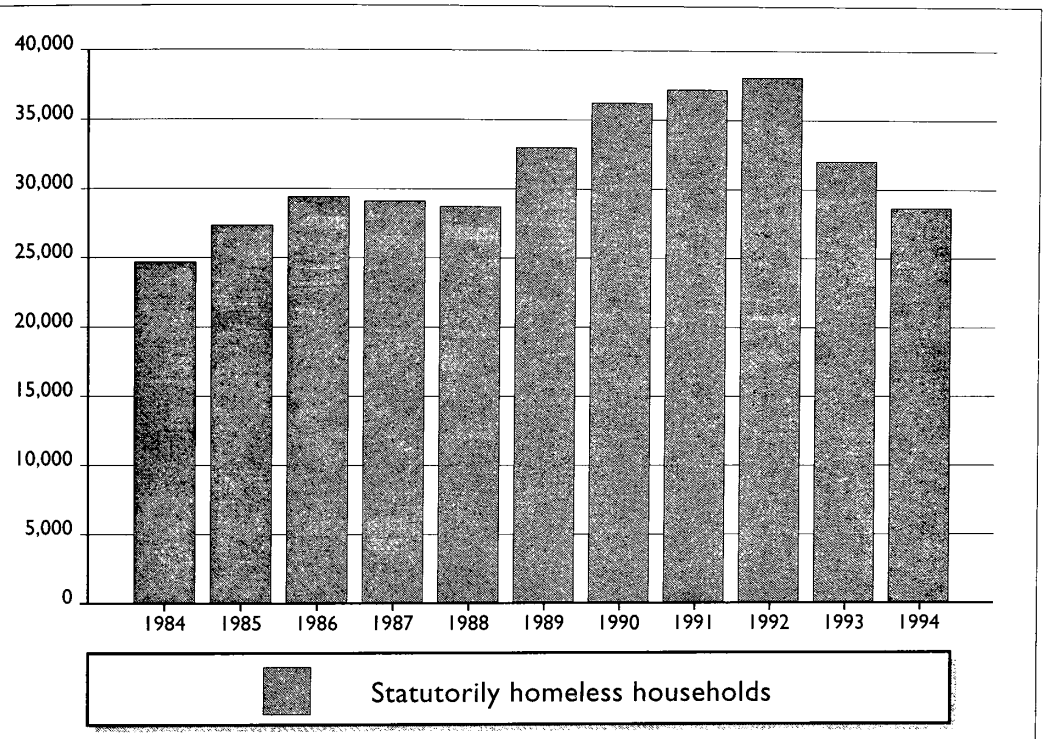

Figure 2 Statutory homelessness in London, 1984–1994

Source: Department of the Environment, March, 1995.

Estimating the scale of homelessness in London in the last quarter of 1994

At the time of writing, the most up-to-date series of data on homelessness in London was from the last quarter of 1994. Figure 3 shows an *estimate* of the number of homeless people in London during this period. Several points need to be considered when examining this figure. First, data on the number of *individuals* who were accepted as homeless by local authority housing departments are not recorded and the number given here is an estimate based on the figures for *homeless households* in temporary accommodation in the last quarter of 1994. Second, the figures on squatting and rough sleeping cannot be seen as anything other than broadly illustrative. There are also limitations with most of the other data. Finally, while most of the data are from the last quarter of 1994, some were collected at earlier and later dates.

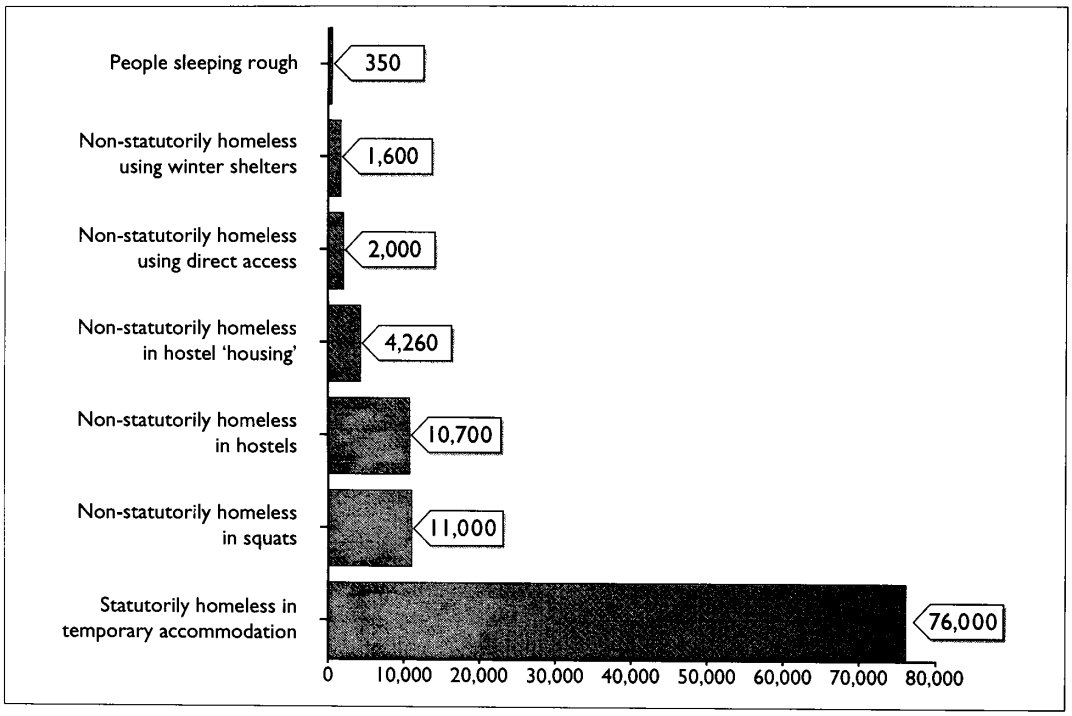

Figure 3 The estimated number of homeless people in London in the last quarter of 1994

Sources and calculations used to produce the estimate:

Statutorily homeless in temporary accommodation: CHP estimate drawing on December 1994 P1E Returns and 1991/92 Housing Investment Programme Returns which detailed the size of homeless households. There were 27,000 statutorily homeless households in temporary accommodation in London in the last quarter of 1994; recent data on the size of statutorily homeless households (on a borough by borough basis in the 1991/92 HIP Returns) can be used to estimate that these 27,000 households contained 76,000 men, women and children.

Non-statutorily homeless in squats: Housing Investment Programme Returns for London boroughs in June 1994, covers council housing only (Department of the Environment, 1994).

Non-statutorily homeless in hostels: This figure is based on research and estimates from the Resource Information Service (RIS), which covers all of London's hostel accommodation. The type of accommodation referred to here is generally single rooms in large buildings with shared facilities, although accommodation can range from facilities that are like a flat for each resident to dormitory-like arrangements. Hostels for working people only, people looking for work, students, single parents, people 'returning home', group homes and housing schemes that are specifically not for homeless people are excluded from the totals shown here – the RIS defines these hostels as not accommodating homeless people. Figures refer to the average number of places filled.

Non-statutorily homeless in hostel 'housing': Some hostels in London are defined by the RIS (and themselves) as providing housing. These 'hostels' are often not contained within one building but instead supply housing management and support services to residents who stay in houses or flats that can be scattered over quite wide areas. Homeless people living in these housing schemes are still regarded as homeless because they do not generally have tenancies (even though there is quite often no limit on their length of stay). Figures refer to the average number of places filled.

Non-statutorily homeless using direct access: Hostels where homeless people can queue for beds on a night by night basis. People are turned away once they are full. Again, this figure has been supplied by RIS, who calculate that there were 1,962

direct access (DA) and night shelter places in London. In addition, some 1,000 of the other hostel places can be regarded as broadly similar to direct access places but have not traditionally been described as such. Some organisations such as the Homeless Network in London count these 1,000 places as direct access, and consequently estimate that the homeless population of DA provision is closer to 3,000 (Homeless Network, 1995) (within Figure 3 these 1,000 places are counted as part of the population of homeless people living in hostels). Figures refer to the average number of places filled.

Non-statutorily homeless using winter shelters (very basic shelter provided on a first come, first served basis): Construction Industry Relief and Assistance for the Single Homeless (CRASH) monitoring of the Rough Sleepers' Initiative; this shows the number of people using the temporary winter shelters provided during the winter of 1994/95 (CRASH, 1995).

People sleeping rough: This is taken from the count conducted in central London by the Homeless Network on 25 May 1995 and covers the West End, Kingsway and the Temple, Waterloo and the Bullring, The Strand, Victoria, Lincoln's Inn, Euston and King's Cross, Whitechapel and the City.

Based on the available data, the number of homeless people in London towards the end of 1994 can be estimated at approximately 106,000. As noted above, this figure should be treated as a *guideline* only, since the available data allow only crude estimates with regard to statutory homelessness, and information on squatting levels and rough sleeping levels must be viewed as only very broadly indicative. Most of the homeless population at any one point have been accepted as homeless under the 1985 Housing Act and are awaiting rehousing (71 per cent in the last quarter of 1994); the remaining elements of the homeless population (29 per cent in Figure 3) are non-statutorily homeless people and people who were sleeping rough.

Recent estimates of the scale of homelessness in London have produced similar results to the total shown in Figure 2. Health Action for Homeless People have estimated the homeless population at 100,000–120,000 (Health Action for Homeless People, 1994), but the definition used included travellers, who are not generally regarded as being homeless. In 1991, Scheuer *et al.* estimated that the total homeless population was approximately 60,000, if one counted people living in bed and breakfast hotels, short-stay accommodation, hostels and those sleeping rough, but stated that it would be closer to 100,000 if one counted squatters and other groups (1991, p. 17). A study conducted in Westminster in 1993 indicated that the population of *single* homeless people in that borough alone was 5,000 (Fisher *et al.*, 1994).

People sleeping rough in London

A visible increase in the number of homeless people sleeping rough on the streets of central London led the Government to introduce the Rough Sleepers' Initiative (RSI) in 1990 for a three-year period. During this period almost £100 million was spent on advice and outreach work with homeless people, new hostel places and various schemes providing temporary and permanent accommodation. Expenditure continues under the initiative at present and now stands at almost £160 million. Research by Randall and Brown (1993) indicated that this

programme had produced a significant reduction in the number of people sleeping rough, concluding that:

> *As a result of the initiative, several thousand people with a history of homelessness and sleeping rough have been provided with accommodation. The number of people sleeping rough in central London has reduced substantially. But the initiative has not yet achieved its objective of making it unnecessary for anyone to sleep rough in central London. A continuing programme will be necessary to achieve this.*
>
> *(Randall and Brown, 1993, para S.102)*

Not long after the RSI began, the 1991 Census reported the population of London who were sleeping rough as 1,275 people, which Randall and Brown later reported had dropped by around 70 per cent as a result of RSI (1993, para S.89). However, the Office of Population Censuses and Surveys stated at the time that the Census was conducted that the rough sleeping figure almost certainly represented a significant underestimate, a view echoed by various researchers (Anderson, 1993). Recent work by the Homeless Network, Shelter and SHAC (1995) has included a series of surveys of the number of people sleeping rough over an area of central London including the West End, Kingsway and the Temple, Waterloo and the Bullring, The Strand, Victoria, Lincoln's Inn, Euston and King's Cross, Whitechapel and the City. This has indicated that, in May 1995, 347 people were sleeping rough across a limited area of central London, which suggests that the total across London was somewhat higher. Some of these homeless people may have been accommodated in the winter shelters provided across London for about a third of the year and may not have been sleeping on the street during some of the last quarter of 1994. However, during the night on which the 347 people sleeping rough were counted, only eight places remained available in the 48 hostels with open access or direct access surveyed by Shelter and SHAC, which between them had 3,199 beds[8] (Homeless Network, 1995, p. 31).

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8. There is a slight definitional difference between the Resource Information Service and the Homeless Network as to which hostels in London are direct access (provide accommodation on a first come, first served nightly basis). RIS defines 2,000 hostel beds as being DA beds (see Figure 3) and adds that another 1,000 beds are broadly equivalent to DA beds – Shelter, CRISIS and the Homeless Network count these additional 1,000 beds as being DA beds.

Perhaps the most important evidence about rough sleeping comes from the CRASH (1995) monitoring of the winter shelters provided under Phase II of RSI (set up after Randall and Brown's 1993 study of Phase I). Winter shelters are provided for around 100 days a year to shelter people who are sleeping rough from the cold weather; the most recent figures (incorporated into Figure 3) show that the five shelters provided in the winter of 1994/95 housed 1,613 individuals over 32,800 'bed-nights' in 331 bed spaces. Given that 3,000 DA or DA-like hostel places are provided in London every night and that data from the Resource Information Service (1995) indicate that 98 per cent of these beds are generally occupied, the scale of activity in the winter shelters seems quite considerable. This has to be balanced against anecdotal information, which suggests that some people using winter shelters also use other forms of accommodation and are not necessarily spending the time that they are not in winter shelters on the street. CRISIS and Shelter estimated that in 1993 the number of people who were sleeping rough in London was around 2,600, about 30 per cent of the UK total (CRISIS, 1994), but in reality the figure is probably not this high. Nevertheless, the limited available information indicates that the number of people who may at least be *periodically* sleeping rough in London is well into the hundreds.

Clearly, the RSI has had an impact, but the data about winter shelter activity in central London during 1994, and anecdotal information from the day centres and medical services visited for the Review in the summer of 1995, indicate that the scale of rough sleeping remains very considerable. Street homelessness remains highly visible throughout central London at night at the time of writing.

Squatters

The estimate given in Figure 3 for squatting is based on the only official data collected by the London boroughs as part of their Housing Investment Programme Returns to the Department of the Environment. These figures are based on the number of squatters in the council housing that the London boroughs own and manage, rather than estimates of the total levels of squatting across all the housing tenures in the borough as a whole. Local authority housing represents between 25 and 40 per cent of the stock in each London borough, the remainder being housing association, private rented and owner-occupied accommodation. Some boroughs reported that they had no squatters at all in 1994, others reported several hundred. There are two factors that may mean that the data in Figure 3 represent an underestimate. First, counting squatters is very difficult, as most London boroughs manage thousands of housing units with relatively small numbers of staff. Second, the bulk of housing stock in each borough is not included in these estimates because the estimate only applies to council housing.

London in comparison with the rest of England

Data that allow comparison between London and the rest of the UK are limited to the data on statutory homelessness collected by the Department of the Environment. Examining these data for the past five years, it can be seen that the relative level of *statutory* homelessness, measured in terms of homelessness acceptances per 1,000 households, has remained considerably higher in London than in the rest of England. This point is illustrated in Figure 4.

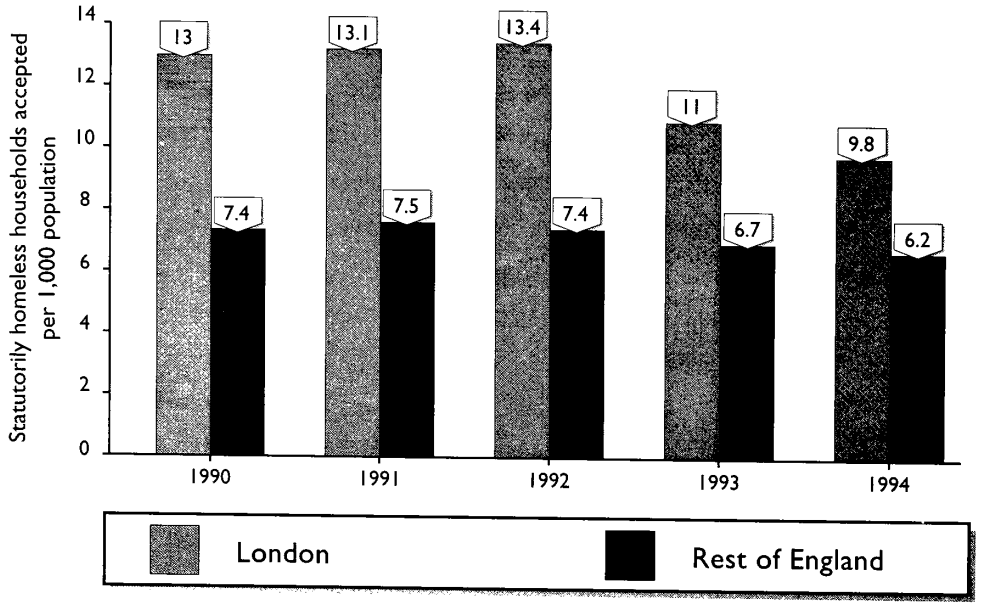

Figure 4 Homelessness acceptances under the 1985 Housing Act per 1,000 households between 1990 and 1994

Source: Department of the Environment, *Information Bulletin*, 14 March 1995. Figures refer to households accepted.

As noted in relation to Figure 2, the overall level of statutory homelessness has declined in recent years. Government explanations of this change point to improved economic performance and other factors, such as the level of new social housing building, as the cause of this reduction. Groups concerned with homelessness and some researchers view the reduction as a function of local authorities having access to such a limited amount of available housing that their interpretation of the 1985 Act has become increasingly strict (Butler *et al.*, 1994). Nevertheless, however the recent reduction is interpreted, the fact remains that statutory homelessness in London is well above the average for the rest of England.

It is generally accepted that people who are sleeping rough are more concentrated in London than in any other part of the UK. The level of rough sleeping in London is perhaps best illustrated by the response of Government in recent years. Two initiatives, the Rough Sleepers' Initiative (RSI) and the Homeless Mentally Ill Initiative (HMII), have been set up at a cost of well over a hundred million pounds; the first stage of RSI was focused on London and, even though RSI-2 has a wider remit, the HMII is entirely focused on central London.

Homeless people from ethnic minorities

Only a limited number of studies have been conducted that have examined the experience of homelessness among people from ethnic minorities in London. The limited data that are available suggest that the experience of homelessness can differ for people from various ethnic groups. Hinton (1992) in a study of single homelessness in Hackney found that Black people were not visible on the streets, nor in the hostels, day centres and shelters provided for homeless people. It was instead the case that they used informal means to cope with their situation, many staying with friends, some in bed and breakfast hotels and some in squats. Recent research has shown that Asian households are more likely than others to be overcrowded and Hinton's research in Hackney showed that this was reflected in the pattern of homelessness in the Asian community, with the majority of homeless people staying with relatives or friends. A high number reported that they had not had a home of their own in the last five years. Other groups, such as recently arrived Turkish and Kurdish homeless people, were found to be using private rented accommodation or squats. Similar research by Hinton in Newham (1994) has confirmed the findings of her earlier study.

Homelessness among people from ethnic minorities in London is very difficult to measure. Many homeless people from ethnic minorities are concentrated in the group of homeless people defined as 'group III' by the Royal College of Physicians (see p. 5), which includes all the current and potential households in the UK with significant housing need. No data whatsoever are systematically collected on this group, and arguments continue between different housing organisations, academics and government about who should and who should not be seen as homeless when they are staying with friends or relations. Given the scale of homelessness among people from ethnic minorities that existing studies have suggested, it could well be the case that the homeless population among Black and Asian people, for example, runs into thousands.

One source of information on homelessness is the ethnic monitoring that local authorities are required to undertake of all the homeless households that approach them for rehousing and

the households that are accepted as being homeless. Unfortunately, the Department of the Environment does not publish this information and, because it is viewed as sensitive,[9] was unable to release it to the authors for the purposes of the Review.

Refugees, asylum seekers and homelessness

Data on the number and characteristics of asylum seekers in London are poor, and information on the numbers of people within these groups who are experiencing homelessness does not currently exist. The situation is perhaps best described by a health advisor working for a leading refugee organisation in London during the summer of 1995:

> *It's very difficult to collect accurate figures of refugee communities and also what element of that is homeless. I've tried to collect figures from the local boroughs on the size of refugee communities and there is nothing that is remotely accurate. The only figures are attendances at the homeless person's unit. The anecdotal evidence is that there are very few refugees on the streets, there's a large number who are homeless, but they're staying on people's floors or in bed and breakfast hotels.*

It is probable that refugees' and asylum seekers' experience of homelessness might be similar to that of London's other homeless people from ethnic minorities, in that they could tend to use friends' floors or perhaps get themselves into a bed and breakfast hotel, rather than sleep rough or use provision such as night shelters or hostels. There may be a variation in experience between people coming to London where there is an established community of people from the same country, such as people from Bangladesh or Somalia, and asylum seekers and refugees from countries whose nationals have not often arrived in the UK before. For example, the experience of people from former Yugoslavia might be different from that of someone who can use established community groups and other resources, such as those operated by Black British people in London.

Rather ironically, it is the removal of an element of assistance that was available to asylum seekers that has generated data on the scale of the homelessness problem among this group of people. Asylum seekers previously had the same rights as the general population to rehousing under the 1985 Housing Act, but this right has recently been withdrawn and the Department of

9. Recent racial tensions in Tower Hamlets, which led to the election of an openly racist British National Party councillor, focused on the extent to which council housing allocations on the Isle of Dogs were made to people from ethnic minorities.

the Environment has asked local authorities to record the number of homeless households they reject for assistance because they are asylum seekers. During 1994, 1,345 households applied for rehousing under the homelessness legislation in London and were refused assistance on the basis that they were asylum seekers, an average of 42 households per borough (Department of the Environment, P1E Returns for London, 1994).

The geographical distribution of homelessness in London

Figure 5 shows the distribution of the estimated homeless population of London on a borough by borough basis. London has been subdivided by local authority area because most data on homelessness are collected on that basis and the boroughs have broadly similar levels of population. As with Figure 3, the data that are presented here are estimates that need to be treated with caution. The estimates that are used are calculated on the same basis as Figure 3, but they exclude rough sleeping, people using winter shelters and squatting, because reliable data that break down London-wide estimates by borough are not available. Homeless people living in hostels, squats, night shelters and short-stay hostels have been grouped together in order for comparisons to be drawn between the statutorily and non-statutorily homeless populations in each borough.

It can be seen that the level of homelessness varied widely between different areas of London during the last quarter of 1994. Particularly high levels were found in Hackney, Haringey, Newham and Brent, and non-statutory homelessness was especially prominent in the inner London boroughs of Westminster, Camden, Tower Hamlets, Southwark, Lewisham and Lambeth.

The estimated levels of non-statutory homelessness shown in Figure 5 confirm the findings of previous studies in London, indicating that it is much more prominent in inner London than outer London. However, the pattern of statutory homelessness is less clear, with both inner and outer London boroughs having quite high levels. The estimates indicate, in line with previous studies, that some of the outlying boroughs such as Sutton, Richmond-Upon-Thames and Havering have quite low levels. In contrast, other outer London boroughs such as Enfield, Croydon and Ealing had quite high levels and several, such as Newham, Haringey and Brent, had amongst the highest levels. The reasons for the variation in levels between boroughs are probably linked to the structural and socioeconomic forces that are known to influence levels of homelessness (Anderson, 1994). Although some commentators have suggested that levels of acceptances under the 1985 Act reflect different political control of the councils and that homeless people are drawn to areas where a more liberal interpretation of the Act holds sway,

there is no real evidence to suggest such a pattern in London. The higher number of services for single homeless people and people who are sleeping rough in central London should also not be seen as acting as an attraction for homeless people; the evidence is that the homelessness arrived before many of the services did (Greve, 1971, 1991).

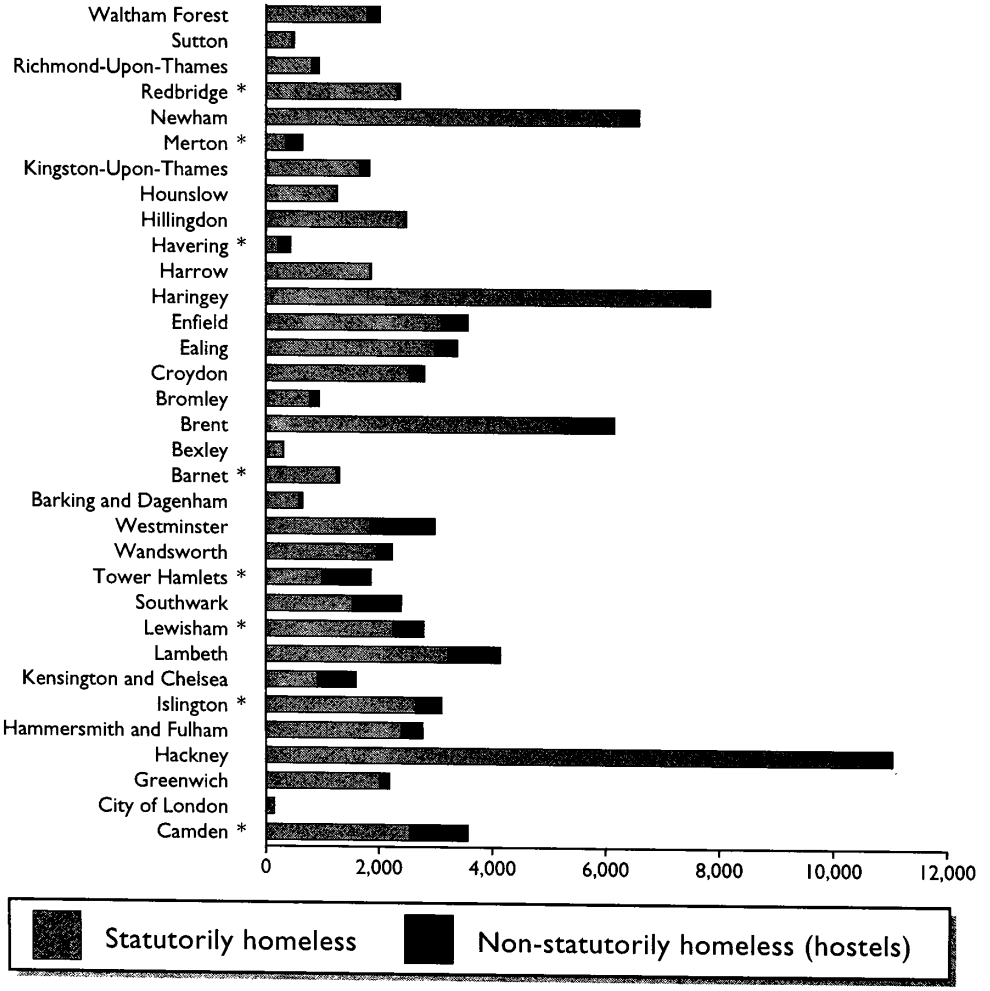

Figure 5 Statutory homelessness and non-statutory homelessness in hostels in the last quarter of 1994 by London borough

* Data are incomplete – estimates have been generated by using the average and median values for either inner or outer London (depending on where the borough is located).

Sources: As Figure 3. Figures *exclude* squatters, people using winter shelters and estimates of people sleeping rough.

In summary, non-statutory homelessness in hostels is concentrated in inner London,[10] with 62 per cent of the population being found in the 13 inner London boroughs, and the evidence is that rough sleeping is also concentrated in inner London. The pattern of statutory homelessness across London is more mixed, with 43 per cent (33,000 people) of statutorily homeless households being accepted in the 13 inner London boroughs and 57 per cent (43,000 people) in the outer London boroughs. On *average* the level of non-statutorily homeless people in hostels in each borough is much higher in inner than in outer London (560 people compared with 170 people), and the level of statutory homelessness is also slightly higher (2,500 people compared with 2,100 people).

Homelessness by health authority/health commissioning agency areas

For the purposes of administration, the NHS in London is divided between several forms of agency. Two regional health authorities, North and South Thames, have responsibility for strategic planning within London and sections of the surrounding suburban areas. Within these two regional health authority areas, Greater London is divided into 16 smaller districts. Until relatively recently, each of these 16 districts had a Family Health Services Authority (FHSA) and a District Health Authority (DHA), the former being responsible for *primary care* services (general practitioners and other community-based services), and the latter being responsible for *acute or secondary* (hospital-based) services. At the time of writing FHSAs and DHAs in London were forming joint health commissioning agencies, which are responsible for the purchase of primary and secondary care.

The commissioning agencies in London are very varied in size. Some are coterminous (share boundaries) with single London boroughs, while others cover the boundaries of two or three boroughs and are responsible for much larger geographical areas and populations. The estimated levels of homelessness shown in Figure 6 for each of the health commissioning agencies reflect these differences in size. Again, the data are for non-statutorily homeless people in hostels and statutorily homeless people only, since the other data used in Figure 3 are too unreliable to be broken down by health authority area.

10. Inner London is defined by the Department of the Environment as including: Camden, the City of London Corporation, Greenwich, Hackney, Hammersmith and Fulham, Islington, Kensington and Chelsea, Lambeth, Lewisham, Southwark, Tower Hamlets, Wandsworth and Westminster.

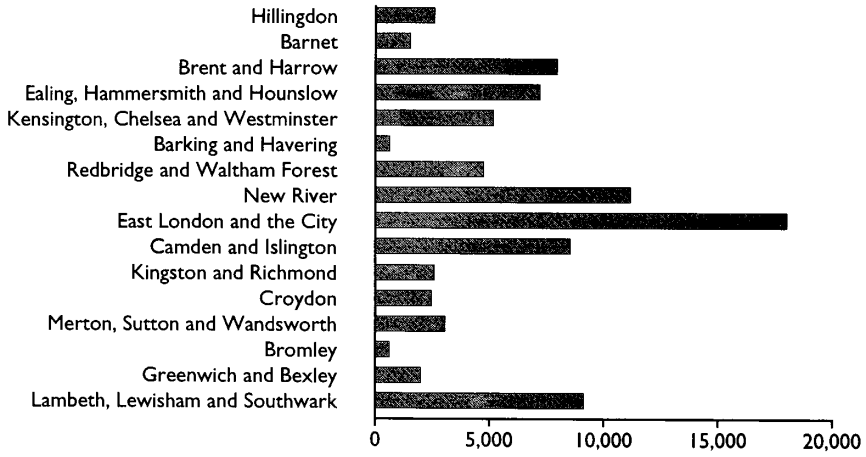

Figure 6 Estimated statutory homelessness and non-statutory homelessness in hostels by health commissioning agency/health authority areas in the last quarter of 1994

Sources: As Figure 3. *New River* covers Haringey and Enfield. *East London and the City* covers Hackney, City of London, Tower Hamlets and Newham. Figures *exclude* people sleeping rough, squatting and winter shelter users estimates.

The characteristics of statutorily homeless people in London

While data are not available on the composition and size of statutorily homeless households, information is collected on the *reason* why a household has been accepted as statutorily homeless. Using these data, it is possible to arrive at a broad understanding of the characteristics of the people who were accepted as homeless by the London boroughs in the last quarter of 1994. Figure 7 summarises the reasons for acceptance as homeless by *household* for London as a whole in the last quarter of 1994.

The information in Figure 7 refers to the pattern of acceptances under the Act for the last quarter of 1994, not to the homeless households already in temporary accommodation. In other words, the figures refer to the newly homeless households who joined the existing statutorily homeless population between September and December 1994. Typically for London, households containing children were the biggest group (52 per cent); these households were followed by those accepted because of vulnerability (31 per cent), with households containing a pregnant woman accounting for most of the rest of the 5,600 acceptances (15 per cent). As noted above, the proportion of 'vulnerable' acceptances in London is much higher than that in suburban and rural areas of the UK, but broadly similar to other urban areas.

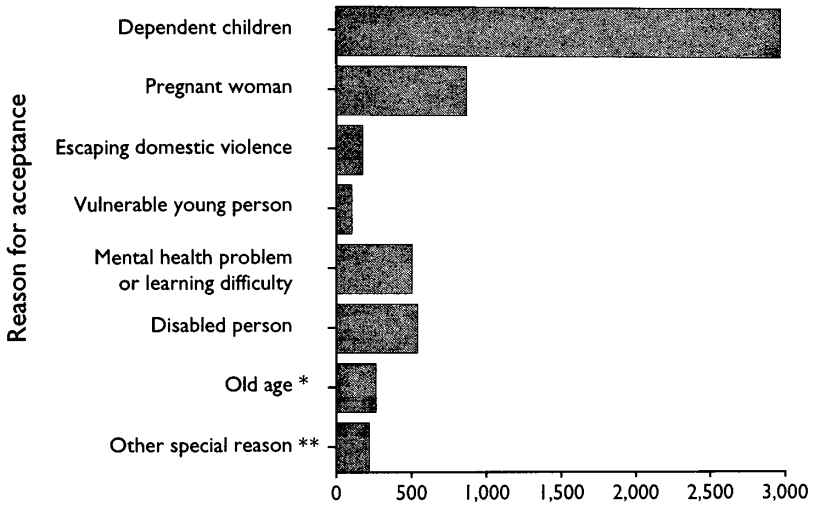

Figure 7 Reason for acceptance of homeless households during the last quarter of 1994

* *Old age* refers to the household containing someone who is defined as being unable to manage by themselves because of illness or disability associated with age.

***Other special reason:* this can include people who are dependent on drugs or alcohol, certain categories of ex-offender, and people with life-limiting or threatening illnesses such as HIV. The exact interpretation of this category varies between local authorities.

Source: P1E Returns for the last quarter of 1994, Department of the Environment. Data for Lewisham and Islington were not available for this period.

It is not possible to estimate the extent to which the statutorily homeless population living in temporary accommodation mirrored the composition of the households that were newly accepted as homeless during the last quarter of 1994, for two reasons. First, the rate at which people move from temporary to permanent accommodation (i.e. how long they wait in temporary accommodation in each borough) is not known. Second, it is not known whether or not people in certain groups (e.g. people with a physical disability or people with children) have to wait longer than others for suitable housing to become available.

Although broad detail on the statutorily homeless population of London can be gained from examining the reasons why households were accepted, little detailed information exists. For example, the number of people in a homeless household, their age, gender and ethnic background are not recorded. The data are also limited in terms of answering key questions about homelessness, for example, the number of homeless households containing dependent

children are thought to contain a high proportion of woman lone parents, but information to confirm or refute this is not collected. Another key problem with existing data is in relation to 'vulnerable' acceptances, the majority of which are assumed to be single homeless people, but again, this cannot be confirmed because data are not collected.

Household composition among statutorily homeless people

The last detailed study of the use of temporary accommodation by local authorities was undertaken for the Department of the Environment in the late 1980s by Thomas and Niner (1989). The findings of this study are summarised in Table 1.

Table 1 The characteristics of statutorily homeless households in temporary accommodation from Thomas and Niner's 1989 study

Homeless household	*Average age*	*Gender*
Single homeless person	40	61% Male 39% Female
Lone pregnant woman	20	100% Female
Lone parent	27	4% Male 96% Female
Childless couple*	35	50% Male 50% Female
Couple where woman is pregnant	22	50% Male 50% Female
Couple with children	29	50% Male 50% Female
Other	31	41% Male 59% Female
Total (average)	29	52% Male 48% Female

Base: 774 households, 347 (45 per cent) of which were in London.

* Thomas and Niner's study defined 'couples' as heterosexual and consequently the gender split is 50:50. Some councils operate equal opportunities policies for gay and lesbian couples.

Source: Adapted from Thomas and Niner (1989), Tables 4.2, 4.6 and 4.7.

Table 1 shows that statutorily homeless people were generally quite young (average age 29) and that approximately 50 per cent of them were in relationships. Thomas and Niner's study also shows that the majority of homeless households contained children (as would be expected; see Figure 7). The average age was quite low, particularly among the relatively small number of lone pregnant women, and only rose significantly above 30 in the case of single homeless people.

While the information in Table 1 is now outdated, it is reasonable to assume that the patterns of age, gender and household composition that it found among single homeless people are similar to those that would have been found in London towards the end of 1994.

More recent research carried out by the London Research Centre (1991) did not record the age and gender of the members of homeless households, but it did record their ethnicity. It was found that only 48 per cent of statutorily homeless households had a 'white UK' background, 25 per cent were Black, 15 per cent were Asian and 3 per cent were Irish (Thomas and Niner had similar findings). This is markedly different from the figures on the ethnic background of homeless people in the rest of the UK collected by Thomas and Niner, which indicated that 87–96 per cent of homeless households had a 'white UK' origin. The much greater number of homeless households from ethnic minority backgrounds in London reflects the much greater ethnic diversity of the capital. More generally, some academics would interpret the high numbers of Black and Asian people as evidence of the systematic disadvantage faced by people from ethnic minorities.

Length of stay in temporary accommodation

Again, evidence on the length of stay in temporary accommodation is limited to studies conducted in the late 1980s and early 1990s. Both the work by Thomas and Niner (1989) and the London Research Unit (1991) indicated that statutorily homeless people faced long waits in temporary accommodation. Thomas and Niner found that the households they surveyed were waiting 33 weeks in temporary accommodation and that those in London were waiting an average of 40 weeks. The later work by the London Research Unit found a longer average wait of 47 weeks, with the average *increasing* according to the number of children in a household. Households with no children waited the shortest average time at 35 weeks, while those with four or more children waited an average of 67 weeks. This pattern can probably be explained by the 'Right to Buy' policy which the Conservatives introduced in the early 1980s and which gave council tenants the ability to buy their homes at discounted prices. Disproportionate amounts of family-size housing have been sold under this policy, which also significantly

reduced the UK's council housing stock, and it would therefore be expected that a longer wait would be necessary to secure larger permanent accommodation in London. While this information is out of date, there is no evidence to suggest that the situation in London has improved since these surveys were carried out.

Non-statutorily homeless households

Characteristics of non-statutorily homeless single people

As noted at the start of this chapter, non-statutorily homeless people are generally single homeless people who live on the street, in hostels and in night shelters. The available evidence, which is substantial, strongly indicates that this is a highly vulnerable group of individuals with a range of care, social support and health care needs (Drake *et al.*, 1981; Anderson *et al.*, 1993; Craig and Timms, 1992; Dant and Deacon, 1989; Vincent *et al.*, 1993). This research indicates a disproportionately white and male population, with an increasing number of young men and women joining it.

During 1991, CHP conducted a major study of non-statutory single homelessness in England for the Department of the Environment. This study included interviews with 1,346 single homeless people living in hostels and bed and breakfast hotels, as well as 507 users of day centres and soup runs who were sleeping rough (Anderson *et al.*, 1993). A total of 51 per cent of those single homeless people living in hostels were living in London, and 83 per cent of the people sleeping rough who were surveyed were living in London.

Within London, 70 per cent of the hostel population was male (slightly lower than the rest of the UK) and over 90 per cent of the people who were sleeping rough were male (slightly higher than the rest of the UK). In common with the other areas visited, the single homeless people in London were aged mainly between 25 and 44 (39 per cent of hostel users, 48–9 per cent[11] of people who were sleeping rough) and younger people were less likely to be sleeping rough (10 per cent) than in hostels (28 per cent). Almost all the people who were sleeping rough were white (96–9 per cent), but 24 per cent of the single homeless people in bed and breakfast hotels were Black (most of the others were white (64 per cent), with a small number of Chinese and Asian people).

11. Two groups of people who were sleeping rough were included in the study; the figures refer to the range between the two groups.

By examining the functions of the different hostels in London, it is possible to ascertain broad information about the characteristics of the homeless people who use them. It can be seen in examining Figure 8 that considerable numbers of the single homeless people using hostels in London during 1994/95 were individuals with at least some support needs. The definition of 'support' received in hostels varies, but it generally includes one or more of the following types of services:

- *Support services*. This includes assistance with physical tasks and with the organisation of one's life. Broadly speaking, anything from helping an individual clean their home or look after themselves physically can be described as being support. Support services are usually defined as *excluding* any form of medical services.

- *'Advocacy'*. This is a form of support that can exist separately from other support services. It basically refers to housing support workers or key workers representing individuals in their care when those individuals are claiming benefits or trying to get access to services.

- *Training in daily living skills*. This includes educating certain groups (usually young people) to live independently. It includes teaching people to handle money effectively, cope with organising things for themselves and mastering basic tasks such as cooking for oneself. To use a crude example, cooking for someone is usually defined as providing them with support, whereas teaching them how to cook is usually defined as training in daily living skills.

- *Social support*. This is the most difficult of services to define. It can include actual emotional support for distressed individuals, but can also include helping people address the problems of isolation that often accompany homelessness by introducing them into situations where they can socialize and form relationships.

A high proportion of single homeless people in hostels were receiving at least some degree of support in 1994/95. Some 21 per cent were in 'low-support' hostels, another 11 per cent were in semi-supportive schemes and 7 per cent were in schemes that offered full support services. Many of the 'housing' projects that are defined as hostels offer at least some degree of support, and 24 per cent of the homeless people in the hostel population were living in them.

The intensity of support is measured both in terms of the types of services received (with people in high-support schemes being more likely to receive physical assistance with day-to-day tasks) and in the level of contact (low-support hostels may provide only limited amounts of time and restricted services to residents). Looking at hostel provision used by non-statutorily homeless single people as a whole, only 14 per cent of residents were in hostels that were not explicitly offering quite intensive support services (short-stay hostels, night shelters and traditional hostels). None the less, many of these hostels also have support workers and other services for their residents.

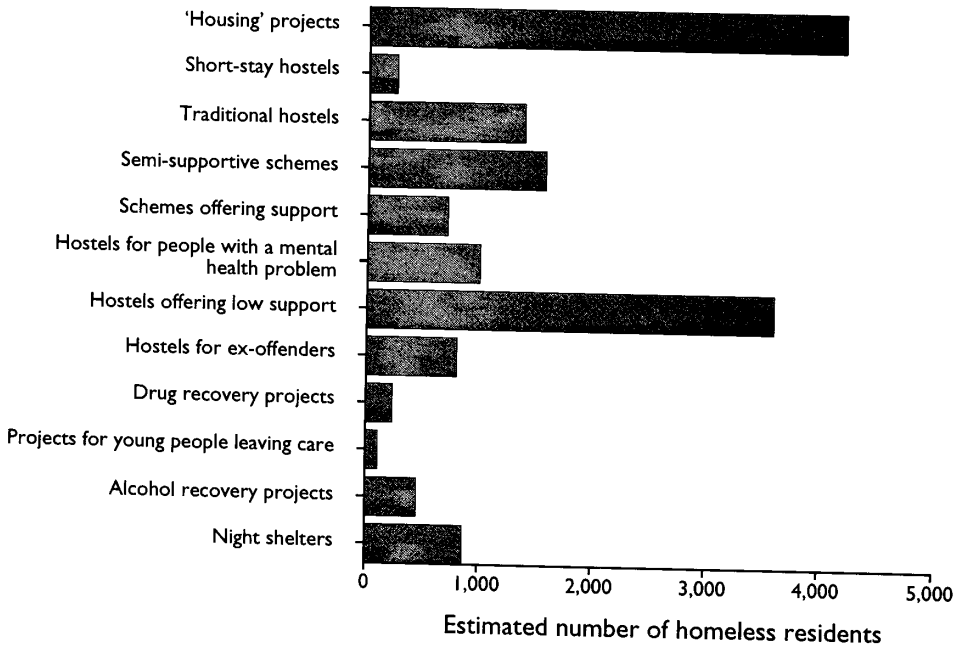

Figure 8 Estimated non-statutory homelessness by type of hostel

Source: Resource Information Service. Figures refer to the estimated number of homeless people in each category of hostel; they exclude non-homeless residents where applicable. Hostels for working people only, people looking for work, students, single parents, people 'returning home', group homes and 'housing' schemes that are specifically not for homeless people are excluded from the totals shown here.

Non-statutory homelessness among refugees and asylum seekers

As noted above, there is little available data that can be used even to estimate the size of the refugee and asylum seeker population that is homeless, and the same poverty of information exists with regard to their characteristics. Existing studies in London (Hinton, 1992, 1994)

have reported that British Black and Asian people who are homeless tend to be quite young and that the division between the genders in the homeless population is about equal. Hinton found that in Hackney, over half the homeless Asian people were parents. Data are highly limited with regard to the experience of other ethnic groups.

Home Office statistics show that the majority of people seeking asylum in the UK are generally young (75 per cent were under 35 in 1992) and that a high proportion are male (80 per cent in 1990). It is also the case that most do not have dependants (84 per cent between 1987 and 1989: The Home Office, 1992).

The characteristics of people who sleep rough

Existing research on people sleeping rough indicates that while they are disproportionately male, white and in early middle age (Anderson *et al.*, 1993; Randall and Brown, 1993), an increasing number of young people and women are sleeping rough.

A survey of people sleeping rough conducted by the Homeless Network (May 1995) in central London confirmed the findings of these earlier studies. Nine out of ten of the 347 individuals found on the night of 25/26 May 1995 were men and the great majority of people were white (although an average of 10 per cent were found to be Black, an increase on earlier surveys). The survey confirmed that increasing numbers of young people were being found on the street, with 25 per cent of those found being aged under 25 in the central London survey (which included the West End). However, in the Whitechapel and City areas of London, the pattern was much closer to that suggested in earlier studies, with 80 per cent of those surveyed being aged between 26 and 59. Among the women who were sleeping rough, a third were aged under 25 and a quarter were over 60. It was also found that two-thirds of the people sleeping rough had been sleeping on the street regularly for more than a year.

The users of winter shelters

The organisation CRASH (Construction Industry Relief and Assistance for the Single Homeless) has systematically collected data on the winter shelters provided under the Department of the Environment's Rough Sleepers' Initiative over the winters of 1993/94 and 1994/95. These data give an insight into the characteristics of the people who are sleeping rough for at least part of the year (when the shelters are closed) and who are spending the day on the streets of London.

The people who used the shelters during this period were overwhelmingly middle-aged white men. It is widely thought that women are less likely to spend time on the street than men because of the dangers involved, and this may explain why the representation of women is so low. However, the evidence for this argument is anecdotal and it should therefore be treated with caution. In addition, there is some evidence that suggests that men and women may avoid using winter shelters and other direct access accommodation because they feel the physical conditions and physical risks within such schemes are worse than those on the street.

Information on ethnicity was also collected by CRASH on the users of winter shelters. The data confirmed the findings of previous studies into people sleeping rough in showing that the bulk were white (described as 'English and Welsh' by the CRASH statistics). However, Black people were present in quite high numbers amongst people sleeping rough, with just under a fifth being 'Afro-Caribbean'. A fairly high number of Scots and Irish men also showed that a popular conception, that of people heading to London from these countries and finding adversity rather than employment, may be partly true.

Gaps in information

Detailed information on homelessness in London is very limited. The official statistics on statutory homelessness reveal little about the characteristics of the households that are housed; it is simply not known what their characteristics are in terms of age, size, gender or ethnicity, and little detail is known about their health status. Few data exist on people who are sleeping rough, other than the records of organisations providing services for this group, and there are no data that can be used to generate a robust figure of the number of people sleeping on the street in London.

For other homeless people, particularly people who are squatting and homeless and people staying with friends out of necessity or in overcrowded households, the data are so poor that it is not possible to produce anything other than crude 'guesstimates' covering London as a whole. Data are also very poor on homeless people who have admitted themselves into bed and breakfast hotels. Many homeless refugees, asylum seekers and homeless people from ethnic minorities are thought to live in these situations, and getting reliable information on them is not currently possible.

Data collection on housing status within the health service is also restricted, quite often confined to the rather nebulous 'no fixed abode' classification, rather than taking account of

the different forms of homelessness that are in existence. As a leading researcher in health and homelessness in London put it in the summer of 1995:

> *I think a lot of it is about quantifying the problem. It would be lovely to see monitoring of housing status, for instance, in the health service, which matched up health service use with housing status. It would help enormously and answer all sorts of questions, and then if you could match it up with data on ethnicity ... but just collecting that data on ethnicity is incredibly difficult and the same applies to data on housing status.*

While there are considerable problems in the way existing data are collected, the most obvious being an absence of data on household size among statutorily homeless households, these difficulties are not easy to address. It is not a question of simply collecting statistics that are not collected now, because collecting information on sections of the homeless population of London would be extremely difficult. Unless people living in squats and who are in housing need and unwillingly sharing accommodation identify themselves as homeless to agencies that collect data, the only means of estimating the size and characteristics of the homeless people in these circumstances is a regular major survey, which would be prohibitively expensive. People who are sleeping rough are also very difficult to count; there are suggestions, for example, that women on the streets hide away because of the dangers inherent in their situation and are under-represented in counts of people sleeping rough. This group of people is also highly mobile and probably includes a considerable number of people who intermittently sleep rough when they cannot get access to night shelters and direct access hostels (which often operate on a first come, first served basis). Counts of rough sleepers in the same area on different nights can sometimes produce quite different results.

A balance also has to be drawn between gathering information for planning purposes and the accessibility of services to homeless people. Of particular importance in the collection of information on homeless people is the stigma attached to homelessness in popular culture. Homeless people can feel isolated and embarrassed about being homeless and this, coupled with possible problems dealing with bureaucracy because of low literacy or illiteracy and low self-confidence (Dant and Deacon, 1989; Vincent *et al.*, 1993), is likely to mean that some homeless people could be deterred from using services if they are asked lots of questions.

Summary

There is little agreement about what homelessness actually is. Definitions of homelessness are often tied to political and ideological ideas about individual responsibility and the role of the State, so it is unlikely that any one definition will ever be universally accepted. It is possible to define homelessness as including everyone who physically lacks housing of any sort, people that the current law in England officially defines as homeless, and people who unwillingly share unsuitable housing.

Data on homelessness and the characteristics of homeless people are generally very poor. Little information is collected and official Government statistics only record details of 'households' that are homeless, not collecting any data on the size, composition, age or gender of those households. Information on the numbers and characteristics of people squatting in London is highly limited, as are data on rough sleeping and people using hostels. The information available on homelessness among people from ethnic minorities and people who are refugees or who are seeking asylum in the UK ranges from poor to non-existent.

Using the limited data that are available, it is possible to estimate that the homeless population of London was approximately 106,000 during the last quarter of 1994. This figure excludes people living in households that they are sharing unwillingly because no data exist on this group. Over the year, many people enter and leave the homeless population of London, so that while approximately 106,000 are homeless at any one point, the actual number who will experience homelessness during a year is much greater.

Existing data and research can be used to surmise that the majority of women with children who become homeless are assisted by the boroughs. Most of the homeless people in London (76,000 in the last quarter of 1994) at any one time are being temporarily accommodated by a London borough. The smaller number of homeless people who do not qualify for assistance from the boroughs are usually single, the population in hostels is quite mixed in characteristics and some ethnic minority groups are highly represented. Most of those non-statutorily homeless single people living in hostels have some form of support need. People sleeping rough are disproportionately male, white and middle-aged, although increasing numbers of young people, people from ethnic minorities and women are being found in this group. Nothing is known about the true numbers or characteristics of people who squat in London.

Chapter 2

Health and homelessness in London

Introduction

The links between health and homelessness need to be considered carefully because the relationship is not a simple one. This second chapter begins with a discussion of the relationship between health and homelessness and then moves on to examine existing studies of health and homelessness in London, considering information on statutorily homeless families and individuals before moving on to non-statutorily homeless single people housed in temporary accommodation. The chapter then considers the health status of people who are sleeping rough. Chapter 2 concludes by reporting the views of professionals working with homeless people in London and the views of homeless people themselves.

The links between homelessness and poor health

Poor health arises because of many different factors, which combine with one another in complex and subtle ways. Variations in overall health can be linked to: genetic variation; occupation; gender; ethnicity; relative and absolute poverty; personal behaviour (such as smoking or not smoking); and a host of other factors such as a person's living environment (Taylor and Bloor, 1994).

Many different factors represent a *risk* to health, but their presence or absence does not guarantee that health will always be good or bad. Modifications in diet, taking regular exercise and managing stress, for example, may reduce the risks to good health, but they do not *prohibit* the onset of disease. We know that healthier living will increase the chances of a long and active life, but it would be wrong to suggest that healthier living *always* meant that this would happen. A genetic predisposition to certain diseases, or inherited disease, for example, cannot necessarily be countered by changes in lifestyle. The understanding of what causes ill health also changes over time. For example, the importance in reducing fat intake began to be understood only relatively recently (Taylor and Bloor, 1994).

The impact of homelessness on health should therefore be seen as one variable among many that may affect the health of families, couples and individuals, rather than being seen as the *sole factor* that contributes to poor health. Health problems may *predate* homelessness or be

one of the causes of homelessness rather than a consequence of it. Equally, experiencing homelessness may cause health problems to appear or mean that existing health problems become worse (Snow and Anderson, 1987; Winkleby and White, 1992; Royal College of Physicians, 1994). In addition, health problems may develop or not develop while someone is homeless because of factors that are *unrelated* to their homelessness.

An increased risk of health problems

Homelessness represents an increased risk to health because it means that families, couples and individuals are exposed to a range of factors that are associated with an increased prevalence of health problems.

I People who are homeless face an increased risk of contracting *infectious disease* because they often live in overcrowded, cold, damp and insanitary conditions and have low incomes that limit the use of heating systems or mean that their diet is poor. These risks may be greater among certain groups of homeless people, particularly older homeless people and young children. Recent evidence also suggests that stress may also undermine the immune system (Taylor and Bloor, 1994, p. 43).

II People who are homeless face an increased risk of *mental health problems*. Homeless people are often subject to massive stress because of the factors that made them homeless (such as escaping violence or abuse, or the loss of a family home due to mortgage arrears), or because of the experience of homelessness itself (such as parents confined to one small room with young children for prolonged periods). Overcrowding has also been associated with poor childhood development (Standing Conference on Public Health, 1994, p. 32).

III People who are homeless face an increased risk of *physical health problems*. Poor diet, stress, cold, damp, along with inadequate sanitation and food storage or preparation facilities, all increase the risk of physical health problems. For example, prolonged exposure to cold puts strain on the heart, and high stress is associated with a raised incidence of heart disease and cancers. There is also an increased risk of trauma (physical damage) because of an increased risk of violence faced by some single homeless people (*The Big Issue*, 1995) and an increased risk of accidents among homeless children in temporary accommodation, which is associated with limited play space for children and poor safety levels (Standing Conference on Public Health, 1994).

Several of these risks to health are not unique to homelessness. For example, the effects of relatively low incomes on quality of diet are known to be a problem for all households and individuals with limited incomes, not just for those who are homeless. In addition, while at

least some stress is likely to result from homelessness, the problem of stress-related health problems is one that affects a large element of the population. It should also be remembered that poor housing conditions affect a large sector of the general population, particularly in London, where much of the housing dates from the nineteenth century and large sections of the stock across all tenures are in poor repair.

There is sufficient evidence to enable the assumption to be made that the risks to health that are associated with homelessness vary with the type of homelessness that is being experienced. Being statutorily homeless and temporarily rehoused in a warm, dry and partially furnished flat by a London borough (which is a possibility) is very different from being on the street. According to the current understanding of homelessness, risks to health are likely to increase the further a homeless person or household gets from being in adequate housing. The risks of infectious disease rise as soon as accommodation is cramped, overcrowded or insanitary, and the risks to physical health are likely to be at their most extreme when people are living on the street. In short, although the direct evidence is not conclusive, it is not unreasonable to assume that homelessness poses an increasing risk to health as the environment in which someone is homeless becomes more and more unfit for habitation.

Health problems leading to homelessness or homelessness leading to health problems?

While it is the case that homelessness represents an increased risk to health, because it means that people are exposed to a greater range and level of risk factors than the general population, demonstrating the link between homelessness and health is more problematic. There are two reasons for this. First, much of the material on health and homelessness in general, and on single homeless people and health in particular, is not as methodologically sound as it could be. The Royal College of Physicians (1994) point to the absence of comparison with the general population, reliance on self-diagnosis and work based only on individuals who visit a particular health service in many studies on health and single homelessness. In addition, most studies of the health of homeless families have focused on one form of temporary accommodation (usually bed and breakfast hotels, which is generally the worst), rather than reviewing health among homeless families in different forms of accommodation and comparing their health with that of the general population.

Second, understanding of the extent to which ill health *causes* homelessness remains rather limited. The best example that can be used to discuss this is the prevalence of mental health problems amongst non-statutorily homeless single people. Some argue that certain people with

a mental health problem, given the poor quality of community care services, cannot cope with ordinary life and become homeless because of this (Craig and Timms, 1992). The high prevalence of mental health problems among single homeless people can be used to support such arguments. However, it is illogical, although some American studies have done it (Basuk, 1984; Ziefert and Brown, 1991), to see mental health problems as the sole cause of single homelessness. Clearly, not everyone who becomes homeless has a mental health problem, and only a minority of all the people who will experience a mental health problem in their lives ever become homeless (Cohen and Thompson, 1992). The arguments that suggest mental health problems are the sole cause of single homelessness are further undermined by studies that indicate that the experience of homelessness can *cause* mental health problems to appear in previously healthy people (Snow and Anderson, 1987; Winkleby and White, 1992). Nevertheless, given that mental health problems can lead to unemployment, difficulties in dealing with day-to-day life and other problems that may lead to homelessness, it would be equally illogical to dismiss the possibility that at least some single homeless people become homeless following the onset of mental health problems (Royal College of Physicians, 1994).

Homelessness and ill health

While it is possible to say that homelessness does represent an increased risk to health (because it exposes people who experience it to a range of factors that have been demonstrated as exacerbating the chances of ill health), it is not certain exactly what the effects of these risks are. For this reason, it is difficult to quantify precisely what the impact of homelessness on health actually is.

One reason for this is that we must assume, based on current evidence, that at least some people who become homeless have health problems that predate their homelessness and that may, in whole or in part, have led to it. The other reason is that the interrelationship between the factors that may cause an increased risk to health is so subtle and complex that it is still not fully understood (Taylor and Bloor, 1994). In consequence, precisely separating out the effects of homelessness (as opposed to other factors) is not really possible.

The health problems of statutorily homeless people in London

Homeless families and children

Early studies of the effects of homelessness on the health of families centred on the increase in the use of bed and breakfast hotels to temporarily house increasing numbers of homeless

families in the late 1970s and early to mid-1980s. Attention was drawn to the problems of maintaining hygiene while trying to live in very cramped conditions and to an increased prevalence of infectious disease amongst children (particularly gastroenteritis, skin disorders and chest infections; Royal College of Physicians, 1994, p. 42). Poor diets, linked to limited incomes and limited facilities with which to prepare food, were also reported. Concern increased that childhood development was being impaired, with deficiencies being reported in the motor (walking and coordination) and speech skills of young children. Children were also reported as showing depression, disturbed sleep, overactivity, bed-wetting, toilet-training problems and violent mood swings. There was also evidence that children and their parents were being subjected to isolation, boredom and loneliness that was taking a toll on familial relationships and on their general health (Barry *et al.,* 1991; The Health Visitors' Association and the General Medical Services Committee, 1988). Studies also suggested that pregnant women faced an increased risk of problems with their pregnancies when living in bed and breakfast accommodation.

Cramped conditions in bed and breakfast hotels were also associated with an increased risk of trauma to children, both as a result of accidents (e.g. kettles being placed on the floor because nowhere else was available), and as a result of stressed and frustrated parents using force against children, sometimes to the point of abuse (HVA and GMSC, 1988). In one study in Oxford in 1991, 55 per cent of homeless parents said that they were irritated by their children and 65 per cent said that they often lost their temper (cited in Royal College of Physicians, 1994, p. 42).

In 1990, a London Boroughs' Association report estimated that 9,000 children were living in unsuitable bed and breakfast accommodation in London. Three-fifths of bed and breakfast hotels lacked adequate bathrooms and toilet facilities (in many cases shared by nine or ten people) and almost all lacked adequate sinks and food preparation facilities. Bed and breakfast hotels (B&Bs) in London are concentrated in areas like Paddington, King's Cross, Finsbury Park and Earl's Court, all of which have a reputation for crime. Before it was disbanded, the Inner London Education Authority (ILEA) carried out a survey which found that parents in B&Bs were reluctant to let children out and were concerned about harassment (Taylor and Jones, 1990). Recent research in Liverpool (Stitt *et al.*, 1994) has shown that among homeless families in B&Bs in that city, diets are deficient in terms of all the Department of Health nutritional guidelines.

A study that concentrated on the bed and breakfast hotels in London (Parsons, 1991) found a high proportion of children born in B&Bs had low birth weights. Some 30 per cent of homeless children were also considered not to be in normal health, although the relative poverty of the area meant that 20 per cent of housed children were also in this category. Richman *et al.* (1991) conducted a study of paediatric admissions to St Mary's Hospital, which covered the Bayswater area, which has many bed and breakfast hotels, and found that children from B&Bs were more likely to attend[1] with infectious diseases than other local residents, although there was no variation in the types of infection. In terms of injuries, although patterns were quite similar, children from B&Bs were twice as likely as others to attend with burns and scalding, while among children under the age of five, the attendance rate of those who were homeless was almost twice that of other children. Victor *et al.* (1989) conducted a study of the use of hospital facilities in the Parkside Health Authority area, which covered Paddington and North Kensington. This study also found that homeless people, mainly living in B&Bs, were high users of Accident and Emergency (A&E) facilities, paediatric services and inpatient beds, although it qualified its results by stating that it was uncertain whether this greater use of hospital facilities was the product of greater morbidity[2] or poor access to GPs.

Some studies of homeless families have lacked a comparative element and need to be treated with caution. In other words, the health of homeless families has quite often been analysed, but it has not often been compared with the health of the general population. As Victor (1992, p. 388) points out:

> *Although there are many speculations and suppositions about the health status of homeless people living in bed and breakfast hotels, most of these data are derived from small scale anecdotal surveys or relate to service utilisation. There have been few surveys which have attempted to compare the health of homeless and non-homeless populations by means of a standardised survey instrument.*

In her survey, which included 319 homeless households (65 per cent of which had children) living mainly in B&Bs in Ealing, Kensington and Chelsea, Westminster and Brent, Victor found high levels of acute and longstanding limiting illness. However, in comparing the data on

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1. The term 'attend' refers to people reporting to hospital with a health problem. Sometimes people who report to health services with a health problem are described as 'presenting'.

2. 'Morbidity' refers to the tendency of a population to develop health problems. A population with high morbidity is one with a high proportion of health problems.

homeless people with the general population, the high prevalence of acute illness (10 per cent) and longstanding limiting illness (34 per cent) was found to be very *similar* to that of the housed population in these areas. In common with other major cities throughout the industrialised world, London's population has relatively poor health, a function of environment, high levels of relative poverty and a host of other factors. In other words, while the homeless families in London have disproportionate levels of certain health problems, so do the poorer parts of the rest of the population. Victor's analysis did, however, point to a much higher level of mental health problems amongst homeless households than was present among the housed population (45 per cent of homeless people, compared with 18 per cent; 1992, p. 387).

Another study of admission to hospital of homeless children in St Mary's Hospital, Paddington Green Children's Unit, St Leonard's Primary Care Centre and the Royal Free Hospital found that high admission rates among homeless children may not necessarily reflect the severity of their health problems. Examining the admission of 70 homeless children, it was found that the decision to admit by doctors in 77 per cent of cases was influenced by 'social factors', which included family circumstances and accommodation,[3] compared with 43 per cent of a control group (non-homeless children). Overall, the homeless children had *fewer* pronounced health problems than housed children who were admitted, but unlike any of the housed children, three homeless children (4 per cent) died of overwhelming infections (Lissauer *et al.*, 1993).

While it is important not to exaggerate the health problems of homeless families in relation to the relatively poor housed population, this point is to some extent academic. Whether or not the general population has similar levels of need in terms of acute or longstanding illness, the problem of a high prevalence of such illnesses, in sections of either the housed or homeless populations, is still a matter of concern.

Studies in the US of homeless families have found the low birth weights, poor development and disproportionately high levels of serious illness among children reported in studies conducted in London: Muller *et al.* (1988) found 49 per cent of children in US shelters for homeless people had acute or chronic health problems; Zima *et al.* (1994) found that 78 per cent of 169 homeless children suffered from a behavioural problem, depression or 'severe academic delay';

3. 'Social factors' such as accommodation refer to the risks to recovery a child faces, i.e. it is illogical to expect a child to recover from a health problem in an environment that may have caused or exacerbated it, thus the child is admitted to hospital.

and Eddins (1993) found 61 per cent of homeless children had a 'developmental lag'. Comparative research from the US (Ziesemer *et al.,* 1994) also indicates that some problems, such as poor childhood development, are almost equally prevalent in the relatively poor sections of the population who are not homeless.

The decline in the use of bed and breakfast hotels

In the mid-1980s campaigning bodies and the media began to attack the practice of using bed and breakfast hotels for families, and the use of such accommodation has since declined very sharply in London. Although 9 per cent of statutorily homeless households were in bed and breakfast accommodation in the last quarter of 1994, this figure was much lower than the peak of 59 per cent during the second quarter of 1987 (Department of the Environment, 1995). Instead, there has been an increasing emphasis on the use of leased accommodation (40 per cent of households in the last quarter of 1994). This leased accommodation is normally private rented sector housing, in which conditions are generally somewhat better than in bed and breakfast hotels (London Research Centre, 1991). Housing association housing, either directly provided or arranged via agreements with private sector landlords, is also used quite frequently.

Although more statutorily homeless households were in ordinary housing while awaiting their permanent council or housing association home, over a third of households were in hostels, bed and breakfast hotels or 'homeless at home' (accepted as homeless, but staying in their current accommodation until a permanent council or housing association dwelling became available).

As noted in Chapter 1, data on statutory homelessness are limited to those collected on households, and no record is kept of the size or composition of the households by the type of temporary accommodation in which they are housed. It is not possible at present to determine whether the relative decline in the use of bed and breakfast hotels to house homeless families and other homeless people has had any positive health benefits. While living in less cramped and hazardous conditions might be expected to produce some improvement, the other risks to health associated with homelessness remain unaffected by whether a family is in a bed and breakfast hotel or a leased flat.

Statutorily homeless couples and single people

Data on the health status of statutorily homeless childless couples and single people is not collected in London. Unlike homeless families and non-statutorily homeless single people, no studies have been conducted on the health care needs of these groups. It is reasonable to assume, based on existing research into statutory single homelessness (Pleace, 1995), that most single homeless people accepted by the boroughs require at least some health care, and that quite high numbers may need relatively intensive levels of health care.

Non-statutory homelessness and health in London

Single people

The Royal College of Physicians (1994) point to a series of methodological problems with research into the health of single homeless people. Many studies are based on individuals attending doctors or other health services, rather than on representative samples of the whole population, while others rely on 'self-diagnosis' by single homeless people, which is fraught with difficulties (because there is the chance that health problems are not recognised or misdiagnosed). In addition, as with some studies of health among homeless families, quite a lot of the research focuses on homeless people and does not use a comparison group. Some studies are based on mortality rates rather than morbidity and this is also problematic, because other disorders may exist in a person who dies of one particular health problem and suicide is generally under-reported in the UK. More studies have been conducted among single homeless people than homeless families and the greater detail of this section reflects this.

While it is important to note that existing studies of single homelessness and health in London and elsewhere in the UK should not be treated as having produced scientifically determined facts, the level of consensus between these studies is striking. In addition, as the Royal College of Physicians (1994) note, comparison between UK studies and methodologically more sound work conducted in other countries shows that the results of UK studies are often similar to those conducted elsewhere in the industrialised world. In considering the health care needs of non-statutorily homeless single people in London, it is important to make a distinction between people who are staying in some form of accommodation and those who are sleeping on the streets on a regular basis. The research on the health of single homeless people living in some form of accommodation indicates that, like homeless families, their overall health is quite poor in comparison with the general population and particularly poor when the prevalence of mental health problems is examined. However, the research on homeless people

living on the street in London, and the very extensive research on street homelessness conducted throughout much of the industrialised world, strongly indicates that the health status of people who sleep rough is *distinctly worse* than that of any other section of the population.

Bines (1994) has compared the health of non-statutorily homeless single people living in hostels and B&Bs and people sleeping rough with that of the general population using the data from an earlier CHP survey conducted by Anderson *et al.* (1993) for the Department of the Environment. Most of those single homeless people who took part in the survey were living in five London boroughs (Brent, Camden, Lambeth, Tower Hamlets and Westminster). Bines found that the (self-diagnosed) health of single homeless people in hostels and B&Bs was significantly poorer than that of the general population, and that among people sleeping rough health problems were even more prevalent. Her findings are summarised in Figure 9.

Figure 9 shows that chronic chest and breathing problems were twice as high among single homeless people in hostels and B&Bs than among the general population, and three times higher among people sleeping rough. A similar pattern emerged with regard to skin complaints and ulcers, musculoskeletal problems and other health problems such as frequent headaches. Heart problems were found to be generally lower among single homeless people, but this may have been related to self-diagnosis (breathing problems and musculoskeletal problems which might be symptomatic of heart conditions were frequently reported). Mental health problems, defined as 'depression, anxiety or nerves', were 11 times higher than in the general population among people sleeping rough, and eight times higher amongst single homeless people in B&Bs or hostels. A re-examination of the original CHP single homeless survey data conducted specifically for the Review showed that the pattern of health problems reported among single homeless people in London was practically identical to that elsewhere.

A recent study of single homeless people in Sheffield (Westlake *et al.*, 1994) also measured health status according to individuals' own perceptions of their health. The findings were similar, with single homeless people coming out as having significantly worse health than a standard London population in 'all dimensions'. Anxiety and depression were found at raised levels among all the groups of single homeless people who took part in the study.

Balazs and Burnett (1990) in their examination of the Homeless Health in East London Project (HHELP), which provided primary and mental health services to people sleeping rough, also found a high prevalence of mental health problems. Respiratory disorders (usually bronchitis),

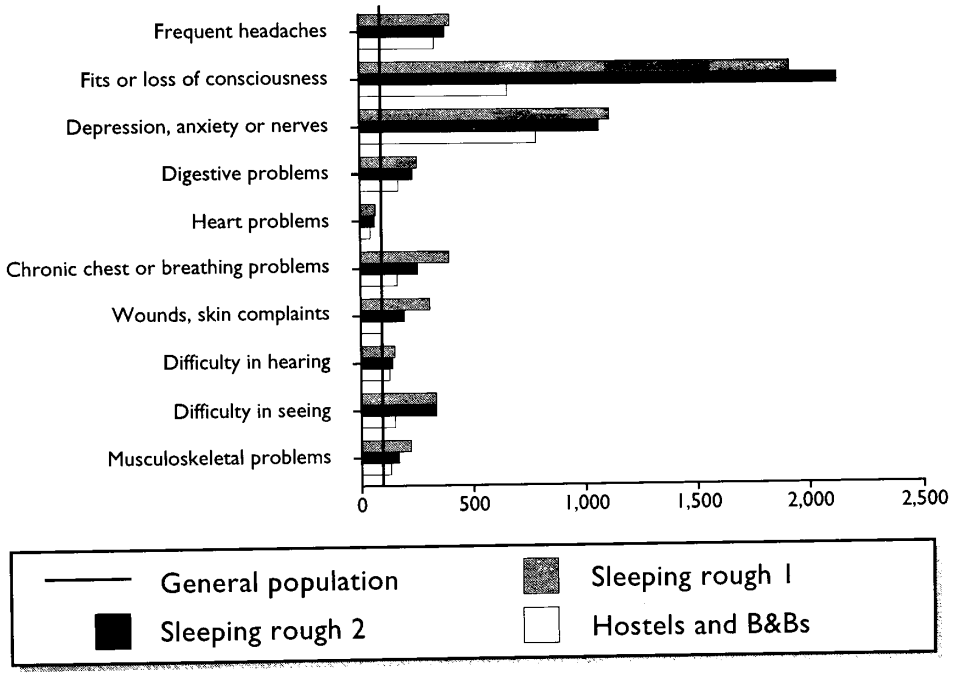

Figure 9 Bines' standardised morbidity rates of single homeless people living in hostels, B&Bs and sleeping rough in comparison with the general population of the UK

Sleeping rough 1 refers to a sample of people using soup runs. Sleeping rough 2 refers to a sample of people using day centres.

Source: Adapted from Bines (1994, p. 6). The solid vertical line represents the standardised morbidity for the general population (standardised by age and gender). In all the categories shown above, the prevalence of disease and health problems in the general population is shown by this line, which is represented as being equivalent to 100. Where the figures for homeless people show a rate of, for example, 500, this indicates that the prevalence of that particular health problem is *five times greater* than in the general population.

which the authors linked to very high levels of smoking and poor nutrition, were also very prevalent. Skin problems, such as scabies, were also very common, as were lice and leg ulcers. Some (but not all) people sleeping rough had very high rates of alcohol consumption and some had a severe drug dependency. Poor dental hygiene was also reported. Fungal infections and other damage to feet were commonplace among people sleeping rough.

In a more detailed report on the HHELP project, Balazs (1993) described four years of activity during which the project saw 3,000 homeless individuals. He reported a shift in the age profile and gender profile of the street homeless population in the East End (in terms of attendances at HHELP), with the population becoming younger and an increasing number of women being

present (although the population remained largely male and was 95 per cent white) as the 1980s came to an end. About a third of the people seen were living on the streets and another third were in hostels; most of the rest were in temporary accommodation of other kinds, with a small percentage living in squats. High consultation rates with GPs were found for some forms of health problem, including mental health problems and dermatological (skin) problems. While the incidence of respiratory problems was found to be similar to the general population, single homeless people were more likely to have lower tract infections, which generally need antibiotic treatment, than upper tract infections (which the general population get more frequently and which are less likely to need antibiotic treatment) (Balazs, 1993, p. 67).

Alcohol misuse was reported as 'very common' among the single homeless people who attended HHELP, almost half the men attending during the four-year period examined drank harmful levels (Balazs, 1993, p. 75), although the figure is distorted upwards because a detoxification unit was also part of the project. Cirrhosis was found to be quite rare, perhaps because single homeless people only have funds to drink occasionally, but damage to nerves, muscles and the brain related to excessive alcohol consumption were all found among users of the HHELP service. In some instances, single homeless people developed alcoholic dementia. In contrast, the use of 'hard' drugs was quite small (around 1–2 per cent of attenders), although there was a problem in relation to the abuse of minor tranquillisers (7 per cent of attenders were using them) (Balazs, 1993, p. 79). Severe problems in relation to the general condition of single homeless people's teeth and feet were again reported.

One of the more disturbing findings from Balazs's study was the nature of trauma (physical damage caused by accidents or force) among single homeless people using the HHELP service. While the incidence of trauma reported is similar to that of the general population, homeless people were more likely to suffer *severe* trauma and violent death than the general population. This to some extent confirmed a report by CRISIS (Keyes and Kennedy, 1992), which examined the death certificates of people sleeping rough and found that they were 150 times more likely to be fatally assaulted than the general population, and 34 times more likely to kill themselves. The CRISIS report authors examined their data and found that the average age of death among single homeless people sleeping rough was 47, compared with an average life expectancy for males in the general population of 73.

There is a concern about the prevalence of HIV and AIDS among young single homeless people who are drug users or who are active sex workers. While many studies indicate that the prevalence of HIV is greater among people using drugs or who are sex workers, there has been

little systematic work on the problem of HIV prevalence among the homeless population of London. Studies in the US (Zolopa *et al.*, 1994) have suggested a high prevalence of HIV among single homeless people, but various factors, such as the generally higher level of intravenous drug use and HIV infection in the US, could mean that the level in the UK is not really comparable with what these studies suggest.

Tuberculosis

There is an increasing concern about the prevalence of tuberculosis (TB) among single homeless people because of the impact it has on their health and because of fears in relation to the health of the general population. TB is known to evolve in response to drug treatment and 'strains' that resist certain drugs have developed over the years. The concern in relation to single homeless people, and in particular people sleeping rough, is that they may lead chaotic lifestyles or have to move between areas, and will not be able to complete a course of drugs to cure their TB. Resistant strains then emerge because drug courses are not completed.

CRISIS has carried out X-ray screening for tuberculosis in three phases: at its Christmas shelters (December 1992 and 1993); in its cold weather shelters in London (March 1994); and in hostels and day centres in Camden and Westminster (August and September 1994). It found a prevalence of tuberculosis of 2 per cent among the 611 single homeless people it screened in the third phase in inner London, which was 25 times the level found in the last screening of the general population in London in 1983 (Citron *et al.*, 1995). Similarly high levels of tuberculosis infection have been found among single homeless people and people sleeping rough throughout the industrialised world, including San Francisco (Zolopa *et al.*, 1994); New York (Concato and Rom, 1994); and Nagoya in Japan (Yamanaka *et al.*, 1994).

After a long period of decline, the prevalence of tuberculosis (which some associate with relative poverty) is now increasing again among the general populations of several industrialised countries. However, available evidence in the UK is that the level of TB among single homeless people is *not* related to this general increase in the prevalence of the disease, but instead reflects the fact that the prevalence of TB among single homeless people never fell to the low levels now found among the general population. During 1977–81, for example, TB caused 25 per cent of all the deaths related to respiratory causes among single homeless people in Manchester, and a high prevalence of TB among people attending clinics for homeless people has long been recorded in London (Royal College of Physicians, 1994).

Mental health problems

The very high reported level of mental health problems among homeless people in general, and single people sleeping rough in particular, has led to a large number of specific studies being conducted in London, the rest of the UK and throughout the industrialised world.

The common, incorrect, perception is that the increased level of mental health problems among homeless people is the result of former long-stay hospital patients becoming homeless as these hospitals were closed down. In fact, very few people that have left long-stay beds have become homeless. Instead the increase in numbers of single homeless people with mental health problems appears to be related to the decline in acute psychiatric beds, poor service integration and the widely reported failures of community mental health services (The Audit Commission, 1994). The high numbers of single homeless people who have mental health problems are not individuals who have been in long-stay hospital, but are people who may have entered long-stay hospitals 20 years ago for whom the community mental health services designed to replace long-stay provision have proved inadequate (Craig and Timms, 1992).

British studies indicate a prevalence of serious mental illness (including schizophrenia) of between 12 per cent and 26 per cent among single homeless people (Royal College of Physicians, 1994, p. 79), with the overall prevalence of all mental health problems being between 30 and 50 per cent. Like the studies conducted elsewhere, the studies conducted in London report different levels of mental health problems among single homeless people according to the sample of people used and the definition of a mental health problem that is employed. Reed *et al.* (1992) interviewed 96 users of a cold weather shelter in central London and, although there was a high level of alcohol use, the level of psychosis was lower than expected (definitely present in 8 per cent and possibly present in another 4 per cent, p. 1,028). This has to be balanced against the finding that 28 per cent of those interviewed had previous contact with psychiatric services and 18 per cent had been admitted into a psychiatric hospital at some point. Marshall and Reed (1992) examined the health status of 70 homeless women in inner London and found that 45 of them (64 per cent) met the criteria for schizophrenia, according to one test for the presence of this mental health problem, and that a high number had been admitted to hospital. Fisher *et al.* (1994) estimated that 44 per cent of men and 47 per cent of women over 30, in the (largely male) homeless population of Westminster, had mental health problems. Interestingly, in the single homeless population aged under 30 in Westminster, women (24 per cent) were less likely to have mental health problems than men (34 per cent) (in the general population more women than men have mental health problems).

The Great Chapel Street Medical Centre,[4] which caters for people who are sleeping rough and other homeless people in central London, conducted a survey of the health care needs of the 220 homeless people who used its services in the week of 14–18 November 1994. The survey found that 30 per cent of its patients (67 people) could have been described as having a severe and long-term mental health problem.[5] Some 30 per cent of patients had a psychosis, 27 per cent had depression and 30 per cent had severe personality disorders (many had more than one psychiatric diagnosis). Alcohol use was associated with mental health problems in 52 per cent of cases and drug use was associated in 30 per cent of cases.[6] In 1990, the CHP survey of single homeless people (Anderson *et al.*, 1993) found that more than a fifth of people who were sleeping rough and a tenth of single homeless people in hostels and bed and breakfast hotels had had contact with psychiatric units.

There are arguments about the extent to which mental health problems are caused by environment and the extent to which they are caused by physical illness. Among one group of people, those aged over 60, there is a much higher incidence of degenerative physical illness leading to mental health problems. Crane (1992) attempted interviews with 130 older homeless people on London's streets and was able to complete interviews with 50 of them. Diagnosis is difficult, because behaviour that might be associated with dementia, for example not knowing what day it is, can simply be a function of being homeless – no access to the media and the absence of a regular routine would be likely to disorientate anyone. An absence of basic subsistence such as food and warmth is likely to have an even more adverse effect on this group than younger homeless people and Crane (1992, p. 35) suggests that some symptoms, such as depression, might subside if their environment were to change. Overall, Crane found that 45 per cent of older men (15 per cent of women) felt depressed and that 65 per cent of women (but only 17 per cent of men) appeared to experience 'thought disturbances', such as paranoid ideas and hallucinations. In addition, 40 per cent of women and 11 per cent of men appeared to have severe memory problems.

International studies also report high levels of mental health problems among single homeless people. Susser *et al.* (1991) examined patients leaving a short-stay US State mental hospital

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4. See Chapter 4.

5. A mental health problem of greater than 18 months' duration or psychiatric inpatient admission for more than six months out of the last 12.

6. Source: Great Chapel Street.

and found that 28 per cent had a risk of becoming homeless at some point during the following three years. Other studies have suggested a serious deterioration in mental health after many single people become homeless (Winkleby and White, 1992; Snow and Anderson, 1987), and pointed to the high level of mental health problems being related to very negative life experiences, such as post-traumatic stress disorder, among sections of the single homeless population (North and Smith, 1992).

While there is a general consensus that the numbers and proportion of single homeless people with mental health problems are increasing, there is not universal agreement on this point. A study conducted in Edinburgh compared the prevalence of schizophrenia among hostel residents in 1966 with the prevalence in the same hostels in 1992. The results were surprising; a marked reduction in levels was found despite the fact that there were 66 per cent fewer psychiatric beds in the area in 1992 than there were in 1966. A prevalence rate of 9 per cent was found in 1992, compared with 25 per cent in 1966. Although this study indicates that statements about a constant increase in the prevalence of mental health problems among single homeless people over time may need to be treated with caution, its results are not dissimilar to those of other studies in reporting levels of serious mental health problems that are very high. The reported prevalence of 9 per cent found by the Edinburgh study compares with a prevalence among the general population that is generally estimated at between 0.5 and 2 per cent (Geddes *et al.*, 1994, pp. 816–19).

Homeless people from ethnic minorities and health problems

Very little information exists on the health of statutorily and non-statutorily homeless people from ethnic minorities. As noted in Chapter 1, there are not even any available estimates of the size of the homeless population of London that might be from an ethnic minority. It is possible to surmise that the health status of homeless people from the Black, Asian and far Eastern communities is broadly similar to that of white homeless people, but this has to be qualified by the (albeit limited) evidence that suggests that they experience homelessness in a different way.[7] While it should also be noted that variations in health care needs might occur because of minor genetic variations (e.g. Black people and the prevalence of sickle cell anaemia), the limited research that there is (East London and the City FHSA and Tower Hamlets Health Strategy Group, 1995) indicates that the patterns of poor health associated with homelessness are broadly consistent across ethnic groups.

7. See Chapter 1.

The health problems of homeless refugees and asylum seekers

There has been no systematic research into the health care needs of London's population of refugees and asylum seekers. As noted in Chapter 1, there are considerable problems in estimating even the numbers of refugee and asylum seeker population in London, let alone the numbers and characteristics of any homeless population. It is reasonable to surmise that a high proportion of people who are seeking asylum or who are refugees will have experienced high levels of stress, and that some will have mental health problems because of what has happened to them before they arrived in London. The number of mental health and psychiatric services and support groups in London for refugees and asylum seekers would seem to support this assumption (see Chapter 4). In consequence, it would be expected that people from the asylum-seeking and refugee population of London who become homeless would, in common with other homeless people, have a high prevalence of mental health problems. Generally, as with people from ethnic minorities, it would be expected that homelessness would be associated with a similar pattern of health status among refugees as among any other group that experiences it. As noted above, it is generally difficult, in any homeless population, to disentangle the impact of homelessness on health status from disease that can predate homelessness.

The views of professional people working in health and homelessness agencies

As described in the Preface, 36 interviews were conducted with key representatives of agencies working in the area of health and homelessness for the Review. The comments of these professionals largely reflected the findings of existing research on the health status of homeless people.

The health of homeless families

The professionals interviewed who had considerable experience of working with homeless families described both the considerable physical and mental health problems that affect families, and children in particular.

> *One of them catches something and the whole lot get it, because of the cramped conditions, hygiene. They're not significantly malnourished, they may eat the wrong foods from the purist's point of view because they eat the cheapest and I think there*

seems to be no failure of compliance with treatment regimes, but there is a limit to what they can achieve in such circumstances.

(Director, A&E) [8]

I've got families in bed and breakfast and the women's refuge here as well. Then there's the hostel with young single girls who are pregnant. And I would say that some of those children are very disturbed, so often they've seen so much violence [and] *their mothers are disturbed, their mothers have no patience with them. The mothers forget the kids are also reacting to the situation in their own way, but they cannot express it, verbally.*

(GP, specialist medical centre)

Whilst professionals were still working with many families in B&Bs, they did acknowledge the changing pattern of temporary accommodation being provided by local authorities for homeless families. The use of leased accommodation, and the greater likelihood of reasonable facilities and space that this brought, was felt to be better in many ways for the health of families. However, professionals were concerned that families were more likely to be isolated than they would have been in B&Bs,[9] and that this would make it difficult to ensure that adequate health and other services were reaching them.

Single homeless people

Professionals stated that while the health problems experienced by single homeless people were not different from those experienced by the general population, the prevalence and severity of those problems were often greater. One GP explained that homeless people would generally present with worse health problems than other people and that these problems were less likely to be cured, partly due to the lower success rate of treatment programmes.

8. A&E – Accident and Emergency room in a hospital.

9. Since leased accommodation is often outside the borough that is rehousing a homeless household (see Chapter 1).

They would be the same problems as anyone else has but they are exacerbated by the lifestyle, and people who are a lot younger having problems that you would not normally expect to see till they were 60 or 70.

(Health care coordinator, hostel)

The particular point about the homeless is that they are more likely to have chronic problems or acute or chronic exacerbations of problems, they're more likely to have multiple pathologies ... By the very nature of their life circumstances, their problem is likely to come back, part of the chronicity of it as it were.

(Director, A&E)

Interviewees confirmed that people sleeping rough invariably experienced the greatest health problems of all homeless people, although they were felt to be remarkably resilient considering the conditions they had to endure sleeping out:

The street homeless characteristically present with a multiplicity of problems, usually of greater severity, very often alcohol-related or psychiatrically related or a mixture of the two. They too present with chronic skin infections, and foot problems and so forth. Interestingly enough, they don't present with hypothermia, they don't present with pneumonia, they don't present with malnutrition, their overall survival and fitness is very impressive.

(Director, A&E)

Many providers took the view that, amongst all the other health problems, mental health and alcohol problems were perhaps the two single greatest health problems experienced by single homeless people, particularly for those sleeping on the street:

Mental illness is the most common reason for coming here, and alcohol goes under that, and then respiratory illness is the next one, a lot of skin problems: infestation, scabies, that sort of thing, ulcers – either from injecting or not looking after their feet. Quite a lot of drug users have Hepatitis C. HIV infection is obviously around, but usually by the time they get symptomatic they get looked after elsewhere, because they

usually get housing and support. What else? There is quite a lot of cardiovascular problems from heavy smokers and drinkers, stomach ulcers, quite a lot of trauma as well, either getting mugged or falling over when drunk.

(GP, specialist medical centre)

Providers stated that they saw very few people with mental health problems who had stayed in long-stay psychiatric units, although some had had sporadic contact with acute mental health services. A few professionals commented that few young people presented with 'classical' mental health problems, but none the less had a high level of need, often related to drugs or alcohol or traumatic life experiences.

Many professionals working with different groups of single homeless people repeatedly commented that they were increasingly working with a client group who had *multiple* health problems. Particular emphasis was placed on the number of single homeless people who had both mental health problems and a drink or drug dependency.

The relatively high levels of tuberculosis amongst homeless single people was a large cause for concern. The risk of homeless people becoming infected with HIV was also mentioned. Although it was thought that the numbers of people with HIV were small, some professionals were worried that the true levels of infection were unknown. It was thought that most people with HIV would get accepted for rehousing by local authorities, although it was also stated that it was important that there was quick access to good housing.

Temporary accommodation ... is a really big problem for someone who has a terminal illness, for someone to spend 18 months or two years in temporary accommodation, that might be most of the rest of their life.

(Housing advisor, specialist agency)

A few respondents explained that homeless single women often had different health needs from homeless men. It was asserted that a majority of homeless women living in hostels were probably not suffering from the very poor physical health and alcohol and drug problems experienced by many homeless men. Mental health was still considered to be a major issue, but in a similar way to the pattern among young homeless people, in that it was often felt to be related to the causes of homelessness, such as experience of violence or abuse. However, it was

reported that the small number of women who slept out did usually suffer similar health problems to men sleeping rough, and sometimes with a greater severity:

> *The women who are street homeless do have the same problems as men, and probably more. The women who are not street homeless, but still homeless, tend to have perhaps not those acute drug and alcohol and mental health issues, but there are other things that are there, for instance around surviving abuse, more emotional needs.*
>
> *(Director, hostel/housing provider)*

Asylum seekers and refugees

Professionals thought that among homeless single people and families who were refugees or asylum seekers the pattern of health problems was often attributable to their experiences and origins. Although local authorities place fewer homeless families into B&Bs, it is known that considerable numbers of families seeking asylum live in bed and breakfast hotels, as they now cannot qualify for rehousing under the homelessness legislation. One respondent running a clinic in a large hotel where many asylum seekers were staying on arrival to the country commented on their health problems:

> *There is a high incidence of depression, which is partly related to the shock and worry of being a refugee in a strange country, and also there is often a history of violence and torture, a lot of illnesses are related to that, and a significant number of people have injuries related to torture. So there is more psychiatric illness. There are a lot of young children and we find an increased incidence of congenital problems which are untreated, simply because there have not been local resources* [i.e. medical services in their countries of origin].
>
> *(GP, running specialist clinic)*

The relatively high prevalence of certain health problems was sometimes thought to be related to cultural practices such as female circumcision. Rates of HIV infection were also a cause for concern, particularly in relation to areas of Africa where the disease is highly prevalent.

Professionals thought that the most common health problem was depression, related both to refugees' past experiences and their present homelessness. Below, some refugees describe how

cramped and insanitary conditions in temporary accommodation, often in the private sector, affect their mental health.

The views of homeless people in London

A series of five discussion groups with homeless people was conducted during the summer of 1995 for the Review. Three of these discussion groups were with a mixture of homeless people in different housing circumstances, one was with a group of homeless asylum seekers, and one was with young people who were homeless.[10]

Many of the homeless people interviewed commented that the bed and breakfast hotels, hostels and other temporary accommodation in which they were staying were detrimental to their health. Some young people and other homeless people said that conditions in some hostels were such that they would sleep rough rather than use them. Particular reference was made to the poor condition of showers and toilets in hostels:

> *The B&B definitely affects your health, living with other people with the same* [mental health] *problems. There is not the same consideration, a lot of noise, no money and no phone. The waiting to move affects your health.*
>
> *(Homeless woman in her twenties, medical centre)*

> *The hostels make it worse, they are not clean.*
>
> *(Homeless man in his twenties, day centre)*

> *I looked at it, at the showers, I said 'I'm no fucking livin' here'.*
>
> *(Homeless man in his twenties, day centre)*

> *Some hostels are a health hazard, some of them are right bad. Some of them, even the rats wear boiler suits.*
>
> *(Homeless man in his twenties, medical centre)*

10. The research methods used for the Review are described in the Preface.

It's like a lot of these cheap hotels around here, I mean, they're absolutely diabolical, you know what I mean? How the councils can allow them to exist, or the fire brigade for that matter, I mean if there were a fire, everyone would be fried.

(Homeless man in his sixties, medical centre)

Among the homeless refugees and asylum seekers from East Africa who were interviewed, there were very strong feelings about the effect that poor accommodation was having on their lives. A number of people had been sleeping on friends' floors, or in very overcrowded private rented accommodation for several years, and spoke openly about the physical and the psychological effects that they viewed as being associated with their living conditions:

I stay for the last four years. Many different people have come. There has been domestic violence, alcoholic violence, mentally violence, religions, different problems. [It] *is changing in my life so many different things,* [it] *is changing my targets, I could not do my studies for the last four years. I could not do qualifications because I am living with different kind of people, I could not do the work which I want to do. Pressure has changed me from who am I* [who I used to be] *from being* [a] *friendly* [person] *to being all to myself* [isolated]. *I want to live alone, to do my own thing, to get my own chance.*

(Homeless man (asylum seeker) in his twenties)

I have done that so many times [slept on the street rather than go to his temporary accommodation], *you have to go away, you have to, because the pressure is too much. It is like carrying heavy things, but not, it is like such a big thing that you cannot even carry it.*

(Homeless man (asylum seeker) in his twenties)

Being in a temporary place, you cannot set your goals, your future and you are not quite sure what you are doing. In temporary there are all the noises, you know? For example, I live with other three families, downstairs, up and whenever you start to do paperwork or something, the noise starts. When you are in bed they wake you up and when you go to work they sleep, so all the time, even if you go to school or work you

are not fruitful, you cannot think about your work, because you haven't got enough. Emotionally you are hurt. I hate it, I hate the house, so sometimes I go to a friend's house and sleep the night.

(Homeless woman (refugee) in her thirties)

She lives a nomadic life, going from one place to the other, and she told me that she doesn't have any settled life. With the health service, she told me that moving from place to place she is only registered on a temporary basis, so every time she goes it is a strange doctor. She was telling me that her daughter is exposed to many things and is all the time sick, and she herself in stress all the time, all the time she has back pain and headaches, constant headaches.

(Woman (asylum seeker) in her thirties with young daughter, via translator)

Some homeless people, including people who were sleeping rough at the time the interviews were conducted, commented on the effects of living on the street on their health. Their comments were focused on the impact of alcohol and drugs dependency. The risk of becoming dependent was strongly associated with feelings of isolation and depression that were part of sleeping rough. People who were sleeping rough also talked about the effects of being outside on their physical and mental health:

There's a lot of guys used to come down here, died, being on the streets, liver infections, drug abuse and other things, they were only 47, 37. Look at 'em, they look 80.

(Homeless woman in her forties, day centre)

I came to London when I was 15 on the run from sexual abuse, physical abuse, right. And you ask does the street affect you? Yeah it does, 'cos when I come here I was clean living, I had a good education, had a very nice foster family, foster father got killed, went to the children's home, got abused and run away. Yeah the street affects people, I been on the street twenty-odd years now, been here for twenty years, 15 when I come here, 35 now. You sit on the street and you meet people, the people, fellow homeless people, and you start drinking and then someone says 'do you want a snort of this?', bit of whizz [speed] *or something – it affects, when you're on the street and you don't*

know nobody, you're grateful for anybody to approach you, if it's drink, drugs whatever, you're just grateful for the company. I got a mate, Tommy, he died a couple of weeks ago, choked on his vomit, 35 years of age, nice guy, never did anybody any harm, liked to drink, never took drugs, but he liked to drink.

(Homeless man in his thirties, day centre)

Well, it does, doesn't it? I mean, where can you wash in the morning? Most people, 90 per cent of the people on the streets want to keep themselves clean, there's no facilities is there, that you can go and have a shower.

(Homeless man in his sixties, medical centre)

I've got asthma, and when I'm on the streets my asthma gets bad, the dampness, lying on the floor and all the rest of it.

(Homeless man in his thirties, medical centre)

Sleeping rough and all that, you're gonna catch things, if you're on the streets for a very long time, you get colds and God knows else what. I knew one person who got skin disease and passed it on to one of me mates and he ended up going to hospitals and doctors and that, so sleeping on the street you're gonna catch things.

(Homeless man in his late teens, day centre)

You weren't brought up to live on the streets, it's a big change in your life, so it must affect you mentally in some way.

(Homeless man in his early twenties, day centre)

If you get 'flu and that, you can end up getting really bad with it, you're not at home and you haven't got access to like paracetamol and stuff like that, yeah, you just end up getting worse and worse.

(Homeless man in his early twenties, day centre)

Some of the older homeless people who were interviewed described a long history of major health problems and some were apparently sleeping on the streets even though they said that they had conditions that would in time prove fatal. Severe illnesses such as TB and double pneumonia had also been caught by several people while living on the street. Several people also openly talked about their use of drugs and alcohol. A few people also commented on the presence of people on the streets with severe mental health problems:

> *I'm an asthmatic, I've had five minor heart attacks in the last three years. I went through domestic violence, I walked out of a three-bedroom flat and that made me homeless. I went over East Ham, to stay with a mate, but her husband started getting funny, so I had to walk over there. I slipped over to Waterloo* [under the bridge] *and I got double pneumonia and I got really ill with the pneumonia and the asthma and yellow jaundice and that. Me liver's gone, with drinking, I was a heavy drinker, I had me kids taken through the drink.*
>
> *(Homeless woman in her forties, day centre)*

> *I'm HIV, except I've got full-blown AIDS now and cancer of the lung.*
>
> *(Homeless man in his thirties, sleeping rough)*

> *You see people on the streets, they're not drug addicts, they're not alcoholics, they're mental, which to my mind is a crime.*
>
> *(Homeless man in his sixties, medical centre)*

Summary

The evidence strongly indicates that homelessness leads to a significantly increased risk to health, but many studies into the health of homeless families and single homeless people are not methodologically sound and need to be treated with some caution.

Studies of homeless families in London in recent years have shown risks to children's health and development to be associated with homelessness. In addition, limited living space while in temporary accommodation (particularly bed and breakfast hotels) has been associated with an increased prevalence of infectious disease. There is also evidence of mental health problems

related to severe stress among both the parents and children of homeless families, and of poor childhood development. Studies of single homeless people who are not statutorily homeless have indicated a generally higher level of health problems than the general population and a particularly high prevalence of mental health problems, especially among homeless women. In addition, some evidence also indicates that people who are sleeping rough have very poor health in comparison to that of the general population.

There is only very limited evidence available on the health status of homeless people from ethnic minorities. Generally, it would be anticipated that their health status is similar to that of any other group who experience homelessness. Among homeless people who are refugees or asylum seekers, some variation would be expected owing to the experiences that made individuals leave their countries of origin (mental health problems might be associated with post-traumatic stress disorder more frequently than among other homeless people, for example).

The findings of a series of interviews with professionals working with homeless people and groups of homeless people in the summer of 1995 generally confirmed the problems indicated by earlier studies. A group interview with homeless people who were asylum seekers or refugees indicated that health problems were strongly associated with overcrowded temporary accommodation.

Chapter 3

Homeless people and mainstream health services in London

Introduction

Homelessness not only increases the risks of poor health, but there is also evidence that it limits or prohibits access to appropriate health services. This third chapter is concerned with the experience of homeless people using, or trying to use, the *mainstream* health service in London.

The chapter begins with a brief discussion of why homeless people find it difficult to access mainstream health care. The second section discusses the implications of poor access to services and then moves on to review recent studies of homeless people's access to health that have been conducted in London. This section also considers the available evidence on the attitudes and behaviour of health professionals towards homeless people, and the impact that this can have on the quality of health services that single homeless people receive. The third section presents the findings of the interviews with professional people working with a range of health and homelessness organisations, and the final section is concerned with the opinions and experience of the homeless people who agreed to be interviewed as part of the Review.

Chapter 4 examines the health services that are specifically provided for homeless people in London.

Access to health services and homelessness

There are five main reasons why homeless people have difficulty in using the mainstream NHS in London. These are summarised below.

1 *Stereotypes and prejudice.* This affects some categories of homeless people more than others. Negative experiences in trying to use general practitioner (GP) services and Accident and Emergency (A&E) services are widely reported by people who are homeless. People sleeping rough, in particular, are sometimes treated badly or refused access when trying to use NHS services in London (Hinton, 1992; Martin *et al.*, 1992).

Homeless people are consequently reluctant to use some NHS services and may not use them until disease has become debilitating or painful (Fisher and Collins, 1993).

2 *The geographical decentralisation of the NHS.* Many homeless people are relatively mobile, a few lead lifestyles that mean they are rarely in one place, but the majority who move fairly frequently often have to, as short-stay accommodation ceases to be available. The NHS in London, as elsewhere, operates more or less entirely on the basis of geographical decentralisation. Commissioning agencies are required to provide for the populations of particular areas and organise themselves on that basis, with the result that a move between areas means a move between health services. This makes it difficult for homeless people to ensure continuity of care and to maintain contact with health services (Standing Conference on Public Health, 1994). This problem can be exacerbated by the low incomes of homeless people, which can prohibit them travelling to services.

3 *Procedures within the NHS.* Geographical decentralisation means that access to services is organised according to where one lives. Many administrative systems, particularly those in GP surgeries, work on the basis of someone having a permanent address in the area and date from a time when homelessness was not seen as a significant issue. Medical and administrative staff are often not trained to meet and understand the needs of homeless people. In short, much of the mainstream NHS is *not designed to deliver health care to homeless people* and its staff are *not trained to meet the needs of homeless people* (Martin *et al.,* 1992; Health Action for Homeless People, 1993).

4 *The social marginalisation of some homeless people.* Some homeless people can lack social skills and find it difficult to express themselves (Dant and Deacon, 1989; Vincent *et al.*, 1993). Some evidence suggests that this social marginalisation, sometimes combined with factors such as a high level of sub-literacy or illiteracy among homeless people, makes it difficult for them to advance their case if they are faced with hostility from NHS services, difficult for them to deal with bureaucracy and difficult for them to complain (Martin *et al.*, 1992).

5 *Relative scarcity.* The NHS is a service which faces very high demands with a finite level of resources. Recent evidence indicates problems with regard to sufficient access to GP services, acute beds, mental health services and the ambulance service for all of London's population. It is important to consider the additional problems that homeless people may face in getting access to and using health services in the light of this situation.

The implications of poor access to health services

Figure 10 shows the model of primary care used by the Royal College of General Practitioners (cited in Taylor and Bloor, 1994) to describe the process of disease management and treatment by health services. The first role of health services is to attempt to prevent diseases by getting (or assisting) people to modify their behaviour or environment to reduce the risks to their health. This aspect of health services' role is generally regarded as underdeveloped in the NHS, though increasing emphasis has been placed on it in recent years. The second role is that of early detection, which can significantly aid treatment, via the use of regular health checks and frequent contact with medical services. These two services are described by the Royal College of General Practitioners (RCGP) as 'anticipatory care'. The next stage of health services' activity is referred to as 'disease management' and refers to attempts to treat disease, then contain its effects, and finally to minimise discomfort once death is inevitable.

Anticipatory care		**Disease management**	
Primary prevention	*Secondary screening*	*Tertiary management*	*Quaternary (palliative) care*
DISEASE PREVENTION	DISEASE DETECTION	DISEASE MANAGEMENT	DISEASE CONTAINMENT
Health protection	Detection of early signs of disease before symptoms	Management of established disease to avoid limit of the development or disability or handicap	Management of advanced disease to acceptable death
Lifestyle management Removing the cause			

Source: Royal College of General Practitioners (cited in Taylor and Bloor, 1994).

Figure 10 The terminology of primary care

The problem of poor access to health services for homeless people means that it is more difficult for them to receive 'anticipatory care'. They are less likely to be able to build up a relationship with their doctor and less likely to receive the continuity of care that is potentially important in disease detection and health education. The chances of early detection are

probably reduced because of the other pressing concerns that people have when they are homeless. It is necessary to focus on day-to-day existence, and access to medical services may be a low priority, particularly when disease appears to be temporary or has only a slight impact (Martin *et al.*, 1992).

Homeless people are more likely to present themselves to health services at the point at which disease has to be managed. In some cases, treatment will be longer and more difficult because a disease has advanced further than would have been the case before most housed people would have gone to the doctor. In other cases (a good example is the dental health of single homeless people), the damage is irreversible in many cases and health professionals can only work to limit any further harmful effects. Anecdotal evidence suggests that at least some single homeless people only use or get access to health services at the point at which it is too late.

The CRISIS investigation (Keyes and Kennedy, 1992) of the reasons for death of single homeless people, which was largely focused on London, showed that alcohol was a contributory factor in 14 per cent of deaths and that single homeless people were three times more likely to die of pneumonia or hypothermia than the general population. CRISIS estimated that 65 per cent of deaths were probably preventable given proper housing and good health care. The CHP survey of single homeless people showed that less than three-quarters of those people who had a health problem were receiving treatment for it, with the rates of treatment being lower among people who were sleeping rough than other single homeless people (Anderson *et al.*, 1993).

The findings of research in London

Primary care

Primary care services include the general practitioner services, practice nursing services, dental services and opticians provided by the NHS at a local level. These services were organised by Family Health Service Authorities (FHSAs), which had overall responsibility for planning at the time of writing. In London, the size of FHSAs varied between one borough and four London boroughs and there were 16 at the time the Review was carried out.

Within primary care a distinction is made between GP services and 'community' health services (the latter including nursing, dental services, opticians and services like chiropody). In some instances, community health services are provided on a shared site with GP services; in other cases community health services are available from health centres that do not have

GPs. There is also a distinction between non-fundholding GPs and larger semi-independent 'fundholding' practices that are able directly to purchase hospital services for their patients from hospitals.[1]

Hospital-based services are usually referred to as 'acute' or *secondary care* services. This includes inpatient beds in hospitals, outpatient services and A&E departments. The acute side of the NHS was organised under District Health Authorities (DHAs), which were coterminous with FHSAs in Greater London at the time of writing.

General practitioners

Access to GP services and most other NHS services is arranged via registration with a GP. Registration takes two forms. *Permanent registration*, which is usually abbreviated to registration, should take place if a patient is going to be resident in a GP's area for three months or more. In inner-city areas like London, GP surgeries usually cover an area of about half a mile around their practice. Permanent registration means that a GP contracts to provide 24-hour care for a patient, issues them with an NHS medical card and will, usually, receive their medical records from their last known GP. The GP can then arrange access to all other primary and acute services as necessary for that patient. This system is designed to ensure continuity of care via the organised transfer of medical records from one doctor to another as the patient moves. *Temporary registration* is designed for people who are going to be in an area for less than three months and is intended for seasonal workers and people on holiday. Medical records are not transferred and the patient does not receive a medical card. In addition to registration, treatment can be provided by GPs under *emergency treatment* rules. The system is designed for sudden emergencies and accidents for someone who is visiting a GP's area for less than 24 hours.

There are several fundamental problems with this system for homeless people who attempt to use it. First, GPs are not salaried or patch-based and receive finance from the FHSA on the basis of registrations. A permanently registered patient who moves before the end of a

1. The Review is not designed to provide detailed explanations of the administrative structures of the NHS and its internal markets. Several volumes have been published that examine the impact of these changes in detail; see, for example, Baggot (1994). At the time the Review was being written the structure of the health service was still in flux in London and the rest of the UK, with FHSAs and District Health Authorities (DHAs) in the process of merging into joint health commissions, being responsible for both primary and secondary health services in their area.

financial year takes the money that is associated with him or her to a new area. In contrast, if a patient is temporarily registered, the GP can guarantee the income from that person for up to nine months. Financial considerations are increasingly significant to GPs, who are conscious of maximising budgets at a time of continuing fiscal constraint in the NHS. Homeless people move around a lot, often not by choice, and easily cross the small distances between GPs' areas. Permanently registering a family, or an individual, that is only going to be in the area for a few days or weeks makes no sense to a GP in budgetary terms, yet many homeless people fall into this category (Fisher and Collins, 1993).

Second, GPs have no obligation to accept someone onto their lists. They can refuse registration unless the FHSA insists that they take someone on, although the FHSA's power to do this is limited to a period of three months. Certain homeless people can be refused access to a GP on the basis of that GP's (or the receptionist's) attitude to them or if the GP is concerned about the attitude of other patients. Some GPs also fear being 'swamped' with demand from single homeless people in inner-city areas. Some researchers have suggested that there might also be a relationship between the health of homeless people and a refusal to register them. The reason given for this is that budgets are limited, and homeless people are often relatively ill and consequently relatively expensive patients (Fisher and Collins, 1993). At the time of writing no hard evidence to support this assertion has been collected.

Third, because of the way registration operates, many GP surgeries work on the basis of expecting someone to have a permanent address in order to register permanently. People who do not have a permanent address often cannot register because of the way in which many surgeries operate. By definition, homeless people do not have permanent addresses.

For many homeless people, temporary registration, with no medical card and no transfer of medical records, is the norm (Fisher and Collins, 1993; Martin *et al.,* 1992). It should be noted, however, that a few GPs do offer permanent registration to homeless people, sometimes using the surgery's own address for administrative purposes (Hinton, 1992).

Statutorily homeless families

Direct evidence on the access to GP services that homeless families have in London is quite limited. However, studies of the use of ***hospitals*** that show a high level of attendance by homeless families are quite often seen as evidence of insufficient access to primary care (the assumption being that a frequent use of hospitals is resulting from not being able to get access to doctors elsewhere). Some policy documents (The Health Visitors' Association and the

General Medical Services Committee, 1988) assume that the high use of hospital services by homeless families does indeed reflect poor access to GP services, and make recommendations on that basis.

This argument may provide only part of the explanation of the high use of secondary health services. Homeless families and indeed any other homeless people might use hospitals because they have not got access to GPs, but following this logic discounts what is probably an equally important explanation of the use of hospitals by homeless families. This alternative explanation is simply that homeless families may use hospitals more than other groups because they have more health problems and are more likely to have *serious* health problems than the general population.

One London study (Victor *et al.*, 1989), has linked the use of A&E departments with low registration among homeless families. However, this was against a background of low registration amongst *all* users of A&E, which suggests that the problem could extend beyond the homeless population.

Other research suggests that access to primary health care services is not especially poor for homeless families. Existing studies indicate that registration rates are quite high. Victor (1992) found rates above 90 per cent among homeless people in the north-west of London[2] and a heavy use of GP services by homeless households, although she did not differentiate between temporary and permanent registration. Victor's study also undermines the claim that a high use of acute services reflected low access to GP services, since she found that a high use of A&E and inpatient acute services went alongside the high use of primary services by homeless people.

Recent studies conducted in London by health service commissioners and providers have produced a mixed picture of registration among homeless families. A study of homelessness in Earl's Court reported that there were general problems with registration among homeless people in temporary accommodation in that area, but that particular problems existed for single people rather than for families (Kensington, Chelsea and Westminster Commissioning Agency and the Royal Borough of Kensington and Chelsea, 1995). Another study in Haringey found the high registration rates reported in other studies that have looked at the access to primary care that homeless families have, but it also reported that many homeless families

2. The registration rate for the general population is approximately 98 per cent.

were not registered with *local* GPs. Some could not remember either the name or address of the GP with whom they were registered, and quite a number gave the name and address of the GP with whom they had last registered before moving to their current address, some of which were outside the borough (CARIS, Haringey Homeless Families Project, 1994).

A third study among Bangladeshi and Somali families in Tower Hamlets, who had recently been rehoused after being homeless, found high registration rates (89 per cent) predating their moves into permanent accommodation. However, a substantial minority of families (16 per cent) had reported some difficulties in registering with a GP (East London and the City FHSA and Tower Hamlets Health Strategy Group, 1995).

Although the evidence is not clear cut, it is reasonable to assume that at least some problems exist. For example, it is likely that homeless families are generally temporarily registered, because they will not have a permanent address. The absence of permanent registration means no continuity of care. It is also reasonable to surmise (HVA and GMSC, 1988) that among homeless families the pressures of day-to-day living are sufficient to mean that registering with a GP will not be a priority and that health care might get left to one side until a problem emerges. Finally, while there have been no studies that have examined the attitude and behaviour of primary care staff towards homeless families, if the situation is at all similar to that experienced by single homeless people in London then there is considerable cause for concern (see below).

Statutorily homeless single people and couples

Again, information on this group of people and their access to medical services in London and elsewhere in the UK is limited. A study by one of the authors in 1994, which included an inner London borough, examined the access of statutorily homeless single people to community care and NHS services. This research found that access to health and social services among single homeless people who were living in temporary accommodation (and formerly homeless single people in permanent accommodation) was often poor. Attitudes towards single homeless people in general, and single women in particular, were often reported as negative. Some health services, including GPs, were viewed as sometimes unsympathetic and occasionally as downright hostile towards single homeless people. It was felt by housing staff that this sometimes detracted from the quality of care that single homeless people received (Pleace, 1995).

Non-statutorily homeless people and people sleeping rough

There have been several recent studies in London and other areas that have indicated that registration with GP services is low among single homeless people in general, and very low among some groups of people who are sleeping rough. In the last major survey of single homeless people, it was found that 80 per cent of single homeless people living in B&Bs or hostels, and just 61 per cent of one sample of people who were sleeping rough, were registered with a doctor, although most knew of a GP service they could use (Anderson *et al.*, 1993, para 2.61). Separate analysis of these data for the Review showed that, among single homeless people in London, the levels of registration and knowledge of doctors who would provide services if they were unwell were almost identical to these figures.

Two detailed studies of access to primary health care for single homeless people in London have been conducted by Hinton (1992, 1994). The findings of a study in Hackney point to severe problems in access to health care for certain groups of single homeless people. Hinton tested how easy it was to register in Hackney by using three 'actors' (who were actually homeless people) and sending them to try to register with 30 surgeries across the borough. The homeless people who were employed as 'actors' were a male Londoner who was living on the street, someone whom Hinton describes as having 'an unkempt and scruffy appearance'; a Kurdish man who was living in squats and in friends' houses and who spoke little English; and a white, middle-class, educated woman who was living in a squat. Hinton found that the reception given to each of these people by GP surgeries varied markedly, with some staff being very helpful indeed and others being hostile. None was consistently treated well and the likelihood of a poor reception appeared to worsen with the level of the individual's homelessness. The man living on the streets was refused registration more frequently than the Kurdish man who moved frequently, despite the latter's limited command of English. Perhaps unsurprisingly, the middle-class woman was offered permanent registration much more frequently than the others (Hinton, 1992, p. 44). Table 2 shows the results of Hinton's experiment in registration.

In 19 of the 30 surgeries visited, one or more of the 'actors' were told that they could not register, either permanently or temporarily, without an address. In five surgeries, the Kurdish man was asked for a passport, despite informing them he had been resident in the UK for more than one year (Hinton, 1992, p. 47). Overall, Hinton estimated that 74 per cent of the single homeless people in Hackney were registered with a doctor (who was usually local), with the likelihood of registration falling with the severity of homelessness.

Table 2 Outcome of attempts at registration by single homeless people recorded by Hinton's study in Hackney in 1992

Outcome	*Rough sleeper* (%)	*Kurdish man* (%)	*Middle-class woman* (%)
Permanent registration	7	33	54
Permanent registration on producing an address	7	0	0
Temporary registration	3	10	15
Offered immediate treatment (only)	20	7	4
Refusal (no address)	33	30	12
Refusal ('lists full')	27	20	12
Outcome uncertain	3	0	4

Source: Adapted from Hinton (1992, p. 45). Figures are rounded.

Patterns of registration were also found to vary according to ethnic group. Rates of registration were directly related to the length of time spent in the UK. During the first year of arrival in London they were as low as 37 per cent, and steadily increased to a level of 81 per cent after five years or more in the UK. Turkish speakers in Hackney were among the most recent arrivals and had the lowest registration rate, whereas the established Black British/Caribbean population had among the highest registration rates. People sleeping out and squatting, regardless of ethnic group, were the least likely to be registered with a doctor. In expectation of a hostile response, only one-fifth of the group of people sleeping rough and people squatting included in Hinton's study had tried to register (Hinton, 1992).

In her later study in Newham, Hinton (1994) found a similar situation. Again, a considerably lower proportion of the single homeless people in the borough were registered with a doctor than was the case among the general population (83 per cent of single homeless people against 98 per cent of the housed population). Younger single homeless people, refugees, asylum seekers and those experiencing the most extreme forms of homelessness were the least likely to be registered; again, a high proportion anticipated a negative response and had not tried to register. Hinton noted that GPs in Newham were under considerable pressure (many were in lone practices) and that the extra work that catering for single homeless people brought did not lead to any increase in the resources at the GPs' disposal.

Some work in London has suggested that being unregistered is the norm among people who are sleeping rough and some other single homeless people. The Primary Care for Homeless People Team (PCHP)[3] operates in Camden and Islington. It provides an outreach service to homeless people in the area and tries to improve access to mainstream NHS services. PCHP's annual report for 1993 shows very low registration levels among some single homeless people, with only 13 per cent of all the users of the service being *registered* with a local GP. Most of those who commented on why they did not have a doctor said that they were too mobile, although a substantial minority reported that they simply had not thought to do it. Some reported either a fear of bureaucracy or refusal as the reason why they had not registered. Hinton's study in Newham found that more than a third of people living in squats, night shelters or sleeping rough were unregistered, and that among people who were sleeping rough or using night shelters, many of those who were registered were actually registered outside Newham (34 per cent and 43 per cent respectively) (Hinton, 1994). In her earlier study in Hackney, Hinton found a similar pattern, with 40 per cent of the people interviewed who were squatting or sleeping rough not being registered (Hinton, 1992).

Community health services

Data on homeless people's experience and use of community health services in London were very limited at the time of writing. There have been no studies that have focused on the use that homeless people make of community health services in London or the rest of the UK. It is generally assumed that access to these services is poor, particularly among the non-statutorily homeless population. The reasons for this are threefold. First, access to community health services is mainly arranged via GPs; if access to GPs is poor, it follows that access to community health services is also poor. Second, many of the specialist medical services for homeless people in London (see Chapter 4) provide services such as opticians, dentists and chiropody, and demand for these services is high. If access to the mainstream outlets for community health services was adequate, it could be presumed that there would not be such high demand for these services. This has to be balanced against what is probably a very high demand for such services from homeless people, so the frequent use might partly reflect frequent need, as well as a function of not being able to get the service elsewhere. Third, data that are available on dental problems, eyesight, hearing and foot problems indicate that they are often apparently untreated, or are in an advanced state before they are treated. Again, this suggests that poor access may be a problem for some homeless people. In addition to these three factors, there is no reason to suppose that the administrative systems and the personnel

3. See Chapter 4 for details on this and similar projects for homeless people in London.

in community health services are any more disposed towards dealing sympathetically with homeless people than those elsewhere in the NHS.

What evidence there is on the experience of single homeless people in London (Hinton, 1992, 1994) shows that access can be problematic. For those single homeless people and people who are sleeping rough who do not or cannot claim benefit, claiming free treatment from dentists and opticians is very difficult. In the case of dentistry, the decline of the NHS service and the problems that there can be in locating a dentist that will provide NHS services has been widely documented as a problem for the general population, which may make access very problematic for homeless people. Access to chiropody can be very important for people who are sleeping rough, because of the physical damage that occurs to their feet. However, chiropody is provided free in the NHS only for older people and pregnant women, and access to this important service may be very difficult for homeless people.

Acute/secondary services

Accident and Emergency (A&E) services

Statutorily homeless families

Again, detailed information on the experience of homeless families in using A&E departments in London has not been published and may not even have been collected. There is a similar poverty of information with regard to the rest of the UK. As noted above, it is known, based on limited existing research, that homeless families do make quite intensive use of these facilities in London, a fact that is sometimes linked to a possibly poor level of access to primary care. Information on how staff in A&E departments behave towards homeless families, whether there are differences in the way in which they are treated, or problems with access, has not been collected.

Information on this group of people is difficult to gather, because A&E departments collect only limited and nebulous information on housing status (whether or not the household is 'no fixed abode'), and a special study would be required to detail the experience of homeless families with regard to these services.

Existing studies (Victor *et al.*, 1989; Victor, 1992) suggest a high use of A&E by homeless families in London, which suggests that there is not a particular problem with getting access to these services. It may be that this element of the health service remains relatively accessible

and useable by homeless families in London, but again, a caveat has to be attached to this statement, in that detailed evidence on the experience of single homeless people in A&E does not suggest homeless people are a welcome sight in the eyes of many A&E departments.

Statutorily homeless single people and couples

There has been no direct study of the use of hospital services in London, or elsewhere in the UK, by this group of people. The study of access to health and social services for statutorily homeless single people conducted by Pleace (1995) indicates that the general attitude of health and social services to this group was quite often poor and that access to services was, generally, difficult. The extent to which this was the case with regard to A&E departments was not recorded.

Non-statutorily homeless people and people sleeping rough

Martin *et al.* (1992) examined the use of London's acute services by older people and single homeless people as part of the King's Fund commission on the future of acute services in London. The study found that single homeless people were often viewed as 'inappropriate attenders' by A&E staff, because they had primary care needs that should have been treated by a GP. The study also reported negative attitudes towards single homeless people, such as the feeling that health problems were self-inflicted (e.g. via excessive consumption of alcohol).

According to Martin *et al.* (1992), these attitudes among staff had several consequences. First, single homeless people were kept waiting, with single homeless people themselves talking of periods of eight or nine hours spent in waiting areas before being seen by a doctor. Second, single homeless people and some people who worked with them reported that the treatment received was often cursory. Third, some evidence suggested inappropriate discharge of individuals with serious problems without sufficient follow-up to ensure that they would receive any necessary remaining treatment or to ensure that they did not, in extreme cases, get discharged onto the street when they needed an environment in which to recuperate.

Numerous other problems were identified in the study. Social work presence was often inadequate, access to detoxification services was also poor and there was also evidence of direct discrimination by doctors and others, who openly stated that their attitude to single homeless people was different to their attitude to other patients. In particular, the link between health problems and behaviour among some single homeless people was greatly emphasised, with very limited sympathy being shown for people dependent on alcohol.

Some pieces of research have called into question the stereotyping that Martin *et al.* (1992) identified among staff in A&E. In her study of access to health care by single homeless people in Hackney, Hinton (1992) found that, contrary to the beliefs of doctors and other staff in hospitals, most single homeless people attending A&E were appropriate attenders. Most had been referred by a GP or a health worker, with only 16 per cent stating that A&E was their only option when they had a non-urgent illness. While 55 per cent of single homeless people using A&E were not registered with a GP, most of these individuals were 'legitimate' attenders, in that they had a health problem of sufficient magnitude to mean that they *had* to go to an A&E department. The largest number of complaints were the result of accidents and physical attacks on single homeless people, with head injuries being particularly common. In addition, severe illness resulting from drug or alcohol use was also quite frequent. Staff in the A&E department reported great problems in managing some patients who were homeless. Additional health problems, particularly mental health problems and dependencies, also made it difficult to treat patients. Like Martin *et al.* (1992), Hinton found problems with regard to discharge procedures and links with other agencies.

Fisher and Collins (1993) note that there are considerable difficulties in estimating A&E activity with regard to homeless people in the UK because of the limited information available and the need to rely on estimates. They state that some studies report a high frequency of use, while others record relatively infrequent visits. Like other researchers in the field, they state that there is little evidence that single homeless people are malingering in A&E and also suggest that the perception of some single homeless people as 'problem' patients can lead to an inappropriate refusal of treatment.

Inpatient services

Statutorily homeless families

Yet again it has to be noted that there is very little detailed information on the experience of homeless families and their use of inpatient services. The existing research on hospital use in London that has already been cited indicates a high level of use of inpatient services by all homeless people. For example, Scheuer *et al.* (1991) estimated that homeless people in London accounted for 7,500 unplanned admissions into hospital each year, the pattern varying between areas possibly because of the nature of the homeless population in each locality. Victor's study (1992) of households in temporary accommodation in north-west London also indicates a high use of inpatient services by homeless families, and her earlier study (Victor *et al.*, 1989) showed that homeless families in B&B hotels were more likely to be admitted for

emergency care in an inpatient setting than local residents in Paddington and North Kensington.

The high levels of admission are probably related to poor access to, and possibly a poor quality of, primary care. Members of homeless families may enter hospital because earlier intervention that could have prevented disease developing did not take place. In addition, the high admission rates are also related to the impact of homelessness on health, which may lead to a higher prevalence of serious disease.

These assumptions have to be balanced against the findings of one study of homeless children and hospital admissions in London. Lissauer *et al.* (1993) conducted an analysis of the admissions of 70 homeless children and found that, in 77 per cent of cases (compared with 43 per cent of housed children), the decision to admit was influenced by 'social factors' (i.e. accommodation and circumstances that could exacerbate or prevent recovery from disease), and that homeless children had generally *less severe illnesses* than the housed children who were admitted, although, unlike any of the housed children, three homeless children who were admitted died of overwhelming infections. The pattern may vary between homeless children and adults, but this study indicated that in some cases the decision to admit was influenced by the very fact of homelessness itself.

Statutorily homeless single people and couples

There is no direct information on the experience of this group in relation to getting access to and using inpatient facilities. It may be the case that while living in temporary accommodation, their experience is not markedly different from other single homeless people in temporary accommodation of some kind.

Non-statutorily homeless people and people sleeping rough

It is known that single homeless people make extensive use of inpatient services. The last major survey of single homeless people found that a fifth of people who were sleeping rough and a tenth of those in hostels or bed and breakfast hotels had been in general hospital for more than three months at some time in the past (Anderson *et al.*, 1993).

Martin *et al.* (1992) described staff attitudes to single homeless people in hospitals in London as being like those towards older people, in that single homeless people were seen as 'bed blockers' who would take a long time to recover. While there was no firm evidence, this study suggested that it might be the case that the increasing pressures on acute beds in London (which continue to be widely reported) could influence the threshold for admission upwards

for single homeless people, compared with the rest of the population (though the work of Lissauer *et al.*, 1993, suggests the opposite). However, it was also suggested that once in hospital, there was little stigmatisation, but that single homeless people were more likely to discharge themselves than other groups because of the regimes in hospitals. As was found in A&E departments, preparation for discharge was described as frequently inadequate.

Mental health services

Statutorily homeless families

Evidence on the health status of homeless families in London and elsewhere indicates that household members experience high levels of stress and depression among homeless families, and existing knowledge indicates that mental health problems are likely to be caused or exacerbated by homelessness. However, data on homeless families and their use of mental health services remain highly limited.

It is known that severe mental health problems have an *isolating* effect. Someone who is permanently or periodically affected by a problem such as schizophrenia will tend not to have continuity in employment, nor will he or she enjoy the friendships and personal relationships that most of the rest of society take for granted. In short, some people who develop problems of this nature will cease to have social and emotional links with their families, or will be less likely than other people to form families in the first instance. The Royal College of Physicians (1994) describes these isolating effects of schizophrenia and notes that most people with this health problem lose contact with families, remain single and have few if any friends. The reasons for these problems are various, but mainly reflect a loss of 'life skills', such as the ability to interact socially, and the tendency of some people with this health problem to exhibit socially unacceptable behaviour.

The nature of severe mental health problems therefore makes it probable that an individual who develops them will either not have social and emotional relationships, or that those relationships that are in existence will be put under sufficient strain to mean that most of them collapse. The absence of research into severe mental health problems among homeless families may reflect the strong evidence that many people who experience severe mental health problems have to cope with them without the support of a family unit or a relationship.

The prevalence of less severe mental health problems, such as depression, is generally high in the population as a whole. A large percentage of people will consult their GP about some form of mental health problem during their lifetime, and the reliance of considerable sections of the

population on mild antidepressants, sleeping pills, and other stress-management drugs and therapies is well recorded. The evidence is that these problems are more pronounced among homeless families (Chapter 2). There is insufficient evidence to be certain about the extent to which primary health care services are accessible, or successful, in treating these health problems.

Statutorily homeless single people and couples

Research by one of the authors, which included London, identified severe problems with access to mental health services for statutorily homeless single people while they were living in temporary accommodation, and continued problems once they had ceased to be homeless and were permanently housed. Housing department staff working with single people reported that people with severe mental health problems were accepted as homeless under the 1985 Act, but sometimes had to be evicted from temporary and permanent accommodation. This was because support services from social services and health were not made available, and the housing staff and neighbouring tenants could not cope with them. There was concern that a 'revolving door' situation was developing, with people with mental health problems being accepted as statutorily homeless, being rehoused and then being unable to manage without support, abandoning the housing they had been given and becoming homeless again (Pleace, 1995).

Non-statutorily homeless people and people sleeping rough

Single homeless people and particularly people who are sleeping rough have a high prevalence of mental health problems. The widely reported problems with community mental health services and the presence of people with severe mental health problems in the single homeless population are generally seen as the product of the way in which resources are used, spending limits, and inadequate interaction and coordination between agencies (The Mental Health Foundation, 1994; The Audit Commission, 1994).

Existing research among single homeless people and people who are sleeping rough in London shows a high prevalence of mental health problems and also shows a high level of service use. In 1989, Hamid and McCarthy estimated that one in three of the people using *mainstream* NHS community mental health services in one inner London district was homeless, while in 1994, Fisher *et al.* generated their estimates of the number of homeless people in Westminster through contacts with social services, hospitals, a mental health team and primary care services, because it was anticipated that many single homeless people would have a mental health problem.

Although contact rates with services may be quite high, some evidence suggests that the main routes by which single homeless people are referred to mental health services leave something to be desired. The most extensive research carried out into this subject is probably that by Martin *et al.* (1992) in their review of hospital services in London for older people and single homeless people. The most common route of admission into mental health units in hospitals is via A&E, and Martin *et al.*'s findings showed that there was considerable anecdotal evidence that A&E departments were, because of the nature of their main function, an environment that was generally unused and unsuited to people with a mental health problem. Problems were reported in relation to insensitive or hostile attitudes from staff and very long waiting times.

Another means of admission for homeless people into mental health units is via 'sectioning' under Section 136 of the 1983 Mental Health Act by the Metropolitan Police, which gives the police power to detain anyone who appears to be 'mentally disordered' in a public place. As Martin *et al.* (1992) reported, there have been concerns about the use of this power because of the disproportionate number of Black people who have been detained using it. However, since Martin *et al.*'s work the Metropolitan Police now have access to a Community Psychiatric Nurse[4] service attached to a specialist Homelessness Unit at Charing Cross police station, which aims to divert homeless people with a mental health problem away from the criminal justice system. Nevertheless, some homeless people are referred via the courts to mental health units and other services.

In examining the level of mental health services, Martin *et al.* noted problems in relation to the often reported shortage of long-stay psychiatric beds in London, and also pointed to a shortage of acute beds and problems in relation to an increasingly limited hospital social work service. In addition, the split between detoxification services and mental health services was viewed as problematic, since some single homeless people have a combined mental health and alcohol/drug dependency problem, and services generally cater for one health problem, but refuse people with the other.

In addition to problems with accessing services, there is also considerable anecdotal evidence from ex-users of mental health services about negative experiences and insensitive treatment from hospital services, with an emphasis on the use of drugs, rather than therapy, being most frequently commented on. As was the case with regard to other hospital services, there was also felt to be insufficient attention to making suitable arrangements for discharge, according

4. A representative of the Metropolitan Police was interviewed for the Review.

to Martin *et al.* (1992). Hinton's reviews of access to services for single homeless people in Hackney (1992) and Newham (1994) indicated similar problems of access to mental health services and, in Hackney, problems in relation to patients that should not have been discharged because they had nowhere to go.

Homeless people from ethnic minorities and homeless people who are asylum seekers or refugees

Existing studies have generally not compared the registration rates or the use of secondary services among the different ethnic groups in the homeless population of London. The evidence that there is suggests that problems of access are more related to the degree and nature of homelessness rather than ethnic origin. Someone may be refused registration with a GP or have difficulty in getting services in a hospital because they live on the street and either have an alcohol dependency or are presumed to have one, but they will not, other things being equal, be refused a service because they are Black or Asian (Hinton, 1992; Martin *et al.*, 1992).

However, existing studies have identified problems when someone cannot speak English or has only a limited command of the language. This applies to people who are asylum seekers or refugees, but also to British citizens who do not speak English. There is some evidence of inappropriate practices, such as GP surgeries asking for passports when someone tries to register with them (Hinton, 1992), and access to health services can be hampered frequently for people who require someone to interpret for them. A study in Tower Hamlets among recently rehoused Bangladeshi and Somali families showed that 46 per cent relied on interpretation services in order to visit the doctor and that when these services were not available, they were unable to go (East London and the City FHSA and Tower Hamlets Health Strategy Group, 1995). Work in Haringey among homeless families showed that those who could not speak English were much more likely than others to find GP surgeries unwelcoming (CARIS, Haringey Homeless Families Project, 1994). Existing research has also indicated that when people are relatively new arrivals in the UK they are less likely to be registered than other people (Hinton, 1992, 1994).

The views of professionals working in the field of health and homelessness in London

Primary care

The problems in gaining access to health care for homeless people that have been suggested by research were affirmed by the professionals interviewed. Most professionals discussed the problems that homeless people encounter with respect to registering with GPs, and the overall difficulties associated with using GP services. It was thought that GPs and other practice staff generally had little understanding of the nature of homelessness, and that this lack of knowledge fuelled any fears they might have about the client group, making homeless people unpopular patients.

Whilst it was acknowledged that a minority of homeless people (as well as a minority of other people) may be difficult and sometimes aggressive, it was thought that improved training would dispel many ideas about homelessness. However, despite this general problem, a number of professionals commented that there were sympathetic GPs who provided services to significant numbers of homeless people, including GPs who had taken on sessional work for homelessness agencies.

As well as a general lack of knowledge around homelessness, some professionals also thought there was a lack of clear information on and understanding of the registration process. GPs appeared to hold differing viewpoints on whether a permanent address was required to register with a practice, and both practices and clients had difficulty accepting that an address such as a day centre could actually be used for registration.

The funding of practices was seen as constituting a significant problem in undermining access for homeless people to GP services. It was felt that there was a financial disincentive to registering homeless people in practices as they may require longer consultation periods, present with more complex problems and be more likely to be mobile. In addition to this, many professionals commented that in many parts of London, GPs were considerably overstretched, which understandably made them less able and willing to take on homeless people. One FHSA that took part in the Review itself acknowledged that there were insufficient GPs in its area. Community health care services like dentists who were willing to take NHS patients were also viewed as too few in number and consequently overstretched.

Even when homeless people did manage to register with a GP, professionals stated that the way the services were delivered made it difficult for homeless people to use them. It was widely asserted that a considerable proportion of homeless people, due to their lifestyle, found it hard to keep appointments. In some areas almost no GP surgeries appeared to operate any open access[5] sessions. The appointment system was also thought to make referral on to secondary services by GPs problematic. A number of people felt that GPs were sometimes reluctant to refer people on to other services as they thought a person was unlikely to keep the appointment. The mobility of some homeless people also was seen to act as a barrier to effective continuation of treatment, as it was difficult to keep the patient informed of appointments or changes in arrangements.

Overall, the professionals interviewed appeared to state that there were access problems related to both the characteristics of the client group, and more significantly, with the way primary health care services were delivered.

Acute services: A&E and inpatient care

The professionals interviewed did not report any major problems concerning homeless people gaining access to A&E departments. None the less, a few concerns were raised with respect to the way the service was delivered. The problems appeared to be connected to staff attitudes, operational structures and staff workloads which made services difficult to use for some homeless people.

The length of time it could take to see a doctor in casualty was thought to be an issue by a few professionals. It was suggested that some people may have relatively low tolerance levels to waiting to be seen. One professional also explained how the collection of information at A&E departments could be offputting for some people as it could take people 15 minutes just to get past the receptionist:

> *My own view is that it's compounded by the ever increasing amount of data we are urged to collect on all our patients coming to the Accident departments in this*

5. 'Open access' refers to a system where no appointment is necessary – individuals simply turn up and wait for a doctor to be available. Such services operate on a first come, first served basis.

country. So being interrogated by an A&E receptionist is a fairly gruelling business, even if you haven't got anything to be ashamed of or worried about or embarrassed by.

(Director, A&E)

It was also acknowledged that some homeless people, particularly if under the influence of alcohol, may be likely to be (or be perceived to be) difficult and disruptive patients by staff. Significantly, professionals thought that some staff may feel unable to address the recurring and multifaceted problems being presented by some homeless people. While it was felt that some staff took the view that certain homeless people had health problems of a severity that made them think intervention was futile, it was also the case that health service staff could sometimes take the view that other homeless people were using hospitals when they should only have been using a GP:

The problem with homelessness is that it tends to clutter up A&E departments because that is not what they are in the business of doing, and also slows down discharge if you've got to spend a lot of time liaising with your social services and housing departments. So it is an inconvenience factor as far as the NHS is concerned in so far as people not fitting their normal template for service.

(Director, NHS Executive)

Again they [people sleeping rough] *present general management problems because their compliance is limited, they're recurrent attenders, they don't get a sympathetic hearing, they often ask for immediate admission for detoxification and there simply are not the resources to do that. They present a management problem in so far as, certainly in the street homeless, there are a multiplicity of problems, including homelessness, difficulties with the police, impending court cases, or whatever, and there is a sense of impotence and frustration amongst A&E staff in addressing all the issues that need to be addressed.*

(Director, A&E Department)

With respect to admittance to inpatient services, many of the problems facing homeless people were thought to be those commonly faced by the general population. In the main, this amounted to there usually being pressure on beds, and waiting lists for some treatments being

excessively long. However, one professional was concerned that the knowledge of a person's housing status may dissuade a hospital from admitting someone if they thought a homeless person might need the bed for longer as a result of having nowhere to be discharged to.

By far the largest concern of professionals concerning acute care was the lack of adequate arrangements for the discharge of homeless people. It was stated that sometimes homeless people were referred to hospital social workers to ensure discharge was planned; none the less, it was felt that this process was slow and could not be relied on. As one interviewee said:

> *I feel that homeless people quite often come bottom of the list when it comes to getting a service, particularly from hospitals. If they leave hospital and they have no address, that's it, they're just forgotten about. I know there are outreach teams and day centres that will try and reconnect them and things like that, but it is the continuity of service that's the problem.*
>
> *(Mental health worker, specialist day centre)*

Professionals considered that inappropriate discharge to temporary accommodation was very common. The problem was thought to stem from the fact that hospitals, like other forms of mainstream health care, were simply not set up to respond to the special needs of homeless people. There was also thought to be a more general problem of managing what should be the seamless primary and secondary care interface – not only were people being discharged to inappropriate accommodation, but their treatment was often not being followed up by the primary care services.

Mental health services

One of the main problems with access to mental health services was again seen to be a general one likely to be experienced by any sector of the community – that a mental health problem has to be severe to be picked up by the services. Thus many homeless people might be seen as ineligible for help when a service is only able to respond to a crisis. This situation was compounded by the fact that a lot of homeless people, although in need of health care, were thought not to have a diagnosable mental illness. This was felt to be particularly the case with young people, and it was considered that mainstream (and specialist) services were ill-equipped to meet the needs of this group:

Something like 50 per cent of young homeless people have some form of mental health problem, there are no real services for those young people. The Joint Homelessness Team[6] is the nearest we have to access to statutory services, but they are pretty well overloaded, and the Homeless Mentally Ill Initiative[7] really has focused exclusively on the older homeless and not really focused on young people.

(Director, day centre)

Alcohol and drug services

Most professionals stated that it was very important that alcohol services could be quickly accessed by homeless people. Despite this need, it was widely reported that access to detoxification facilities for homeless people was extremely difficult.

The first problem mentioned was a general lack of provision of detoxification services in London, even to the extent that in some areas there were no detoxification beds available at all. The number of detoxification beds for homeless people was very limited indeed, with only two beds being available in Westminster for homeless people at the time the research was conducted. These few beds also seemed to cater for older homeless people and it was felt that there was no suitable provision for younger people with alcohol problems.

Second, there was an issue of gaining access to the few available beds. Due to the limited provision, the units were usually oversubscribed. Even if there was a bed, some detoxification centres would not accept a person who had used the facilities for more than a specified number of times. It was felt that this judgemental attitude was unhelpful as the success rate of detoxification was accepted as being low for homeless people.

Third, and most important, securing funding for a bed was reported to be extremely difficult. Since the advent of community care, social services departments have been the funders of detoxification services in London.[8] Many professionals explained how difficult it was to obtain

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6. See Chapter 4.

7. See Chapter 4.

8. State funding for people who cannot afford these services was provided by the Department of Social Security on a national basis until the NHS and Community Care Act changes in April 1992. Individuals now

social services funding, particularly as homeless people were usually asked to demonstrate a local connection to the social services area:

It is all sort of based on the community care idea that if you are living in an area your local social services should be responsible for you, and the whole thing is fine and well if somebody is living and has been living for some years in an area and has some established links or family connections there, but it's not geared up at all for homeless people who are very transient and move about.

(Alcohol worker, day centre)

There was also a concern that alcohol services would not accept people with drug problems or mental health problems. Since relatively high numbers of single homeless people and people sleeping rough were seen by professionals as having both mental health problems and a dependency on alcohol (and sometimes drugs), this was viewed as a major problem.

There were three detox. centres which were being used, one accepted people who had mental health problems but would not accept people with drug problems, another accepted on those grounds but reversed them, another would not accept people with mental health problems or drug problems.

(Social worker, specialist medical centre)

There are very few services for people with an alcohol and mental health problem ... I mean, generally speaking those people get left to the voluntary sector, and although some of the voluntary sector is very sophisticated and provide very good services, equally they are sometimes provided on a shoestring, so that is an area we are increasingly concerned about.

(Team manager, specialist outreach team)

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have to apply to social services departments (based within each borough in London) to secure funding – social services budgets are limited and individuals are expected to demonstrate a local connection.

Whilst most professionals discussed the lack of detoxification facilities, only one or two commented on the availability of longer-term substance misuse treatment programmes. However, these were apparently similarly difficult to access for homeless people, again mainly because of the problems of securing funding.

Homeless people from ethnic minorities and refugees

The professionals interviewed for the Review discussed two main areas of concern with regard to access to health services for refugees and people from ethnic minority groups.

The first, well-documented, problem was that of language and interpretation. The lack of a professional interpreter in a GP consultation session was seen as being in danger of leading to a misdiagnosis, since family members or friends who could translate for a patient would not necessarily be able to translate medical terms. Language barriers were also seen as an almost insurmountable problem in connection to delivering mental health services, in particular effective counselling was viewed as impossible without a bilingual counsellor.

Non-registration with a GP was also considered to be a problem with some communities and particularly with asylum seekers, who may arrive in the country without knowledge of their rights of access to health services and find some GPs reluctant to accept them onto their lists.

The views of homeless people in London

The results of the group discussions with homeless people in London in the summer of 1995 confirmed the findings of earlier research. Access to services was quite often reported as difficult, particularly for people who were sleeping rough. In addition, health service staff were sometimes described as unfriendly, even hostile, by the homeless people interviewed.

Registration with GPs was particularly problematic for people who were sleeping rough and other single homeless people living in bed and breakfast hotels, hostels and night shelters. This was especially true if they had a drug or alcohol dependency:

> *In the past I've had many experiences of trying to register with a doctor, living rough and whatever, everything is down to, well, if you haven't got an address, that's it.*
>
> *(Homeless man in his forties, medical centre)*

You can't register with any GP in Victoria, it's as simple as that. If they think you've got a drink problem or a drug problem, then that's it, you're finished. You know, they just say 'sorry we're full up' or 'lists full'.

(Homeless man in his sixties, medical centre)

Soon as you admit that you're an alchy or a drug addict or whatever, if they do take you on it's reluctantly, very, very reluctantly.

(Homeless man in his twenties, medical centre)

You can't register with a doctor. The only ones you can see is either in the hospital, or here, or Great Chapel Street.[9]

(Homeless man in his late teens, day centre)

You're talking about doctors, I can't even get one.

(Homeless woman in her forties, day centre)

Problems with registration were also very prominent among the group of homeless refugees and asylum seekers who were interviewed for the Review. In a straw poll of the nine East African people participating in the discussion, seven were found not to have any registration at all, including a woman with a small child:

As we said, most of us, we haven't got permanent accommodation, some are staying with friends, so it is not easy to get a doctor.

(Homeless man (asylum seeker) in his twenties)

I had a friend, I took her to the doctor because she got asthma, allergic from the house that she was in, because it was very humid. And I was taking her, interpreting, two, three times and she was told 'I cannot give you an appointment [at the hospital],

9. See Chapter 4.

because you are staying in temporary accommodation and you are registered on a temporary basis', because the girl was very sick and I had to take her to the MP, and she has now an appointment.

(Homeless woman (asylum seeker) in her thirties)

The experience of homeless people with A&E services also echoed the findings of previous research in this area to a considerable extent. Long waits were reported, even when someone felt themselves to be very ill, but interestingly, this was often associated with the resources available to A&E departments rather than seen as a function of a poor attitude to homeless people in general:

I had to wait four hours. I don't think the nurses get enough money and I know for a fact that the doctors are overworked anyway.

(Homeless man in his forties, day centre)

I go there, I walk in, and I'm ill, yeah? I'm coughing up blood or something. They sit me down, they say XXX, just sit there, but we're busy, just wait for ten minutes, yeah? It's not enough, there's not enough staff there, I think it's wrong that someone should wait, yeah? Not so much me, but I've seen other people waiting that's been worse than me.

(Homeless man in his thirties, day centre)

Some homeless people also reported being refused a service in A&E departments. As with access to GPs, homeless people with a dependency on drugs or alcohol quite often reported being refused a service in A&E. While most homeless people without a dependency on drugs or alcohol reported long waits for services rather than a refusal of services, some young people said that they had sometimes been refused a service or had had to insist on being seen by a doctor before they got attention:

You know if you go into a hospital, right? And you're really sick and you smell of drink, automatically, they don't wanna know. I don't know why because I think alcohol is a sickness, people don't get pissed for the sake of getting pissed. I get

annoyed, when I'm sick and they won't see me, but I can see the other side, where the nurses get attacked by drunks and all that.

(Homeless man in his thirties, day centre)

I got told go away, because it was not major enough, important at all, even though the fact that I couldn't walk properly.

(Homeless man in his late teens, day centre)

Had to wait for five hours and after they told me to go to see a doctor, sent me away.

(Homeless woman in her mid-teens, day centre)

I waited for four hours and I still would not move until they treated me. They told me to go away, but I wouldn't, I said that at the end of the day that is what they got paid for, my hand's hurt, do something about it, if not I want to see someone higher than you.

(Homeless man in his early twenties, day centre)

The homeless people who took part in the discussion groups were generally positive about the treatment that they received once they had been seen by the doctors in A&Es, and were also positive about GP treatment (though this was usually from specialist services for homeless people rather than mainstream practices). However, the homeless refugees and asylum seekers from East Africa who took part in a discussion group generally reported quite negative attitudes from the doctors and other medical staff that they had experience of:

The GPs are not aware of people that are coming from other countries. They are not conscious about stress or other problems.

(Homeless man (asylum seeker) in his twenties)

I had the situation where I wanted to change my GP and you can't do that. I mean, if you have a situation where you cannot communicate with your GP and they are not

considerate, you are not allowed to do that. You don't even have a choice and if you're a refugee it's more of a defect, it's like there's something wrong already anyway, they're doing you a favour by having you on their books ... There is this thing, 'do you come from Africa?', which I thought was a myth, you know, I never once thought it would happen to me. They sit there talking about 'you come from a different country, you come from Africa', they say that you could have this, you could have that, rather than you've just got a headache, you do get treated differently.

(Homeless woman (asylum seeker) in her twenties)

I remember one time, I had a toothache, it was Saturday, a very bad one, you know it feels when it's ... and I went to hospital and they still have to get the recommendation from the GP. I had to go back, I think that's the rule and regulation of the hospitals.

(Homeless man (asylum seeker) in his twenties)

Last time I was really sick and I was really cold and I couldn't walk or nothing. I went to the doctor to do something, to get better not to get worse, he is not caring for me, not caring for me really as a human. Treats me differently. I'm not like a cow or something, I'm human.

(Homeless man (asylum seeker) in his twenties)

Some homeless people in the discussion groups talked about when they were likely to go and see a doctor. Young people generally agreed that they would not visit a doctor unless a health problem did not go away after a few days or if it became troublesome, something that was occasionally linked to bad experiences with medical services in the past:

I've had a sore throat a few times and the first few days, don't bother, and then if it gets worse I have to go and see a doctor. But usually I wait until Tuesday or Thursday and see a doctor here.

(Homeless man in his twenties, day centre)

If you get turned away, it puts you off going again. You remember the last time you were ill and what happened then and so you stick with it, wait for it to go away.

(Homeless man in his late teens, day centre)

Many of the older people who were interviewed had either a single severe problem or a combination of diseases that meant that they had to use health services frequently, so this issue did not really arise for them. Unlike the other homeless people who were interviewed, people who were refugees or asylum seekers reported that bad experiences with doctors deterred them from attending services unless it was necessary, there being general agreement that doctors were not friendly and, while they would treat symptoms, they would not try to comfort the person.

Experiences of prejudice

The scale of prejudice against homeless people is difficult to determine. Certainly, as this Review and other research has shown, it can form a barrier to services for homeless people in the mainstream health service and deter them from using it. However, measuring the extent to which prejudice against homeless people prevents access to health is difficult. There are no records of how many homeless people might be turned away from A&E, and while there is evidence that it is difficult to register with a GP, that has to be balanced against a considerable number of people in the worst affected groups not having tried to register (Hinton, 1992). In short, while there is a problem, it is not certain how great that problem actually is.

In this instance, it is perhaps relevant to talk about the day-to-day experiences of homeless people in London. Homeless people live in a society that, in terms of popular cultural conceptions, views them as either having mental health problems, being dependent on alcohol, or being 'dossers' or 'layabouts' who refuse to work. This may affect the attitude of some homeless people towards the health service, in that, because they are treated badly everywhere else, they might *expect* to be treated badly if they try to use a primary or secondary care service. When this is combined with an actual experience of hostility, or even something that is interpreted as hostility by someone who is already perhaps painfully aware of their situation and how others see it, some homeless people may well feel that they are running the gauntlet every time they even walk into an A&E department or another health service and ask for help:

What I'm trying to say is, people, doesn't matter if they're homeless or if they've got a house, you're still people, you're still human, you've still got emotions, you know.

(Homeless man in his thirties, day centre)

You're talking to someone in a bar or a coffee shop or whatever, and you say 'I'm homeless'. And boom, you can feel it straight away, he's a dosser, he's whatever. It doesn't matter why, you could have had a bust up with your wife, your family, whatever, but as soon as you say you're homeless, you're classed as a dosser, irrespective of what your problem is. And, of course, you know, dosser, other things come to people's minds, you're either a wino or a junkie or whatever, you know, and you can be neither of them. I mean, I know loads and loads of people on the street who don't even touch drugs or drink, I know loads of them, totally clean. I mean, they are there for other reasons, but the stigma is still there. I mean, people walk by, see someone in a doorway: 'junkie', 'alchy'.

(Homeless man in his forties, medical centre)

This problem of experiencing prejudice seems to have been most pronounced among the group of homeless refugees and asylum seekers who were interviewed for the Review. Their experiences of treatment by doctors and by other aspects of the health service seemed, if anything, to be worse than that reported by the other homeless people who were interviewed, with the possible exception of those people who were dependent on drugs and alcohol (see above). However, some of the difficulty seemed to revolve around the problem of language; doctor and patient could not sometimes understand one another and this made the whole process more difficult.

Summary

There are considerable problems for a sizeable element of the homeless population of London in getting access to GP services. While evidence is limited on the extent to which homeless families can get access to GPs, there is some research that suggests that access is quite poor for people living in temporary accommodation such as bed and breakfast hotels. Previous research, which is quite extensive, suggests major problems for single homeless people and people who are sleeping rough in getting access to GPs from the mainstream NHS.

Evidence on access to community health services for homeless people in London is extremely limited. What information there is suggests that problems may exist in this area too, because of the role of GPs in arranging access to community health services in the first instance, and because the prevalence of problems such as dental decay among homeless people also suggests that access is poor.

Previous research has also registered concern about the way in which mainstream NHS services based in A&E departments react to some homeless people, particularly homeless people who are sleeping rough.

The results of the research carried out for the Review in the summer of 1995 confirm the findings of previous studies, and have also identified serious concerns about the experience of using NHS services by homeless people who are asylum seekers and refugees, and homeless people with dependencies on drugs or alcohol. There was also some evidence of negative experiences among homeless young people using mainstream NHS services. The interviews with professionals also confirmed the findings of previous research and identified additional problems, most notably with the quality and availability of drug and alcohol services for homeless people and the lack of dual mental health/detoxification services.

Chapter 4

Specialised health services for homeless people in London

Introduction

This chapter examines the services that have been designed to make health care more accessible to homeless people in London. The chapter begins with an examination of primary care provision and then briefly examines secondary or acute services. The chapter concludes with a discussion and examination of the role of community care in addressing the needs of homeless people in London.

The material used in this chapter is drawn almost entirely from the fieldwork that was conducted for the Review in the summer of 1995. The chapter draws on a postal survey of 172 organisations in London that had a role in the provision or funding of health services for homeless people. Overall, 78 organisations (45.6 per cent of those surveyed) responded, an unusually high figure for a postal request for information. A total of 13 commissioning agencies (or FHSAs and DHAs where commissions had not yet been formed) responded, which represented 81 per cent (13 out of 16) of the health authority/health commission areas in London. Just under half of London's boroughs (16 out of 33) also responded to the postal survey. Between them these 16 boroughs covered much of the area of central London.

While the information presented in this chapter is as comprehensive as possible, it does not represent a definitive description of all the specialised health services that were available for homeless people in London in the summer of 1995.

Primary care

Mainstream services

The Review found that there were a number of initiatives in London designed to promote access to mainstream GP services. The most common form of service provision was in the form of health visitors, link workers or health advocates for homeless people. Although the detailed

job descriptions of these posts varied, one of their central roles was to promote access to primary care for homeless people and to assist homeless people in getting access to GPs. The worker might physically assist someone with the registration process or might simply direct them to surgeries where GPs were willing to register them, at least on a temporary basis.

Examples of this sort of initiative included one operated by East London and the City FHSA, which extended existing health advocacy work to homeless people. Another example was in Enfield and Haringey, where two health visitors for homeless people (one per borough) were being provided. In Merton, Sutton and Wandsworth a project worker had been in post since 1994, the worker having the role of providing better access to health care for homeless people and also aiming to generate a better understanding of homeless people's needs among the medical community. A liaison health visitor was also in post, who provided 'drop-in'[1] services at several sites and encouraged registration with GPs. In Hammersmith and Fulham, two permanent health and homelessness posts had been established by Ealing, Hammersmith and Hounslow Health Agency. Finally, in Croydon, the FHSA had also established a link worker, with a specific role in relation to bringing homeless families into contact with health and other support services; the 'target groups' for this service also included refugee families.

In addition to these services, a number of the organisations that took part in the research were also undertaking other work focused on access to GPs. In most cases, this involved research and planning that were intended to inform adaptations to practice, but there were also a number of other initiatives. In Bayswater, an area with a concentration of bed and breakfast hotels, the Kensington, Chelsea and Westminster commissioning agency had recently closed the open access (no appointment necessary) Bayswater Family Doctor Practice, but had commissioned research into the possibility of integrating homeless people into mainstream practices. In East London and the City FHSA's area, several developments had taken place, including the establishment of a specialist commissioning team for health services for homeless people and the provision of dental services. A joint strategy for the health care of homeless people and mobile communities in East London was produced in January 1994. Similar planning and research were taking place in Camden and Islington (also covering

1. 'Drop-in' is a term used frequently in relation to health services for homeless people. It usually refers to peripatetic (travelling) health services that visit several sites during a week and provide an open access (no need for appointments) service. Sessions held at different venues on different days are often described as being 'drop-in' services. However, the term is also sometimes used in a different sense from the one here, referring to services that are open access but based on one permanent site.

refugees) and in Barking and Havering. In Hillingdon, commissioning strategies were being designed to account for the needs of homeless families and children.

In Brent and Harrow, training was being provided to health service workers as part of an initiative to improve the access to services for people from ethnic minorities, homeless people and refugees. In Enfield and Haringey, leaflets and other information about access to health that was targeted on homeless people were being produced. Two health authorities –Lambeth, Southwark and Lewisham, and East London and the City – had TB screening services for homeless people in operation at the time that the research was conducted.

The adaptations within mainstream primary care services were often relatively small in scale or remained embryonic at the time the Review was conducted. There were relatively few examples of global planning and service adaptation, for example. Only a few health commissions were examining their commissioning strategies with regard to homeless people and although some services were in place, these were generally fairly limited, such as one health visitor with a role focused on homeless people covering a whole borough.

Specialised health services for homeless people

In recent years, there has been a tendency within London to address the problems that exist for homeless people in accessing and using mainstream primary health services by providing separate services targeted on homeless people. These services are designed to be more accessible than the mainstream services, generally not using appointments but instead allowing homeless people to turn up at certain times and wait until they are seen. These services also do not require registration before health care is delivered. There are two broad types of service provision; the first is fixed-site provision, and the second is the outreach or peripatetic service.

Essentially, these two broad forms of specialised health service for homeless people do the same job but in different ways. Both are focused on primary care, usually including nurses and GPs, and both also often incorporate mental health and drug and alcohol services. Fixed-site provision is a service for homeless people that does not travel, whereas outreach services visit many different sites during the week, often covering a considerable area. Outreach teams tend to visit day centres and hostels, and may also visit the streets or areas where people who are sleeping rough are known to congregate. Visits may take place on a daily, weekly or monthly basis. In addition to the core staff who work in these services, specialists from the mainstream health service may make their services available to homeless people via either fixed-site

provision or the outreach teams. Opticians, dentists, chiropodists and counsellors may visit fixed-site provision or work with outreach teams, usually on a monthly or weekly basis.

Health centres and other fixed-site services

The fixed-site health services for homeless people in London did not confine their activities to the provision of health care. Most were day centres for homeless people, which aimed to counter people's isolation, provide social support and assist them as far as possible in their situation. Some provided clothing, several provided cheap or free food, and many had counsellors, workers, advocates and other professional staff in post to help address the whole range of different social needs, support needs, housing needs and health care needs of homeless people. Several day centres almost constituted a form of welfare state in miniature, providing services that were aimed at addressing the many different problems associated with homelessness. Most medical services that were targeted at homeless people should not, therefore, be seen as a separate version of the mainstream NHS only for the homeless population of London. Instead, they may be more accurately described as a component in the wide-ranging welfare provision for homeless people provided by a range of organisations.

It is also important to note that these organisations did not work in isolation from the mainstream NHS. For example, Great Chapel Street and the Cardinal Hume Medical Centre, both of which are described below, had close and successful working relationships with local acute services and would regularly send patients to nearby hospitals, although there were concerns that quite a number of homeless people did not subsequently attend arranged outpatient appointments.

Great Chapel Street was established in 1979 in a side road leading off Oxford Street. It was the most purely 'medical' service among all the fixed-site providers of health care that took part in the Review. The services provided included several GPs, chiropody, a dentist, nurses and a psychiatrist, and it also provided a social work service. The centre opened during the afternoon on week days.

A recent survey by Parkside Health Trust indicated that 70 per cent of the homeless people using Great Chapel Street were male, the average age was 35, and the majority were white. Between 1979 and 1994, Great Chapel Street estimated that it had seen 18,493 patients and undertaken 81,797 consultations (Annual Report, 1993/94), and that approximately 14 per cent of patients between 1984 and 1994 had used its psychiatric services. Between 1987 and 1994, the most common health problems encountered were alcohol dependency, often associated

with mental health problems (26 per cent of all patients); drug dependency (9 per cent of all patients); airways or respiratory disease (6 per cent); need for chiropody services[2] (6 per cent); and epilepsy (4 per cent). Many patients were thought to be people sleeping rough.

The incidence of TB (1.2 per cent) and HIV (0.5 per cent) amongst users of Great Chapel Street was very much higher than that found in the general population. In addition to the high prevalence of alcohol use, Great Chapel Street reported that at least 54 per cent of its patients were smokers. Great Chapel Street had a facility for homeless people called Wytham Hall at its disposal. The 'sick bay' in the hall provided accommodation for 14 patients in seven shared rooms, and was designed for homeless people who were chronically sick but who were not likely to be admitted into hospital. Wytham Hall also provided this service to homeless people with a mental health problem. It had 24-hour cover provided by resident doctors and two full-time administrators. Great Chapel Street was mainly funded via Parkside Health Trust and the Kensington, Chelsea and Westminster commissioning agency. It also received some charitable funding.

St Martin's-in-the-Field Social Care Unit provided 'midweek' and 'weekend' services in a medical centre attached to the church in Trafalgar Square. It was open on Tuesdays and Fridays, with the 'weekend' services being provided on Sundays. The people who used this facility were similar to those using Great Chapel Street, being mainly male (there were eight male consultations for every female consultation) and in early middle age. Again, there was a high prevalence of alcohol problems associated with mental health problems, other mental health problems, drug dependency and respiratory disease. A high proportion of users were people who were sleeping rough. During 1994, the St Martin's-in-the-Field services carried out 806 consultations (Parkside Health Trust). The Social Care Unit was supported by the London borough of Westminster, the London Boroughs Grants Committee, and other sources such as donations and legacies. The medical services were funded by the Parkside Health Trust.

The West London Day Centre provided showers and baths, laundry services, a clothing store, canteen, advice and referral service, and counselling services. In addition it contained a medical centre that was open four and a half days a week. It provided GP services and a practice nurse, and visits from an optician and a worker from the Joint Homelessness Team

2. The need for chiropody services often stems from foot problems that are associated with poor access to facilities for hygiene and spending time on the street. This can include trench foot, fungal infections and other damage.

(see p. 99) for the area. Again, the characteristics of the people using the service were similar to those found using the other fixed-site medical services: white, male and in early middle age. The centre saw 126 homeless people in February 1995. The housing status of the users of this service was more mixed: 50 per cent were in hostels and 38 per cent were described as 'street homeless' (Parkside Health Trust). Medical services were again funded by the local elements of the NHS, whilst other sources of funding for the day centre included 19 companies and banks, 19 churches and numerous individual donations.

The Passage Day Centre for homeless people near Victoria provided food, clothing, advice and other support services. Nurses worked in the medical room on site and there were visits from doctors. Between June 1993 and May 1994, there were 2,433 nursing treatments conducted and 1,023 doctors' consultations at the Passage (Annual Report, 1994). The Passage was supported by a great many organisations, 56 during 1994, with contributors including the Department of the Environment, the London Boroughs Grants Committee, a host of charities (including the King's Fund) and a large number of private companies. The medical staff were provided by the NHS (in the case of the GPs) and by retired nurses volunteering their services.

The Cardinal Hume Centre provided day centre facilities and a range of other services to homeless people. This included supported housing for young people and 'special care' accommodation for young people with a drug or alcohol dependency, a homeless family centre, education and training and, on a nearby site, medical services. The attached medical centre provided GP services (mainly provided by one doctor, with three supporting doctors), a practice nurse, general counselling services, and specialist drug and alcohol counsellors. There was also a visiting optician. Again, the pattern of health problems among homeless patients seen in 1994 was very similar to that of other medical services catering for homeless people in London. Mental health problems were particularly prevalent among the homeless people using the centre (59 per cent of all presenting problems), and similar prevalences of skin disorders (6.5 per cent), respiratory complaints (12 per cent), and dependencies on drugs (16 per cent of all adults) and alcohol (24 per cent of all adults) as were reported by the other medical services were also found among the centre's patients. Like Great Chapel Street, the medical centre reported that around 50 per cent of the people using it smoked. Mortality statistics for the medical centre in 1994 showed that nine patients had died, the average age at death being only 46 (Annual Report, 1994).

Particular concerns were focused on an increasing prevalence of HIV and Hepatitis B and C among patients at the Cardinal Hume Centre during 1994. There were 1,614 patients during

1994 and 6,303 consultations; 89 per cent of the patients were adult and 59 per cent were male. A much higher proportion of homeless people using the facilities were women (47 per cent) and children (11 per cent) than was the case for many of the other medical centres for homeless people in London. Ethnic monitoring by the medical centre showed that 44 per cent of all users were not from the UK and that 10 per cent were refugees or asylum seekers. A total of 15 per cent of homeless people using the centre had a language difficulty. Like Great Chapel Street, the medical centre provided home visits from its GP. The Cardinal Hume Centre was dependent on personal donors, charitable trusts, congregations of churches and statutory bodies for finance. In the 1994 Annual Report, 30 funding organisations were listed.

A number of other fixed-site services that provided primary health care did not take part in the research. These included South Westminster Centre for Health and the Croydon Resource Centre, both of which provided a range of primary services. The South Westminster Centre also provided some outpatient services. Cricklewood Homeless Concern, another centre, provided nursing, detoxification and psychiatric nursing services.

Outreach

Two Government initiatives, the Rough Sleepers' Initiative (RSI) and the Homeless Mentally Ill Initiative (HMII), have contributed to the development of outreach services in London. Under the RSI[3] outreach workers were provided to assist people who were sleeping rough in London to move into accommodation. Under the HMII, a time-limited initiative (1990–95) funded jointly by the Department of Health and the Mental Health Foundation, five specialist teams were established in three areas of inner London to provide outreach services to single homeless people with a mental health problem.

The teams funded by the HMII included: the Homeless Health in East London Project (HHELP) team, which covered the City and Tower Hamlets; the Joint Homelessness Team, which covered Kensington, Chelsea and Westminster; the Mental Health Team, which covered Lambeth, Lewisham and Southwark; the Hart Team, which covered Hackney; and FOCUS, which worked in Camden and Islington.

The teams were multidisciplinary, involving psychiatrists, community mental health nurses, street outreach and housing workers. They were designed to try to address the needs of the high proportion of single homeless people and people who were sleeping rough in London who

3. See Chapter 1.

had mental health problems, by providing medical services and a range of other support. The teams also had a specific objective to bring homeless people into contact with mainstream services, thus combining their role as a specialised provider of health services with a role in promoting access to the mainstream NHS.

FOCUS, which was based at King's Cross and covered Camden and Islington, provided an outreach service to single homeless people with a mental health problem at drop-in centres, in hospital wards, at homeless persons' units and on the streets. It had an open referral service and also took telephone referrals from other agencies. The team included nurses, project workers, social workers and a psychiatrist, and also had access to a consultant psychiatrist. FOCUS was initially established with RSI money in 1992, but was 'purchased' by Camden and Islington NHS Trust in April 1994. Like other medical service providers working with homeless people in London, the team was concerned with the level of homeless people with dependencies, the continuing high prevalence of mental health problems and the level of TB infection among its users (FOCUS team profile, 1995).

Recently, the Mental Health Foundation (1995) has published research into the working of four of the HMII teams in London. Most of the teams referred the authors to this research, rather than directly providing reports of their activities in the way that FOCUS did. This research, which included FOCUS, showed that the other teams worked in a very similar way. Typically, each team comprised: a team leader; social workers; psychiatrists; community mental health nurses; street outreach workers; and housing workers. Between them these teams handled 2,175 referrals between the launch of the initiative in July 1990 and the end of 1993. The main reasons for referral were possible psychosis (45 per cent); mood disorder (25 per cent); and social problems (9 per cent). The research into the HMII teams concluded that they were very effective in re-engaging single homeless people with mental health problems with mainstream services, but that greater accommodation services and more joint commissioning were needed for them to be more successful still. The research report into HMII criticised mainstream services for providing insufficient continuity and intensity of care for people with a mental health problem and thus increasing the risk of them becoming homeless in the first instance (Mental Health Foundation, 1995), which reflected the findings of other research in this subject area (see Chapter 3).

There were also a number of other outreach services in London with varying emphases in their pattern of service provision.

The St Mungo outreach service provided primary care to people on the streets of Soho between the hours of 6 p.m. and 9 p.m. on Tuesday nights. It was estimated in 1995 that the team saw approximately 30 people each month. The characteristics of the people using the service, who were mainly people who were sleeping rough, were similar to those homeless people using Great Chapel Street and St Martin's-in-the-Field. The team was managed by Parkside Health Trust and funded by Brent and Harrow Health Authority.

The Primary Care for Homeless People Team (PCHP) was based in Camden and Islington. The team included two clinical nurse specialists, a health advocate and a GP facilitator, who in 1993 arranged clinical sessions for homeless people with 12 local GPs from nine different practices. Chiropody, counselling, and dental and optical services were also arranged at a variety of venues in the area. The venues visited included the Arlington day centre, the Parker Street drop-in medical centre, Alone in London and the New Horizons project. Consultations with the team and the services that it arranged had increased steadily between 1987, when it was established (576 people, 2,022 consultations), and 1993 (1,586 people, 5,184 consultations). Again, most of the homeless people who were seen were single, white and male. Most of the users of the service in 1993 were staying in short- or long-stay hostel accommodation, and only a minority were people who were sleeping rough (15 per cent) or people who were squatting (2 per cent). The project was funded by Camden and Islington FHSA (Primary Care for Homeless People, Annual Report, 1994).

Thames Reach was initially established to provide services to people who were sleeping rough, but had increasingly moved towards the provision of specialist services for people with a mental health problem who were sleeping rough. The outreach team provided street services on four evenings a week and consisted of seven workers and a team leader. The team helped people with a mental health problem get off the streets, register for benefits, and provided counselling and emotional support and other services. Between April 1993 and March 1994, the outreach team contacted 2,188 homeless people, the majority of whom were white, in early middle age and male. In addition, Thames Reach provided accommodation (for 124 people between April and March 1994) in a number of hostels. Thames Reach worked in close association with the Mental Health Team that was funded by the HMII for Lambeth, Lewisham and Southwark. The Thames Reach organisation itself was funded by the London Boroughs Grants Committee, the Department of the Environment (under RSI-1 and RSI-2) and the Department of Health (under HMII). Approximately 100 charitable organisations and companies supported the project between 1984 and 1994 (Thames Reach, Annual Report, 1994).

In addition to these services, there was the Three Boroughs Primary Care Team, based in Lambeth, Southwark and Lewisham, which was funded by the local health commission. Detailed information on the team's activities was not available, but data on the types of services it provided were available, through the annual report of one of the venues it visited. The venue, the St Giles Trust Day Centre in Southwark, provided a range of support services for single homeless people and other vulnerable people at its day centre. This included facilities such as a laundry, showers and an activity room, alongside resettlement work. St Giles Trust had a health centre, which worked using services from the Three Boroughs Primary Care Team and the local Mental Health Team. The service provided a mental health social worker, dentist, community psychiatric nurse (CPN), optician, district nurse, chiropodist and massage on different days of the week. High prevalences of mental health problems, HIV, TB and Hepatitis C were reported among patients during 1994. There were 997 consultations between April and December 1994, the main reasons being: dental (55 per cent); nursing treatments (12 per cent); using an optician's services (12 per cent); mental health problems (10 per cent); and chiropody treatments (10 per cent). Again, patients were disproportionately male (80 per cent) and middle-aged (St Giles Trust, Annual Report, 1994). In addition to the services it provided at the St Giles Trust Day Centre, the Three Boroughs Primary Care Team also visited 26 other sites.

Mixed services

Some services that work with homeless people provided a mixture of outreach and fixed-site provision. Two organisations used outreach services to locate and assist individuals, and sometimes referred them to residential care or supported housing that they operated.

Tulip provided services to people with mental health problems in Haringey and had a specific focus on 'hard to reach' people (which included homeless people) and people from ethnic minorities. There was an outreach service for people with a mental health problem, and four projects that provided a mixture of accommodation and support services for people with a mental health problem. Separate data on the number of users of the service who were homeless were not available, although Tulip reported a particular concern about the numbers of people in short-term accommodation with a mental health problem. The project's income came mainly from the Haringey Health Authority Homeless Placement Scheme in 1994, with additional funds coming from the New River Health Authority and charges to residents of its accommodation and other housing management-related income.

Like Tulip, the Rugby House Project, which worked in central London, had a wider remit than homelessness, but because of its focus on alcohol dependency it had contact with a large number of single homeless people. The services provided included the Crisis Centre and four houses that provided support and accommodation to people coming off alcohol. Their mobile alcohol service included a Black Outreach service (for Black people), services for women, services for people with a mental health problem and services for homeless people. Between January 1993 and June 1994, the mobile service contacted 231 people, of whom 135 (58 per cent) had no fixed abode, 35 (15 per cent) were squatting and 87 (38 per cent) were in hostels. The project was supported by grants, donations and other fund raising.

Other arrangements for the delivery of primary care

Some services for homeless people arranged medical care with local health services without using the specialist homelessness provision in London. Formal arrangements might be made with local mainstream NHS services, or individuals within the NHS might be more flexible than others with regard to homeless people and take the initiative in providing services to homeless people on an informal basis.

An example of this was the London Connection, a day centre for young homeless people that provided a range of support, training and other services. In addition to its other services, it also had GPs who visited the centre on Tuesdays and Thursdays and a range of other visiting health services. Due to its specific focus, the age of most of the people using its medical facilities was under 25, although it was similar to the other special projects in that most of the homeless people using it were white and male. Another important difference was that, while the tendency of the people using it to drink was less than that of the people visiting other specialist services, a high number used drugs. Condoms were freely distributed on site and the London Connection made an effort to ensure that sex education was available to the young people who used its services, as disproportionate numbers of young men (particularly) and women were sex workers. There were approximately 800 consultations a year (Parkside Health Trust). The London Connection received contributions from the Department of the Environment, Department for Employment and Education, the European Social Fund, the London Boroughs of Camden and Westminster, Riverside Health Authority, Westminster Drug and Alcohol Advisory Council and over 100 other different charities, private companies and statutory bodies. The visiting GPs were funded by the local FHSA (Kensington, Chelsea and Westminster).

Some charities, such as CRISIS,[4] also made similar arrangements to the London Connection. As an extension of the 'Open Christmas' programme, which provides shelters for people who are sleeping rough on a very temporary basis over Christmas in London, CRISIS arranged chiropody and dental services with local health services, on a semi-formal basis.

Another, more informal, example was a local GP who was interviewed as part of the Review and who had, largely through his own initiative, begun providing outreach medical services to a large group of homeless asylum seekers living in a hostel within his practice's patch. There was also anecdotal evidence of GPs who were sympathetic to the needs of homeless people and also of other health professionals who had sufficient control over their time and their referral and registration systems to allow access to homeless people. The possible scale of individual initiative among GPs and others that facilitated homeless people's access to the mainstream health service was unknown, but some other research has also suggested that it happens. For example, Hinton (1992) found GP surgeries that were prepared to register permanently single homeless people without an address, sometimes using the practice itself as an address, amongst a majority that refused registration. These arrangements were very much down to individuals and were all but impossible to map, since it would be necessary to examine every individual health service in London to get a true picture of their extent. Generally, however, it should be noted that as demands on the NHS continue to increase in relation to resources, the flexibility within the system that allows these more informal arrangements is likely to decline.

The funding of health services for homeless people

Within the health service, two sources of limited-term finance were significant. The first of these was the five-year developed plan for the London Initiative Zone (LIZ), the Government's response to the Tomlinson Enquiry in London, which reported problems in relation to both primary and secondary (acute) care in certain sections of the capital. Croydon FHSA had, for example, built its proposed services for homeless people into a bid for LIZ finance that was submitted for 1993/94 and 1994/95.

The second source of additional finance was usually referred to as 'Section 56 finance'. The 1977 NHS Act (Section 56) gave the Department of Health the power to fund special schemes to address the needs of single homeless people (who are non-statutorily homeless), with the

4. A charity that provides grants and arranges welfare and support services for single homeless people on a national basis.

money being controlled by FHSAs. The cash-limited part of Section 56 funding, a section of the budget the Department of Health provides that is being run down, accounted for just over two-thirds of the total available finance in 1994/95 and just over half in 1995/96. Contributions from the Department of Health ceased in March 1996 and schemes that were dependent on this element of the finance will no longer be supported unless they can find an alternative source. One part of the Section 56 finance, covering mainly payments to GPs for providing primary health care to single homeless people, was at the time of writing set to continue. In London, schemes covering Camden and Islington, the City and East London, Cricklewood, Ealing, Hammersmith and Fulham, Kensington and Chelsea, Lambeth, Southwark, Lewisham and Westminster used Section 56 finance. Recent research found that most schemes funded under Section 56 were generally viewed as more successful in providing good quality services to homeless people than in integrating homeless people into mainstream services (Department of Health, 1995).

Acute services

Among the organisations that participated in the research there was no evidence of any large-scale projects designed to make the use of A&E or other hospital services easier for homeless people. There was evidence of good coordination between hospital-based specialists providing outpatient and inpatient services, A&E departments, services such as sexually transmitted disease (STD) and HIV testing, and other hospital-based services and some specialist health services such as Great Chapel Street and the Cardinal Hume Medical Centre. Relations between the HMII teams and mainstream mental health services (including hospitals) were also reported as good in the recent research into the effectiveness of HMII (The Mental Health Foundation, 1995).

One health authority that participated in the research, East London and the City, had recently researched the use of A&E with the use of HMII funds, but the other health commissions and DHAs that took part in the Review did not seem to be undertaking similar work.

There was some evidence of special provision for homeless people at the level of individual hospitals, such as the provision of two homeless workers in the A&E department at University College Hospital (UCH). These workers would seek to arrange access to housing, voluntary and social services for homeless people so that they could be discharged into an appropriate environment. Unfortunately, the timescale and resources for the research meant that only a few hospitals were contacted during the course of the research, so it was not possible to

determine the extent to which UCH, which is near to a large concentration of homeless people, was representative of other hospitals.

Community care and homelessness

Homelessness is a multidimensional problem. People who are homeless may have several different forms of need that require services to be provided by several different agencies. For example, a single homeless person with a mental health problem will require services from the NHS and from a housing agency simultaneously if he or she is going to be able to recover, or at least manage the problem. Providing housing for such a person will not address their medical need, and providing a mental health service will not address their homelessness, which is in itself more or less prohibiting any chance of recovery from their mental health problem.

Community care, as introduced by the Government in April 1993, represents the most fundamental alteration to the structure of the welfare state since the Beveridge Report. Community care is designed to introduce elements of personal choice for people using welfare provision and, fundamentally, is designed to promote *joint assessment*. Joint assessment should mean that all an individual's needs are assessed and that appropriate services are involved from the outset in meeting his or her needs as part of a *multi-agency response*. In other words, community care is designed to mean that someone's health, housing and other support needs are jointly assessed and jointly met by a combination of the appropriate agencies.

The implications of joint assessment, a multi-agency response and the joint planning between agencies that is necessary, is obvious with regard to homeless people. Research clearly demonstrates a multi-agency response is often *essential* in addressing homeless people's needs; their health problems cannot be dealt with properly unless they are adequately housed, and rehousing may not work unless health and other support needs are met, so they can cope with living independently (Dant and Deacon, 1989; Vincent *et al.*, 1993; Pleace, 1995).

Since community care should in theory involve the main agencies that exist to meet the various needs of homeless families and single homeless people in London – social services, housing associations, housing departments, the NHS and the voluntary sector – it can in theory provide the joint response that is necessary to meet the needs of many homeless people, and put an end to their homelessness and the health problems that accompany it.

To take a theoretical example of joint assessment, several things should happen if a homeless family containing a woman escaping violence and two children with respiratory and behavioural problems approaches the local housing department. First, since the household qualifies under the current homelessness legislation, it should be rehoused by the housing department. Second, as part of the joint assessment process, the housing department should either have social services involvement built into the homelessness assessment procedures or have a rapid referral system, so that a community care assessor or care manager can arrange appropriate services, such as those from voluntary sector support organisations for the woman who has experienced violence. In addition, social services or the housing department should ensure the involvement of NHS services, perhaps arranging registration with a GP, who can then treat the health problems of the children, help the woman with the stress she is likely to be experiencing, and arrange secondary care if necessary. In an ideal situation, appropriate educational services would also be arranged to help with the children's behavioural problems.

The problem of relatively poor access to NHS services and the problem of health status deteriorating because of the risk factors associated with homelessness can therefore, theoretically, be addressed simultaneously under joint assessment. One of the major causes of poor access to health, the lack of a permanent address, is overcome by the provision of housing, treatment then follows from health services, social support is provided if necessary, and the long-term risks to health status associated with homelessness are ended.

The reality of community care has, to date, generally fallen quite a long way short of joint assessment, with problems of communication and coordination between health, social services and the voluntary sector being particularly prominent when the system began operation. In particular, little or no involvement from housing agencies was found in the planning for community care, nor in assessment procedures, nor in the day-to-day operation of services (Arnold *et al.*, 1993). The reality of operation on the ground is sometimes still best described as uncoordinated, with cooperation between housing, health and social services in the field of single homelessness remaining poor, or sometimes non-existent (Pleace, 1995). However, in recent months there has been increasing evidence of progress in joint planning, though the extent to which this has fed through into service delivery and the development of joint assessments is less certain.

Community care planning, joint working and homelessness in London in 1995

The social services departments of the London boroughs are the agencies that have the lead responsibility for community care planning in London, each being responsible for planning in

its own area. Several of the boroughs that participated in the Review identified a number of joint housing, health and social services projects for single homeless people and homeless families that were either operating in their areas, or that were planned for the near future.

In Kensington, Chelsea and Westminster, the health commissioning agency was in the process of developing a Homeless Strategy in association with the housing, social services and education departments of the two boroughs in its area. A report had been produced in July 1995 into the large homeless population in bed and breakfast hotels in Earl's Court which generated a series of recommendations for housing, social services and health, and which also noted a number of cross-agency issues. The recommendations were designed to ensure that each agency participated in a multi-agency response to the needs of homeless people. An allowance for the housing needs of homeless people with health problems, such as people with a mental health problem, was also built into the strategy for housing people with special needs produced by the Kensington and Chelsea housing department and the community care plan for the borough.

Lambeth, in its 1995/98 community care plan, stated that arrangements for joint working between housing and social services had been established since 1993. Support services, involving social services, were also to be developed to meet the needs of tenants with mental health problems. A joint strategy between housing, health and social services was also being developed for the anticipated redevelopment of the Bullring near Waterloo (a place used by many people who are sleeping rough). A series of other initiatives was also taking place; in particular, finance had recently been secured to fund an officer at the A&E department in St Thomas's Hospital to address health and homelessness issues for outpatients. Housing Services also produced a poster and a guide to community care services for single homeless people in five languages.

In Barnet, a specialist health visitor had been operating with homeless people, funded by the health authority for two years. This member of staff had liaison with seven housing departments (since homeless people from other boroughs are often placed in Barnet), and made sure that homeless people stayed in contact with health and social services during the time that they were in the borough. There was also liaison with the voluntary sector. In addition to this, the 1995/96 community care plan described the anticipated development of a day centre for single homeless people; refurbishment of council accommodation (specifically play areas for children); planned research into developing suitable supported accommodation for homeless people with a mental health problem; a service review; and a needs assessment of

up to 600 of the 1,400 homeless households in the borough. Work in services for women escaping violence was also anticipated, which is unusual in community care planning, since only local authority housing departments have any statutory duty towards this group.

Within Tower Hamlets, specific research had been commissioned by the FHSA into the health and resettlement[5] needs of homeless families under the Health for Rehoused Families Project, which included many people from ethnic minorities. This research, conducted between 1991 and 1994, called for greater involvement of GPs in resettlement, greater sensitivity to the language needs of many of Tower Hamlets' homeless people, and the incorporation of the needs of homeless families into health commissioning strategies.

In Camden, the housing strategy statement mentioned several initiatives with which the housing department was involved, such as fast-track assessments for people with alcohol dependencies, local HMII outreach and associated hostel services. The community care plan for the borough also discussed the needs of homeless people with a mental health problem and refugees. The housing service also had specialist 'advocacy' workers who tried to arrange access to support and health services for vulnerable homeless people accepted under the 1985 Housing Act for rehousing, and a specialist service for tenants with a mental health problem.

In Southwark, the housing department was in the process of establishing a health and housing advisor post within the housing department. A housing, homelessness and community care group was established in 1993 which provided a focus for community care planning in this area. The needs of groups of homeless people, such as young people, were discussed alongside the needs of other tenants and potential tenants who required community care services.

Barking and Dagenham also included homelessness in the five-year health strategy for the borough produced in 1995. The borough had adopted the policy of not placing any homeless people in bed and breakfast accommodation, although problems with access still remained for the homeless people placed in B&Bs in the borough by other authorities. Agreements were being sought with the boroughs that were placing people in B&Bs in Barking and Dagenham, so that the health services could be made aware of their numbers and characteristics, and adapt services accordingly.

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5. 'Resettlement' is a short-hand term used to describe the rehousing process for homeless people. As well as the provision of a house, it also generally refers to any support services that a homeless person or family will need in order to live as independently as possible in their new home.

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Hammersmith and Fulham housing services had recently submitted a bid for a 'One Stop Homelessness Project' that would develop a multi-agency response to the needs of homeless people, involving housing associations, housing services and health services. Planning by housing services for 1995/96 had also considered the needs of homeless people with a mental health problem under the role of housing in community care. An extensive review of the housing needs of people with HIV in the borough was also carried out in 1994.

In Croydon, the health commissioning agency had established two 'think tanks' on housing and health, which included representatives from housing and social services and considered the needs of Croydon's homeless population. There was also housing involvement in the health promotion policy for the area. The 'Homelessness Forum' established in Croydon in 1992 included representatives from primary and secondary care sections of the NHS, social services, community development and housing. In the published housing strategy covering 1995/96 for Croydon, the housing needs of homeless people were considered alongside the needs of other groups that were likely to require community care services.

Sutton's publicly available plans for social housing in 1995 included the provision of housing services for single homeless people and other groups of homeless people, such as women escaping violence, in terms of the wider strategy for the housing department's involvement in community care.

In some cases, the level of joint planning between housing, health and social services with regard to homelessness seemed to be quite limited. The City of London Corporation, Harrow, Wandsworth, Bexley and Greenwich were examples of where there was a low level of planning. In three of these authorities, publicly available strategy documents discussed homelessness in isolation from community care planning, and in the other two, no specific mention of joint working between housing, health and social services was found.

Funding community care services for homeless people

The funding of mainstream services for homeless people comes from various sources. To a considerable extent, relatively small amounts of the public money controlled by social services, health commissions and housing departments are used to extend or invest in service provision. It is quite common, as in the case of the proposed development of the 'One Stop Homelessness Project' in Hammersmith, for all the agencies involved in a policy response to the needs of homeless people to contribute something towards it. Other initiatives, such as the provision of certain adaptations to existing health services, or the research commissioned into the health

care needs of homeless people, will be solely funded by one agency. Health commissions or their component FHSAs and DHAs are more likely than social services or housing to fund projects without the assistance of other agencies.

Summary

There was a diversity of health service provision targeted towards homeless people in London. Initiatives appeared to be focused on improving access to primary care by the use of advocates and link workers to help homeless people get into contact with mainstream health services and, more significantly, on special provision. Special provision for homeless people was often a mixture of health and other support services, often combining primary health care with community mental health services. Two mechanisms, fixed-site provision and the use of travelling outreach teams, were used for delivering these services. Relatively little work appeared to be happening with regard to homeless people's use of A&E and inpatient services. Many of the boroughs and health service funders and providers were working on the provision of community care services for homeless people, although the developments were often small in scale.

Chapter 5

Health services for homeless people: the views of professionals and homeless people

Introduction

This chapter presents the views of professionals, and the perspective of homeless people, on the delivery of health care services to homeless people in London. The discussion draws on the interviews conducted specifically for the Review, consisting of 36 interviews with professionals (providers of health care, funders of services and policy specialists), and five group discussions with homeless people.

The chapter begins by outlining the views of professionals on the provision of mainstream and specialist services for homeless people, with particular reference to primary health care. Subsequent sections examine access to acute care, the need for mental health and alcohol services for homeless people, and the delivery of health services to people from ethnic minorities. The views of professionals on communication between health services and coordination under community care are then reported. Finally, the chapter presents the perspectives of homeless people on the best way to deliver health care.

Improving access to mainstream primary health care services

Professionals commented that improving access to mainstream services was an enormously complicated process, which needed to be tackled from a number of different approaches.

Unsurprisingly, professionals stated that the process of registration with a doctor still required attention. It was felt that GPs and practice staff needed to be more closely instructed on how homeless people could be registered, as there appeared to be confusion around the process of registering. However, it was strongly felt that registration was not enough in itself. There was a clear need for a broad education of GPs on the issue of homelessness, which it was hoped would both increase their willingness to register homeless people and crucially ensure that a good service was available to homeless people once they were registered:

GPs need to have a level of knowledge and understanding about homelessness before they can really do any good ... I think that if homeless people don't get a good GP, but are registered, they become more marginalised because they don't get linked into services.

(Coordinator, outreach team)

A number of methods were discussed and recommended by professionals to better inform GP and other primary care staff about homelessness. First, interviewees stated that it was necessary for agencies to engage GPs and other staff in the issue. One provider in the study was doing this through facilitating meetings where GPs' own needs and concerns on homelessness could be discussed. Many felt that specialist workers were required to train GPs and coordinate this process. A number of professionals stated that the production of written material for GPs could be useful, but stressed that information needed to be developed in consultation with GPs to ensure it addressed their concerns. Information on homelessness and related agencies in the area could be particularly helpful in enabling GPs to feel more confident in referring people on to other health and homelessness services.

It was felt that training of GPs would also encourage practices to consider restructuring the way they delivered their services to make them more accessible to homeless people. For instance, one problem outlined in Chapter 3 was the difficulty that some homeless people have in keeping appointments. A number of professionals suggested that GP practices should operate an open access policy at times throughout the week, and indeed felt it would represent good practice in providing flexible services to the general population.

There was a concern that a financial disincentive did exist for GPs to register homeless people. A number of professionals suggested that practices taking on significant numbers of homeless people or other groups of people who may need greater health care treatment should receive an extra staffing allowance. Alternatively, or additionally, it may be necessary for the health agency to fund workers that could support GP practices in their work, for example link workers or health advocates that could, for instance, accompany homeless people to hospital.

From a wider health agency perspective, a couple of health agencies included in the interviews were developing specific service specifications whereby providers would need to ensure that health services being delivered were accessible to homeless people. The specifications stated the need for open access appointments and other flexible methods of working. However, the

process of implementing a service specification was described as a very difficult one, and it was necessary to explain and negotiate with providers to arrive at a workable tool. None the less, the health agencies felt that it was an important process to undergo as it constituted a much broader approach to improving access for homeless people than isolated projects did:

> *... but wouldn't want to give the impression that just because we have a service specification that everything is hunky dory ... but got to take a comprehensive overview which I think is vital – not to get sucked into projects.*
>
> *(Assistant director, health agency)*

Whilst the professionals interviewed concentrated on the issue of changing the way health services were delivered to homeless people, a number of people also stated that it was necessary to educate homeless people themselves. As it has already been reported, health care issues can be a low priority for homeless people:

> *It is also about looking at the hierarchy of needs homeless people have, health care is not the immediate thing, there are a lot of practical issues around that: something to eat, a place to sleep, a change of clothes, to wash, that's immediate and priority in terms of the hierarchy of need – health care comes way down the list.*
>
> *(Development manager, health agency)*

It was thought that homeless people's knowledge about health issues and their rights to health care was quite poor. Despite this, it was considered that health education had been more or less completely ignored with respect to this client group. Whilst one person questioned whether it was appropriate to address health education when people clearly needed their wider circumstances being improved, others did feel that it would be beneficial to provide more access to health information. However, a few people suggested that existing health promotional material was inappropriate for use with homeless people, and new material needed to be developed. The production of information leaflets and the targeting of these also required consideration. One provider pointed out that some people would have difficulties with reading and this needed to be borne in mind when designing health promotional material.

A number of representatives from health agencies who were interviewed outlined how the health service could overall work to improve access for homeless people:

Although the health service cannot solve homelessness, as you know there are set things that we can do to get our own house in order, even if it is putting sticking plasters on, so we have a package ...

(Assistant director, health agency)

As described earlier, a number of health agencies had made a start in addressing access for homeless people, and in a few cases had a number of initiatives, including training of GPs, the development of a service specification and also the funding of specialist services.

Providing specialist health services for homeless people

The professionals interviewed for the Review described the role that specialist health services presently played in providing health care to homeless people. Many of the advantages associated with specialist provision were clearly aspects of provision that mainstream services had traditionally been unable to provide. Following an examination of the views of professionals with regard to specialist services, this section goes on to debate the relative value of the different ways of delivering health care services to homeless people.

Specialist services were seen to be able to offer a broader service to homeless people than mainstream provision. Individual staff, for example nurses based in hostels and day centres, were often able to provide a wider role than they would traditionally have done in GP practices. One day centre nurse described how a large part of her job was identifying people who were in priority need for housing and supporting their application to the local authority. Even specialist GPs were able to refer people on to specialist homelessness agencies as well as health services. Additionally, specialist services were often located in day centres and hostels, which enabled people to access a whole range of services under one roof. As one professional explained:

Why just come to the [mainstream medical] *centre where you see just a nurse, when you can go to the* [day centre] *and you can see a nurse, see a doctor, sort out your feet, get your lunch, get a bit of advice about benefits, get some advocacy on the criminal justice system, when there is a whole host of things that you can access somewhere else ...*

(Manager, community health care trust)

Professionals generally felt that specialist services were able to operate in a more flexible manner, successfully operating open access surgeries. In the knowledge that some homeless people may not return on a second occasion, it was thought that consultations were more likely to treat and follow through a health problem in the one session. This point was particularly made with reference to specialist dentists:

If they went along to a dentist that wasn't our dentist they would get a ten-minute appointment, and then they would have to go back and have another follow-up appointment, whereas with the dentist we employ she would do everything there and then ... because there is no certainty that they are going to come back, and you can't send somebody off, I mean it has been tried before, with a half-finished job, where you expect them to come back, because they may not, and too often people are found with their jaw wired up with the gums growing over it and horrible things like that.

(Team manager, specialist outreach team)

As well as responding more quickly to a problem, it was also stated that specialist services could allow more time to encourage a person to take up treatment in the first place. This time factor was particularly important when trying to reach homeless people who were disengaged from mainstream services. Professionals working with people with mental health problems felt this was a very important issue, as it could take many months before someone was actually able to access a service properly.

Sometimes the time between the first meeting and getting them to a service is months and months, and it is quite often unsuccessful, just because they're so transient and so disconnected that they're always moving.

(Mental health worker, day centre)

A few professionals postulated that specialist services were actually preferred by homeless people, certainly as compared to mainstream services as operated at that time:

I do happen to believe that if homeless people were given specific services they would use them more readily than being encouraged to try and get access to mainstream health services, and I have changed my mind over this over the years. I think that,

generally speaking, specific predesignated services developed in favour of homeless people are probably likely to be more effective.

(Director, voluntary provider and funder)

Access to specialist services

Some interviewees stated that there were problems with ensuring access to specialist services. Providers of such services realised that they were not always reaching all homeless people, and were particularly concerned that young people, women and people from ethnic minority groups were not always using the services:

We also have a problem in getting young people to go to —. It tends to be predominantly an older client group [there], *and older and younger homeless people don't tend to mix that well.*

(Director, day centre)

As one interviewee commented, homeless people were not a homogeneous group, and careful consideration needed to be given to equal opportunity policies. Outreach workers said that they were increasingly seeing young people, women and sometimes people from ethnic minorities, but that much more proactive work was necessary to make the services more accessible to these groups. Agencies felt that it would be easier to target women and young people than people from ethnic minorities. They also stated that there were cost implications of better targeting services, as staff had to undertake development work with new agencies which might mean that their caseload went down. One day centre worker also described how the building could also dissuade some people from using services, both because of poor physical access and an intimidating atmosphere created by a group of homeless men sitting outside the door.

Although specialist services were able to run sessions without appointments, a disadvantage of some services was the fact that sessions could only be provided on a few days a week, for instance people may have to wait a number of days to see a doctor at a day centre.

It was acknowledged that specialist services were likely to be more expensive than mainstream services, although some economies were present when specialist services were delivered on fixed-site premises:

Certainly in the inner city because of a chronic underfunding ... there is always a desire to cut back on specialist-type services, which are expensive, and get the good old GPs to do everything as cheaply as possible – that is slightly cynical, but I think cost does come into it.

(GP and policy specialist)

Specialist versus mainstream services

Most professionals felt that in practice both mainstream and specialist services were required to meet the needs of homeless people. A majority felt that for as long as there was homelessness, specialist services would be required in some shape or form to ensure that adequate health care was delivered to homeless people. Whilst the ideal was seen as the use of mainstream services by everyone, this was matched by the aim of eradicating homelessness. However, it was felt that whilst homelessness existed, and everyone agreed that it was unfortunately not going to be solved in the foreseeable future, some specialist services would be necessary:

The notion that we may do ourselves out of a job is not real, but on the other hand we wouldn't want to build our empire so that clients were never reintegrated into mainstream services.

(Team manager, specialist outreach team)

Many of the outreach team and providers had dual aims: to provide specialist services, whilst also working towards improving access to mainstream services for homeless people. Overall, agencies were able to reconcile these two aims, seeing them as complementary parts of a service to improve health care for homeless people.

Only a few people appeared to be more in favour of either specialist or mainstream services:

I do not think it is ghettoisation of services, I think you provide better services to people who are actually in the greatest need. I am all in favour of specialist clinics.

(GP, running specialist hotel clinic)

Absolutely mainstream services – it sends all the wrong messages if you have to make special provision for people whose only real difference may be that they do not have a permanent home.

(Director, large funding body)

However, most people firmly considered that both specialist and mainstream services had to be provided to homeless people:

I personally think that you have to have a mixed economy in most things, that, yes, the aim would be to take advantage of the mainstream services offered, but you will always need some specialist outreach services, but maintaining the right balance between the two is something you have to constantly negotiate and evaluate ... some sort of a mixture, a balance between the two, is always going to be needed, as long as you have people who have chronic mental conditions, who are abusing substances, and who are on the streets, then there is going to need to be some sort of service to reach out to them.

(GP and policy specialist)

You need both as there are some people who will never, ever access mainstream services. Obviously our aim is to encourage people to access mainstream services; they should have the same opportunities that you and I have, but there are some people who will never be able to access mainstream services.

(Senior manager, FHSA)

There is no point in expecting very generalist services to adapt in such a specialist way to meet the needs of a relatively small group of people. I think at the outset when people are homeless and on the streets they need specialist services, but part of that specialist role is then to help them to access long term the generalist services.

(Director, voluntary funding organisation)

There was a concern that for mainstream services really to be accessible to homeless people a lot of work and investment was required to ensure that people were receiving a fair and equal

service. Specialist services were important as a back-up service, and as an access point for people so they could move on to use mainstream services effectively. The key point at the end of the day was, as one interviewee stated, that health services were actually available to homeless people, and whichever method was most effective should be employed.

Acute services: A&E and inpatient care

The main recommendation that the professionals interviewed consistently mentioned with respect to acute services was the need for specialist workers to be attached to hospitals. It was felt that such workers, both within A&E departments and inpatient hospital services, would be able to plug people into other services that they might need, which the normal staff simply did not have the time or resources to address. Specialist homelessness workers could also perform a vital training function, raising the awareness of hospital staff around the issue of homelessness:

> *Without the intervention of a homeless persons' worker, relationships and inter-agency working involving A&E are poor to bad and that may be for a variety of reasons. A&E departments on the whole are rushed off their feet most of the time and so there is only a limited amount of time for the staff there, who are clinical staff by and large, to make the telephone calls to have a conversation about, 'Well, what does Mr A. really need and what happened to him last time and what have we already tried?', and the people on the other end of the phone are equally busy, I mean getting through to the local housing department or whatever, is very difficult.*
>
> *(Director, A&E Department)*

Development work was thought to be particularly needed in discharge procedures for homeless people. A discharge worker would be able to identify homeless people staying in hospital early on, and start planning their discharge. The discharge worker would not work alone; rather he or she could pass people on to hospital social workers, or other services, as appropriate. A number of professionals interviewed commented that there was a need for a specific discharge policy for homeless people, which would need to be developed with involvement by all hospital personnel.

A few people interviewed also questioned whether there should be somewhere where homeless people could be discharged to for convalescence rather than return to often inappropriate temporary accommodation:

It would be nice if there was some sort of convalescence place that someone could go to, so they didn't go straight from being very well cared for in hospital, to being dumped in a shelter.

(Health care coordinator, hostel)

Other key health services for homeless people

Mental health services

As described in Chapter 2, the incidence of mental health problems amongst homeless people, particularly those sleeping rough, was very considerable at the time of the Review.

Most professionals considered that mental health had been recognised as a major problem, chiefly through the Homeless Mentally Ill Initiative (HMII), and felt that mental health needed to remain a key priority for health care for homeless people.

Some professionals suggested that mental health workers, both on an outreach and fixed-site basis, were still required in some areas. CRISIS had recently identified the employment of outreach mental health workers as one of its focus areas of work.

As mentioned previously, a number of professionals felt that the mental health of young people needed more attention. In particular the researchers were informed that a proposal by the Joint Homelessness Team was being submitted to health purchasers to employ a development worker to look at how to deliver mental health services to young people. It should also be noted that Professor Tom Craig, who evaluated the HMII, was at the time of the Review undertaking a study on mental health and young people in the West End.

Finally, a number of people commented that appropriate supported accommodation for people with mental health services was in very poor supply. It was recognised that the HMII had not produced as much housing as had been first hoped. It was felt that the development of good quality housing to meet the needs of people with mental health problems was a priority area.

Alcohol and drug services

Alcohol services, and to a lesser extent drug services, were stated by many of those interviewed to be areas that required urgent consideration.

First, there was considered to be a need for more detoxification facilities, both generally and units that specifically targeted their services at homeless people. Specialist provision was suggested on the basis that many homeless people may have other problems, along with the alcohol misuse. The difficulty in gaining funding for beds from social services also needed to be addressed. Finally, a number of people were concerned at what they saw as the often judgemental attitude in the policies of much existing provision, such that people would not be allowed to use the services more than a couple of times. The issue of how most effectively to address people's alcohol problems also needed to be considered:

> *Policy makers and the voluntary sector need to make up their mind about the consequences of providing such services. What I mean by this, I think there is a fear amongst some policy makers and funders that if you provide more detoxification services for homeless people, is all that you will end up doing is drying them out so that they can drink more effectively ... It is time for a rethink about appropriate services and how success can be measured amongst people who are drinking heavily. And I think that has to be done with a fair amount of confidence, i.e. we are not going to make this problem worse, we are going to improve it, you should get off the fence and address it head on.*
>
> *(Director, voluntary provider and funder)*

Second, a number of professionals working with homeless people felt that more 'wet' hostels needed to be provided, where people could drink on the premises. Such provision would, it was hoped, enable more opportunities for rehabilitation, as well as provide shelter for people who otherwise might sleep out. Some research had already recommended that more 'wet' and 'damp' hostels for homeless people be provided (Ham and Carter, 1996). Some developments in 'wet' provision had taken place over the last few years, for example the Rough Sleepers' Initiative (Phase 2) included the development of three schemes, with the Department of the Environment providing some of the capital for the housing costs. However, one provider interviewed for the Review had been trying to get a wet hostel funded for years, but so few schemes were being approved that even though the scheme was prioritised and had social services support, they had not managed to secure funding.

Finally, with respect to alcohol services, there was felt to be a need for more counselling services, to allow work to be done around building up homeless people's confidence to address their alcohol problems, whether this be to come off alcohol or manage their alcohol

consumption more satisfactorily. It was suggested that often such support needed to be over a long period of time, rather than for a programme of a specified number of sessions.

As mentioned above, drug services were less discussed by interviewees. However, it was thought to be a continuing problem, and one which required constant re-examination. One professional suggested that GPs were needed who would be prepared to look after drug users. One FHSA included in the interviews had already addressed this issue by giving an incentive to GPs to carry out this kind of work:

> *We are working with GPs generally – we have a scheme whereby if you have so many methadone patients we will give you an incentive, because drug use is such a problem, and drug users do find it very difficult to get a GP.*
>
> *(Senior manager, FHSA)*

Ethnic minorities and refugees

A number of recommendations were outlined by interviewees to improve the access to health services for ethnic minorities, and particularly refugees.

It was thought that, after years of battling, some refugee communities, the larger and better established ones, had managed to develop reasonable links with health services. However, many issues remained salient and in need of addressing. The main problem identified in Chapter 3 of difficulties around language and interpretation facilities was still an area of concern.

A few people suggested that there was a need for employing more ethnic health workers, particularly in areas where large numbers of refugees were living. Although it was warned that this needed to be done sensitively, as it could not be presumed by appointing a worker from a particular refugee community that he or she would be able to meet the needs of that community, appointments needed to be done with a very good understanding of the political situation that refugees have flown from. It was also felt that there continued to be a need for information and development work to ensure that refugees were aware of their rights, and that refugee support groups, which could play a key role in empowering their communities that support refugees, should be given enough guidance and support.

Overall, it was recognised that the issue of health care for refugees was a very important area, but the precise way of tackling the issue was to some extent unknown:

> *With the refugee communities, everyone is aware that something is needed, but I'm not quite sure what.*
>
> *(Director, advice agency)*

Finally, two other recommendations were made to improve particular services. First, it was asserted that services for refugee women and women from ethnic minorities were important, particularly the provision of well-women clinics that understood the problems of refugees. Second, the specific needs of people suffering from sickle cell anaemia should not be ignored:

> *I think a lot of the other illnesses that are common to all communities, there is discussion, there is research, there is some debate about which services should be provided, there is very little discussion or acknowledgement about people with sickle cell, and I would very much like that to be part of the agenda when looking at what services are needed and what projects should be developed for homeless people.*
>
> *(Director, advice agency)*

Funding issues

A number of charitable funders of homelessness and other voluntary agencies were interviewed as well as statutory health and local authority funders. They were all asked about how they decided upon their funding strategy.

The process by which charitable funders arrived at their funding priorities was unique to each organisation, but they all tended to follow the same pattern of identifying a small number of priority areas for a specified period of years. The areas were usually decided by a committee of trustees, who identified current social problems. One charitable funder set its priorities by reference to research where possible. One trust explained how it decided which projects to fund:

> *Grantmaking is not a science ... we ask is there a clear need, who else is funding it, do we think there is enough statutory involvement ...?*
>
> *(Director, small trust)*

Generally, funders wished to ensure that the agencies they were funding were viable projects, and were concerned that they did not fund areas where there was a statutory responsibility:

We will not fund something that somebody else ought to be.

(Director, large funding body)

Most funders felt that they had allotted homelessness a sufficient level of funding priority, alongside other areas of need. Health was often only one aspect of their homelessness funding strategy.

Funders of the voluntary sector stated that they had quite a lot of contact with other similar funders, usually on an informal basis. However, as the quote below shows, there was little overall coordination between funders:

It is not a coordinated liaison – we do not sit down and look at all of our programmes, you won't get charitable trusts ever to do that, it's not the way they work – but there is an exchange of views in a general way, we talk to each other about specific projects when it is needed; there is, though, the Association of Charitable Foundations.

(Director, large funding body)

Generally, the representatives interviewed from health agencies considered that their organisation was placing quite a high priority on homelessness and health. Certainly, they were all funding some initiatives, and were all concerned to improve access to mainstream provision, but were also supporting specialist projects. They felt that there was still room to develop policies and services, particularly in some areas that were less well served than others, and had the intention to continue to be active in these areas.

The providers of health services interviewed for the Review were asked to identify any major funding issues for their organisation.

The funding for specialist outreach teams under the HMII had recently been devolved to the local purchasing health agency. Most of the funding for the teams' work was now effectively permanent, much like other community health services. The security of this funding base was

obviously welcome, though long-term funding was obviously still in the hands of the health agency:

> *It is permanently funded but obviously in a purchasing culture, if at some time in the future priorities change, or things go out of fashion, we'll have to be arguing our case more strongly.*
>
> *(Team manager, specialist outreach team)*

The few providers who were funded by the London Initiative Zone (LIZ) monies were overall satisfied with the funding, but were worried what would happen in 1999 when the funding would run out. A few people also felt that this Government money should be for the whole of London, rather than just inner London:

> *But the LIZ money in a way was a godsend ... but I don't know what will happen when the LIZ funding dries out because, although the remit of the team is to enable access, the reality is that is not something that happens overnight, with GP fundholding coming on it's not going to be solved overnight. The very reason why LIZ money was given will not go away when it ceases ...*
>
> *(Assistant director, health agency)*

Some providers were funded by a combination of funds, or were funded for a specific one- to three-year period. The main concern here was obviously continuity of the funding base. One-off costs not supported by the main funding base were sometimes problematic to fund, such as for health information and training materials. A number of providers were seeking funding for particular posts, such as a mental health worker, to expand their services. However, the real problems for funding came with respect to trying to get major new developments off the ground, such as alcohol 'wet' provision.

Communication between health providers

Communication between different health providers was considered to be extremely important to ensure that effective health care was available to homeless people. Good communication was necessary in order to address some of the access problems described earlier.

One specialist medical centre GP stated that the centre had very good relationships with the hospitals in the area. This medical centre had developed a practice of contacting or writing a letter of introduction to hospitals and primary health care providers such as dentists:

> *I never send anybody in without asking the hospital, because I think it is really, really important with the people that I am dealing with to foster good relations. I send a letter with them, telling them* [the hospital] *as much as I can about the problem and the history.*
>
> *(GP, medical centre)*

It is likely that this practice helped ease any problems of access connected with staff attitudes or assumptions about homeless people when they presented at the service.

In effect, most specialist providers tried to some extent to ease the transition from one service to another, although it was explained that referring someone on was often very difficult:

> *A lot of the* [homeless] *young people we see have obviously been quite badly damaged and they have a lot of trouble in building up trust with anybody. So having built up a level of trust with us it's quite difficult to transfer that to someone else.*
>
> *(Director, day centre)*

The homeless outreach teams had formulated an agreement between themselves to alert each other when someone with whom they were working, who was felt to be particularly vulnerable, went missing. It was hoped that this would ensure some continuity of service, as well as avoid duplication of effort, whilst minimising the effects of homeless people's mobility on the health care delivery. As someone explained, this type of communication could prove crucial:

> *Communication – a good example is a guy that eventually dies and has presented with headaches at five different places, because those five instances are not strung together, nobody realises that he had this fatal disease that he was going to die from, and so nobody did anything about it ... and there is no consistency about how people record clinical records, and no sharing either.*
>
> *(Team manager, specialist outreach team)*

Despite the team liaison described above, a number of people, as illustrated by the last quote, commented that communication needed to improve between health services. There really was a particular problem with working across boundaries:

> *There's nothing sort of London-wide, everyone works in their own patch, whether it's health authorities or social services, but when it affects homeless people, boundaries mean nothing to them at all.*
>
> *(Mental health worker, day centre)*

One relatively recent initiative mentioned by many interviewees was London-wide hand-held medical records for GPs. After a number of pilots, agencies were meeting to try and agree on a uniform record, and were seeking funds to get the initial hard copy off the ground. It was considered to be crucial that only one version of the hand-held record was put into operation to ensure that information recorded would be consistent.

A community health care trust representative suggested that there needed to be more work around the interface between mainstream services and specialist clinics, with mainstream supporting specialist services. Health visitors for people in temporary accommodation helped interface with community health services, but it was thought that much more could be done to liaise with specialist providers instead of leaving them to get on with the job alone. This respondent also suggested that services that people would expect at home should be delivered to hostels, for instance palliative care for people dying if they wished to remain in the hostel.

As can be seen, a number of different approaches were being taken to address the issue of improving communication between health service providers. However, with the exception of the hand-held medical records, such approaches tended to be informal procedures developed by individuals or groups of providers rather than established communication mechanisms.

Community care and joint working

Community care not only requires effective communication between health agencies, as discussed in the last section, but coordination and communication between different statutory and voluntary bodies involved with providing health, housing and social care services to people. The professionals interviewed in the Review asserted the importance of the underlying idea of community care – that of addressing all of an individual's needs together:

... the other thing that is clear is that there is no point in just looking at the pure health needs, or just looking at the homeless needs, or even tackling the two together; it's the whole range of things, including day-time activity and money and social networks and everything, that if people are going to move off the streets successfully and improve their mental health, a whole lot of issues beyond health and housing have to be tackled at the same time, and that is the same for people moving out of hospital – if all the bits of the jigsaw are not in place then the thing will break down. I mean, the two most important things are probably health and somewhere to live, but issues like poverty come very close, and social support, are very, very close behind.

(Director, voluntary funding organisation)

However, in practice, professionals commented that in their experience community care was working less than effectively:

Community care – in theory it's a good thing, but in fact it is not working.

(Health liaison worker, day centre)

Everyone produces these lovely plans year by year, but actually putting them into practice tends to slip away. There needs to be a commitment to interdisciplinary support and working.

(GP and policy specialist)

A number of agencies confirmed other research finding that joint working around community care, and homelessness, had improved over the last few years, although in one or two areas joint-planning mechanisms which had been put in place a few years ago appeared to have fallen away.

A lot of agencies were able to say that they had good links with mainstream health services, or housing departments, or social services, and sometimes two of the above, but rarely all three of the key agencies in community care:

[X] *SSD* [social services department] *have got a liaison group around homelessness as part of community care planning, but housing are not represented, and health are not*

represented. The housing department has a liaison group around homelessness, but social services and health aren't represented, so I don't think it is happening as it should ... I think you need a body which meets at least three times a year, to review what is happening, and that needs to be linked into frontline agencies who have all the information on what is actually happening, and that can feed into policy and joint planning.

(Coordinator, outreach team)

It was commented that some agencies had yet to appreciate their role in delivering community care. It was also recognised that community care necessitated agencies with very different cultures working together, and that establishing effective lines of communication required planning and joint training of staff in each other's respective roles. At present it was still difficult to identify the people responsible for different aspects of community care in the agencies. A couple of people felt that the health service was particularly difficult to understand:

I continue to be baffled, as I think everyone else is, in so much as three months ago it was such and such an area that was covered by such and such a named bit, and now it's not that any more and it's called something else. The whole thing frankly is a complete and utter mystery ... I think I am not alone, this organisation is not alone in being confused by the health service.

(Director, day centre)

Professionals interviewed also outlined a number of specific difficulties with the actual process of gaining access to community care for their clients. A particular difficulty was seen to stem from there being different routes to accessing different services. This was particularly an issue when people had more than one need, for example both a mental health and alcohol problem:

In general terms access to housing and access to community care still go down different avenues, administered separately, and I think that is a barrier really to the effective delivery of care.

(Team manager, specialist outreach worker)

... we increasingly have people with multiple diagnoses, who clearly have a mental health problem but also have quite a severe alcohol problem, and the care management arrangements require people to go down one channel or another, and I think we are now only beginning to realise that quite a number of people actually fit in both.

(Team manager, outreach team)

Quite often people do not score enough eligibility in any one area to get a service, but at the same time, the multiplicity of their needs is not taken into account either. So you could have a bit of eligibility on children and families, alcohol, mental health maybe, but not enough to give you enough priority to get a service, and even if you do, there are not many services for you.

(Team manager, outreach team)

As the last quote illustrates, there was a general problem in being able to demonstrate eligibility for community care services. It was commented that there usually had to be a real crisis in someone's life before a person gained access to services. This was further complicated by the strict adherence to working in area boundaries:

Immense problems with social services, because if you are from out-of-borough then everyone assumes that the borough that put you in the unit will sort out your social service problem, but unless you happen to be rampaging down the corridor with a pick-axe, in which case it is an acute problem or child abuse, then the local social services will pick it up, they are forced to trek long distances to cope with not only social services, but housing departments in boroughs some way away.

(GP, running specialist hotel clinic)

It was thought that better coordination and joint working could achieve a lot of improvements in delivering services to homeless people. Within this, joint commissioning of services was clearly required to provide new services to meet the multiple needs of many homeless people, particularly for supported housing. Indeed, there was a particular plea for the provision of more suitable housing within overall community care plans. It was felt that a variety of different forms of supported accommodation needed to be developed that reflected the varying health and support needs of homeless people.

The overall shortage in housing was also a major cause for concern:

If the housing was there it would be wonderful, but I mean that the other dispiriting thing is knowing how long people are going to stay homeless, or housed in temporary accommodation, because of a combination of Government policy and the housing crisis. I mean, there are not the council houses for people to move into, that is the depressing side of working in homelessness.

(GP, running specialist hotel clinic)

There needs to be a constant supply of move-on accommodation because a lot of people can go into their own flat as they leave special accommodation of one sort or another, and want to, and do, except the supply is not there because of cuts to the Corporation programmes etc., and so it goes on, and I think there is a continuing issue about direct access off-the-streets accommodation, where there was a better supply under the RSI, but the funding is running down and out for those, so we have lost a number of places, and frankly there are as many people sleeping on the pavements as ever.

(Director, large funding body)

A couple of professionals were also concerned that the new homelessness legislation would make the housing situation much worse for homeless people:

I think that the proposed homelessness legislation is going to make it a hell of a lot worse. Homeless Persons' Units will be able to house homeless people out of their borough in private sector accommodation for temporary periods, and one of the most likely routes for people walking out and losing contact with support services is being housed out-of-borough.

(Mental health worker, campaigning group)

Improved coordination of Government departments was felt to be required, as well as reforms to policy areas which could only be made by the Government. A number of people mentioned the importance of, in particular, the Department of the Environment and Department of Health working together. Planning and coordination of the two departments were described as crucial to provide services to address both homelessness and health, as each is able to fund

services only within its own policy area. In recent years, coordination has existed between the two Departments around the HMII and RSI. For example, in RSI-2, the Department of the Environment set up five consortia of statutory and voluntary agencies, which enabled collaborative working between joint homelessness teams under the HMII and other outreach workers under RSI. Recently, an interdepartmental ministerial group has been set up to look at rough sleeping, which was a clear recognition that issues were wider than the Department of the Environment could tackle alone. These initiatives must be welcomed, although some providers felt there was still a long way to go to address the problems of homeless people:

> *... everybody has said for a very long time that the lack of cooperation between the DoH* [Department of Health] *and the DofE* [Department of the Environment] *and the DSS* [Department of Social Security] *is just more trouble than it is really worth on the ground, and it requires political solutions either at a local level or London-wide level ... For us that is where the heart of the matter is really, it's in social policy and Government policy, it's not really about health resources particularly.*
>
> *(Team manager, outreach team)*

The views of homeless people

The areas outlined above represent a professional viewpoint on the need for health services for homeless people. However, a number of agencies stressed that services should be developed following user consultation. It was acknowledged that user involvement in service provision around homelessness was poorly developed. Some suggested that advocates may be required to elicit the views of some homeless people, but this was seen as an achievable and desirable aim:

> *We need to perhaps consult with the user group, see what it is they would like. We consult with every other user group, I don't see why we shouldn't consult with the homeless user group, and look at street homeless, and hostel dwellers and B&B users.*
>
> *(Manager, community health care trust)*

The Review included group discussions with homeless people in four of the day centres and medical centres that provided health services specifically targeted at homeless people in London. The homeless people who were interviewed were generally positive about the services that they were using and quite often stated that, without the presence of a particular service, there would be nowhere else for them to go. The only homeless people who were not that

positive about the services that they received were the young people; however, most of them stated that they would use the services specifically provided for them out of preference to other health services. The homeless asylum seekers and refugees who were interviewed did not make any use of the specialised services for homeless people in London, relying on hospitals and GPs for their health services:

> [Here it] *doesn't matter who you are, what you are.*
>
> *(Homeless man in his sixties, medical centre)*

> *Before I was HIV, right, I was just alcoholic and I used to take drugs, yeah? I used to take skag* [heroin] *and that, yeah? I used to jack up* [intravenous use] *and all the shit, yeah? ya know? And I used to get ill, right, clucking, mainly clucking* [effects of withdrawal], *ya know? Got no drugs, go to the doctor, just something to take, to calm you down, diazipan, tamazipan, whatever, yeah? And when I was on it, the only people that looked after me was Great Chapel Street, I couldn't go to any other doctor, they don't want to know.*
>
> *(Homeless man in his thirties, day centre)*

> *This place is brilliant, they know how to treat me, they've seen me in some really rough states. There's some lovely people here, there really is, I've got everything here I want.*
>
> *(Homeless man in his forties/fifties, medical centre)*

> *You can come anytime, they're not shocked by anything, they are used to dealing with all sorts.*
>
> *(Homeless woman in her twenties, medical centre)*

Summary

The professionals interviewed in the Review considered that gaining access to mainstream primary health care was still difficult for homeless people. It was felt that there was a need for training of GPs and practice staff which would, it was hoped, lead to a greater sensitivity to homeless people as well as a more flexible style to health care delivery (e.g. open access

appointment systems). There was also a need for the development of service specifications in this area by health agencies, and the provision of health education for homeless people themselves.

Most professionals acknowledged that there was a need for both mainstream services and specialist services, working alongside each other, to ensure that homeless people received the health care they required. Specialist services were seen as offering a broader and more flexible service for homeless people, with better follow-through of clients. It was thought that many homeless people preferred specialist services, though it was pointed out that there were problems of access to these services for some groups of homeless people, such as women and people from ethnic minorities. The interviews with homeless people seemed broadly to support such an assertion, with those interviewed using specialist services being very satisfied with the service (though this was true to a lesser extent with young people), whilst refugees and asylum seekers tended to rely on mainstream services. Most professionals agreed that equal access to mainstream services for homeless people was the ideal policy objective.

Professionals asserted that there was a need for more specialist homelessness workers in the acute sector, particularly hospital discharge workers. Discharge policies were also required to ensure homeless people did not return to the streets or temporary accommodation on leaving hospital. The provision of mental health services and drug and alcohol services for homeless people remained priority areas for development work. Interviewees considered that more outreach workers were required, and that there was a great need for more 'wet' provision and detoxification facilities.

Funding remained an issue of fundamental concern. Whilst some organisations delivering health care to homeless people had a relatively secure funding base, many were worried about the permanence of their funding and the lack of money available for the development of new projects like 'wet' hostels. Communication between different health providers was fairly informal and ad hoc. The establishment of more formal systems of communication was thought to be required. With respect to community care, professionals were still concerned at the lack of development of coordinated services for homeless people, particularly for people with more than one health problem. Finally, many professionals were worried about the implications of other areas of Government policy, most specifically the proposed homelessness legislation.

Chapter 6

Discussion

The possible impact of the planned changes in the homelessness legislation

At the beginning of 1994 the Government published a consultation paper that described planned changes to the homelessness legislation. This consultation paper contained three suggested changes to the homelessness legislation that are relevant to health and homelessness in London. First, and most important, the right of statutorily homeless people to *priority access* to permanent housing was to be ended. Rather than being allocated a permanent council or housing association home as soon as one became available, homeless households would instead join all the other households on the waiting list, thus ending what the Government described as 'queue jumping' by homeless households. Second, a new duty to accommodate statutorily homeless households temporarily for up to six months while they were on the waiting list was to be introduced (this was later extended to one year). Third, a much greater emphasis was to be placed on the use of the private rented sector. These changes were subsequently confirmed as going ahead in the 1995 White Paper *Our Future Homes.*

It is not possible to predict what impact these changes will have in London. It *may* be the case that the time statutorily homeless households spend in temporary accommodation will generally increase, which may have implications both for their health and in terms of their access to the NHS. The available evidence suggests that at least some forms of temporary accommodation (particularly B&Bs) have a negative impact on the health of single homeless people and homeless families, and also suggests that the lack of a permanent address hampers access to GPs and other medical services.

The impact of a greater use of the private rented sector (PRS) for 'permanently' rehousing homeless households and other households in housing need is also difficult to predict. Again, there is the possibility of some negative effects, as demand on the resources of PRS may increase, because more homeless households are being temporarily housed in it for longer periods and because more households are being permanently rehoused in it. As demands on the PRS increase, it could be the case that boroughs will again have to make more use of B&Bs, because other forms of temporary accommodation will be in less plentiful supply. There is also

the question of how secure homeless people will feel in PRS accommodation that has only a six-month or year-long tenancy, as opposed to the more secure tenancies offered by councils and housing associations. This is not to suggest that PRS tenancies are inherently more insecure than those in social housing, because there is no evidence to suggest this. However, formerly homeless households may not feel as secure in a PRS dwelling, knowing that their tenancy is only for six months or a year. In addition, there may be a problem in terms of the continued availability of sections of the PRS should the housing market recover, since some evidence suggests that the recent increases in the size of the PRS are largely explainable by owner occupiers who have moved renting out their former homes until it becomes economic to sell them.

The problem of health and homelessness in London

The Review has shown that there are several major problems in relation to the provision of health services to homeless people in London. The first of these is the very poor quality of information on the numbers, characteristics and health care needs of homeless people. In the case of homeless households that are unwillingly sharing and squatters, information is practically non-existent. This lack of data is especially apparent in relation to people from ethnic minorities, asylum seekers and refugees who are homeless.

Second, the Review has confirmed the findings of the other recent studies of health and homelessness in London and the rest of the UK. The prevalence of certain infectious diseases, such as HIV and TB, and of mental health problems among the single homeless population is a particular cause for concern. The absence of rigorous work on the subject means that it is not possible to state the extent to which the health of the homeless population is worse than that of the general population, although the existing research does signify that this is the case. With the exception of people sleeping rough, the extent to which the health of homeless people may be worse than that of other sections of the population who live in poor conditions and have low incomes remains uncertain.

Third, the Review indicates that the access to health services that homeless people in London have is generally fairly poor, particularly with regard to access to GPs. Other evidence suggests that there may be problems in terms of how some homeless people are treated when they use secondary services, and that homeless people may be sometimes turned away by hospitals when they should not be.

Finally, it is apparent from the findings of the Review that much of the provision for the health care needs of single homeless people in London operates *separately* from other health services. While positive steps were being taken to produce more integrated responses in many areas, and most of the services for single homeless people made considerable efforts to liaise and cooperate with the mainstream NHS, many single homeless people received their health care from agencies that existed to provide health care services for homeless people. The extent to which this should be seen as a cause for concern or as a suitable policy response is debatable. On the one hand, it can be argued that specialist services are needed, because staff need expertise in dealing with homeless people in order to understand their needs and deal with them sympathetically. Conversely, it can be argued that the effective exclusion of homeless people from the mainstream NHS reinforces both their exclusion from society and existing prejudices.

Homelessness and community care

The Review has shown that an increasing emphasis was being placed on addressing the problem of homelessness via community care planning and joint service delivery in London. The development of integrated services involving a range of organisations that can provide housing, community care services and health services is, in terms of our current understanding of health and homelessness, the most desirable policy response. The health problems and poor access to health services that are associated with homelessness can be solved via a combination of services which rehouse homeless households and meet any support needs that they have. However, communication and coordination problems still existed among the good practice that was found.

In reality, the extent to which community care can address the needs of London's homeless people is limited. Both health and social services in London face very considerable demands on their finite resources. The Review found no examples of joint assessment or full joint working beyond individual workers and projects; none of the boroughs, for example, appeared to have universal joint assessment or joint working between agencies to cater for the needs of homeless people. The limited scale of developments should not necessarily be viewed as neglect, or a failure to appreciate the problems of homeless people, but should instead be seen in the context of the many other demands made on health, housing and social services resources in one of the largest cities in the world.

The combination of high demand in relation to resources in the case of the health service and social services, and the high demand in relation to declining resources in social housing in

London, places limits on the role that community care can take in addressing homelessness. The statutory agencies and voluntary sector organisations involved in community care have to ration their services, for example by focusing on statutorily homeless people, or sometimes just sub-groups of the statutorily homeless population that are seen to have very high needs, such as homeless families or single homeless people with a mental health problem. Initiatives for some other sections of the homeless population, such as squatters or people who are among those living in very overcrowded conditions with friends or families (such as many Black and Asian households), are notable by their absence in much community care planning.

The scale and coverage of services for homeless people

Access to the mainstream health service, specialist provision and services provided under community care appeared to vary considerably between different areas of London. Provision was most intensive where levels of homelessness were at their highest, but nevertheless often remained small in scale. For example, health authority or health commission work on improving access to health services for homeless people might be limited to a specialist health visitor or an advocacy worker covering a whole borough, or outreach services might be in a certain area of London for only one or two mornings a week. In some areas of London, such as the outlying boroughs, provision for homeless people was apparently quite limited or even non-existent. In contrast, in central London, most notably in the West End, there was a concentration of provision in a relatively small area.

The diversity of provision and coordination

One finding of the Review stems not so much from the results of the research as from the process of conducting the study. Many agencies provide medical and other services for homeless people in London. The organisations that have some input into the health of homeless people number in the dozens, and if all those charities, hostels and other forms of provision that have an input into the broad welfare of homeless people are included, the number increases to just under 200.

While some organisations, such as the South East London Consortium, the Homeless Network and CRISIS, help form links and networking among all the different statutory, voluntary and charitable funders and providers, the number of agencies involved remains very large. Merely determining what services there were for homeless people, and where they were, proved, in itself, to be a very major exercise. No one central register of resources existed and agencies were sometimes not aware of each other's existence. The large number of small projects, both

in the statutory and non-statutory sectors, made the measurement of services difficult and made strategic planning for homeless people across London a difficult exercise.

Many agencies were relatively small and some were tiny, perhaps assisting only a handful of homeless individuals. The extent to which it is efficient to have, for example, ten agencies involved in providing 500 hostel places or health services for 1,000 homeless people, each of which has its own administration, could be viewed as debatable. It may be the case that a significantly smaller number of agencies would operate more efficiently, because the bureaucracy necessary to provide those services would be reduced and more resources could be devoted to service delivery. In addition, the ability of small agencies to determine what they provide and to whom (subject to funding being available) could, in theory, also make effective planning and coordination difficult. A reduced number of agencies might also make the planning and organisation of health services for homeless people an easier undertaking.

Conversely, it can be argued that the strengths of small-scale voluntary sector and specialist provision are a benefit for homeless people, because these agencies are able to innovate and specialise more easily than large-scale providers.

Further research would be necessary to determine the extent to which provision for homeless people in London could be rationalised to increase levels of service delivery and simplify planning.

Increasing the provision of affordable housing for rent

It is simplistic to suggest that all forms of homelessness can be solved simply by an increased provision of affordable housing for rent. Research into the characteristics of single homeless people and people sleeping rough, for example, has shown that simply providing homeless people with housing and not paying sufficient attention to their social, financial, medical and other support needs will often not provide a solution to their homelessness (Dant and Deacon, 1989; Vincent *et al.*, 1993; Pleace, 1995). Other research has also shown that the causes of homelessness are far more complex than the decline in affordable stock. For example, the increased rates of relationship breakdown over the last 20 years may be contributing to homelessness (Bull, 1995).

Nevertheless, it is impossible to ignore the fact that the rise in homelessness has been closely associated with the very substantial reduction in council housing stock, caused by a combination of budget cuts and the 'Right to Buy', that has occurred during the same period. It

is possible to argue that the decline in the supply of council housing, which still represents the bulk of the UK's affordable housing for rent, has created a situation where housing is harder to access, which in turn has led to more homelessness. This link between the decline in the availability of council housing and the rise in homelessness has been repeatedly demonstrated (Anderson, 1994; Greve, 1991; Royal College of Physicians, 1994). This does not mean that social housing provision in London is likely to come to a stop, but that there is now less stock available to councils and much of what is available is deteriorating because of budgetary constraints. The boroughs, in common with other local authority landlords, have effectively ceased to be developers of new housing for rent, and while housing associations have an important role as the main developers of new social housing, the sector is a fraction of the size of council housing and 'new-build' projects are generally quite small.

The provision of more decent, affordable, social housing for rent in London, combined with attention being paid to the special requirements of some single homeless people in terms of specialised and supported accommodation, would not be a panacea. However, increased provision would help to address the problem of health and homelessness in two ways. First, those risks to health associated with homelessness can be at least partly addressed by ending homelessness. Second, and perhaps most important, the provision of a *permanent* address would end the disadvantage of living in temporary accommodation for long periods, which limits or prohibits access to the NHS by homeless people.

Recommendations

Community care

1.1 The provision of a multi-agency response via joint working to meet the needs of homeless people is generally desirable. Someone who is homeless may well need housing from a social landlord, health services, community care services from a social services department or a specialist voluntary organisation, and may also need befriending and social support. In addition to homeless people requiring a combination of services from different service providers in a multi-agency response, there is also the question of the extent to which some homeless people fit into the 'client group' structure that community care still employs. Criticism has been directed at the continued categorisation of all community care services users into groups such as 'older people' or 'people with learning disabilities' as being oversimplistic and as matching people to services rather than services to people. For example, significant numbers of homeless people, particularly people who are sleeping rough, have a combination of drug and/or alcohol dependency and a mental health problem, but services to meet their needs are restricted. In practice, the level of coordination between agencies that is possible may be limited by resource constraints.

General recommendations

- Service development needs to place equal emphasis on the health care, social care and housing needs of homeless people. Good health services for homeless people are insufficient; the problem of homelessness itself and any associated non-medical needs must also be addressed. It is essential for statutory and voluntary agencies to work together in providing a comprehensive service for homeless people. It is recommended that joint planning and joint commissioning of services for homeless people involving social housing providers, social services, the health service and the voluntary sector is established throughout London.
- There is evidence that services take insufficient account of the number of single homeless people who have mental health problems and are dependent on alcohol (and sometimes drugs). Services are divided between mental health and detoxification or rehabilitation, and relatively rarely combine the two. Research and development by health service commissioners is required in this area.

- The role of social housing providers in London in relation to dealing with homelessness should be reviewed, and the possibility of increasing the resources available to boroughs and housing associations should be considered. Coordination and increased joint working cannot function in relation to homelessness in London if the overriding problem of insufficient access to decent affordable housing is not dealt with.

Patient rights and user involvement

1.2 Health service provision should be sensitive to the needs of the people who are using it, both in terms of services being as accessible as possible (people are more likely to use a service that treats them well), and in terms of efficiency, since the provision of ineffective services is a waste of limited resources.

General recommendations

- Health service commissioners and providers should ensure that homeless people enjoy the same rights as other health service users as defined in the Patient's Charter.
- Users' forums or self-advocacy groups for homeless people should be developed by health service commissioning agencies to enable them to make their opinions and any grievances known to health service providers and funders. Particular emphasis should be placed on the most marginalised groups, such as homeless people who are sharing accommodation, squatters, homeless people who are asylum seekers or refugees, homeless people from ethnic minorities, and women who are homeless.

Data on homelessness

1.3 The data on the number, characteristics and needs of homeless people in London are generally poor. The absence of proper information makes it very difficult to understand the scale and nature of the health problems of homeless people, and to plan services in order to meet those needs.

General recommendations

- It is recommended that initiatives designed to improve the quality of data on homelessness are supported or established. The major gaps in information are:
  - (i) with regard to the housing status of homeless people using health services, which is the responsibility of health service providers;

(ii) with regard to the household composition of statutorily homeless households, such as the number, age and gender of the people within them. Data on ethnicity are collected but are not made publicly available; without the release of these data statutory homelessness in London cannot be fully understood;

(iii) aggregated data on the users of specialised services and accommodation for homeless people are required, particularly with regard to hostel users; there is a possible role for a cross-London funding body in providing a comprehensive information service that aggregates the data on homeless people using such services.

- It is recommended that comprehensive studies examining the numbers and health status of all homeless people, paying particular attention to groups on whom available data are very limited, such as people from ethnic minorities who are homeless, are jointly undertaken by health commissions and London boroughs to inform their strategic planning.
- Data on health and homelessness are plentiful, but their quality is sometimes dubious. Systematic studies that examine the health status of people experiencing different forms of homelessness and which compare their health to that of the general population (using medical diagnosis in combination with self-diagnosis) are required in order to gain a more detailed picture of the relationship between health and homelessness in London. In addition, the pattern of health service use by homeless people and their experiences in using health services should also be the subject of rigorous comparative study. Such studies might usefully be undertaken within NHS research and development programmes.

Primary care: GP services

1.4 There is strong evidence of poor access to GPs among some groups of homeless people in London. As approximately 90 per cent of all illness is managed and treated outside hospital settings, it is vitally important for homeless people to be registered with a GP, not simply in terms of access to the services that a GP can provide, but also because GPs are the main means of access to many community health services and hospital inpatient services.

General recommendations

- Training for GPs and other primary health care professionals in relation to homelessness should be arranged by health purchasers and providers. This training should promote greater understanding of the diversity of needs of homeless people and discourage the use of stereotypes. It should take into account the views of health care professionals and address their concerns about homeless people as well as promoting greater understanding of homelessness.
- Greater information should be made available to GPs and other health professionals about the welfare, support and specialised medical services that are available for homeless people. This could be achieved by the production of a 'directory' of services for homeless people that organises the different services by borough/health commission area and by function, and provided contact details. Such a service might be provided by regional health authorities working with other bodies with a cross-London remit.
- Access to mainstream primary care, and particularly permanent registration with GPs, appears to remain limited for many homeless people. It is recommended that further research, perhaps associated with actual experiments in the modification of services (such as open appointments), is supported in order to attempt to improve permanent registration levels. Particular emphasis needs to be placed on the needs of one group, people who are sleeping rough. As well as examining the impact on homeless people as service users, such a study should also examine the impact on GPs and other people using the mainstream service. This research might be undertaken within NHS research and development programmes.

Primary care: community health services

1.5 There has been very little research that has considered the use that homeless people make of community health services other than GP services. Several community health services, such as community nurses, midwives and health visitors, are primarily accessible through GPs and it can be presumed that access for some homeless people is poor because of low levels of GP registration. Problems are presumed to exist for homeless people with regard to access to dentists and opticians, and many special projects providing primary care for homeless people in London provide these services in addition to their GP service. Some of the same barriers to access that homeless people experience when using hospital or GP services may be encountered if they try to use community health services based in health centres, but this has not been examined as

an issue. Access to services that are associated with mental health, such as counselling, also appears to be limited for homeless people.

General recommendations

- Not enough is understood about the use that homeless people make of community health services or their experience in using these services. Research into the accessibility of community health services and the experience of homeless people should be undertaken by the NHS Trusts in London. If a problem exists, service development should follow this research.
- There is a service gap with regard to the delivery of counselling services for homeless people. Research is required into the development of appropriate models of the delivery of counselling for homeless people. It is recommended that such research is undertaken, particularly with regard to the needs of young people, people with alcohol or drug dependencies, homeless women and the provision of bilingual counsellors. A combination of statutory and existing voluntary services might develop initiatives in this area.

Acute health services

1.6 The Review demonstrated that acute health services such as A&E departments remain inaccessible or difficult to use for some homeless people, particularly people who are sleeping rough who are dependent on alcohol. There was a general concern about the adequacy of discharge procedures for homeless people using A&E and inpatient facilities.

General recommendations

- There is evidence of a continued need for better support services and planning for homeless people when they are discharged from hospital. Greater integration of hospital provision with primary health care, housing providers, social services and the voluntary sector should be developed. NHS Trusts running hospitals which see a high proportion of homeless people should be integrated into community care planning and service commissioning for homeless people.
- Each hospital should have a discharge planning system for homeless people. As part of this programme, link workers who can facilitate contact between agencies and arrange

a package of services for homeless people leaving hospital should be provided by Trusts as part of this planning. There is a need to evaluate existing hospital discharge models, to ascertain how discharge of homeless people can be best achieved. Hospitals should have access to better information on the range of services for homeless people in their area, though this should be arranged via a London-wide resource and not left to individual hospitals to arrange for themselves.

- Training for health service professionals to make them aware of the needs and characteristics of homeless people should be provided by NHS Trusts in order to overcome the problems of negative attitudes to some homeless people that apparently exist within some hospitals.

Homeless people who are asylum seekers, refugees or from ethnic minorities

1.7 There is a particular lack of information on the needs and characteristics of homeless people in these groups and some evidence that, along with people who are sleeping rough, they are among the most marginalised sections of the homeless population of London.

General recommendations

- There is a need for detailed research into the health status, characteristics and numbers of homeless people who are in these groups. There is insufficient understanding at present to enable the design and provision of suitable services for their needs. Such research could be undertaken by health commissioning agencies in London. Service development could then be pursued based on the results of such studies.

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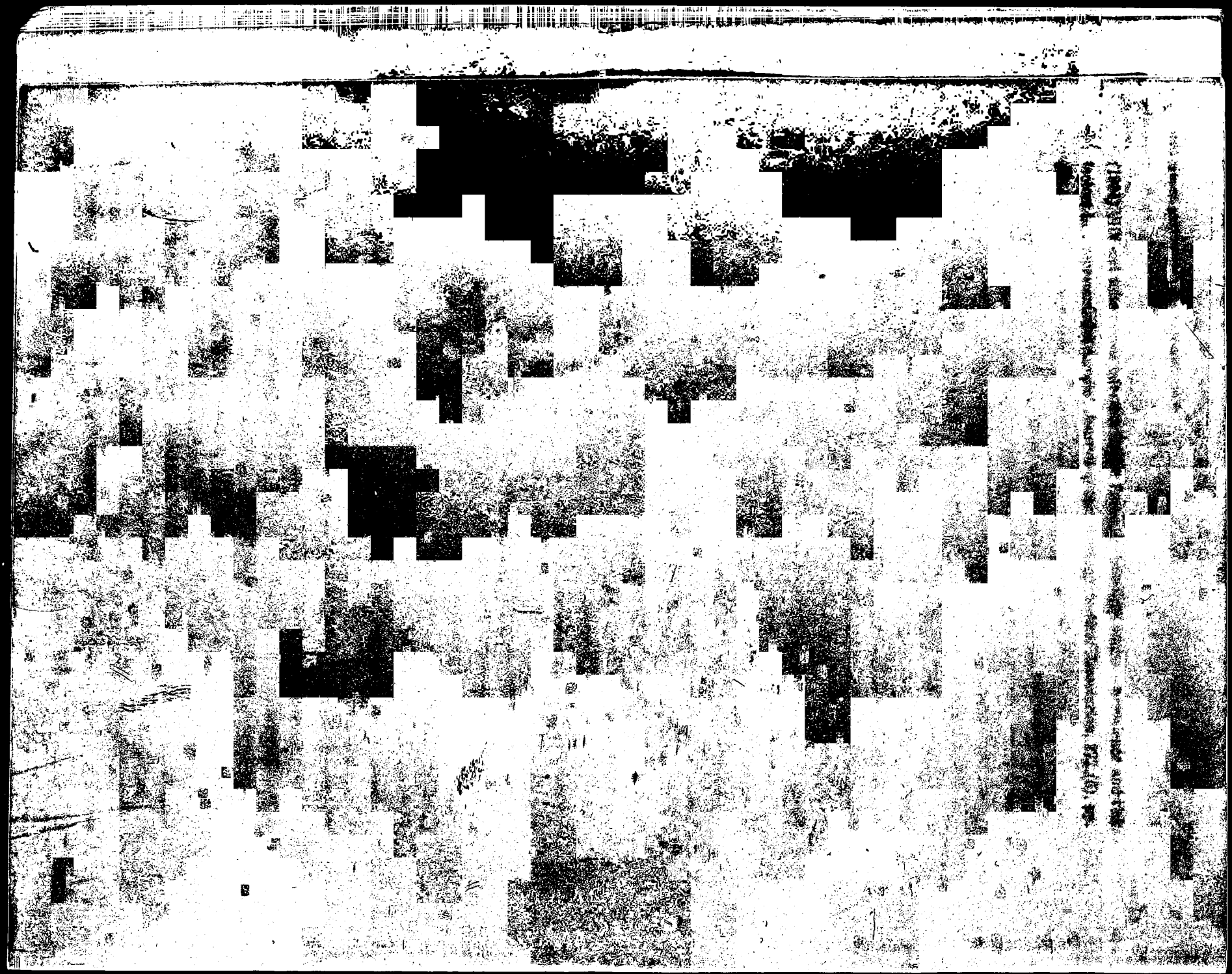

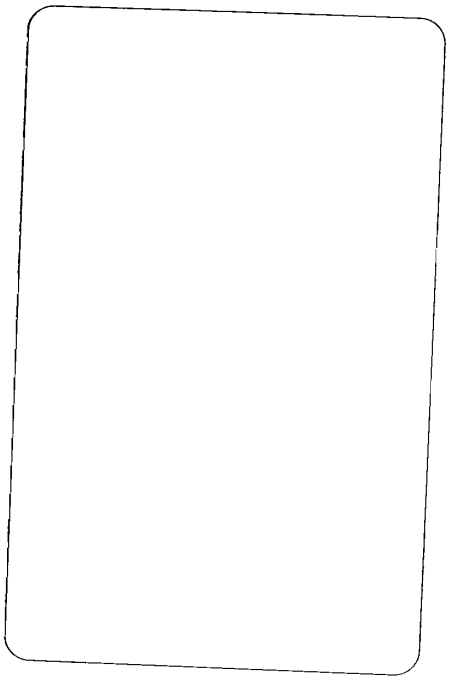

It is estimated that over 100,000 people living in London are homeless. The physical and emotional conditions they experience place them at far greater risk of developing a wide range of health problems.

Despite high levels of need, homeless people encounter severe difficulties in gaining access to mainstream health services as a result of prejudice, stereotyping and the bureaucracy of the system.

Health & Homelessness in London offers a comprehensive review of the situation faced by homeless people in relation to their health and welfare needs and describes the extent and type of provision currently available to them. Based on extensive research and including interviews with homeless people themselves, the study provides analysis and conclusions which are relevant to any large urban centre.

Health & Homelessness in London argues the case for special services specifically designed to address the health needs of homeless people and calls for collaboration between health, housing and social care agencies in developing services and in combatting the root causes of homelessness itself.

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