



OFFICE OF THE
DEPUTY PRIME MINISTER

Addressing the health needs of rough sleepers

A paper to the Homelessness Directorate
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Everyone has the right to a standard of living adequate for the health and well being of the individual and of their family

United Nations universal declaration of human rights 1948

Promoting healthier communities requires action on many fronts – good housing, a clean environment, employment, safe workplaces, healthy diets and opportunities for exercise all help reduce health problems.

Acheson Report

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The full report, *Health of Rough Sleepers: Sleeping Rough in Oxford*, is available at www.phru.org.uk and includes:

- Literature review
- Audit
- Oxford case study
- Partnership advice
- Developing a strategy.

FOREWORD

This report presents the findings from a project commissioned by the Government's Rough Sleepers Unit (RSU) in 2000 to assist policy development in primary care health for homeless people who sleep rough.

The approach taken was to:

- Review current practice and research.
- Undertake a national audit of health authorities in England.
- Gain an understanding of the issues faced by those working with rough sleepers using Oxford as a specific example.
- Produce a report as a basis for further discussion.

The report was produced with the assistance of Allison Thorpe and Carol Dumelow working in Oxfordshire Health Authority. Support from the RSU was given by Kate Noble.

I would like to thank Allison Thorpe and Carole Dumelow for their analysis of the questionnaire and all the participants in Oxford City, particularly John Adcock.

Professor Siân Griffiths

April 2002

Rough Sleeping

Rough sleepers are one of the most vulnerable groups in society, and many suffer from acute health problems. This was recognised by the Government when in 1998 the Social Exclusion Unit (SEU) published a report¹ setting out the way forward for reducing rough sleeping in England. As a result the Prime Minister set a target to reduce the numbers of people sleeping rough to as near to zero as possible but by at least two thirds by 2002.

The Rough Sleepers Unit (RSU) was established within the Department of Environment, Transport and the Regions in April 1999. It was set the task of reducing the numbers of people sleeping rough by at least two thirds by 2002, and to sustain the reduction. The RSU therefore developed a strategy, *Coming in from the Cold*², which formed the basis for work on a radical new approach with three key elements:

- help for those sleeping rough tonight;
- rebuilding the lives of former rough sleepers; and
- preventing a new generation of rough sleepers.

The strategy was different in that it covered not only the housing issues facing rough sleepers, but also recognised the health, drugs, employment and personal background factors that are involved in causing and prolonging rough sleeping.

The method used to achieve the reduction in numbers was one of partnership and joined up working. A network of outreach teams, backed up by hostels, specialist workers, drug treatment and health workers was established. This brought a new focused approach – targeted on the most vulnerable – which reduced the duplication of services, filled gaps and brought the key people together across a range of sectors.

These initiatives had a positive, but often indirect, impact on the health of rough sleepers by helping them away from the streets. However, the health needs of rough sleepers are not currently being met in a systematic and effective way. The problems are complex and need a specific client focus – combining the approaches to dealing with the problems associated with physical ill health, poor mental health and alcohol and drug misuse.

The forthcoming Homelessness Act will require each local authority in England to draw up a homelessness strategy with local partners, to establish levels of homelessness and then to work to prevent and tackle it. It will be important for these strategies to examine the health services available for rough sleepers and to link in to the Primary Care Trusts' Health Improvement Modernisation Plans (HIMPs). There may also be scope to improve services through the work of Local Strategic Partnerships (LSPs), where these have been established.

National Health Policy

The needs of rough sleepers are not explicitly mentioned within recent policy documents from the Department of Health. However, there is an implicit assumption within many of the policy documents that the needs of rough sleepers and inequalities in health care and access need to be addressed.

For example:

- **the NHS Plan**³, includes a chapter which highlights the need to address social and health inequalities as well as meeting the targets set by the mental health National Service Framework.

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- **Primary Care Trusts (PCTs)** are required to work closely with their local authority colleagues within the community planning agenda, playing an active part in linking **Health Improvement Modernisation Plans (HIMPs)**, **Community Plans**, and **Local Strategic Partnerships**.
 - **Shifting the Balance of Power**⁴ has given PCTs responsibilities for health improvement and increased partnership working, which should be reflected through Local Strategic Partnerships.

Other Government initiatives, which could help improve the health of rough sleepers, include:

- **SureStart**⁵, which aims to prevent mental ill health and promote positive lifestyles.
- **Drug Action Teams**⁶ (DATs), which are required to address the problems of drug misuse and commission appropriate services. Some also target alcohol misuse. Increasingly the DATs consider the needs of those with dual diagnosis of mental ill health and substance misuse problems.
- **Prison services** and health services are working together to produce specific Health Improvement Plans.
- **Supporting People**⁷ will, from April 2003, deliver high quality and strategically planned housing-related services that complement existing care services.

It is clear that there are many agencies involved in providing health and health-related services for vulnerable people, including rough sleepers. However, currently the NHS and rough sleeper services are not sharing information or working together to provide services.

The literature review, along with references, can be found in the report *Health of Rough Sleepers: Sleeping Rough in Oxford*.

Who are rough sleepers?

The rough sleeper population has been generally characterised as:

- 90% male.
- 75% aged over 25.
- Between 25%-33% have been in local authority care.
- Having a life expectancy of 42 years, in comparison to a national average of 74 for men, and 79 for women.
- Thirty-five times more likely to kill themselves than the general population.
- Four times more likely to die from unnatural causes, such as accidents, assaults, murder, drugs or alcohol poisoning.
- 50% alcohol reliant.
- Around 70% misusing drugs.
- 30-50% with mental health problems.
- 5% from black and minority ethnic groups.

What are their health needs?

Specific health issues identified for rough sleepers include:

- **Poor physical health** e.g. higher rates of TB and hepatitis than the general population, poor condition of feet and teeth, respiratory problems, skin diseases, injuries following violence and infections.
- **Mental health problems** e.g. serious mental illnesses such as schizophrenia, as well as depression and personality disorders.
- **Drug and alcohol dependency** e.g. high misuse of heroin, crack cocaine and alcohol.

Many rough sleepers will have a combination of the health issues described above, and some will suffer from poor physical and mental health, as well as having a drug addiction.

Barriers to care

Despite the huge health problems faced by the large majority of rough sleepers, they often can not or do not seek help. The barriers to obtaining appropriate health care include:

- Limited or poor access to physical and mental healthcare services, including primary care and accident and emergency services. This is often due to institutional factors such as opening times, appointment procedures, location and discrimination.
- Strong financial disincentives for general practitioners to register rough sleepers. This is a particular problem if GPs believe the person may be transient.
- Lack of integration between mainstream primary care services and other local services (e.g. housing, social services, criminal justice system, and the voluntary sector), which can prevent people from being linked into the services they need at the earliest opportunity.
- The rough sleepers themselves not prioritising their health, as other issues are more pressing, or not knowing where to find help.

3 AN AUDIT OF EXISTING PRACTICE

An audit was undertaken by asking Directors of Public Health in health authorities across England to complete a survey on the relevance of government policy and strategies to the people who are sleeping rough in their areas. There was a total response rate of 74%. The long analysis of the audit is available in the full report.

Results

Across the country:

- 18% of the health authorities felt that the needs of rough sleepers were very relevant to their work.
- 10% felt that rough sleepers were not at all relevant.
- Only 35% of Health and Improvement Modernisation Plans (HIMPs) mentioned rough sleepers.
- 79% of those health authorities that did not currently mention rough sleepers also did not intend to include them in the future.

Specialist rough sleeping services were available in 28 of the 45 areas that responded to the question, and services were open out-of-hours in 55% of these areas. This was mainly through the primary care sector, particularly out-of-hours GP co-operatives and walk-in centres. In some areas (17 out of 51) there was no out-of-hours care.

It was encouraging that in the most concentrated rough sleeping areas (for example London, Oxford and Birmingham) the audit demonstrated the availability of health provision for rough sleepers. 78% of health authorities in London reported specialised primary care provision, with all areas of high concentration outside London having specialised services. However, only 44% of health authorities with lower concentrations of rough sleepers had provision for them. Referral links were identified between health authorities and homeless agencies in over 70% of responses.

The key points from the audit are:

Variability of healthcare provision

- Healthcare provision for rough sleepers and homeless people varies across the country and reflects the size of the rough sleeper population. For example, 88% of inner London respondents reported the existence of identified mental health services for rough sleepers. This compares with 32% of health authorities with lower concentrations of rough sleepers.
- Podiatry and dental services are difficult to access in one third of the areas that responded. However, some health authorities have developed innovative approaches, including drop-in podiatry and dentistry services or sessions provided on a monthly basis at day centres, hostels, or night-shelters. Other health authorities have plans to pilot schemes to increase accessibility to these services, by providing a mobile dental surgery and setting up a chiropody clinic for homeless people.

Inappropriate use of and accessibility to Accident and Emergency services

- Some areas report rough sleepers and homeless people using Accident and Emergency services for non-emergency health problems. This can lead to extra costs for hospitals and means that rough sleepers are not getting timely and appropriate care. Schemes to overcome this problem are in place in some areas, for example the introduction of GP appointment systems in Accident and Emergency and advocacy projects. These projects can result in more appropriate presentations by homeless people, and better treatment of their health needs.

Mainstream vs specialist services

- Access to primary care services is only available via mainstream services in some areas. This should not be an issue if those mainstream services are able to be flexible in their provision to meet the needs of rough sleepers, and rough sleepers are making use of those services. However, other health authorities provide specialist primary care provision for rough sleepers and homeless people, often through Personal Medical Services (PMS) pilots. These services are useful where there is a higher concentration of homeless people, and work best when they are closely linked to mainstream services so that people are not further marginalised and are able to re-join the mainstream as they become more settled.
- In most health authorities, alcohol and drug support for rough sleepers and homeless people is only available via mainstream provision through community drug and alcohol teams. Only 39% of health authorities reported the availability of dedicated drug and alcohol workers. It is noteworthy, however, that 78% of those inside high concentration areas in London reported the provision of dedicated services, along with 80% of high priority areas outside London. Availability of detox services was considered inadequate in all settings and no respondent felt that all the alcohol and drug support needs of rough sleepers were being met – the majority (67%) believing that only some of the needs were being met.
- Current provision of mental health services for rough sleepers involves specific workers with a dedicated remit for the rough sleeping population in most areas, rather than mainstream mental health provision for homeless people.
- Several health authorities reported future plans to improve accessibility of primary care services and alcohol and drug support to rough sleepers and homeless people through the greater use of outreach work. This should be encouraged, and should be done in collaboration with the local authority and DAT.

Supporting rough sleepers and homeless people was considered to be a complex issue, because this vulnerable group has different needs to the general population and can require considerable support to enable them to deal with health issues. The challenges faced in providing this support vary across the country – but there are many examples of successful provision of services providing health care to rough sleepers. Lessons need to be learnt from these services and shared with other areas. It is clear from many of these examples that the provision of rough sleeping services does not always require additional resources but instead needs just a change in ways of working and thinking.

This survey was undertaken in 2000, since when health authorities have been replaced by Primary Care Trusts. Each PCT will have a Director of Public Health and the findings of the audit will be relevant to them in developing future services.

4 DEVELOPING A STRATEGY

The key to delivering effective services is the need for a strategic context for shared care service provision. Provision of care, be it mainstream health care or mental health care for homeless people, is fraught with difficulties. The very nature of homelessness, involving a vicious cycle of deprivation and marginalisation from the community, means that it can be extremely difficult to provide appropriate help for homeless individuals.

Homelessness is often not high on the agenda of statutory health agencies, although it is often higher up the priorities of local authorities. Few health providers have strategies or services to meet the health needs of homeless people, and this has led to the voluntary sector often being the major provider of services to the client group. As such the voluntary sector can possess the knowledge, resources and skills needed to work with homeless people.

Traditionally, statutory agencies have not been good at working together, particularly between health and housing sectors. Adding the dimension of working with the voluntary sector as a true partner adds further complexity. However, if all three sectors do work together, there is the potential to tap into much needed skills and resources, and so provide effective support to rough sleepers.

The long term economic benefits to the health sector of working with homeless people must not be overlooked. For example, the early prevention of health problems before they become more complex, ingrained and ultimately more expensive to treat will be more cost effective, and this can be achieved by providing services which are responsive to individual needs as opposed to crisis intervention services. This has a benefit to the patient, in terms of more holistic service provision, and to the service provider, as procedures are put in place to address the cause of problems and not just the symptoms, as well as saving money.

All partners should take advantage of the opportunity of current policy initiatives to agree a strategy for improving the health of homeless people. This needs to be a part of, or linked to, other initiatives such as the Health Improvement Modernisation Plan (HIMP), Housing Action Plan, Local Strategic Partnership's Community Plan, Drugs Action Team plan, Homelessness Strategies and Prison HIMP. Voluntary expertise needs to be included in all approaches and the views of both those sleeping rough and at risk of sleeping rough taken into account.

It is clear that the task of providing health care to those people sleeping rough is complex and needs to draw on many local agencies. There is a large amount of literature analysing the problems and issues, and some of the attempts which have been made to address them. What is needed now is action that is targeted, co-ordinated, evidence-based and sustained. Recommendations for action are overleaf.

The principles behind delivering improved services are as follows:

- Establishing partnerships.
- Developing shared health strategies across sectors.
- Developing early intervention strategies.
- Improving information sharing and training.
- Creating targeted services.
- Mainstreaming health needs.
- Evaluating and disseminating good practice.
- Developing rehousing and resettlement policies which take account of health issues.

5.1 Establishing partnerships

A local health and homeless partnership could be established by the PCT, in consultation with the local authority's homelessness co-ordinator. This could include having an identified lead person within the PCT with responsibility for the needs of the homeless including rough sleepers. This person could consider health and homelessness issues, drawing on the expertise of people from other agencies including the local authority, social services, DAT, GPs, Community Psychiatric Nurses (CPNs), supported housing providers and voluntary agencies. The relevant agencies – who could form a loose partnership – would need to make the best use of existing resources and expertise, and identifying gaps in provision. This information should be readily available, but may need to be brought together into one place. Ideally, the partnership should focus on the problem in terms of individuals' needs.

The partnership should be concerned with:

- Prevention of rough sleeping – at primary and secondary health levels, by being aware of risky behaviours and crisis points in people's health that could lead to rough sleeping.
- Improving access to appropriate treatment and health care by modifying existing services or sometimes developing new ones.
- Developing continuous services for a client that are not hampered by organisational boundaries, so that a rough sleeper receives meaningful and consistent support. Barriers between agencies need to be broken down so that there is a greater focus on the needs of vulnerable rough sleepers, rather than the service providers. This could be perhaps achieved through case conferencing of some particularly vulnerable clients to see how and when the different services should link together.

5.2 Developing shared health strategies across sectors

A clear-shared strategy with all agencies signed up and working to the same end goals is the best way of improving the often fragmentary and ad hoc availability of health care to rough sleepers and homeless people. The role of GPs in delivering this to the client is crucial and will be even more important with the current changes to the primary care structure. The need for services for homeless people should be specified within NHS contracts, with clear quantifiable targets.

The PCT should work to ensure that all health providers and homelessness services reflect the work of Primary Health Care Teams with rough sleepers within HIMPs, Local Strategic Partnerships, practice plans and other key documents, so that everyone can record their actions and develop services together. Proposals for joint working could be reviewed by the HIMP steering group within the context of the health inequalities agenda.

A key element of the success of this, will be the ability for the service providers to work together and respond to service users. This will help to ensure an effective and co-ordinated service for patients, in which they can access all services through any gateway. This will require the integration of:

- Service users.
- Accident and Emergency.
- Mental Health services – particularly assessment and outreach.
- Drug and alcohol treatment services.
- Social services.
- The Local authority – particularly housing officers.
- Voluntary groups.

In particular, it is critical that the views of service users are sought, so that services can be made more responsive and be tailored more effectively to meet their needs.

5.3 Developing early intervention strategies

Early intervention strategies, which cover the health factors leading to rough sleeping, can help to prevent rough sleeping by providing support for recently homeless people, and can offer alternative ways of dealing with problems before a crisis point is reached. As part of this, health strategies are needed that promote harm reduction and rehabilitation work with rough sleepers as, for many, their behaviour is entrenched and will take time to change. Progress could be monitored against strategic health targets, for instance those given in the NHS Plan. The Primary Care Trust would then have a key role in co-ordinating the health aspects of the local strategy, particularly in liaising with the local authority and voluntary sector, which work with both rough sleepers and those at risk of sleeping rough, in order to seek their views.

Health workers should be aware that a rough sleeper's health needs can be a contributor to sleeping rough; a consequence of sleeping rough; and a vicious cycle of both.

5.4 Improving information sharing and training

At present there is no single source of information on health services for rough sleepers. The development of common systems of information gathering and exchange between relevant agencies, including health, social services, housing and the voluntary sector would ensure that all staff are easily able to access information in a timely and appropriate manner. Information from NHS Direct also has a role, as well as integrating Primary Health Care Teams with voluntary agencies to focus on individual needs.

People working with rough sleepers and their health needs should pool information, enhance communication, assess the possibility of pooled budgets and change ways of working. Ideas to consider include:

- A pack, prepared by a partnership of service providers, offering information on homeless services would be useful for NHS staff and other health agencies.
- Information packs, including what the needs of rough sleepers are and what resources are available locally. This will help health workers to know where to go to provide relevant support, or to find assistance.
- Training should be available to front line rough sleeping workers in hostels and day centres on the health issues rough sleepers will face, how to promote health living, and where to find help.
- Ensuring appropriate literature is made available on local services for rough sleepers. This should be developed in close collaboration with appropriate front line agencies.

- Rough sleepers could be given their own health records to enable continuity of care as far as is possible, particularly as many rough sleepers are transient and may access many services. This would help GPs, A&E staff, CPNs and hostel workers to understand the medication, treatment and general health history of each individual. Alternatively, more use needs to be made of electronic records, with appropriate security systems, to enable the sharing of information where this is necessary.

5.5 Creating targeted services

For some rough sleepers, targeted health services are essential to meet their specific needs, and their current lack of integration into mainstream services. However, specialist provision needs to be balanced with the need for mainstream understanding of needs, and the eventual movement of clients from targeted to mainstream services once they have become more settled.

- Good opportunities for developing targeted services exist with the Personal Medical Services (PMS) funding.
- In some areas, targeted services might just mean flexible, appropriate and timely service provision, with consideration given to a no-appointments system, or GPs visiting hostels or day centres where rough sleepers are.

5.6 Mainstreaming health needs

Mainstream health services must be able to accommodate the needs of rough sleepers and play a part in preventing people from becoming rough sleepers, through the early identification of crises. Specialist services should be able to refer rough sleepers through to mainstream care, once the client is stable. This reduces the marginalisation of rough sleepers from services for the rest of the population, and ensures that they receive the same level of care as any other member of society.

This may mean that mainstream provision needs to be examined to ensure that it is meeting the needs of rough sleepers. Some services may need to be made more flexible if they are to provide accessible services to this marginalised group.

- Within the acute hospital sector consideration should be given to access, procedures for support and protocols for pathways of care.
- In particular, a discharge policy should be developed by hospitals to ensure that no one leaves hospital without a safe home to go to. Any treatment and care can be reversed if the person leaves hospital to sleep on the streets again.
- Consideration should be given to prevention, treatment and care, not only in general practice but also dentistry, podiatry, pharmacy and other community services. Many rough sleepers will use these services before they are ready to visit a GP for more conventional care.
- Protocols should be developed for referral and treatment to specialist health services and non-health services e.g. housing. This may mean developing a shared understanding of each other's resource pressures and language.
- Access to general services for rough sleepers and those at risk of sleeping rough needs to be developed and brought explicitly within the commissioning process. This can include Local Development Schemes and walk-in centres, which are also available to the general public.
- PCTs should promote the use of Local Development Schemes, where applicable, to enable GPs to devote extra time and resources to rough sleeping clients, who will often need longer appointment times and more intensive input.
- Walk-in centres should be used where possible to provide extended opening hours and care for rough sleepers, to remove the need for them to visit A&E for routine treatment and advice.

- An agreed aim of the partnership should be that full registration with a GP is available to all rough sleepers and homeless people – and at the same time providing access on both a temporary and an immediate and necessary basis. As part of this, GPs may need to be reminded and supported to register patients who do not have a permanent address.
- The high levels of drug and alcohol misuse need to be recognised as one of the key challenges to helping many rough sleepers. Work with the DATs should help to identify routes into treatment.
- There is a need to support those with severe and enduring mental health illness, as well as those with other debilitating mental health problems, such as personality disorders, depression and trauma. Easy access to mental health professionals and assessment needs to be developed, with more appropriate detox facilities for those suffering from a dual diagnosis. Establishing better links between prisons and PCTs can help to prevent people in this situation from becoming rough sleepers.
- GPs, other health professionals, and those in hostels and day centres should also consider promoting healthy living. This will be critical in the long term for those who move away from the streets and will have a greater degree of independence.

5.7 Evaluating and disseminating good practice

The growing recognition of the social, environmental and economic factors that impact on health should be recognised in the HIMP, so that negative factors and health inequalities can be minimised. Local authorities will also play a major role in affecting determinants of health, and the cross-cutting nature of these factors should be recognised and evaluated by Local Strategic Partnerships.

The evaluation of the health needs of rough sleepers and how they are met by the health services and local authorities is an important part of monitoring progress in continuing to develop services. The PCT and a health and homelessness partnership could look to identify and spread good practice, and encourage innovative services within and beyond the PCT area. The partnership could also compare its performance with similar partnerships around the country.

In particular, a PCT and local authority partnership could establish a simple performance management framework to assess whether services are improving. Within this should be relevant indicators, such as the percentage of patients whose housing arrangements are known prior to discharge from hospital, or the proportion of front line staff and GPs who would know where to go for information on homelessness issues.

5.8 Developing rehousing and resettlement policies which take account of health issues

The health sector should be actively involved in the local and voluntary sector housing planning processes, particularly the development of homelessness strategies and Supporting People strategies. These will ensure that there are appropriate services in each local authority area for all homeless people, including rough sleepers. The PCT should recognise the importance of making clinical staff available to input into these assessments and at an individual level, to feed into a person's local authority housing applications. Helping a rough sleeper into a stable home is just one part of helping them to lead a sustainable life away from the streets. Ensuring that this home is suitable for any health needs they may have, and that there is adequate support, should they need advice or reach a crisis, is essential. The impact that a home has on a person's health can either be positive or negative, and health service providers need to work with housing providers to ensure that it is as positive as possible.

There is no shortage of information or good ideas to address the health needs of rough sleepers. What is needed now are more focused ways of working across sectors and agencies to address the problems faced by homeless people, and specifically those sleeping rough.

Tackling homelessness needs more than just a housing response: it needs determined and co-ordinated action over a period of time by a wide range of partners. Health agencies should undoubtedly play a key role. Although there are geographical variations in the incidence of rough sleeping, each PCT must consider the level of need, what strategy will be adopted to meet these needs, and then work to ensure its effective implementation.

7 SOURCES

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