



Health of Rough Sleepers: Sleeping Rough in Oxford



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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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Executive Summary

Rough Sleepers are one of the most disadvantaged groups in society. If we are to tackle health inequalities then we need to assess and meet their needs in new and imaginative ways. This report describes factors which contribute to sleeping rough, health problems faced by rough sleepers, current service responses and challenges for the future. It focuses on the need to mainstream health care provision for rough sleepers and on promoting effective partnerships. It has been produced in dialogue with those working closely with rough sleepers and reflects their aspirations. The report proposes an action plan and an evaluation framework. It highlights the wealth of analysis but the slower pace of innovative delivery. The audit which was carried out provides a snapshot of national needs and service responses, whilst the Oxford case study provides a more detailed local description. It is a contribution towards greater understanding of the health needs of rough sleepers and hopefully a contribution to their solution.

Section 1:

Introduction

This report was commissioned by the Rough Sleeping Unit of the DETR in 2000/1 to help develop primary care health policies for homeless people who sleep rough.

The approach taken has been

- to undertake a national audit of health authorities in England
- to gain an understanding of the issues faced by those working with rough sleepers in Oxford by a series of informal interviews
- To produce a report on rough sleeping in Oxford which highlights the key issues which need to be addressed to develop effective services by reviewing the literature and drawing on the local interviews
- To hold a local seminar to discuss and refine the report with those who play a role within the Oxford system
- To publish a final report at a national conference in 2001 which describes the results of the audit and the findings from Oxford, the objective being to identify ways of improving health and health services for those sleeping rough by influencing national policy and local action.

This report is produced as part of the process described above.

Policy context

Rough sleepers are one of the most vulnerable groups in society. This was recognised by the Social Exclusion Unit and the Government when they set a target of reducing rough sleeping by two thirds by 2002- and publicly committed themselves to making a lasting difference on the streets by stopping people arriving there in the first place. (1)

The method to achieve this was clearly one of partnership and joined up working – linking homes and jobs to social and health support to provide opportunities for building self esteem. Its key objectives are to create more bed spaces, target street work more effectively, creating inside space into which to bring rough sleepers to initiate work/care programmes , ensuring a continuum of care with key players providing appropriate support and creating job opportunities .

Within this strategy the health needs of rough sleepers are complex- combining problems associated with alcohol/drug misuse, mental health problems and poor physical health.

The health perspective of the strategy is:

- to prevent rough sleeping,
- to prevent the ill health associated with rough sleeping ,
- to provide appropriate services and
- to create long term solutions. (2)

Significant challenges exist. The strategy points out that the complex mental and physical health needs of those on the streets are not currently being met.

Identified areas of activity to address health needs include:

- Addressing the level of drug misuse on the streets as one of the toughest challenges

'we are working with local authorities to aid access to prescribing services and with hostel providers to enable access to beds for continuing drug users'

- Addressing concern about alcohol misuse.

- Supporting those with severe and enduring mental health problems

'we will work with the NHS executive, Social Services Departments and other health partners to ensure that people sleeping rough who have severe mental illness get the help and treatment they need.'

- Promoting access to primary care

'primary care groups have a duty to ensure that rough sleepers have equal access to primary health care as the rest of the population and must incorporate the needs of rough sleepers into their planning. In addition we will ensure that key day centres and the night centre in London ...have access to GPs and on site nursing facilities'

National Health Policy

The needs of rough sleepers are not explicitly mentioned within the most recent policy documents from the Department of Health. However, it is implicit within many of the documents that there is an expectation that the needs of rough sleepers will be addressed. For example the NHS Plan (3), includes a chapter which highlights the need to address social and health inequalities . Other initiatives such as Surestart (4) aim to prevent mental ill health and promote positive lifestyles. Drug Action Teams are required to address not only the problems of drug misuse but also of alcohol abuse and increasingly consider the needs of those with dual diagnosis of mental ill health and substance misuse problems. (5) Health authorities and Primary Care Trusts are required to work closely with their local authority colleagues within the community planning agenda - playing an active part in linking Health Improvement Programmes and Community Plans in local strategic partnerships. Prison services and health services are working together to produce specific Health Improvement Plans. This trend two aspects of policy:

- The first is the need to work across sectors to improve health – as reflected by the Health Improvement Plans.
- The second is to find new ways of working –in partnership across organisational boundaries which can so often get in the way of delivering services to the people who need them.

Setting the context of the report

When analysing the health needs of any group there are certain basics which it is useful to understand. The key questions for rough sleepers include identifying who sleeps rough, and their population characteristics, as well as the natural history of their condition. The question then arises: what are their health needs? These may be contributory to their sleeping rough, or a result of their sleeping rough or a vicious cycle of both. Having identified their health needs the next question is what health services would best meet their needs and how these can best be provided.

Health services alone will not contribute the totality of the solution so it is also necessary to ask what contribution other agencies have to promoting the health of rough sleepers for the pathway of care - from prevention to treatment to care.

Analysis of the results of these considerations will highlight the practical steps which need to be addressed, what good services might look like, and what needs to be done to develop them at both a national and local level.

Section 2:

LITERATURE REVIEW

Who sleeps rough?

The rough sleeper population can be characterised as male(90%), 75% over 25, one quarter to one third of whom have been in local authority care. DETR research suggests that 50% are alcohol reliant, 20% are drug users, 30-50% have a serious mental health problem and under 5% come from ethnic minorities. (6) Recent surveys suggest the percentage who are drug users is increasing.

Groups particularly vulnerable to homelessness and rough sleeping include: young people leaving care; people who misuse drugs and alcohol; people with mental health problems; people leaving prison; people who have experienced family breakdown and people leaving the armed forces.

Dual diagnosis is an increasing problem among younger people whereas older clients tend to have mental illness and abuse alcohol. These people are particularly vulnerable and have multiple, interacting impairments and special needs requiring intensive services.

The average life expectancy of rough sleepers is 42 years, compared to the national average of 74 for men and 79 for women. Rough sleepers are 35 times more likely to kill themselves than the general population, and 4 times more likely to die from unnatural causes as accidents, assaults, murder drug or alcohol poisoning.

Use of drugs is common amongst homeless young people. A study by the Hungerford project in London found one fifth of homeless young people contacted were using drugs intravenously- and this had associated health problems. The reasons for drug use were identified as experimental, recreational, peer pressure, boredom, self medication and escapism -*drug use among homeless young people is understood as an element of a sub culture offering a support system with its own codes of behaviour, language and ideology* (7). Reid (8) found that despite high levels of drug misuse there was little contact with drug agencies, reluctance to seek help for mental ill health and a need for pro active interagency work to intervene early. Alcohol and drugs may be used as self-medication to deal with physical and mental pain. (9)

Dibblin (10) describes the experiences of women who are homeless, arguing that amongst those under18 homeless females out number males. The numbers are increasing. Poor health, depression, low self-esteem and the use of drugs and alcohol as coping mechanisms are all problems caused by homelessness.

Randalls (11) study of single ex servicemen highlighted the high prevalence of physical and mental health problems in this group of rough sleepers who tend to be older and to have given up looking for accommodation or work. A

1997 Survey, 'Homelessness on Civvy Street', commissioned by the Ex-Services Action Group, (12) found that 22% of those who were 'street homeless' in London on the night of 7 May 1997 were ex-Services. Although this survey agreed that the overall age was higher (50% over 50 and 25% over 60), it found that this population was *less likely* to be affected by drug and mental health problems, but *more likely* to be affected by drink and physical health problems.

The needs of ethnic minority populations tend to be under researched. One London study (13) highlights the lack of accurate figures. From a series of interviews it does however highlight the need for better primary care services. Registration rates were low and the Black African population had had particular problems when trying to register with GPs.

Having been in prison is a contributory factor to homelessness- with unemployment and lack of educational achievement being over represented. (14) The cyclical nature of homelessness as both a cause and result of imprisonment highlights the need to break this cycle. This is particularly since research shows short sentences can result in special needs ,such as those relating to mental health being overlooked.(15)

What are their health needs?

Bines (16) compares health of single homeless people with that of the general population. The key findings were worse physical and mental health; greater prevalence of skin, chest and musculoskeletal problems, which are negatively effected by sleeping rough; high levels of mental health problems across the range with a tendency to be trapped in the revolving door of crime, mental illness and homelessness.

A study in a North London based A&E department explored differences of health experience between those who were housed and the single homeless. 10% of the attendances were for mental health problems and there was an over representation of health problems- assault, wound infection, depression and self harm, gastro-intestinal problems, asthma, epilepsy, skin problems, chest disease, drug addiction. Only 30% were registered with a GP and 57% of the visits were inappropriate. (17)

Many studies identify the need for more long term care with greater liaison and collaboration between health, housing and community care. This is a recurrent theme within the literature on services. For example, a study of young people in Edinburgh (18) identified poor general health, low energy levels linked to hunger and more than a third having had major depressive episodes. There was a correlation between the duration of homelessness, a history of depression and history of suicide attempts. The study concluded

that there is a need to increase accessibility of existing services and build on work of HMII/specialist services

Those sleeping rough also have special health problems. The prevalence of TB is 2% amongst middle aged and elderly men on the streets- 200 times the incidence in the general population. Failure to comply with treatment is a cause of concern and better co-ordination between hospitals, health services and homelessness services is needed. Also needed are strategies for case finding and monitoring of homeless people with TB. (19)

Collins (20) in Glasgow found that despite their poor health homeless people did not prioritise their health as other daily living concerns were more immediate. There is a considerable unmet need and access to mainstream health services is problematic. Hinton (21) found that homeless people are very aware of health messages. They do worry about staying healthy but feel disempowered. Progress is impeded by a lack of joint working between health services and homelessness agencies- which could be redressed by action from local health promotion departments. This could include having an identified lead person, making training available to front line workers in hostels and day centres, ensuring appropriate literature is made available and doing this in close collaboration with appropriate front line agencies.

Commander (22) assessed the mental health needs of young people in Birmingham. Main messages from this report support the need to integrate services into the mainstream rather than set up special services for the

homeless. Improving support in hostels was important and the key message was the need for a co-ordinated response to youth homelessness and mental health based on multiagency team working. A randomised clinical trial by Susser et al (23) tested an approach to prevent homelessness among mentally ill individuals. This trial concluded that strategies that focus on a critical time of transition may contribute to the prevention of recurrent homelessness among individuals with mental illness, even after the period of active intervention.

The need for a co-ordinated approach to housing and community care at all levels is echoed in the RCP report on homelessness- which also describes the higher rates of death and disease amongst the homeless.

Fisher (24) describes the problems of accessing health care as qualitatively different for the single homeless. Barriers to access to health services arise from structural, administrative and attitudinal problems within the NHS. Access to and quality of healthcare provision for single homeless people could be enhanced by the development of flexible, integrated, multidisciplinary primary care services with outreach and advocacy functions.

Grenier (25) (Crisis)proposes that services need to be targeted to meet the needs of rough sleepers, with more specialist support in the form of healthcare teams. In addition earlier intervention with young people would prevent them adapting to a homeless lifestyle. Monitoring progress against strategic health policy targets , for example those within the NHS Plan could

be helpful. The theme of early identification is picked up by Klee (26) –who identifies the need for early interventions before young people become homeless, for an awareness of risk factors, for support for newly homeless, offering alternatives to street culture before illicit drugs become part of their coping strategies; harm reduction and rehabilitation work with long term homeless.

Assessing the health risks amongst young homeless drug users, Klee again found that the main problems were linked to environment and isolation. Drugs were present as part of the homeless lifestyle. 43% had attempted suicide and 25% had tried more than once in this Manchester based sample Knight (27) also suggests that health services for homeless people should be routinely assessed and provided for. Healthcare tends to be inflexible and unsympathetic to the special problems of homeless people.

Improvement in services is often hampered by difficulties in collaboration. *Affinity and trust between agencies, agreement on roles and responsibilities ,perceived gain to all parties and absence of alternative resources were understood to be key factors in successful co-operation (28)*

Perhaps one of the most important things to do is to rethink delivery of primary care to homeless people. Many studies identify the need to improve GP registration and rough sleepers access to main stream health care.

In a review for the Department of Health Pleace and colleagues (29) found there was a high use of A&E services because many rough sleepers found it was easier to attend there than a GP surgery. Some of the reasons for this

include prejudice against, and fear of, people sleeping rough by service providers; low self esteem and depression amongst homeless people making it difficult to access services; financial, organisational and administrative factors inherent within general practice . They suggested that better information about homeless services and for homeless people might be helpful- as well as targeted services and the need for rehousing and resettlement .In a study by Pleace published by the Kings fund (30), the greater health needs of single homeless were demonstrated by the higher levels of TB and mental health problems they encountered. Young people have higher risk of exposure to HIV and hepatitis. Health problems were compounded by problems with access to mainstream services. Access to primary care was particularly difficult, with problems getting registered and with attitudes of primary care towards them. Access to A&E was easier- but there were problems around discharge from all hospital services.

Addressing the needs of vulnerable groups and acting upstream poses particular challenges. Prisoners have particular health needs. They are mainly young men, many with drug related problems. A report by NACRO (31) points out the problems of short prison sentences and the decline in voluntary aftercare. *The vast majority of such prisoners are released without any supervision or assistance at all.....Few prisoners had adequate preparation for their release. Access to pre release courses was patchy and many prisoners were discharged with little idea what was happening to them and with no access to support or advice.* Although the report does not comment on links to health services, the lack of initial support on release –

particularly for a history of drug misuse- can be assumed. The report by the GLA (32) –Blocking the Fast track from prison to rough sleeping - was compiled from interviews with prisoners and professionals. Again, it did not include health and access to health services within the interviews although it does comment on specific problems of drug and alcohol misuse and mental health problems. When asked about mental health problems, many respondents said they had felt depressed, but smaller numbers had had serious mental health problems, often associated with substance misuse. There was a high incidence of drug and alcohol misuse in the prison population. Many felt they did not need treatment for their drug and alcohol use, but those who did thought there was not enough help available in prison to address their addictions, particularly for those with short sentences. The need exists for better targeting of those prisoners who are ready and willing to consider treatment. Addressing their addictions is a major part of addressing their offending behaviour and their often chaotic lifestyles. This is particularly so for people being discharged to insecure accommodation, particularly for those who have had previous short sentences, whose chances of being homeless are hampered by lack of support to find stable accommodation and establish relationships. People with mental health and addiction problems are particularly vulnerable.

Another group who may present particular challenges to health care providers are older street sleepers. They may not be able to give accurate medical histories, may not have insight to their health problems and may be non compliant with treatment (33) . In Lambeth, Southwark and Lewisham joint

primary care team nurses have found they have to escort confused and forgetful older clients to hospitals and clinics to keep appointments and that others have low self esteem and fear of being stigmatised by health care workers. (34)

Alcohol poses a particular problem in older homeless- creating multiple physical and mental health needs inter-related with heavy drinking. *'long standing alcohol abuse, poor nutrition and self neglect tend to produce progressive physical and mental health problems.'* The response to these needs has changed from a traditional containment to more active development of detox units, counselling services, rehab programmes and transitional housing all established to help heavy drinkers. There is also increasing availability of wet hostels- which adopt a harm minimisation approach and aim to reduce damage caused by alcohol abuse, to encourage abusers to control their drinking and to promote healthier lifestyles. Examples of the wet shelter approach include Providence Row in London and Equinox Old Steine in Brighton. Providence Row is set up with a palliative rather than rehabilitative philosophy and results in a higher rate of accommodation up take and retention than is common in programmes set up for street drinkers. No pressure is exerted to reduce alcohol in take but support services are offered. This includes close supervision of each residents general health , of their dietary and alcohol in take and provides for easy access to a range of external primary health services. An evaluation of Equinox found that *for one of the most vulnerable and excluded groups the Old Steine Centre provides basic needs, shelter, warmth, food and hygiene...we can see individuals*

developing regular patterns of attending the centre in the midst of chaotic lives....we can see clients developing positive relationships ... we have evidence of individuals beginning to function within the community....a potentially profound process of resocialization can begin in a centre of this kind. (35). From the literature it becomes clear that access to physical and mental healthcare services, to alcohol programmes that are responsive to urgent need, to social services and to support for healthier eating are all needed.

Mental health problems may be addressed by HMII teams. These are specialist outreach teams of mental health, housing and social workers who work on the streets and in hostels. They use the model of a key worker and developing individual care plans. But – many fall through the service gap.

The issues identified in the review of the Homeless Mentally Ill Initiative (36) 1990-1997, suggests that the needs of homeless mentally ill people are not fully met, particularly if they:

- have additional needs, i.e. drugs and alcohol,
- are from black and minority ethnic communities,
- are asylum seekers,
- have a personality disorder,
- have become entrenched in their lifestyle,
- are women.

The report highlights the pressures on the system as:

- the need for close involvement of a consultant psychiatrist in the work of the HMII
- gaps in the co-ordination of the system
- potential operational overlaps with other specialist services working with homelessness and mental illness
- exclusion of HMII services from full integration within local strategic and operational planning structures
- limited expectations of the services funded under HMII to collect common or comparable data, with a reliance on qualitative data as a measure of effectiveness.
- under-utilisation of HMII project housing accommodation, as a result of restricting access
- lack of clear protocols, pressure on hospital beds, pressure on community care budgets and lack of suitable accommodation hamper involvement of statutory agencies.

The Sainsbury Centre has highlighted the need for combined approaches to Mental Illness and addiction for dual diagnosis- and teams need appropriate expertise. HMII teams may run into problems when trying to resettle older homeless people because of lack of resources and reluctance of social services and Community Mental Health Teams to take on responsibility for people who needed long term support (37). Finding appropriate housing may also be a real problem.

What next?

From the review of the literature it is clear that the task of providing health care to those sleeping rough is not an easy issue to address. 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 is action which is targeted, co-ordinated, evidence based and sustained. A template for such action can be derived from *A Place in Mind*, (38) the Health Advisory Service report on mental health services for homeless people. Although produced within a different political climate it approaches the need to create a strategic context for shared service provision, many of the principles of which hold true today.

The report starts with the statement that 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 is extremely difficult to locate and provide help for homeless individuals satisfactorily. It points out that homelessness is often not high on the agenda of statutory agencies, that few have strategies or services to meet the health needs of homeless people and that the voluntary sector is often the major provider of services to the client group. As such it possesses knowledge, resources and skills in working with homeless people. Statutory agencies are not good at working together, particularly health and housing. There are problems getting homeless people registered with GPs and in the provision of primary care. The HAS report was partly compiled through visits and the

document states: *The teams experienced problems in making contact with GPs during their visits. The overall response rate to the questionnaire sent out was low and generally very few attended meetings. The questionnaire returns indicated a low level of awareness of issues of homelessness or the housing status of their patients. In many cases it appeared that primary healthcare workers did not know about the routes to specific services and agencies for homeless people.*

The report goes on to suggest some ways of improving primary care. The key message from the service visits was the need for a clear-shared strategy with all agencies signed up. This was seen as the best way of improving the often fragmentary and ad hoc availability of mental health care to homeless people. The role of GPs in this was seen as crucial and this will be even more true with the current changes to primary care. An agreed aim should be that **full registration with a GP is available to homeless people**- and at the same time **access on both a temporary and an immediate and necessary basis**. Other authors have noted that many GPs are reluctant to register homeless people, particularly those sleeping rough because: they lack a permanent address, tend to move around, have multiple problems and high index of need, result in deficiencies in remuneration, display problematic behaviour such as not keeping appointments and disrupting surgeries. They also have low uptake rates for specialist services.

Randall (39) in a review of health services for the DETR, found:

- there was a strong financial disincentive for General Practitioners to register fully homeless people who did not stay with the practice for longer than three months, as they received no payment for these patients.
- Receptionists in GP practices were identified as an important barrier.

However a study by Varnam and Varnam (40) found that despite a general consensus that homeless people would not find integration into mainstream health services acceptable, the results suggested that integration of the single homeless into the practice had positive impacts on their health, with a reduction in their excessively high consultation rates being measurable between 1990 and 1992.

Accident and Emergency Services

Wake 1992 found that 22 per cent identified A&E departments as their main point of access to primary care (41). A&E departmental staff felt that homeless people were time consuming, had multiple health and social needs and made extensive use of inappropriate facilities, using considerable resources in an ad hoc way. One third of homeless attendees to A&E were alcohol dependent, but there were no formal links between A&E and alcohol agencies. In addition, beds in overstretched psychiatric wards were being inappropriately used for homeless people with multiple needs, simply because there were no alternatives to which they can be discharged (42). A shortage of detox beds and a lack of follow up support after discharge was identified

There was a better chance of gaining access to therapeutic services and reducing drinking problems once someone has a stable home, than when they are homeless. The implication of this is *'the need for services for homeless people to be specified within NHS contracts, with clear quantifiable targets'* (43)

The Mental Health Foundation (44) reports that the Association of Directors of Social Services believe that the statutory services are likely neither to give sufficient priority to specialist provision for street drinkers, nor to succeed on their own in providing it in an acceptable way. Instead, they propose partnerships between statutory and voluntary agencies.

Rough sleepers often have very poor physical and mental health and some have significant problems with alcohol and drug use. The inter-related nature of multiple needs compounds the issues faced by many rough sleepers. At present their needs are poorly serviced by the configuration of health and social services in residential catchment areas. As a result, rough sleepers have poor access to primary care, low uptake rates for specialist services (particularly because of missed appointments) and poor planning for through care and after care services. Rough Sleepers often use hospital and specialist services in times of crisis, and may be lost to the health and social care system after an episode of care (45)

The problem is compounded by passivity of many homeless people who have low self-esteem, are poorly motivated to seek medical care and fear illness

and doctors. Various primary care models exist and have various points to although risk segregating them, fail to provide good out of hours cover and have difficulty recruiting staff (46)

The Kings Fund project Under One Roof (47) has attempted to find new ways of working between all agencies- voluntary and statutory- to share information and work effectively together. It stresses the importance of investing time and energy in agreeing the purpose of partnership and understanding different motivations and perspectives. The statutory sector needs to accept voluntary agencies as equal partners and voluntary agencies need to acknowledge the responsibility to work collectively rather than blame statutory services when things fail to run smoothly. The report looked at 3 models of services - all services in one place(one stop assessment), all expertise in one place(panels), all services in one person(generic assessor). Their preferred option was for panels and they recommended that their establishment be flagged up in the HImP.

Developing a strategy:

One of the overwhelming impressions from this project is the feeling that there is no shortage of information or good ideas but that what is needed are new ways of working together to address the problems faced by homeless people specifically those sleeping rough. The HAS report suggested a strategic framework, a list of pre requisites, identified good practice and an evaluative

framework. These are included below as a starting point for any health authority/PCT or other agency to consider:

Strategy

The purpose of a strategy would be to:

- Monitor the scale and nature of homelessness locally
- Regulate the establishment of services
- Target resources effectively and efficiently
- Ensure high quality provision
- Promote efficient co ordination of services
- Identify gaps in provision
- Monitor outcomes
- Provide the opportunity to research and produce evidence of what works best

The sort of problems any strategy needs to address are identified by Sills (48), who suggested that local systems currently fall into three models of provision:

- Targeted services, designed to be more accessible than mainstream health services
- Workers who advocate for the homeless
- Adaptations to mainstream services, i.e. training packs for GPs and reception staff, A&E Departments assisting with the discharge of homeless patients, drop in sessions at GP practices, closer working links with local

agencies. These solutions were proposed following analysis of key issues which needed to be addressed:

- The lack of a comprehensive and continuous service, which provides a seamless service between acute and primary care
- Considerable variation in availability and access to health services. Lack of a comprehensive response to the health care needs hinders any local response to provide adequate appropriate and co-ordinated services
- Considerable number of projects are short-term and hinder long term developments of the service. There is often replication of projects across the region without learning from what has gone on before
- Health and Social Care partnerships do not work effectively well
- Nurses working within this field find themselves isolated, working as lone practitioners placed in positions where they have to take risks
- Nurses feel that they and their services are not high on any Trust agenda
- Although there is a sophisticated voluntary sector network, this is not evident within healthcare. This limits the sharing of good practice and opportunities to develop the service
- There is no one source of information on the provision of health services for practitioners working within the acute and primary care setting. This leads to frustration and the inability to ensure that homeless people are offered the best care
- No one source of information to enable services to be planned, definitions and the way statistics are collected vary across the region.

Prerequisites

In constructing an overarching strategy to respond to these needs it would be helpful to know:

- The definition of rough sleepers and other homeless groups e.g. hostel residents
- How different agencies are working together
- What written agreements are in place for access to psychiatric and medical advice and care
- What the policy of the A&E services is, especially towards discharge
- What the service level agreements for drugs and alcohol services look like- with particular reference to community detox and its protocols/support
- How the various statutory mental health guidelines are being put into place/ functioning
- How the health care sector works with housing and social services to meet the needs of rough sleepers/homeless people
- What arrangements are in place to train/promote better understanding of the health sector by the voluntary sector
- Whether there are protocols for referral
- Whether specialist providers can complete a preliminary assessment within 48 hours of all urgent referrals
- How many clients have key workers
- Whether all rough sleepers who have mental health problems are reviewed on a regular basis
- How many practices will register rough sleepers

In addition it would be helpful to know

- whether in the longer term strategy resources have been secured for the voluntary sector to allow stability and development, and as part of this whether consideration has been given to a shared community strategy/local strategic partnership and pooled budgets
- How the targets in the NHS Plan/NSFs are being set/monitored with specific reference to the health of rough sleepers/homeless people

Good practice

Elements of good practice in providing community mental health services for homeless people are illustrated in Table 4, which is taken from the HAS report. (49)

Table 4

Elements of Good Practice in Providing Community Mental Health Services for Homeless People

- Drop in services with self referral
- Liaison and advocacy roles emphasise the requirement for an holistic approach to service commissioning and provision
- Work in partnership with voluntary and statutory services
- Emphasis on listening – services and their staff should be perceived by users as welcoming and approachable
- Effective information and publicity
- Multi-agency working
- High quality clinical expertise with built in evaluation
- Outreach work and out-of-hours services.

As noted before, the description of needs and analysis of action needed is well described. Putting knowledge into practice must be the next step.

Evaluation

A framework for action requires evaluation. The growing awareness of the social, environmental and economic factors which impact on health and the responsibility of local authorities for determinants of health and for partnership working with the health sector will be included within Local Strategic Partnerships. Evaluation of the health needs of the homeless and how they are met by the local health and local authorities is an important part of monitoring progress and continuing to develop the services needed.

Suggested targets for service development include:

Health Gain Area	Service Targets
1. Developing Access <ul style="list-style-type: none"> • Increase the number of initial contacts between homeless people and clinicians 	Targets <ul style="list-style-type: none"> • Invest in multi-disciplinary outreach work in both primary and mental health care • Increase the uptake of registration with GPs • Maximise access to GPs via sessional work and outreach surgeries
2. Health Promotion <ul style="list-style-type: none"> • Seek to reduce the incidence of physical and mental ill health problems in homeless people 	Targets <ul style="list-style-type: none"> • Develop thematic information programmes, eg alcohol, depression • Publicity targeted on Health of the Nation Objectives • Mobile screening units • Joint clinics with social services, including advice on benefits
3. Co-ordination <ul style="list-style-type: none"> • Provide a co-ordinated and flexible service which can respond sensitively to the special and complex needs of the homeless people 	Targets <ul style="list-style-type: none"> • Establish formalised systems and protocols for liaison between relevant agencies and services in respect of this client group
4. Information	Targets

Health Gain Area	Service Targets
<ul style="list-style-type: none"> • Provide appropriate levels of care based upon assessment of individual need 	<ul style="list-style-type: none"> • Develop common systems of information gathering and exchange between relevant agencies, including social services housing and the voluntary sector.
	<ul style="list-style-type: none"> • Ensure that the Care Programme Approach and other care management and planning processes encompass homeless mentally ill people
	<ul style="list-style-type: none"> • Develop collaborative care monitoring systems with other agencies
<p>5. Housing and Resettlement</p> <ul style="list-style-type: none"> • Work with appropriate agencies, to ensure provision of short-term, medium term, and permanent accommodation for homeless people 	<p>Targets</p> <ul style="list-style-type: none"> • Participate in local and voluntary housing sector planning processes
	<ul style="list-style-type: none"> • Collaborate in the establishment of co-ordinating housing bodies such as trusts and consortia
	<ul style="list-style-type: none"> • Ensure the local authority exercises its nomination rights to housing association tenancies
	<ul style="list-style-type: none"> • Employ, or fund, experienced resettlement workers
	<ul style="list-style-type: none"> • Assist the local authority homeless persons unit by input into assessments by ensuring the availability of clinical staff

(Based on HAS report (50))

This evaluation framework could provide necessary information for monitoring progress.

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Section 3:

Sleeping Rough in Oxford

The last count of rough sleepers took place on the 16th October 2000. A total of 29 rough sleepers were found. Very few were identified by name as the weather was cold and they were tightly wrapped up under blankets.

With the help of the database we are fully aware of 22 people who have been sleeping rough in Oxford for 4 months plus – some for a number of years. We are also aware that each month a high number of people will sleep rough one or more nights as the emergency provision may be full, they have been barred or have made a choice to sleep rough. In addition we are also aware of the high number of people who are passing through Oxford as they travel the country, some stay for a night or two before leaving, others for a few weeks.

Provision for Rough Sleepers in Oxford

Support Agencies

The Elmore Community Support Team
The Salvation Army Homeless Outreach Project
Others
Connection
Long Term Floating support team

Provision for over 25s

Lucy Faithfull House
English Churches Housing Group (Will take a limited no of under 25s)
Simon House
Cherwell Trust
60 Lake Street
Stonham Housing Association

Emergency Accommodation

The Night Shelter (over 25s)
The Bridge (under 25s)
The Women's Refuges

Day Centres/Drop Ins

The GAP day centre
Luther Street Drop In
Libra project
The Gatehouse
The Porch
Manzil Way – Wednesday Lunch Club

Rough Sleeping

Latest figures show on average 31-35 sleeping rough every night

Provision for under 25s

Windmill House (Supported Accommodation)
60 Lake Street (Low supported)
The Gateway Project
Substance Misusers Supported Accommodation
Dolphin Project (Dispersed S/c flats)
DISH project (out of Oxford s/c flats)

Rehab provision

The 195 Project
The Ley Community

Medical Services

Luther Street Medical Centre
The Methadone Bus
City Homeless Mental Health Team
Drugs and Alcohol Team

Statutory Sector Services

The Homeless Persons Unit
General Housing Register
Probation Hostel
Bail Hostel
Move-On accommodation (provided by council and housing associations)

HEALTH OF ROUGH SLEEPERS IN OXFORD

This section of the report estimates the health needs of rough sleepers by:

- a) using local reports to describe the numbers of rough sleepers and some of their needs.
- b) using comments from the series of local interviews to highlight key issues.

The definition used is:

The person –

Has slept rough at least two weeks in the last month

Or at least one month collectively in the last year

Or at least 3 months in the past 5 years.

The definition of Sleeping Rough is –

- Sleeping in a shop doorway
- In a park
- On the streets

It does not include –

- Using squats
- Buses
- Trains
- Clubs

A: LOCAL NEEDS

In January 2001, the support needs of the identified 22 entrenched rough sleepers currently show that three people have mental health problems and one person has Dual Diagnosis. (51). Statistics from September 2000 to

November 10th 2000 show that there were 31 people who had slept rough or slept rough intermittently with mental health and dual diagnosis problems. Some of these people have now been accommodated and others have left Oxford or have not been seen.

These statistics show the following:

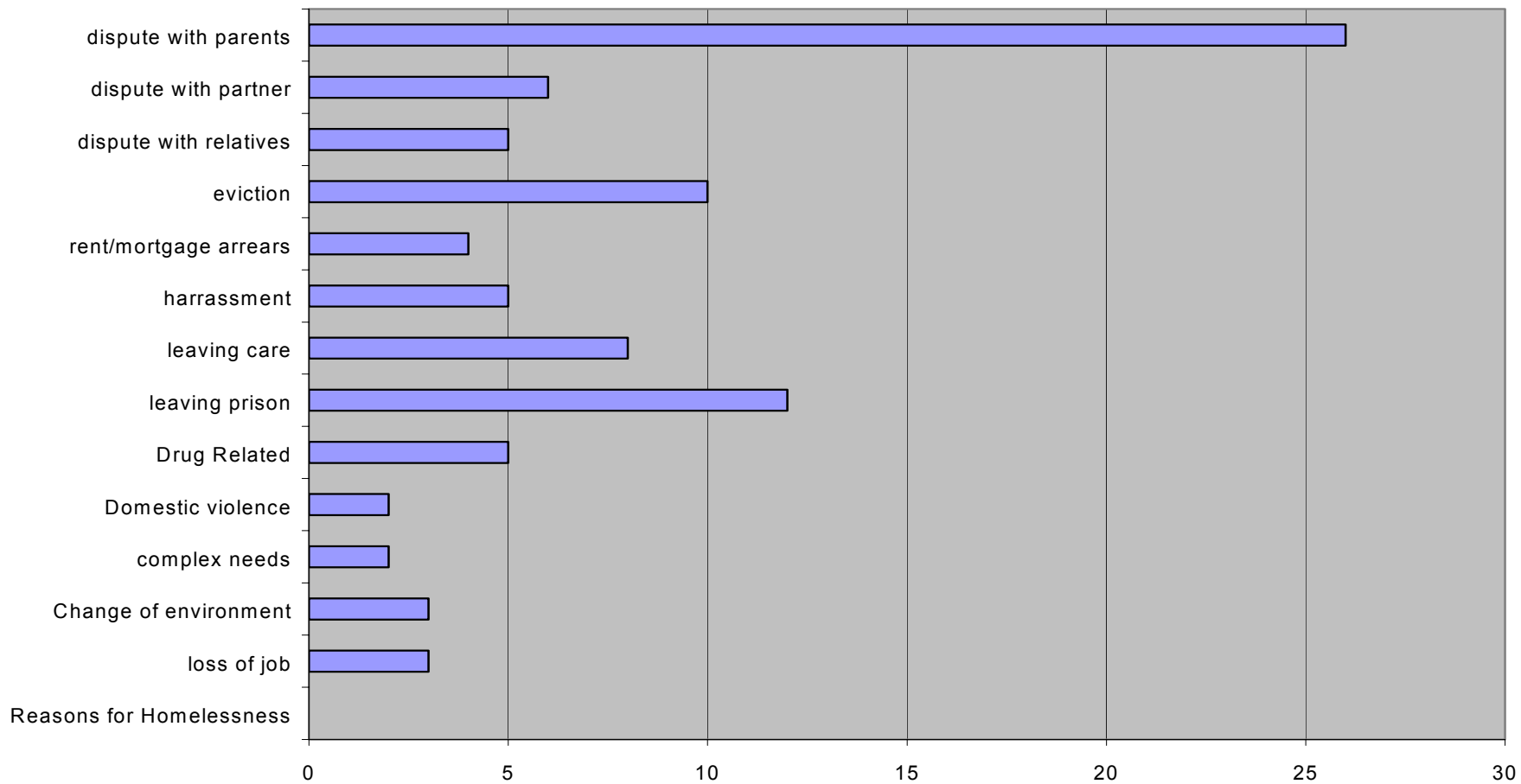
- 2 people were identified as having Dual Diagnosis and were sleeping rough
- 11 People were identified as having Dual Diagnosis and were sleeping rough intermittently, most were accessing the emergency accommodation (The Bridge or Night Shelter) and some of them had their own accommodation.
- 7 people were identified as having a Mental Health problem and were sleeping rough in this period
- 11 people were identified as having mental health problems and were sleeping rough intermittently, most were accessing the emergency accommodation and some of them had their own accommodation
- The 4 people who have been identified in the Entrenched Rough Sleepers list are all being monitored by either the Elmore Team in the first instance or the Salvation Army Homeless Outreach Project. To date, they have not wanted help in addressing this aspect of their life. Most of them are hard to engage with.

Detailed data is collected by a variety of agencies about people sleeping rough and in hostels within Oxford. For example the Shelter report for March

to May 2000 (52) describes the numbers recorded as sleeping rough and those known to sleep rough intermittently. For March this was 67 people of whom 28 had drugs problems, 18 alcohol problems, 6 mental health problems and 6 dual diagnosis problems. During that time period, 16 people had partners and 5 were recorded as travellers. Statistics collected from people sleeping rough and in hostels/supported accommodation confirm the national picture of a mainly white male group who have a variety of health needs including need for primary care, for mental health care, for treatment/ support for drug and alcohol related problems. The major reasons for homelessness were not dissimilar from the national picture- with family/domestic dispute as a major trigger, and leaving care, leaving prison and other institutions as well as housing related problems being listed. The Oxford City Homelessness Strategy highlights that the night shelter accommodated 1149 individuals in 1998/9 of whom 812 were new to the shelter and 312 gave Oxfordshire as their last address. However, needs assessment has been hampered by poor DAT returns from Oxfordshire Mental Healthcare Trust.

The English Church Housing (53) needs analysis of residents again showed the expected pattern of many residents having problems with drugs and alcohol (36%) , mental ill health 53% and also physical health problems (53%).

Reasons for Homelessness (out of 94 records)



Graph 1: Reasons for Homelessness

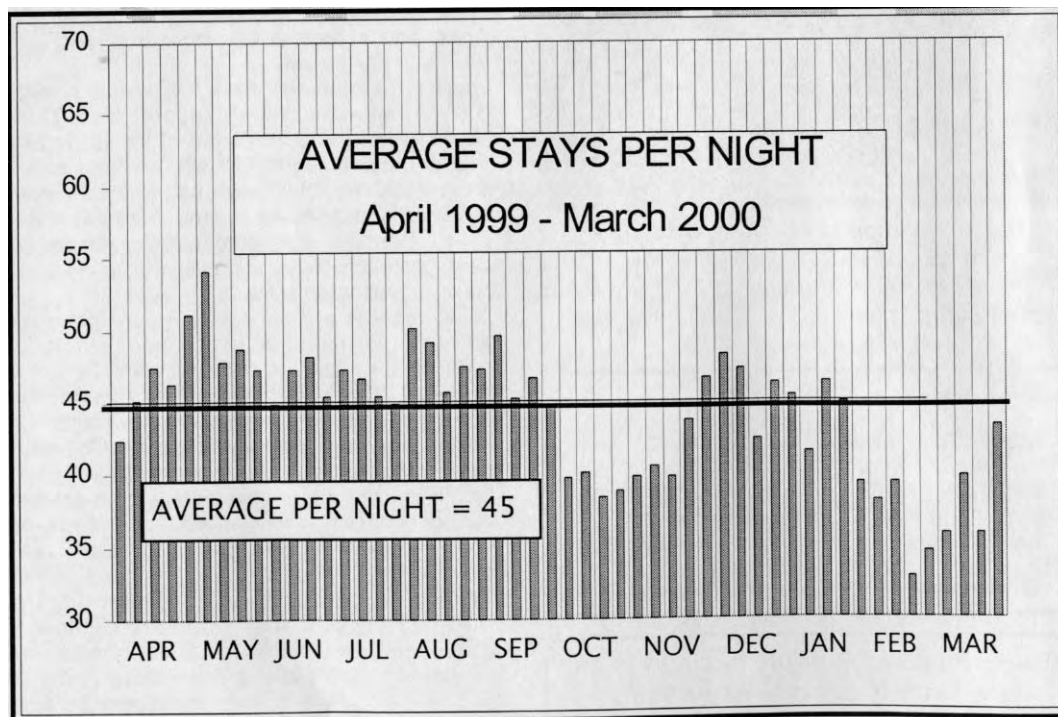
Source: Adcock J (2001) Statistical Report of 16-24 year old homeless people in Oxford City Centre – Jan'00 – Jan '01

Figure 2: Breakdown of Drop In Centre Users

Breakdown of Drop in Centre Users				
Male	89%		Drug Users	24%
Female	11%		Alcohol users	31%
Under 30	24%		Mental health problem	16%
30 to 65	76%		Disability	6%

Source: Oxford Night Shelter Annual Report 1999 –00

Figure 3: Average stays per night



Source: Oxford Night Shelter Annual Report 1999- 2000

Problems with drugs and alcohol are common amongst people attending the Gap. In the 3 month period from April to June 259 individuals attended the Gap, 221 males and 12 from ethnic minority groups. The total attendances were around 4500 with an average of 70 a day. Full needs assessments were undertaken for 76 clients of whom 4 had mental health needs, 18 had substance misuse problems(class A) and 5 had alcohol related problems. Oxford City Council produces a single homeless strategy annually. (54) This is predominantly concerned with housing issues. It states that the 206 direct access beds in 4 hostels have been full almost every night for well over a year and there are 100 people of no fixed abode on the council's housing register. This pressure , due to lack of available accommodation, severely frustrates the work of the RSU and HMII. Since January 1999 the Single Homelessness project has been establishing needs and looking for partnership solutions to direct access provision, supported housing, move-on, resettlement and day care services, employment and training and provision for the under 25s. The strategy reports on the analysis of the returns from a survey they undertook- but the results need to be seen in the light of poor response from mental health residential projects and the night shelter. It highlights the problem that providers of longer term accommodation will not accept intravenous drug users and private landlords are reluctant to accept people under 25 on benefits because of restrictions on rent covered. The view of the group is that drugs support is best provided on a visiting basis and that drug users should not be accommodated in cluster flats or hostels because of the problems of local residents. A project for 10 users in dispersed but supported accommodation is currently in development.

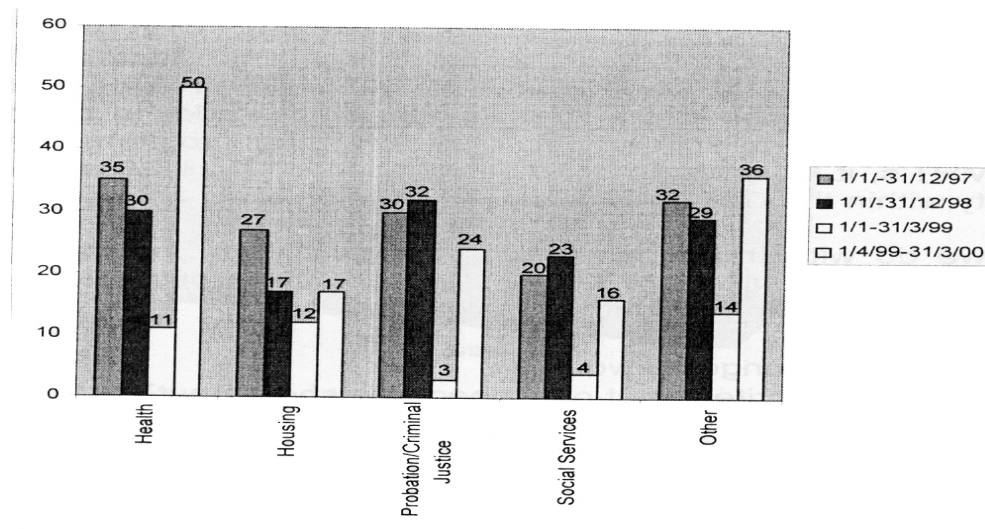
It is estimated that 30 more bed spaces with on site daytime support are required for people dependent on alcohol. Some of these need support with giving up or staying off alcohol whilst others will wish to continue drinking. At present no hostels in Oxford permit alcohol consumption on the premises- although work elsewhere has shown only 54 % wanted to be in a hostel where others drink.

The strategy cross refers to the Health Improvement Programme - highlighting the priority given to mental health and to drugs and alcohol misuse. It also refers to the commitment to support vulnerable groups and to work more closely with local authorities to reduce the health inequalities of vulnerable groups including the homeless, those from ethnic minorities and those with dual diagnosis.

Statistics from the Elmore Team show that they have worked with multiple agencies,

Graph 1 – Source of Referrals in 1997, 1998 and 1999-2000 Total referrals

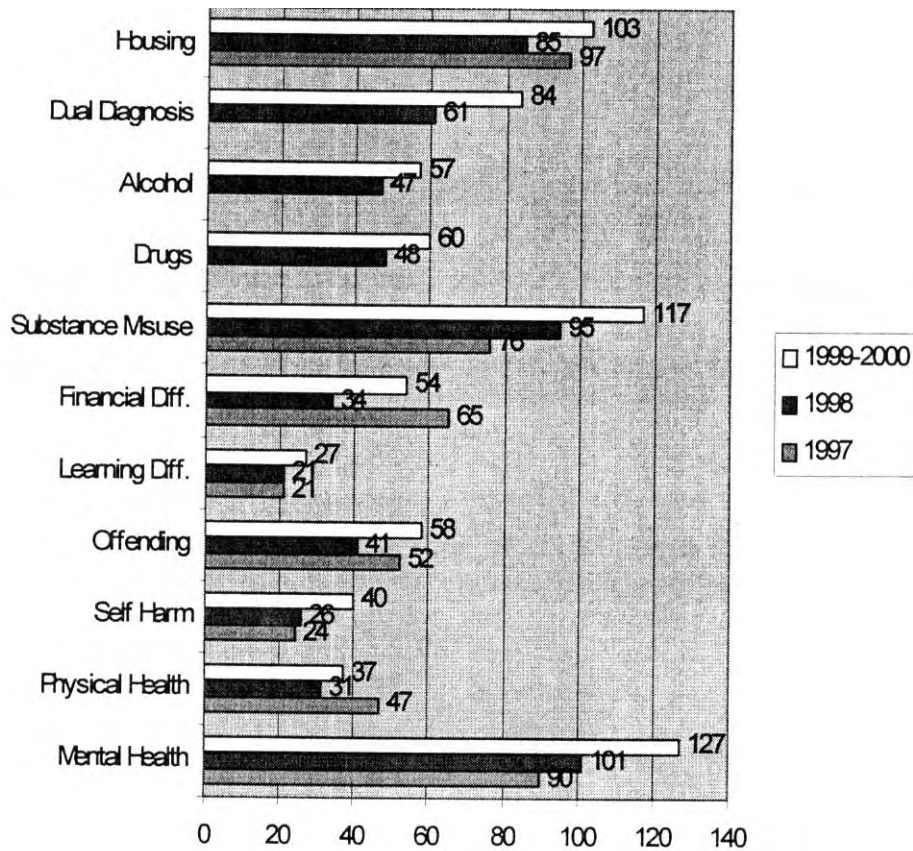
in 1997 - 144; 1998 – 131; 1999/2000 - 144



Source: Elmore Committee Annual Report January 1999 – March 2000

Graph 2 Known needs of clients in 1997, 1998 and 1999/2000

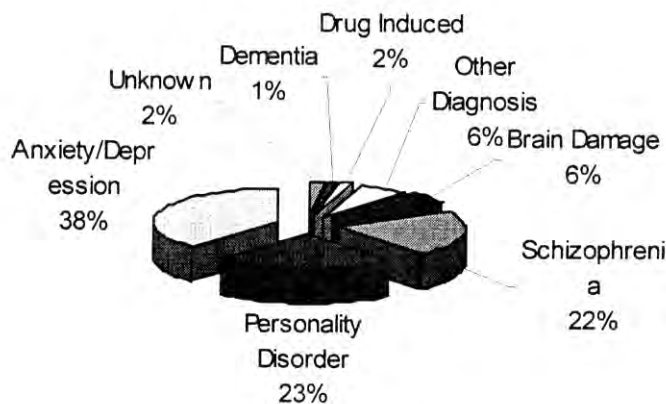
Total number of clients in 1997 – 108; 1998 – 117; 1999/2000 - 144



Source: Elmore Committee Annual Report January 1999 – March 2000

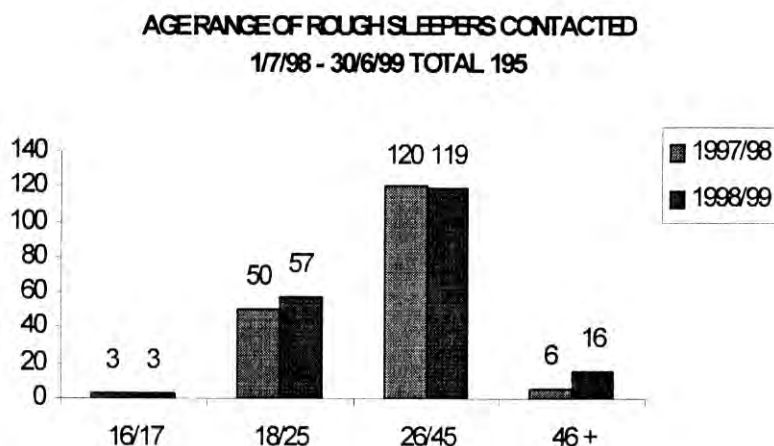
Graph 3 – Breakdown on Client Mental Health Problems in 1999/2000

Total number of clients in 1999/2000 – 144



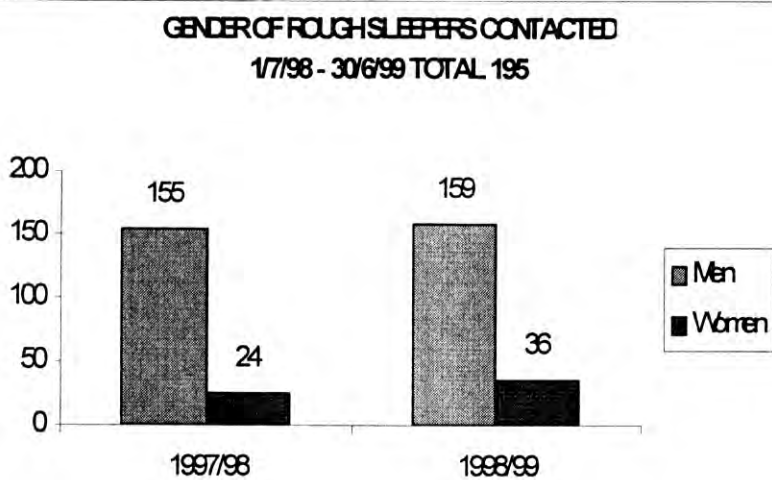
Source: Elmore Committee Annual Report January 1999 – March 2000

Graph 4: Age range of rough sleepers 1/7/98 – 30/6/99



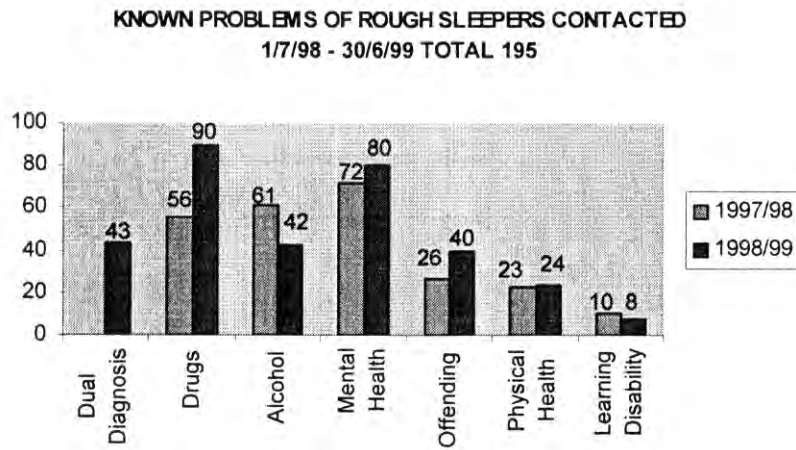
Source: Elmore Committee Annual Report January 1999 – March 2000

Graph 5: Gender of Rough Sleepers 1/7/98 – 30/6/99



Source: Elmore Committee Annual Report January 1999 – March 2000

Graph 6: Known problems of rough sleepers 1/7/98 – 30/6/98



Source: Elmore Committee Annual Report January 1999 – March 2000

Dual Diagnosis

Jeremy Spafford (55) in his recent study of dual diagnosis amongst Oxford's homeless population defined it as:

'Dual Diagnosis is where a person has a mental health problem and a substance misuse problem and, if one was to be resolved, the other would still cause significant concern and where the duality of the diagnoses prevents agencies from being able to offer an adequate service'

'At any one time, between 5 and 20 people in Oxford are living a very chaotic lifestyle and are involved with most if not all the relevant agencies without getting an effective service from any of them.'

'Up to 315 people whose lives are less chaotic but who still receive an inadequate service due to their dual diagnosis and who may become part of the smaller group if nothing is done'

The change in recent years has been away from alcohol as the drug of choice for the homeless towards Class A drugs obtained illegally, particularly heroin. In Oxford the homeless patient population is younger, more likely to be affected by drug use and much less able to access even services specifically for homeless people. For instance, there is a chronic and absolute lack of hostel accommodation for under 25s. There are significant levels of clinical depression among substance misusing street homeless people, as well as significant numbers of psychotic illnesses and especially anxiety related disorders. Everyday brings us new patients with substance misuse issues, many of whom will be seeking to change their usage and take control of their lives in the period after registration. Luther Street is currently the only service willing and able to offer this type of support to the homeless people of Oxford. Other services tend to exclude by demanding high levels of compliance or behavioural changes that are, in the short term, unrealistic for those living on the streets. A longer term perspective on care is needed, and action and political backing is needed for the development of the Luther Street Model as part of an integrated programme of care. (56)

The core recommendations from this report are:

- The production of acceptable working definitions of relevant terminology

- The development of common assessment protocols for mental health, substance misuse and risk
- The introduction of multi-agency conferencing at a high level to help resolve gaps in service to people with multiple needs
- Improving access to existing treatment services
- The introduction of more specialist services via existing teams or in a new team

In the recent review of Heroin, Crack and Crack within Oxford by Richard Huggins of Oxford Brookes University (57) significant unmet need, in terms of support and treatment, amongst problem drug users in Oxford was reported. Users and ex-users of heroin and crack often had highly complex sets of individual difficulties to overcome, of which drug use is only one aspect. The need for support and treatment services to be able to respond in a flexible manner to such needs was stressed. The study found that 69.2% of respondents had experienced some form of contact with support agencies at some time, but only 25% of respondents felt that they could access treatment services quickly enough, and only 20% felt that they could access treatment when they wanted to. 66.7% of respondents felt that methadone was not an effective way to come off heroin and nearly 100% of respondents either wanted to stop using heroin and crack altogether or, if they had already stopped, to stay off these drugs.

From this review a certain number of recommendations have arisen. These include:

1. the need for greater availability for support and treatment, with assessment and referral times being cut. There is a need to be able to refer clients into proper and suitable programmes.
2. There should be a single comprehensive assessment record
3. Increased co-ordination about services, education programmes and information
4. Greater attention to risk factors
5. Clearer links into the social exclusion initiatives, since many individuals reporting both established drug misuse patterns and histories of criminal offending have often been outside the conventional systems of education prior to becoming involved in both drugs and crime.
6. Provision for education and prevention should be more effective, with greater customising of services
7. Greater use of prisons as the locale for treatment and intervention
8. Whatever is achieved in prison must be backed up by specific and targeted support for ex-prisoners on release.
9. There needs to be pooling of data, information and research to help us understand and be more effective across the system.

Further details of these recommendations are within the report.

Comment:

The description of those sleeping rough on the streets of Oxford and within hostels is probably not significantly different in profile from the results of the literature review. The major problem facing the city is the lack of appropriate

accommodation. Despite the good intentions of the Health Improvement Programme, there is a gap between intention and developing a comprehensive approach to the health needs of those sleeping rough in the city, and again a gap between strategy and implementation of an approach which is based on the pathway of care from prevention through treatment to care.

There are particular challenges in:

- Accessing generalist primary care
- Developing specialist primary care at Luther Street
- Providing appropriate mental health services
- Integrating specialist addiction teams into primary care and community based ways of working
- Co-ordinating attempts of various agencies – statutory and voluntary – to provide the most effective services.

The next section of the report reflects comments from service providers within Oxford and their suggestions for taking the work forward.

Section 4:

This section of the report is a series of quotes from interviews with providers in the voluntary and statutory sectors working with rough sleepers in Oxford. A fuller account of the interviews and services provided is attached in Appendix 1.

The comments are grouped under key themes:

- a) better ways of working together
- b) young people
- c) improving health services
- d) housing issues

A: Better ways of working together

'there are many people working in the field – but organisational interests get in the way. What is needed is collective action, and there is a particular need for better physical resources.' (The Gap)

'There needs to be a round table understanding and trust between health and housing in Oxford City' (Luther Street)

'At the current time there seems to be a lot of talk about reshaping from the specialist to community based services, but it is not absolutely clear who is doing what, what the protocols for referral are' (Luther Street)

'the need for clearer relationships with the voluntary sector is recognised, and work is currently on-going' (Oxford City PCG/T)

'some of the frustrations include failure to be able to get hold of the right people at the right time, particularly access at a time of crisis, and also knowing who to speak to.' (Lucy Faithful House)

'there is a feeling that we all need a clearer way of working together, especially with regard to drugs misuse.' (The Gap)

'we need to provide contemplative space. There seems to be poor links with statutory agencies and lack of clarity about what/how outreach support can be provided' (The Gap)

'Better /co-ordinated follow up from prison would also be beneficial.' (The Gap)

'For those in prison, short term offenders have particular problems, and perhaps it would be useful to focus on short term offenders to see whether they could be motivated, particularly to think about work, preparation for rehabilitation and re-entry into the community, addressing how they got into the position they are in, and what they are going to do next' (Bullington)

B: Young People

'young people find it very difficult to find accommodation within the City' (The Gap)

'One of the major problems has been accommodation for young people who are using drugs' (Lucy Faithful House)

'There is a need for help and accommodation to allow young people using drugs on the street to come in to make decisions about detox. At the moment the onus is on them to detox on the streets, before they can get housing and this is clearly a disincentive' (Salvation Army)

'Younger people won't go to Luther Street because they find it a difficult environment: some find it frightening' (The Gap)

C: Improving health services

'primary care provision is patchy, and Luther Street, whilst providing an invaluable service, is not the totality of the solution. They have a key part to play. There is also a need for closer links with other GPs.' (Elmore Team)

'Luther Street is an excellent resource – but it needs better funding and a clearer role in outreach' (John Adcock)

'Need to outreach to recently, often vulnerably housed, people to help with rehabilitation' (Luther Street)

'Health focussed outreach could be helpful, as could having clinics on site'
(The Gap)

'de-institutionalisation of the environment would help make this better, with better access to primary care, better understanding by primary care' (Lucy Faithful House)

'There is a need in PCTs for better training to promote understanding and gain engagement' (Luther Street)

'There is a gap in GP knowledge at present, particularly about the use of methadone. The need to be more creative in the treatment of drug addiction, community detox is an important gap, with a lack of pre-contemplation places.' (Elmore Team)

'There is a need for easier access into the health care system for those in crisis. Care workers and outreach teams sometimes find it difficult to get help when a person they are working with has a crisis, particularly within mental health' (John Adcock)

'In general, staff and inpatient units have little understanding of illegal drugs, so when patients are using speed on the ward, they often feel scared by their lack of knowledge' (Elmore Team)

'Dual diagnosis is a particular problem. More dialogue between the addiction services and mental health and the adult services in mental health trust would help' (Elmore Team)

'There is no evident alcohol support. They used to refer for counselling, now most of it has to be done in house. This is obviously a gap' (Luther Street)

'Health needs to provide support both in prison, and on discharge, by creating better links to GPs with prior knowledge, notification, overcoming some of the confidentiality issues by engaging the prisoners themselves and asking them whether they would want to be involved in follow through with GPs' (Bullingdon)

D: Housing issues

'there is an apparent lack of a clear pathway through from caseworkers to mental health trust, and people are unclear about the model of community detox' (Lucy Faithful House)

'There seems to be a message that accommodation is around, however everyone working in the field knows that this is not true!' (Simon House)

'The system currently perpetuates the role of the hostels. Although some will always need hostels, the need is to challenge the dependency culture and provide more self-contained rented houses with social support.' (OCHA)

These quotes are only a snap shot of view expressed by a variety of those involved in providing health and social care to rough sleepers. They highlight some of the key issues which need to be addressed – and which formed the basis of the discussion at the Oxford seminar in February.

Section 5

The Oxford Seminar

A workshop was arranged at Wolfson College to look at the health issues surrounding rough sleepers in Oxford. The purpose of the workshop was to present the initial findings from the literature review, and to facilitate discussion on the primary care, mental health, prevention and drugs and alcohol related needs of rough sleepers. Jonathan Sharrock from the Rough Sleepers Unit was asked to present on the national context, Sian Griffiths presented the context of the work and John Adcock gave an overview of the local context and the initial findings from this project were presented. (slides attached)

Delegates were invited from both the voluntary and statutory sectors. Using a series of case studies, delegates were asked to assess the current provision of services and identify gaps in provision and obstacles, before identifying potential frameworks for development.

Members attending the seminar were divided into six groups to discuss key issues raised by different case studies. All were asked to address the questions:

- **What would we like to be doing?**
- **What are the blocks?**

- **What is needed?**

and to highlight key points for feedback.

Feedback:

Case Study 1

Short Term Prison Leaver

26 Year Old White Male

Client 1 has history of sleeping rough for the past 3 years with periods of two to three months prison sentences.

He has a drug dependency which periodically escalates. His prison sentences are a result of shoplifting and burglary.

He has been the victim of physical and emotional abuse from his father for which he received counselling but decided it was a waste of time.

His behaviour can often be intimidating to staff and other users.

Client 1 is articulate and has good literacy skills. He is able to keep appointments when motivated.

Client 1 has often said he wants to settle down, give up drugs and move from sleeping rough/using squats.

Recently, Client 1 was lined up for funding via Social Services Drug & Alcohol Team. Unfortunately, due to another charge, he was sentenced to three months in prison and has since lost this opportunity.

He accesses Outreach and Day Centre services regularly but has periods of non engagement with staff.

He refuses to use local hostels, The Night Shelter and is too old to access The Bridge Project.

What would we like?

- An **action plan** which is agreed between client and partner services and reviewed regularly, to include an exit plan e.g. housing, employment.
- Identify which agency has the **key worker** role & identify the person.
- **Flexibility** within agency boundaries and funding.

What are the blocks?

- **Mismatch between agencies**, cultures, constraints, philosophies.
- **Action plan not agreed** across services.
- Not all agencies are at same **planning stage** & some don't have the **capacity (resources)** or do not want to.
- **Stigma** – 'drugs & criminal justice'.

- **Limited opportunity** for one person to take a key worker / co-ordinator role for support.

What is needed?

- **Joint working** – all key agencies around the table – ‘case conferences’.
- **Way of identifying ‘key worker’ agency** to co-ordinate the case’s multiple support needs & particularly when he leaves prison (when he may be clean).
- **Culture of partnership working** – letting go, pooled budgets etc. (Skills needed.)
- **Flexible service provision** – work in window of opportunity amongst ‘chaos’.
- **Better communication** to improve understanding of how different organisations work – understanding constraints, boundaries etc.
- **Reduce over reliance** on agencies & agency over reliance on clients.
- **Befriending services**
- **Case conferences** – all agencies to be involved.

Summary:

- More effective joint working / ownership / understanding between agencies.
- Mismatch between agencies / cultures / philosophies / working methods / stigmatisation / competing pressures.
- Flexible approach to match individual client needs including ‘exit plans’.

Case Study 2

Care Leaver

18 Year Old White Female

Client 2 has slept rough in Oxford for long periods of time for the past two years. She is in a co-dependent relationship which often subjects her to physical abuse. Her partner also sleeps rough. Both of them use IV drugs.

Client 2 was placed in care at 14 years old, due to neglect. At 16 she was housed in a shared supported house but this didn't work due to her disruptive behaviour. Because of this she was housed by Oxford City Council's Homeless Department. After a short time she was evicted due to disruptive behaviour. At that point she was regarded by HPU as intentionally homeless.

Social Services were contacted on numerous times but because her chaotic behaviour she missed many appointments. When she turned 18 they discharged duty of care.

She engages with Outreach and Day Centre staffs regularly. She has approached staff for help on numerous times in the last year but then has not followed through hence missing opportunities in terms of accommodation and help with her drug misuse.

Periodically she has legal issues which stop her from using services for fear of being arrested.

In the past she has accessed The Bridge Project periodically, since her partner was released from prison she has slept rough with him.

What would we like?

Outreach team should:

- Engage with her
- Assess her needs
- Identify her priorities

Establish a series of goals:

Short term

Food / Clothing / Bedding

Short-term accommodation if desired

Information about services

Access to health care

Address / acknowledge the problem of abuse

Medium term

Drug detox

Rehab

Accommodation

Ongoing support – acknowledging the possibility of relapse

Long term

Housing

Training and education

Employment

Emotional stability

Good physical health

Summary

- **Multi-agency** working to be co-ordinated
 - different agencies / different cultures
 - attitudes including public
- **Value** the individual & their interests.

What are the blocks?

- Age
- Gender
- Drug use
- Fact that she has a partner
- Nature of relationship with partner
- Her previous history / behaviour
- Motivation
- Rigid / exclusive housing selection criteria
- Lack of appropriate housing

Summary

- **Socio-Cultural context** e.g. refugees.
- Dealing with the **multi needs** (education / lifestyles incl. literacy.).

What is needed?

- Identified key worker(s)
- Supported accommodation that is sensitive to her needs
- Psychological and social support
- Good inter-agency communications
- Address the legal obstacles to drug users living in supported housing

- Supportive primary care team with links to voluntary and statutory agencies

Overall shared goals and agendas between the different agencies involved

Summary

- Follow through – **long term support.**
- Services must be **appropriate to needs.**
- **Share goals and agendas** – all the different agencies are recognised, but must still all be working together.

Case Study 3

Row at Home

17 Year Old Female

Left home due to relationship breakdown with mother who was terminally ill.

Client 3 is currently self harming and has attempted suicide on a number of occasions. She has epilepsy and regularly suffers from seizures.

Initially she was placed in supported housing for young people but this broke down as she became too high a management risk – self harm and suicide attempts.

Oxford City Council Homelessness Dept would accept her but are refusing due to the risk factors.

Medical experts have said her behaviour is attention seeking and not related to her epilepsy.

She engages with services, Outreach, Day Centre and The Bridge Project she also sleeps rough for periods of time. Meanwhile her self harm and suicide attempts escalate periodically.

What would we like?

- Clear, cross system, **working protocol**
- Rapid **holistic 24hr** service
- **Assessment** (medical / housing / social)
- **Open sharing of information between agencies**
- **Floating CPN/psychiatrist**
- **Floating support team**, across projects, with community workers and medical supervision/assessment

What are the blocks?

- Access to **support staff for housing**
 - (availability of beds etc.)

- Age of case study – linked to gap in statutory services
- Access to primary care

What is needed?

- **Continuity and co-ordination** of packages of support.
- **Rapid Assessment**
- **Information package** of what is available and who to contact – freely distributed between projects/clientele
- **Extended hour services**
- **Lateral thinking**, i.e. access to family placements
- **Holistic assessments**
- Need to break down eligibility criteria and convoluted access criteria

Case Study 4

Drug Addiction

22 Year Old White Male

Started to use drugs due to peer pressure from friends. When his father died his drug use escalated causing him to lose his accommodation at the family home.

He has since slept rough with times of using The Bridge Project occasionally and now has a 4 year history of being homeless with a chaotic drug use. He is very much caught in the culture of homelessness/drug misuse and can disappear occasionally to avoid dealers to whom he owes money.

Client 4 has recently split up from a long term relationship with his girlfriend who is also sleeping rough and has a chaotic drug use.

In the last four years client 4 has sporadically accessed services for help. Due to his chaotic behaviour he regularly misses appointments for accommodation and support around his drug use.

He has recently asked for help with his drug misuse and has been given a methadone prescription by his GP.

More recently he is choosing to sleep outside of the City and not accessing the Day Centre at all. Outreach Workers are working to maintain contact with him but are having to target him as he is outside their usual circuit.

Client 4 can go home if he stops using drugs and can remain abstinent.

What would we like?

- **Assertive support**
 - **Counselling/Education/primary care**
- **Housing**
- **Work with family**

What are the blocks?

- **Attitudes** (from public, newspapers etc.)
- **Lack of supported Housing** – affordable housing in general
- **Support**
 - Current teams overloaded, offering only short term support
 - Need for long term support
 - Too fragmented/specialist, risk of filling in gaps
- **Detox**
 - Lack of capacity

- Waiting times are too long/people need it when ready, not two months later.
- **Access** to Health Services
 - Primary Care apprehensive of drug users

What is needed?

- Prevention
 - Primary: Education and lifeskills for children
 - Secondary: Interventions at early stage before entrenched
- Sustained tenancy support
 - 'somebody to walk the road with them'
- Equal access for all to services

Cast Study 5 (question 1 & 3 combined)

Mental Health

30 Year Old White Male

Presented in Oxford after travelling and sleeping rough for 3 to 4 months. History of sleeping rough and using Day Centres for 3+ years when not in psychiatric/learning disability units or secure unit.

His diagnosis is Aspergers Syndrome, Learning Disabilities and Personality Disorder.

He has a tendency to lie about his age, real name and where he has come from when he chooses not to trust workers.

He was assessed by the Learning Disabilities Team who said that he did not met their criteria.

Client 5's family cannot support him as he consistently pushes boundaries by his demanding behaviour. This is also experienced by agency staff who also find that he has the tendency to work to divide staff teams.

Accommodations Outcomes to date -

Client 5 accessed The Bridge Project initially but had only managed to be admitted by lying about his age. He left after two days as he decided he had given too much information to staff about his past.

He then used The Night Shelter but felt intimidated by other users and returned to sleeping rough.

He decided that he didn't want to go in the Simon House Hostel. He could not access Lucy Faithfull House (ECHG) due to having arrears at another ECHG hostel in the North.

After the initial few weeks of agency contact, Client 5 told Outreach workers that he had absconded from a secure unit in the North and had been lying low for the fear of being picked up. Outreach workers contacted the unit, explained that he was working with them and with his consent were forwarded his diagnosis.

Using this information Client 5 was accepted as statutory homeless by OCC Homeless Person's Unit.

Unfortunately this lasted a week before Client 5 handed in the key and said he could not cope due to being too institutionalised. He then returned to sleeping rough.

What are the blocks?

- **No suitable accommodation** (ideally want support 24hrs).
- **Lack of co-ordinated statutory input.**
- **No statutory Outreach work** – to go to client, rather than client to worker
- **Rigid criteria** – need flexibility.
- **Lack of Cross-agency co-ordination.**
- **Lack of intensive support** (long term), and responding to need.

What would we like, and what is needed?

- **Engagement with key worker** – address his behaviour, gain trust.
- **Case conference** between all agencies.
- **Willingness of agencies to work together** in a co-ordinated manner.

- **Small (6 – 8 bed) hostel + 24 hour support.**
- **Family placement.**
- Following / **supporting the client’s interests** and developing independent social relationships.

Case Study 6

Alcohol Dependant

45 Year Old White Male

Client 6 has been sleeping rough for the last 14 years. He periodically uses The Night Shelter and has in the past stayed at the ECHG hostel. He left the hostel of his own accord due to his drinking problem.

Client 6 was in the army for many years and left due to his drinking.

He suffers from cirrhosis caused by his long term drinking and osteoarthritis which creates mobility problems.

In addition Client 6 suffers from memory loss, anxiety and depression.

When at the hostel Client 6 expressed a desire to change his lifestyle and looked at constructive ways to fill his days.

Since leaving the hostel Client 6 has been drinking heavily and is intermittently sleeping rough, staying at friends and also using The Night Shelter.

He engages with Outreach Teams but has been unable to keep any appointments due to his present limited motivation.

What would we like?

- Re-creating motivation.
- Detox.
- Look at immediate health issues & mental health.
- Access to primary care with support.
- Providing structure.
- Linking in with other agencies.
- Intermediate care plan – client to lead.

What are the blocks?

- Lack of motivation.
- Type of accommodation.
- Falling into difficulty.
- Memory block.
- System not geared for such a case.

- Mobility / employment.
- Prejudice / fear.
- Lack of training in health.
- Lack of I.T. as a priority.

What is needed?

- Healthcare provided.
- Give support / being valued.
- Continuous engagement co-ordinated.
- Persuasion back to the hostel.
- Flexibility – system being flexible to meet individual needs.
- Addressing mobility issues.

Summary:

- Multi-agency commitment.
- Co-ordination / communication.
- Flexible approach to individual care.
- Valuing individual.
- Legal issues
- Benefits.

SUMMARY

The seminar identified similar issues to be addressed to those identified in the literature review and the Oxford interviews. These are:

- Better and co-ordinated joint working
- Identified key worker
- Improving the partnership culture
- Flexible, appropriate and timely service provision
- Better communication and sharing of information
- Supported accommodation
- Integration of Primary Health Care Teams with voluntary agencies to focus on individual needs
- Continuity, co-ordination and follow through
- Lateral thinking
- Focus on prevention
- Equity of access/treatment
- Client focussed support
- Family placement
- Training of health care staff to improve attitudes and to ensure they have appropriate information
- More detox facilities
- Protocols for pathways of care
- Better links with prisons
- Easy access to mental health professionals

PRIMARY CARE

- To take account of the health needs of rough sleepers
- To consider prevention, treatment and care, not only in general practice but also dentistry, pharmacy and other community services
- To integrate with other services, particularly:
 - Accident and Emergency
 - Mental Health
 - Drug/alcohol services
 - Social care
 - Housing
 - Voluntary Groups
- To have protocols for referral and treatment
- To ensure staff are aware of local resources
- To reflect the work of Primary Health Care Teams with the homeless with HImPs, Local Strategic Planning, practice plans and other key documents
- To establish a performance management framework
- To monitor how needs are being met and what resources are needed
- To think of new ways of working, particularly with the voluntary sector, learning from other districts
- To take account of the views of those sleeping rough
- To ensure barriers to access are removed

In particular, improving partnerships and mainstreaming health needs emerged as two key areas of work.

A: Mainstreaming health needs:

1) Prevention:

- a ensure appropriate health promotion programme is in place

2) Primary care:

- a ensure front line staff have adequate and appropriate information on the health needs of rough sleepers and available local resources.

This could involve:

- b Training
- c Information pack
- d Active links with work on drug misuse
- e Ensure service provision by supporting Luther Street and ensuring homeless people can register with other GPs

3) Accident and Emergency:

- a Ensure front line staff are trained to meet the needs of rough sleepers including knowledge of availability of primary care hostels and other resources

- b Revitalise the discharge pack developed 4 years ago

4) Mental Health:

- a The local needs assessment and literature review show many rough sleepers have drug/alcohol problems, mental health problems or both.

The Oxfordshire Mental Health Care NHS Trust needs to be a key

player in addressing health care needs. This requires clarity about relationships with voluntary agencies and other health care providers to develop partnerships. In addition, it requires targeted resources and staff time.

5) Voluntary Sector:

- a Better co-ordination and agreement of shared common protocols within the voluntary sector would help NHS partners.
- b Relationships with the statutory sector could also be helped by agreement on key workers

6) Rough Sleepers:

- a The needs of rough sleepers need to be listened to.

7) Local Authority:

- a Relationships between health and housing need to be addressed. There needs to be an explicit recognition of the health needs of the homeless, but also the impact of housing on health.
- b Closer working on issues of mutual concern – particularly housing problems of young drug users – need to be taken forward through open and transparent discussion.
- c At a county level, social services play a key role and the health sector needs to support work with looked after children, care leavers and the homeless.

B: Improving Partnerships

- 1) The need for effective partnerships between all service providers to meet the needs of those sleeping rough
- 2) The partnership needs to be concerned with:
 - a Prevention – primary and secondary
 - b Access to appropriate treatment when needed
 - c Developing continuous support for a client which is not hampered by organisational boundaries
- 3) The partnership needs to pool information, enhance communication, assess the possibility of pooled budgets and changing ways of working
- 4) The Housing Department has a key role to play and needs to be actively engaged, as do housing charities.
- 5) All partners should use the opportunity of current policy initiatives to agree a strategy for improving health of homeless people in Oxfordshire. This could be part of other initiatives such as the Health Improvement Plan (HIImP), Housing Action Plan, Local Strategic Partnership, Community Plan, Drugs Action Team action plan, and Prison HIImP.
- 6) Local Strategic Partnerships should address the needs of vulnerable groups including rough sleepers, and consideration should be given to how homelessness is integrated into their development.

Taking Forward Strategic Action

This draft strategic action plan aims to take forward the issues raised in the interviews and workshop with Oxford. It sets out actions in a variety of areas, many of which overlap, and also identifies some milestones. The purpose of circulating this draft is to seek views from all parties about whether these are the right areas to address. It also raises the question of the appropriate forum for the discussion, the nature of any overarching group to take the work forward and the channels of accountability. In the first instance the proposal will be reviewed by the HImP steering group within the context of the work of the Inequalities Task Force. It will also be discussed with Oxford City Primary Care Trust as they will need to play a key role in co-ordinating the strategy, particularly with Oxford City Council.

Draft action plan to improve health care for homeless people in Oxford City

	Task	Indicator	Action by whom
Prevention	<ul style="list-style-type: none"> • Identify key issues/opportunities to work with partners • Agree with Oxfordshire Health Promotion a programme of work 	<ul style="list-style-type: none"> • Establish partnership group • Agreed work plan in place 	

	Task	Indicator	Action by whom
Primary Care	<ul style="list-style-type: none"> • Clarify role and organisation of Luther Street • Improve GP registration • Ensure front line staff receive training • Consider community, dental and pharmacy services • Produce information pack for practices • Devise protocols for treatment/referral • Clarify links with mental health/addiction team 	<ul style="list-style-type: none"> • Joint statement on role to be produced • Improvement on baseline 	

	Task	Indicator	Action by whom
Accident and Emergency	<ul style="list-style-type: none"> • Ensure front line staff receive appropriate training • Update and use homeless discharge pack • Have clear referral protocols 		<ul style="list-style-type: none"> • A&E to lead

	Task	Indicator	Action by whom
Mental Health	<ul style="list-style-type: none"> • Clarify service provision and protocols of care for: <ul style="list-style-type: none"> - SMI - Drugs/ Alcohol - Dual Diagnosis • Work with voluntary sector and primary care to develop appropriate referral pathways • Identify areas for changing practice/additional resources 		<ul style="list-style-type: none"> • Inequalities taskforce • MH inequalities group

	Task	Indicator	Action by whom
Rough Sleepers	<ul style="list-style-type: none"> • Take account of views about health services of rough sleepers by asking them – possibly via voluntary agencies such as English Churches Housing and the Salvation Army 	<ul style="list-style-type: none"> • Engagement of homeless in service provision decisions 	

	Task	Indicator	Action by whom
Prisons	<ul style="list-style-type: none"> • Prison HImP to consider needs of prisoners with homeless history/known housing needs • Use custody to work as an opportunity for pre/- discharge work • Link drugs support work between prison and community 	<ul style="list-style-type: none"> • Presence in HImP • Programme developed • Current work extended 	

	Task	Indicator	Action by whom
Drugs and Alcohol	<ul style="list-style-type: none"> • Review detox facilities and agree strategy, including protocol for methadone. • Ensure rough sleepers needs are considered in the DAT strategy • Develop alcohol strategy and support • Wet facility development to be kept under review 		

	Task	Indicator	Action by whom
Voluntary Sector	<ul style="list-style-type: none"> • Improve co-ordination • Share protocols • Develop partnerships with statutory providers • Agree policy on key workers • Work together on joint strategy 		

	Task	Indicator	Action by whom
Local Government: County	<ul style="list-style-type: none"> • Consider health support, esp prevention to looked after children and care leavers • Consider health and joint working for vulnerable groups • Link to social services/county programmes 		
Local Government: Districts	<ul style="list-style-type: none"> • Housing policy should be jointly developed with health to consider needs/impact • Strategic approach to housing provision to be developed 	<ul style="list-style-type: none"> • Increased health role in local authority housing process 	

Area of Activity	Relevant Health policy
Prevention	Our Healthier Nation Inequalities in Health (Acheson)
Primary Care	NHS Plan: developing PCTs
Accident and Emergency	NHS Plan: access
Mental Health	NHS Plan: inequalities Mental Health NSF Care Trusts
Rough Sleepers	
Prisons	Prison HImP
Drugs and Alcohol	NHS Plan: Inequalities DAT strategy
Voluntary sector	Neighbourhood renewal: Local Strategic Partnerships
Local Authority: county	Local Strategic Partnerships Community Strategy Care Trusts
District	Housing Action Plan

Developing A Strategy

CHECKLIST

Prerequisites identified by Sills (ibid)	Oxford Response
The definition of rough sleepers and other homeless groups, eg hostel residents	
How are different agencies working together	
What written agreements are in place for access to psychiatric and medical care and advice	
What is the policy of the A&E service , especially towards discharge	
What do the service level agreements for drugs and alcohol services look like – with particular reference to community detox and its protocols/support	
How are the various statutory mental health guidelines being put into place/functioning	

Prerequisites identified by Sills (ibid)	Oxford Response
How does the health care sector work with housing and social services to meet the needs of rough sleepers/ homeless people	
What arrangements are in place to train/promote better understanding of the health sector by the voluntary sector	
Are there protocols for referral	
Can specialist providers complete a preliminary assessment within 48 hours of all urgent referrals	
How many clients have key workers	
Are all rough sleepers who have mental health problems reviewed on a regular basis	
How many practices will register rough sleepers	
Have long term strategy resources been secured for the voluntary sector	

Prerequisites identified by Sills (ibid)	Oxford Response
to allow stability and development	
Has consideration been given to a shared community strategy/local strategic partnership and pooled budgets	
How are the targets in the NHS plan/NSF being set/monitored with specific reference to the health of rough sleepers/homeless people	

APPENDIX 1: Interviews with providers of services

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Provision for Rough Sleepers in Oxford

Support Agencies

The Elmore Community Support Team
The Salvation Army Homeless Outreach Project
Others
Connection
Long Term Floating support team

Provision for over 25s

Lucy Faithfull House
English Churches Housing Group (Will take a limited no of under 25s)
Simon House
Cherwell Trust
60 Lake Street
Stonham Housing Association

Emergency Accommodation

The Night Shelter (over 25s)
The Bridge (under 25s)
The Women's Refuges

Day Centres/Drop Ins

The GAP day centre
Luther Street Drop In
Libra project
The Gatehouse
The Porch
Manzil Way – Wednesday Lunch Club

Rough Sleeping

Latest figures show on average 31-35 sleeping rough every night

Provision for under 25s

Windmill House (Supported Accommodation)
60 Lake Street (Low supported)
The Gateway Project
Substance Misusers Supported Accommodation
Dolphin Project (Dispersed S/c flats)
DISH project (out of Oxford s/c flats)

Rehab provision

The 195 Project
The Ley Community

Medical Services

Luther Street Medical Centre
The Methadone Bus
City Homeless Mental Health Team
Drugs and Alcohol Team

Statutory Sector Services

The Homeless Persons Unit
General Housing Register
Probation Hostel
Bail Hostel
Move-On accommodation (provided by council and housing associations)

Sleeping rough in Oxford – interviews with key players within Oxford City.

A series of informal interviews and discussions were carried out with key players from the voluntary and statutory agencies within Oxford.

1. The Voluntary Sector

1) The Gap

Visit to The Gap October 20th

Key Contacts: Barry Stacey ,Director ,Glynis Lapage.

The Gap exists for anyone on the streets and is open 9 – 3 everyday,

Wednesday 9 – 1 p.m. It caters for 16 – 25 year olds plus all others.

Attendance figures show about 70 people use the Gap everyday- 640 in the preceding six months. About 14% are Afro Caribbean, breakfast and lunch are available with attempts at healthy menus. Clients are referred via a variety of routes-via the Bridge, via agencies, ex care leavers, self referral.

The aim is to move young people off the streets before they become institutionalised or homeless.

There are a large variety of exciting inputs to the project- including Blooming Arts, OU Homeless Action Group who help develop IT skills, LIBRA including the SWOP scheme.

The Gap works with many partners but there is a feeling that they all need a clearer way of working together, especially with regard to drugs misuse. Drug misuse is a particular problem. There are probably 30 IV users under 25 in touch with GAP but there are no residential facilities for younger users to enable them to come in from the streets to build on motivation to stop using. There are probably 12 or 15 who are consistently on the streets. Dolphin and DISH are both planning to be involved in this in some way but there is a current lack of clarity. We need to provide contemplative space. There seems to be poor links with statutory agencies and lack of clarity about what/how outreach support can be provided.

The Gap adopts a harm reduction approach to its work with clients. To quote from their recent report:

' we are currently liaising with relevant external agencies, including drug service providers in order to shape our future programme in a way that does not replicate existing services but provides for the needs of our clients who in the main are unable to access other mainstream services due to their homelessness and chaotic lifestyles. By October we are aiming to have a rolling programme including Acu-Detox, health promotional work and sessional group work.'

The project has seen an increase in needle exchange work and also one to one support. Gap clients are unable in the main to access mainstream drugs services due to their homelessness and chaotic lifestyles. The Libra 360

programme is not open to homeless people and the Social services team only consider those who are committed to withdrawing from substance misuse.

General comment- there are many people working in the field- but organisational interests can get in the way. What is needed is collective action, and there is a particular need for better physical resources. This is not just space for the support work that Gap is engaged in – but also accommodation for young people who find it very difficult to find accommodation within the City. The funding for Gap is currently unsecured but needs around 222K to run each year. There is a 5 year lease on the current building.

The Health Needs are Physical and mental as well as related to drug misuse Health Provision is indirect; some problems accessing GPs, especially for active drug users. There are no strategic links with OMHT. Current links with primary care are weak but the PCT offers opportunity for improvement.

What could make a difference:

- A better link with primary care is needed. Health focussed outreach could be helpful, as could having clinics on site.
- Younger people won't go to Luther Street because they find it a difficult environment ,some finding it threatening.
- Iv users on streets tend not be methadone users and thus do not use Luther St.

- Discharge packages for care leavers would make a difference, RSU post will help this.
- Better/co-ordinated follow up from prison would also be beneficial.

Summary of key health messages:

- Primary care
- Needs clear strategy with the PCT
- For access to help with health promotion/physical health problems/mental health problems/ drug problems
- Outreach and follow up need to be considered
- Possibility of clinics on site to be discussed
- Mental Health
- Need better access, better communication, more joint working, clearer understanding of what is on offer, direct presence
- Drugs
- Need better detox and clearer understanding of the role of the community addictions team
- No clear understanding of what is on offer, how statutory agencies are supporting community programmes, what can be done re accommodation for young users. what options exist- e.g. some young people go out of county

2) The Bridge

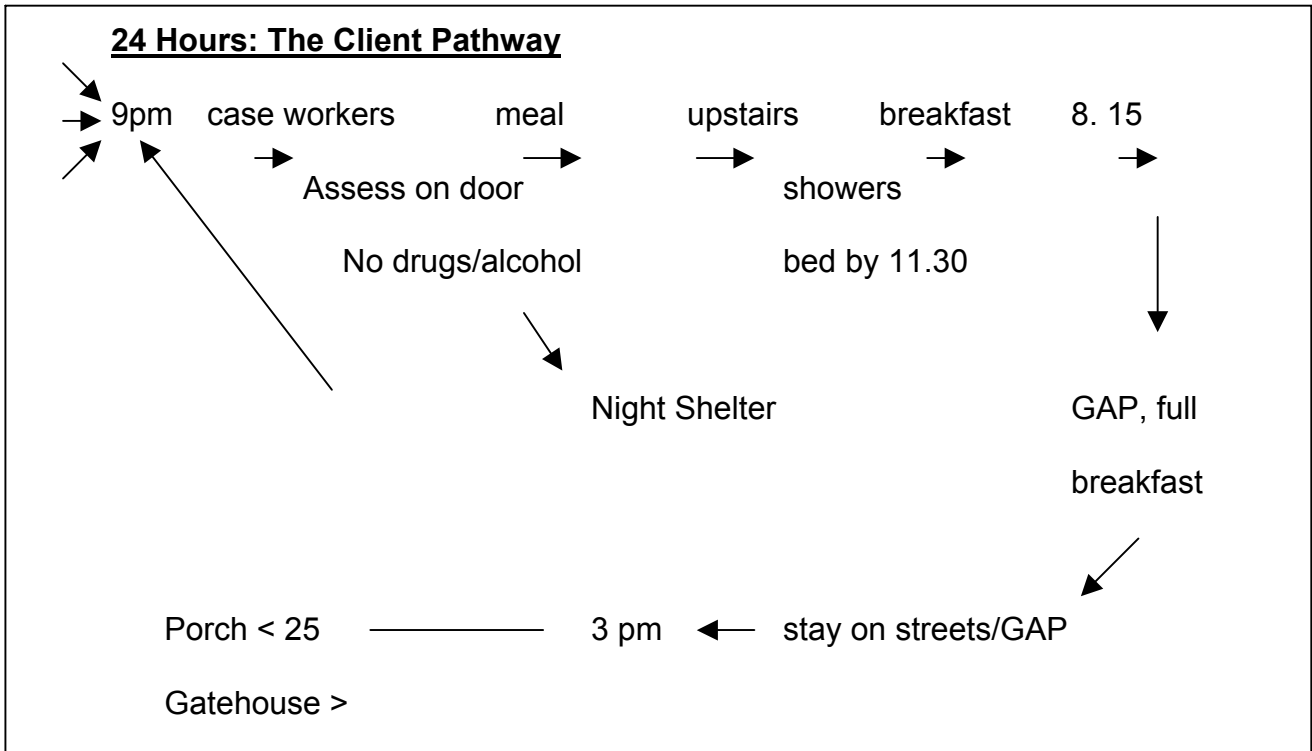
Visit to The Bridge

Date: October 20th

Key Contact: Barry Stacey

The Bridge is a 17 bed hostel for 16-25 year olds. Funded by City Council and Districts it provides for males and females within Oxfordshire. Its main objective is to provide safe accommodation for young, vulnerable people. It is the same organisation as GAP with which it shares information thus able to make appropriate links. The maximum stay is 28 days. Currently looking to extend to the next door building which will give 25 beds and sick bay. Currently no provision if people have flu. Young people come in at 9 out at 8.15 am to the GAP. Basically no drug use whilst in hostel. High level of criminal convictions: ~ 75% involvement with criminal justice; good links with probation.

Prisons may contact project pre-discharge and there are links to YOT. Can use phone – job, accommodation, family



There is a fairly high level of illiteracy. The clients are mainly white which raises the issue of whether ethnic young homeless from ethnic minorities are accessing services appropriately. Many have been in care. Usual figures would be ten out of seventeen being drug users although they are not allowed drugs on the premises. There has been a recent rise in crack use.

For a short time there was a project in Banbury and there is an unmet need in the north of the county- and no strategy for rural homelessness.

Health

Register with Luther Street, mental health problems common. Also poor physical health linked to poor nutrition.

3) Night Shelter – Discussion with Paddy O’Hanlon

Night Shelter is an emergency shelter for single homeless males and females over 25. People under 25 are directed towards the Bridge. It operates 365 nights in the year from 7pm to 8am. The Night Shelter provides a shower, evening meal, tv, etc. They tend not to turn people away, it is a first come first served basis, with 50 spaces, although up to 69 people can be accommodated when the temperature is less than zero, as it is a weather exception and everyone is allowed in.

The history of the Night Shelter is that it was set up by Oxford students because they saw people in doorways. Initially, it was an emergency shelter, with just soup and mattresses, but over the years it has grown and continues to provide a direct access shelter, plus a cooked evening meal, cooked breakfast and personal hygiene facilities with shower and bath.

There is current debate about whether the Night Shelter should be damp or is wet. People with alcohol in them are admitted, alcohol in bottles has to be handed in, and there is no drinking on the premises at present. Drug using is not allowed on the premises, but sharps bins and safe disposal is provided. Clients are not searched on admission. There are few rules, which include no aggression, no drinking, no using drugs. Clients must pay their own way, and if they misbehave at the time of the visit, staff are trained to deal with it. At

times, clients have to be barred for short periods of time, but maybe re-admitted after discussion at the staff meetings.

There are eleven care workers, only four are on duty for any one night; and there are four care workers during the day. There are significant plans for re-development to allow the premises to be upgraded away from the dormitory setting to provide single rooms and also a day centre. Money from the housing corporation is being sought, as well as funding from the City Council. The Wet Shelter proposal was discussed with the City Council, and plans are currently being developed. The Night Shelter is very close to Luther Street Medical Centre, and there are very close links. One nurse is available every night until 11 pm, which meets the primary health care needs. In addition, there is night cover from Beaumont Street Practice, as well as Luther Street. Primary care cover is felt to be good. The re-settlement staff are available Monday to Thursday until 9 pm. The funding for the Drop-In Day Centre, which has come from joint finance from the social services and the health authority, is currently under discussion. The Drop-In Day centre operates Monday to Friday, 10 am to 4 pm, and provides a cooked meal or sandwiches, and hot drinks. From the end of November to the end of March, the Temporary Winter Day Shelter also operates during the day, on Saturdays, Sundays and Bank Holidays. The re-settlement team are not at the shelter during the weekends.

At the present time, 60 –70 have lunch and are engaged in various activities, including gardening, board and card games, tv, etc. Some clients may not be sleeping in the Night Shelter, but are badly housed and use the Day Centre.

Regarding mental health, links are better now and the CPN support via Luther Street and the work of the Elmore Team is much appreciated.

Links with the other agencies exist.

Issues

- Adequacy of mental health cover
- Nature of relationship with Luther Street – is this clear?
- Implications of providing wet facilities for cover from primary care and mental health?
- How the Night Shelter integrates with other services within the City, and what the health care provision ought to be if taken as a whole?
- Strategic development

4. Visit to Lucy Faithfull House

Contact Mark Nightall

The project is for men and women over 18, and initially did not take rough sleeper referrals, but more recently has begun to do so. Its objective is to outreach and to resettle homeless people. It has accommodation for 10 registered cases, 24 moving on to housing, 56 direct access to the community. It can also take two young people from GAP. The major health needs of the project are:

- mental health
- alcohol detox
- lack of prevention
- primary care input
- addiction problems.

Health care provision is being sought by a nurse from Luther Street, although this has not yet been secured. The role of this nurse will be to supervise the detox. Clients have their own GPs, and there is increasing proactivity in primary care. When asked what could make a difference, de-institutionalisation of the environment would help, with better access to primary care, better understanding by primary care.

Other details about the hostel include, that it is a dry hostel, where there are some drugs issues. There is some health input from community nurses, but 50% of residents have mental health needs, and links to the mental health

trust need to be better. Clients stay for about a year, and move on to be re-settled in the community. Lucy Faithfull house is now lowering the age and taking women, and making joint working arrangements with GAP and the Salvation Army. They are involved in community detox for alcohol problems, using the Vaughan House model from Guildford. Medical back up for this comes from Luther Street.

Some of the frustrations of people who work at Lucy Faithfull House include failure to be able to get hold of the right people at the right time, particularly access at a time of crisis, and also knowing who to speak to. There is an apparent lack of a clear pathway through from caseworkers to mental health trust, and people are unclear about the model of community detox that is being considered by OMHT. One of the major problems has been accommodation for young people who are using drugs, and there are plans in discussion about how their needs may be met.

Service development is high on the agenda at Lucy Faithfull House, but they feel they need greater access to, for example, the Drugs Action Team money to enable them to develop some of the models of detox that they have been looking at. They are well linked in with many other agencies, and feel that if there was a road map to help, to know where to go to get better funds for service development and who to contact when clients were in need, then relationships with the health sector would be improved. They rely heavily on Luther Street, which again raises the question of whether Luther Street has

appropriate and adequate resources. They have produced an excellent support needs analysis, which is drawn on in the main body of the report.

The focus of the programme provided at Lucy Faithfull House has shifted towards resettlement and the project aims to provide an effective re-settlement service for all those temporarily resident in the scheme. The team will concentrate on moving clients through the scheme to increase the number of beds available for rough sleepers. It will develop an individual tailored resettlement package, through the assessment of need, with advice and practical help, enabling clients to gain access to appropriate accommodation. (one of the major problems here obviously is the lack of integrating health into the planning, and discharge of the plans).

5. Notes from visit to Simon House

Simon House is a 55 bed hostel for homeless people, plus outreach, plus six registered beds, plus four respite beds for resettlement. Clientele is men 55 + and the objective is to work with them for a year to 18 months, to promote independence and stay dry and off drugs. New post is funded by RSU money. Simon House is part of the network of services for homeless people and rough sleepers. Simon House is noticing, along with many other agencies, such as Lucy Faithfull, that many rough sleepers are getting younger and is considering taking in younger people. This new cohort are increasing the issues of the revolving door.

The approach that Simon House takes is holistic, provides education, training, acupuncture, counselling, sports, gym and cooking to promote skills and self esteem. It provides support to people who are re-housed. Numbers are increasing, and at the time of the visit there had been a large new influx of people, possibly from London, or from the coast. There seems to be a message that accommodation is around, however, everyone working in the field knows that this is not true!

Referrals to Simon House come from the Night Shelter, Luther Street, Salvation Army, Probation, Gap, Elmore, hospitals. There is no self-direct access. 96% occupancy rate. Health care support is provided by Luther Street, however, it is well recognised that Luther Street is under pressure, and

recently had to reduce services due to financial pressures. The on call staff will always come, although links with the drug worker have recently been poor.

Simon House is doing some alcohol detox/community detox and the pressure has increased since the closure of the Chiltern Clinic. There is a lack of provision for those on the streets, although medication is provided by the hostel, methadone is only available via Boots. Simon House are part of the substance misuse forum, and believe that the voluntary agency play a key role in detox. However, they are unable to help injecting users. There is no direct health funding or support. GP services, if needed, are available at night via Luther Street. The problem arises as clients are re-settled, and they need support from a local GP/PCT. Better liaison is needed during this transitional period, between the specialist services, or those services which specialise in homelessness and the more generic primary care services, because these clients often have specific health needs.

Elmore Team provide mental health support, as well as support from the CPN and doctors. We discussed the possibility of more proactive links with Bullingdon, especially earlier rather than later, in relation to discharge. It would be possible to try to plan for those that they know have been in prison, and could act as home for more people. They are anxious to see whether they could play a more proactive role in community detox, and will need better links with the primary care trust/group.

Physical health of residents looked after by Luther Street, for example, flu jabs, and they also use healthcall opticians for eye tests and rely on Luther Street for dental help. Overall, the links do exist on a case by case basis, it would appear that there are no formal agreements for health care provision, particularly for health promotion – this is something that could be discussed further.

6. Notes from the Elmore Team interview with Lesley Dewhurst.

Mission Statement:

The Mission of the team is with those people whose needs are towards the margins of agency based provision in the health care, social care, accommodation or criminal justice systems. Agencies, either singly or within a network of care, perceive such individuals as 'difficult to place' because their problems are multiple, chronic or presented in bizarre or disorderly ways. They therefore require intervention to enable them to make optimal use of the services the agencies ordinarily provide. The Elmore Committee believes this is done most effectively and efficiently when a team having specialist experience of these problems works in an integrated fashion with both the persons and the agencies concerned until such time as those individual's needs can be absorbed into the agencies ' core functions. Such individuals presenting within the City of Oxford will thus be eligible to the services of the Elmore Team' (Elmore Team Mission Statement, Annual Report, March 2000).

The Elmore Team has been in existence since 1988. Its main objective is to help people with multiple problems who don't fit in well with services; who are barred from use of services; who tend to be non-compliant – many of whom may have a personality disorder. It is recognised that there is a gap in services for such people. It is estimated that there are about 150 people in Oxford City who currently fit into this definition.

Over the last 12 years, there have been organisational changes in statutory services, but gaps have still existed. The Elmore Team exist to fill these gaps. 95% of their clients have mental health problems. Clients they work with often have major accommodation problems, and the team work with owner occupiers. Clients are ex-offenders, may have had head injuries, may have attempted self harm and misused drugs.

Until the Rough Sleeper initiative, all such clients in the City were referred to the Elmore Team. Now the RSU money has provided the opportunity to spend time on outreach. The Elmore Team work closely with the Salvation Army, and their main client group are concealed people who are isolated and marginalised, reached through outreach and referrals. The teams work is to 'handhold' and to try to engage with those who don't want to engage.

The team aims to fill in the gaps whilst other agencies get involved. The decision as to whether a case is kept open is influenced by how it is most effective to work with other agencies who are also involved. Clients are kept on the books as long as they need to be. There are seven workers in the team, and two part-time secretaries, and. They offer help with the criminal justice system and want to continue work with rough sleepers.

Funding comes from a variety of sources, including the health authority, Oxfordshire Mental Health Services, Oxford Learning Disability Trust, Oxfordshire Social Services and housing. Thus, because the funding is all short term, a huge proportion of time each year is spent ensuring the funding

is continued to allow the work to continue. The service provided is unique. The emphasis is very much on working closely with other agencies. The team have good relationships with Oxfordshire Mental Health Trust, particularly with those who work indirectly with clients. They work with the Mental health drugs team, and report less problems with the NHS interface than other agencies.

There is an increasing load of community work around dual diagnosis. The team are working effectively with the PCT. They don't go into the prison, the SMART team does this, but they will pick up referrals.

1. Points of Consideration regarding the health services:

1.1. There is a gap in GP knowledge at present, particularly about the use of methadone. The need to be more creative in the treatment of drug addiction, community detox is an important gap, with a lack of pre-contemplation places.

1.2. Primary care provision is patchy, and Luther Street, whilst providing an invaluable service, is not the totality of the solution. They have a key part to play. There is also a need for closer links between primary and secondary care.

1.3. The acute trusts – the client group are vulnerable and there have been some attitudinal problems, particularly by security guards at the JR. A&E are very patient with clients with repeated problems, who are followed up by the Barnes Unit. However, often clients fail to follow up, and there is a need for a link worker to continue to follow up these clients.

1.4. Drugs and Alcohol. Dual diagnosis is a particular problem. More dialogue between the addiction services and mental health and the adult services in mental health trust would help. The Trust restructuring would probably help with this. In general, staff and inpatient units have little understanding of illegal drugs, so when patients are using speed on the ward, they often feel scared by their lack of knowledge. More training here would be helpful, and this could be linked to voluntary agencies.

1.5. What would make a difference?

1.5.1. Quicker Access for accommodation

1.5.2. Flexibility of approach accepted by all

1.5.3. Access to health care workers – although the Elmore Team value the CPN on their team and have good access to psychiatrists, and in particular feel the City Centre CMHT have been very helpful.

1.5.4. Long term strategic approach with secured funding.

7. Salvation Army

The Salvation Army is open 5 days a week. Between 7.30 and 10.30 there is a coffee run, which provides initial contacts, particularly for people in the City Centre, Walton Street and Portmeadow. Four workers are employed by the Salvation Army, two open up the office at 8.30. The office is open between 8.30 and 10 am for drop in, to create new contacts and allow development of relationships. A meeting of team workers takes place between 10 and 10.30 and then outreach work from 11 am to 1 pm. The office re-opens again between 1 pm and 3 pm to provide advice sessions, coffee, food and sleeping bags, etc.

One of the problems with current accommodation is lack of privacy. They often need to take a homeless person to the Church Hall or out for coffee in order to have a conversation. At around 3 pm, there is a de-brief of the outreach, with late outreach between 5 and 10 pm. The way of working is one of assertive outreach. About 20 to 30 people are contacted in the streets each night.

Whilst supporting the RSU line on begging, they believe they also need an alternative, particularly for the under 25s, who have nowhere to go in Oxford. There is a major problem for people who have dogs.

For health care needs, clients are sent to Luther Street, and they are given cards with directions. About 60% probably make contact. There is variable feedback, particularly because of the appointments based system, which highlights once again that Luther Street is under serious stress and needs more support.

Mental health resettlement workers can sometimes find it difficult to get through the system. For example there was one client sleeping rough in Portmeadow, who was clearly unwell, but not sectionable, and the real question was about how to get him into the system. The usual route is to link with the Elmore Team, but the Salvation Army felt that they had no real links with the statutory sector, and no links with the community. They have a phone number to contact the outreach at Luther Street.

Particularly there is a need for help and accommodation to allow young people using drugs on the street to come in to make decisions about detox. At the moment the onus is on them to detox on the streets, before they can get housing and this is clearly a disincentive.

8. Notes from meeting with David Ashmore from OCHA

OCHA is a registered social landlord and has a broad remit in housing provision throughout Oxfordshire, with 2,500 homes in management and over 300 in development. Its priorities reflect local authority's strategic priorities – family houses across the county, single persons accommodation, particularly in the City. OCHA provides and also works with other agencies to provide shared housing projects. A key issue is the provision of appropriate housing and support for single homeless people. To some extent, the current system perpetuates the role of hostels. Although some people will always need or want larger scale hostel/direct access provision, it is important that the strategy seeks to promote independence and autonomy particularly through the development of more self contained rented homes with tailored and flexible care and social support.

This covers all the local voluntary agencies involved in homelessness. More details are available in the notes.

1. Key points about relationship with health services include :

1.1. the need for properly resourced permanent outreach and on-going support services, not only for the client but also for housing officers, and outreach workers.

1.2. Many single people living in self contained accommodation need a range of services and support from other sectors and professionals. Strategic

partnerships between housing, social services and health sectors need to become clearer and more effective.

1.3. Services must be client focused, with support for the individual being paramount. Agencies must tailor their input more effectively and it is particularly important that in emergency/crisis situations (often involving people with mental health problems) intervention and support is available immediately. Lack of a quick response from health professionals, leads to more protracted unsatisfactory and costly outcomes.

1.4. There needs to be better understanding and communication of the continuum of care between primary care, mental health, care workers, and hospitals, so that all are informed of the roles that each other play, and of the roles that the housing sector can play.

1.5. Overall, better information and communication are needed, but at the core, the key issue remains that of resources – staffing and accommodation.

9. Interview with Stonham

Graham Russell manages the Oxford City Project, which has three services:

Roken House at 60 Lake Street; Magellan House at 195 Iffley Road; 81 Cowley Road; and DOLPHIN. Stonham High Care manages Rectory Road and Windmill House.

The Rough Sleeper programme runs out of the newly named Roken House at 60 Lake Street and supports some individuals at the newly named Magellan House at 195 Iffley Road and at Windmill House. Stonham is a housing agency, but in their work with homeless, their main aim is to provide supported housing, not to take responsibility for Detox programmes. The question of access to statutory services via the voluntary sector rose again in the context of linking with prescribing GPs, and the role of Luther Street was once again seen as critically important.

Part of the Stonham initiative is the Dolphin project. Dolphin aims to provide good quality self-contained accommodation for young people with substance misuse needs. Its aims are:

- to provide a safe and secure environment in which young people have the opportunity to explore their substance misuse and any other related issues
- to provide links with other services (health, counselling, employment, activities, training, education)

- to assist young people to develop skills to enable them to sustain a tenancy
- the possibility of accessing self-contained accommodation.

10. John Adcock – [Rough Sleeping Fieldwork Co-ordinator]

John co-ordinates the work on rough sleeping within Oxford. The initial briefing meeting with him identified some key issues to be explored as well as key contacts. In preparation for the meeting John had asked around the system for key messages. These were:

- need for accommodation
- need for easier access into the health care system for those in crisis. Care workers and outreach teams sometimes found it difficult to get help when a person they were working with had a crisis, particularly within mental health. Outreach Team workers felt disempowered by this , that they weren't being taken seriously and should be treated with greater
- Luther street is an excellent resource- but it needs better funding and a clearer role in outreach
- Particular problem of not enough accommodation for under25s- especially since young people often have the greatest problems.
- No health input into the RSI consortium

Prison discharge – to a set of agencies-ECH, Stonham, Simon House, Night Shelter, Bridge- need better follow through although local governor is picking this up

Further meetings-

- central links between drugs work and RSI at a central level would be helpful

Time limited nature of RSU funding was problematic for long term strategic development.

-more joint working might help with longer term strategic development of services

- need more involvement from mental health trust

Some key issues from current discussions include issues around detox/rehabilitation, prevention in prisons, new ways of partnership working.

11. Notes from visit to Crisis

The key themes which Crisis believe are important for health are:

- Repositioning health care within the policy context of work on homelessness with an aim of increasing the quality of life of rough sleepers and reintegrating them into society.

The discussion we had highlighted the work of health and rough sleepers project and offered an opportunity for information exchange. Crisis updated me on the work of their health team, which included:

- Open learning pack
- Homeless in NHS in London
- Scoping exercise – City Parochial
- Information pack.

We also discussed some of the issues relevant to promoting health amongst rough sleepers. These include:

- direct access
- integrating hp perspective @ strategic level
- good practice guide
- Linking – local health structures

- Increasing life skills
- HP in hostels

It was suggested that this could be undertaken by supporting and empowering those currently already engaged in rough sleeping work, i.e. health professionals. A GP idea on improving access to specialist services for example, suggested that GPs could manage the rough sleepers in the community, using an out reach model, with the aim of prevention by early identification of mental health problems, and closing off the feeder routes to rough sleeping:

- prisons
- care
- MH
- Armed forces
- Drugs/alcohol

This would in effect mainstream the issues of rough sleeping, incorporating the health needs of rough sleepers into an active health promotion agenda, i.e.

Twinkles: food and mood.

b) The Statutory Sector

12. Luther Street.

Luther Street is an unique primary care facility for homeless people within Oxford City. It aims to provide health care to meet the multiple complex needs and tends to, because of its workload, need to work in a reactive rather than proactive way. At the moment, it faces the complexities of the primary care changes, and is applying for growth of its current PMS contract. The current PMS contract has been held since 1998, but due to a change in the Department of Health policy position, PMS contracts cannot be held by trading companies. Luther Street itself became a trading company in 1998 because of a prior policy position which stated that charities could not hold PMS contracts. Luther Street currently provides services within a context of:

- A patient count of 1600+ despite capped list size and budget for care of 600
- The continuing arrival of 250 completely new patients per year, plus many returning patients who need full re-assessment
- The loss of consultant-led addiction and alcohol services in Oxford, leaving Luther Street in a position where it has had to employ its own drug worker (whose case load is now saturated) and also had to run GP led community, hostel or even street based alcohol detoxification programmes.
- A delay in the provision of consultant psychiatric support due to the need for re-organisation of consultant sectors in Oxford blighting advertisement for replacement for Dr Foreman, who used to do outreach outpatient

clinics at Luther Street, plus extensive liaison psychiatry. (Both models favoured by the NSF, but now effectively in abeyance).

As an organisation, Luther Street could manage the health care for this sector effectively, but funding adequate to the size of the task would be needed. A copy of the growth PMS Funding bid is attached which the team feel addresses the current short-fall and provides for some positive service development for the future. The size of the staffing establishment is effectively limited by the space available in the surgery, even with significant work going on as outreach. However, whilst the size of the premises does somewhat limit the potential for significant growth of internal delivered services, the scope for some specific internal developments, i.e. case conferencing, etc, and additional services delivered externally is considerable. Should the Night Shelter redevelopment go ahead, some extra consultation space may become available.

There have been several discussions during the time of this project with Luther Street, by both myself and Harry Rutter. We are particularly concerned to improve relationships with the community mental health trust, to gain greater clarity about the role of Luther Street viz a viz the rest of primary care in Oxford City, to ensure that there are clear pathways for treatment, detoxification, for alcohol and drugs and in addition that good physical primary care can be provided at the premises. Luther Street is held in high regard by almost everyone in Oxfordshire, however, it is under severe pressure at the current time and needs to think through its role clearly. A conversation with

Angela Jones, one of the doctors at Luther Street, highlighted the following points:

1. There needs to be a round table understanding and trust between health and housing in Oxford City. Action PCT to pick this up.
2. Social Services. The Adults at Risk manager cannot work with homeless people. There needs to be a similar model provided for homeless people as they fall perfectly into the Adults at Risk category and yet do not seem to have tailor-made statutory social work support. It therefore falls to Luther Street and the various voluntary areas to try and co-ordinate some kind of care plan for these extremely vulnerable and needy individuals.
3. Need to outreach to recently, often vulnerably housed, people to help with rehabilitation. Because of continuity, Luther Street feel that they should continue to be the involved health agency until they are convinced that a stable status has been achieved. There is not enough staff at Luther Street to help with this at present, and possibly a question of whether Luther Street should be involved with this or whether this could be done better through other voluntary agencies. The issue of whether this could be achieved by seeking PMS plus status, which gives access to the community budget and more health visitors at a time, was raised, and this needs to be taken up with the relevant people at the health authority (see note to Carolyne McKinlaye).

Regarding benefits advice/One Stop Shop – some benefits advice is provided at Luther Street via the Liaison Nurse, and the recently appointed

Substance Misuse Support Worker (for those engaged with drugs/alcohol treatment. Negotiations are ongoing between the Claimants Union and Luther Street regarding the development of a sessional benefits surgery to be held at Luther Street. However, the potential for enhanced multi-disciplinary service developments via a developed model of multi-agency case conferencing, or a One Stop Shop service (including representatives from Health, Social Services, Housing, the Benefits Agency and voluntary sector providers) would be considerable.

4. Mental Health – Dr Sara Forman has provided outreach outpatient clinics on a weekly basis, plus extensive liaison psychiatric support for some years, enabling Luther Street to manage their very heavy mental health morbidity largely ‘in house’. This is now being jeopardised by a delay in replacing Dr Forman, who recently re-located to another part of the UK. The problem is that the consultant sectors in Oxford need to be reorganised from 4 to 5, and the funding for another consultant establishment needs to be found. In the meantime, Luther Street may not receive regular consultant psychiatric input. This will have a negative effect on its ability to respond quickly to the needs of its very vulnerable and potentially unstable patients, which will inevitably have a knock-on effect on all the emergency services, both in primary and secondary care. It was felt that a well developed case conference/one stop model would appear a valuable way forward.
5. Alcohol: Luther Street provide alcohol detox for their own patients wherever they are, as well as in Simon House to those patients where Simon House is outside their practice area.

6. Oxford GPs often feel unsupported so don't get involved in the care of homeless people. There is a need for better training to promote understanding and gain engagement (ref work being under taken by PHRU).
7. Since the effective closure of consultant-led services at the Chilton Clinic, there has been no clarity about how drug and alcohol services are going to be provided in the future. There is a great opportunity to start with a clean slate and create exactly what is needed for Oxford, but it needs to be tackled effectively, perhaps by the PCT or the DAAT, who will be responsible for commissioning the service and therefore should have a view of what service it wants. The PCG/T has already taken a lead in development of shared care guidelines, but further thought needs to be given to the interface with the Mental Health Trust in order to ensure adequate support for all the sectors involved, especially with the management of patients with complex needs, also to the interface with the voluntary sector.
8. Sustained funding is essential for the service to continue to support Oxford in the way that it is currently doing.

Luther Street is recognised as an excellent resource for rough sleepers in Oxford City. However, it is recognised that they need to have additional support, with greater clarity of the nature of what they could expect from Primary Care Trusts as it develops. For example, will extra community nurses be made available to work specifically with rough sleepers.

Luther Street is a PMS and general discussions are taking place as to whether it can be a PMS extra, and how the public health potential of the PMS can be utilised to promote the work of Luther Street and support it.

Services and Staffing Levels – April 01			
Staffing	WTE staff		
	1998	1999	2000
Doctors	1.1	1.1	1.2
Nurses	3.51	3.51	3.56
Reception	1	2 (from Nov 98)	2
Admin	0.55	0.55	0.5
Drug worker	1 (non PMS)	2 (non PMS)	2 (inc1x6mtn DASG funded)
Substance misuse support worker	0	0	1 (non PMS) since Jan 01
Practice manager	0	1 (from September 99)	1
CEO	1	1	1 April – Sept 00 0.6 from Oct 00

Services Provided by Luther Street Primary Care – April 01			
	Morning 9.30 – 12.30 Open Access	Afternoon 2.30 – 4.30 Appointments	Evening 7 – 11.00
Mon	GP Surgery Nurse Clinic Nurse Liaison Clinic Drugs worker Clinic Substance Misuse support worker Nurse Clinic – Simon House Hostel	GP surgery Methadone Clinic	Nurse clinic Oxford Night Shelter
Tues	Nurse Clinic Nurse Liaison Clinic Drugs worker Clinic Substance Misuse support worker Nurse Clinic – Simon House Hostel	GP surgery Dental Clinic	Nurse clinic Oxford Night Shelter
Wed	Nurse Clinic Nurse Liaison Clinic Drugs worker Clinic Substance Misuse support worker Nurse Clinic – Simon House Hostel Liver clinic - bimonthly	GP surgery Methadone Clinic Podiatry clinic (monthly)	Nurse clinic Oxford Night Shelter
Thurs	Nurse Clinic Nurse Liaison Clinic Drugs worker Clinic Substance Misuse support worker Nurse Clinic – Simon House Hostel	Psychiatric clinic Acupuncture clinic	Nurse clinic Oxford Night Shelter
Fri	Nurse Clinic Nurse Liaison Clinic Drugs worker Clinic Substance Misuse support worker Nurse Clinic – Simon House Hostel	GP surgery Methadone Clinic	Nurse clinic Oxford Night Shelter
Sat			Nurse clinic Oxford Night Shelter
Sun			Nurse clinic Oxford Night Shelter

It has to be recognised that whilst Luther Street is a key element of the support for rough sleepers, there is also a need for it to be integrated and mainstreamed into the services in general across the PCT, and for other practices to be willing to help homeless people, both by keeping

on and supporting their own patients if they are made homeless and also by taking back patients who have been on the streets but who are now housed and able to utilise mainstream services.

13. Oxford City PCG/T

A variety of discussions have taken place with people who work within the PCG. Particular issues which have been raised are:

1. The need for a strategic approach part, particularly to:

1.1. Access to primary care. We have discussed the need for access to general practice in general, particularly for homeless people, who may have moved off the street into hostels. Further work is being done via the work of the PCG on drugs and alcohol services, but there is a need to tie together issues of homelessness, and to be clear that all GPs and receptionists and primary care nurses, and other primary care colleagues are clear about the nature of the problems facing rough sleepers and also the services that need to be provided.

1.2. Voluntary services. The need for clearer relationships with the voluntary sector is recognised, and work is currently on-going in this area.

1.3. Drugs and Alcohol. Oxford City PCT is engaged in a new scheme which is being introduced to make drugs support services available through more of the city than is currently the case. It is estimated that within the Oxford City PCT at least 28 GPs treat drug users by substitute prescribing and there are thought to be 260 primary care patients on substitute prescriptions. Work is being taken forward on providing support and training to GPs and nursing staff, drawing up local prescribing protocols, supporting the work of pharmacists and developing shared care arrangements. In addition, a specialist generalist GP has been appointed, to help take forward this work, which is linked into the work of the DAT. Although progress is being made, it is unclear what protocols are being used for methadone prescription, which patients are receiving methadone, which GPs are prescribing methadone, and whether, from a governance point of view, standards are being met. This work will be taken forward in the future.

1.4. Communicable Disease. The issues facing rough sleepers and homeless people include increased incidence of TB, increased risk of HIV/AIDS related to drug misuse, and increased communicable disease in general, because of the conditions in which they are living. It may be worth thinking of a specific communicable disease strategy, linked to the work of the TB health visitor and the homeless persons health visitor. This will be taken forward with the Public Health Team.

1.5. General Access to Primary Care. If the principle of equity is to be applied, then homeless people and rough sleepers should be able to have equal access to primary care services, including preventative services. This is something that needs further consideration and planning.

1.6. Mental Health. The changes in the Mental Health Trust will hopefully facilitate community based working and support homeless people and rough sleepers. This is something where further discussion with the OMHT is needed, so that we are all clear of the support that they are providing, not only to people with mental illness in general, but specifically to those with drugs and alcohol problems. There is currently a lack of understanding of the service level agreements which are in place, and feeling amongst primary care that the Trust has been very slow to respond to the needs of drugs and alcohol services, as well as those with mental health problems.

14. Notes from a meeting with Mike Hobbs, Consultant Psychiatrist,
Oxfordshire Mental Health Trust

Rough sleepers were not seen as a huge problem for the Trust. Problems around homelessness include:

- Access
- Discharge
- Links with housing
- Rehabilitation

Links with housing were being address via a strategic housing group. There were good links with the Elmore Team. Regarding the drugs and alcohol policy, progress was admittedly slow, but there was increasing interagency work and co-operation.

Cross referencing between primary care and the Oxfordshire Mental Health Trust and voluntary agencies is beginning to happen, although clear identification of resources available to PCTs was lacking.

The current changes in the Trust, which will de-emphasise age and emphasise locality, creating teams that are co-terminous with PCTs, will aid future development of community based policies. Issues of homelessness and mental health in the City are well recognised, and it was agreed that an

additional consultant appointment to the City would help address the needs of homeless, including rough sleepers. Mike agreed that there would be a HImP improvement involvement from the Mental Health Trust, which would identify what needed to be done to meet the mental health needs and drugs and alcohol needs of homeless and rough sleepers. In the first instance, the paper would go to the Priorities Forum, to be fed through to the SaFF process. We also agreed that it might be helpful to raise the profile of the nature of the changes in the service level agreement for the community addictions team.

15. Meeting with Mark Stevens, who now leads the Addiction Service for the County

Mark used the words 'mayhem' and 'chaos' for the current situation on community drugs policy within the city. There are many resources which are not being used effectively, and he was unclear what the service level agreement for the City was, and implied that no-one seemed to know. There were three groups of problems:

- the over 25s
- the under 25s
- and particularly the under 18s, who are a real and growing new problem, and in need of services.

The main purpose of the discussion was to clarify the situation on Methadone.

Mark's main point was that methadone is a long-term treatment for 7-10 years, and there it is a resource issue. All the evidence is that the prescription seems to be given over a long period of time, thus any resource gets silted up in any sector, unless there is a specification for who will benefit and clarity that methadone will not get you off opiates, it is a long-term treatment.

Many people are too young for methadone and don't want long term treatment. Often if these young people are living with their parents there is more opportunity.

Strategy for detox should be:

1. to stabilise
2. draw up a post detox plan
3. begin detox

It may take weeks or months to work up to the point of detox. If it is a knee jerk reaction, then providing methadone without this context can be more harmful, as young people will despair and go back onto drugs. Thus for homeless young people the need is to deal with their homelessness first, and then create a plan which means continuous support. Use of methadone, although recognised as beneficial, also has its problems. Studies show decreased death, decreased crime and increased stability, but the studies were done on older people not younger people. Altrezone may help to keep people opiate free during stabilisation. Its mode of action is that of antabuse for alcohol. Altrezone could be used as part of a package but a protocol is needed.

Regarding relationships with the PCG, it seems from discussion that OMHT and the PCG have different perspectives. From the OMHT perspective, they want a three year strategy to work with PCTs, make robust decisions re: drugs and alcohol, and work on behalf and with them. Only some PCGs will prescribe and support. The approach taken by the PCTs is that they want all doctors to prescribe, or at least an increasing number to prescribe.

Regarding the voluntary sector, the words 'at war' were used.

What is needed is a tiered service, with common protocols and common agreements. We need to get past the different agendas and discuss different philosophies. The blocks are there, and it is hoped that Sue Gardiner, a psychologist in Reading, will have a new role in smoothing and creating a common pathway.

The meeting had to end at this point because Louise Casey arrived.

16. A discussion with Phil Hormbrey, consultant A&E

Phil's initial comment was that Oxford was lucky to have Luther Street, because it means they don't see large numbers in A&E. This is particularly because A&E is out of town. They liaise with Luther Street, give support, help with treatment, and use faxes as a means of communication.

There is another group of vulnerable people, 18 frequent attendees, many of whom have problems related to alcohol or drug abuse. Since taking over the management of the Self Harm Unit where many of these patients are treated, the A&E Department have noted an 'appalling lack of detox facilities within this region'. Following our meeting, Phil met with Eleanor Feldman the Liaison Psychiatrist, and confirmed that they would be working together to develop better treatment packages f

The A&E Department has a nursing lead for rough sleepers, Sister Julie Stockbridge. Sister Stockbridge has a checklist which nurses try to enact for each rough sleeper on their departure to ensure all actions have been taken to help these patients.

17. **DAT**

Discussion with Bill Holman. The Drugs Action Team for the County is broadening its brief to work across between drugs and alcohol. There is a feeling that closer links are needed with the OMHT to not only develop strategy, but deliver. There is a lack of clarity at the 8wte promised in the plan, when the specialist addiction service was closed. There was a feeling that progress had been slow and that the resources were not being committed to community based drugs and alcohol services.

In addition, there were some complications about the philosophy about methadone, which needed clarification. Further discussion between OMHT and primary care are obviously necessary.

18. Notes from meeting with Penny Randall, Oxford City Council

Penny is the key contact in Oxford City Council for Rough Sleeping. I discussed with her her views on health issues and needs and views on the health services, and also received a lot of background information about the rough sleepers initiative. She explained to me the funding received from the RSU (available notes of interviews). In her view, the initiative was going well; there was strong interagency working; the Elmore and Salvation Teams are doing the majority of outreach work, then linking to GAP, Gatehouse, etc. For example, Andy Jones in the Resettlement post of the Salvation Army has worked with the private sector to get people rehoused and then provides on going support. The resources for resettlement include all the ones who have been interviewed for this report:

- GAP
- Bridge
- NightShelter
- Simon House
- Lucy Faithfull
- Stonham

Issues of detoxification from drugs and alcohol remain to be sorted; at the present time it is unclear what is being provided in the statutory sector.

Details of the work of the City Council are given in Oxford City's single homeless strategy and rough sleeping issues are discussed at the housing

committee. The chief Executive and City Centre Manager and Director of housing are all kept informed, as are key politicians. Half of John Adcock's post is funded by the City, so there is a high level of engagement by Oxford City Council in the issues around rough sleepers. However, when it comes to health issues, there are some gaps and failures of communication. It is recognised that Luther Street is an excellent resource, however it is over stretched and needs greater support. Support from other GPs in the City is limited, and we need a better way of integrating into primary care. There is a suggestion that lack of expertise can create rather antagonistic attitudes to people who use drugs amongst all health care workers. Only a small number of people in primary care are interested – these are currently being worked with via the Oxford City PCT, who are introducing their new scheme of payment to pharmacists and GPs for methadone prescription, which is being evaluated by the PHRU. Luther Street needs to be linked in to routine primary care and supported by outreach workers. The PMS model needs to be looked at to see if it can be developed further.

Drugs. It is well recognised that the nature of the joint commissioning group for the DAT in the county is a step forward, to allow us to take a population based strategy, which will enable the national treatment agency work to be put into place. (ref work of Harry Rutter on drugs alcohol and prisons in the county).

19. OMHT

Regarding the current changes in the Mental Health Trust, the view is still held that these are good intentions but...

New PCTs outside the City feel better supported, but City is still unclear. It feels as if clients are bounced around, there is no link between detox and rehabilitation, or with the criminal justice agencies. We need greater clarity about the scale of the problem, and particularly we need to meet the needs of the under 25s. We also need to ensure that GPs who are engaged and involved in drugs issues are trained and working to common protocols.

Key areas to address include:

- access of black and ethnic minorities
- young people to treatment
- outreach and access to young people , especially the under 18s
- women and parents with children,
- those in rural areas.

OMHT is making progress on community detox, but some of the questions that need to be answered include how do people get in there, with whom do they link, what are the key links between the specialist addiction team and primary care, what are the pathways which people are expected to follow, and what is the service expectation, how is outreach in the voluntary sector played in. If GPs knew this, they could send someone on a clear pathway and programme. There is also a question about methadone maintenance – how

the methadone bus fits in, and whose responsibility this is. Overall, this raises questions about the management structure.

Another key area that is not included in this, is that of prevention and health promotion, which also needs to be considered. In addition there is a clear need for an overall strategy, with the confusion around day care, funding, vis a vis GAP and the NightShelter.

20. Notes from Wet Facilities Meeting

Talk back in Oxford City had earlier in the year identified that many people in Oxford did not wish to see beggars or street drinkers, and there was a feeling that something needed to happen. The original idea had been a wet room in the NightShelter. The proposals were to do this in a very short timescale, by some small structural changes. However, although there was general support that a wet facility would be useful, it was agreed that a series of things needed to be considered. These included evidence of how to establish a wet facility; learning from other places where they had established wet facilities; evaluation of its impact; consideration of long term implications; health and safety issues; what activities would the people using the wet facility be provided with (see reference from Dr John May, Director of the Evan Regional Research Centre of the University of Sussex, who carried out research in September 1999. This is in the literature review).

21. Bullington Prison

Visit to Bullington Prison to discuss rough sleeping with the Governor – this was done as part of the process of developing the health improvement programme, and the work on this needs to be cross-referenced.

The Governor recognised that the many needs of those in prison, particularly mental health problems, drugs and alcohol, which needed to be addressed, not only by the prison system, but also when prisoners are discharged. When asked what could make a difference, as prison could offer the opportunity to break the cycle of deprivation – it is a static space and therefore provides an opportunity to do something –therefore links with other agencies need to be better. It is a question of whether although a lot of good efforts are going in at the moment, because they are not linked into others they could perhaps be wasted. Links need to be made with housing agencies, and the governor was holding a joint day with housing agencies to explore opportunities and particularly those of dedicated spaces. He felt he needed to know what options were available in the community and then what possibility there was for bridging the links. The Ley Community provide an excellent service, both in prison and in the community. This is the only example of the sort of continuity line, and matches prisoners to their needs in the community. The question arises as to whether there is, or should be, discharge support from the Mental Health Trust.

The Ley Prison Programme is a full-time drug rehabilitation programme lasting 4 months, run on a spur of C wing at Bullingdon. It consists of 4 stages aimed at tackling the root causes of drug use and offending behaviour. Resettlement is seen as a vital component, and the programme manager has applied for funding for 2 more resettlement workers to strengthen this aspect.

A house in Oxford is being established as a half-way house for the Ley Prison Programme, four people would go for 3 months following discharge. There will be regular drug testing and a resettlement office in the building.

The Ley Community in Yarnton is a residential drug rehabilitation programme. Some residents have been through the Ley Prison Programme, some are sent by the courts in place of custodial sentences, and others attend 16 months – in the final stage residents move out into the community. Attendance is voluntary, although some residents are sent by the courts. The purpose of the community is to offer a refuge based on total trust and absence of secrets, with peer support an essential factor in this.

The CARATS worker in Bullingdon has also identified through-care as a major problem – there is a lack of places to refer people on to for support on leaving prison, and a great shortage of housing, especially supported housing, available.

For those in prison, short term offenders have particular problems, and perhaps it would be useful to focus on short term offenders to see whether

they could be motivated, particularly to think about work, preparation for rehabilitation and re-entry into the community, addressing how they got into the position they are in, and what they are going to do next. This is something where health support could play a part.

Health needs to provide support both in prison, and on discharge, by creating better links to GPs with prior knowledge, notification, overcoming some of the confidentiality issues by engaging the prisoners themselves and asking them whether they would want to be involved in follow through with GPs. Better links to the Mental Health Trust is one way of breaking the IT failure to communicate, enhancing the thinking skills programme.

These notes fit within the overall context of the discussions that we had at Bullingdon Prison, where we identified similar needs for all prisoners, and we will be taking forward issues around health promotion, drugs and alcohol support, mental health problems, dentistry, and communicable diseases as part of the prison health improvement programme, which will be produced for the health authority for its March meeting.

Prisons

We have briefly discussed the possibility of working with Bullingdon Prison on inreach/out reach to ensure GP registration of prisoners as they are discharged, and in particular support for those who have had drugs and alcohol problems. This work is currently only at the discussion stage, and

needs to be taken further.

22. Discussion on Rough Sleepers with Carlyne McKinlaye

Discussed with Carlyne the status of Luther Street as a PMS. She informed me that the PCG was re-negotiating the contract and there was a need to actually look at more mainstream PMS for Luther Street. It is well recognised that Luther Street's current status is an issue. Carlyne agreed to contact Sharon Shay, who is the PCG PMS lead, and particularly to look at the potential for getting new money in via exceptional variations. Carlyne will also contact the region to tell them we may need to increase the level of variation. She will also make sure that discussions are taken forward with Martin Vincent.

Appendix 2 : Audit of health authorities

Rough sleepers are one of the most vulnerable groups in society. This was recognised by the Government when it set a target of reducing rough sleeping by two thirds by 2002 - and publicly committed itself to making a lasting difference on the streets by stopping people arriving there in the first place. Partnership and joined up working underpin the need to link homes and jobs to social and health support.

As part of a project to advise the Rough Sleepers Unit on future health policy an audit of services for homeless people sleeping on the streets was undertaken through health authority directors of public health .¹

The purpose of the audit was to describe provision of services and to identify both good practice which could be shared, and service gaps which need to addressed.

The DPHs from 69 Health Authorities in England, identified by the Rough Sleepers Unit, were sent a questionnaire via the FPHM DPH network. Responses were collated by the RSU who also followed up no responders. The sampling frame included those districts known to have people sleeping rough or to have special services to address their needs. Those from areas known by the RSU to have a low prevalence or who self-reported that there was no incidence of rough sleeping in their area were excluded.

Respondents were asked to give examples of best practice, and also to identify gaps in service provision for acute care, drug and alcohol services, mental health services and preventive care. Comments on the impact of national policy and local issues on health service provision were elicited and compared.

¹ Since the audit was undertaken, Shifting the Balance of Power has meant that the 90 health authorities have been replaced by Primary Care Trusts (PCTs) who now have the responsibility for improving the health of their populations.

Responses were analysed as a total of those sent the questionnaire, and then by inclusion within (or exclusion from) the priority network of the RSU. Qualitative analysis of the freetext comments was also carried out.

Results :

Sixty nine health authorities (HAs) were targeted for inclusion, with fifty one health authorities responding, giving a total response rate of 74%.

1. Government strategy:

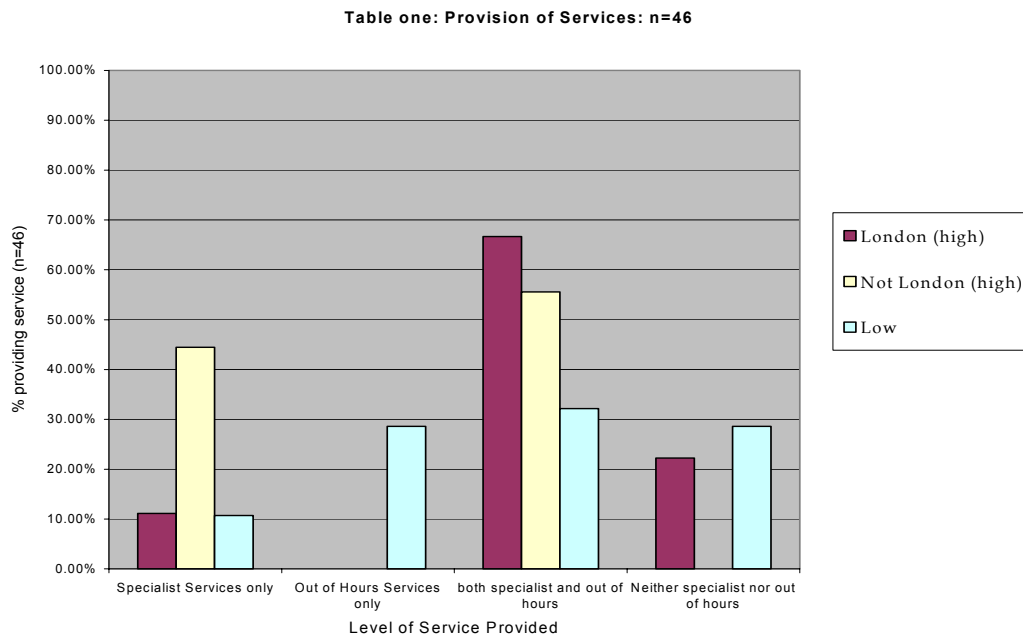
43 DPHs responded to a question, which asked whether they felt that the government strategy for rough sleepers was relevant for their patch. 51% (22) of the total thought it was either very relevant or relevant with only 11.5% (5) saying it was not. 35% (18) of health improvement plans mentioned the needs of rough sleepers , with 31.6% of those areas identified by the RSU as being high priority areas reporting that their health improvement plans did not include specific mention of the health needs of rough sleepers. Overall, of those who had not included mention of the health needs of rough sleepers, only 26% were thinking of doing so – 28% in high priority areas.

2. Services:

Current provision and emerging trends.

A range of specialist primary care provision had developed in areas where there are significant numbers of homeless people. Not unexpectedly, provision tended to reflect the local numbers and needs of rough sleepers. Nearly half of the 46 (43.48%) Health authorities responding to the question said they had specialist primary care provision as well as provision of out of

hours cover. However, 21.74% (10) health authorities reported that they provided neither out of hours services, nor specialist services for rough sleepers. Table one shows the provision of specialised services and out of hours provision.



Out of hours primary care provision was mainly provided by out-of-hours GP cooperatives, walk in centres and primary care centres. In some areas, the only out of hours services for rough sleepers was the accident and emergency service. In others a specific primary care service was available within accident and emergency departments or dedicated sessions were provided in night centres and hostels for the homeless.

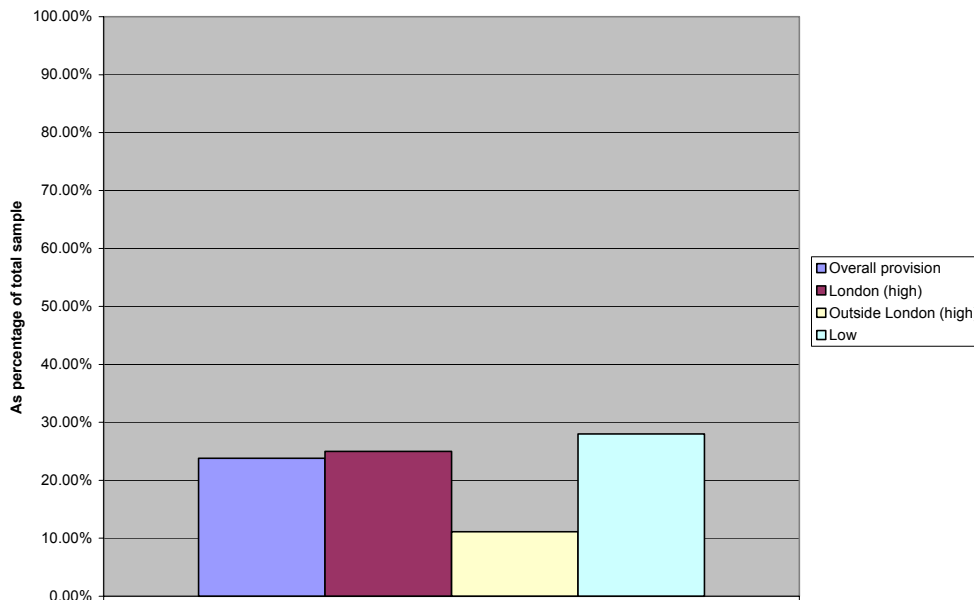
Reported examples of good practice

- A primary dental service with open access

- Out of hours sessions run in a homeless night centre
- GP appointments in A&E
- Mobile medical surgeries for people in housing need
- Dedicated primary care staff input to hostels, day centres
- Mobile dental unit
- Dedicated primary care sessions provided in rough sleepers accommodation
- Hostel support programme to enable unregistered clients to use GP based services.

Access to Primary Care Services

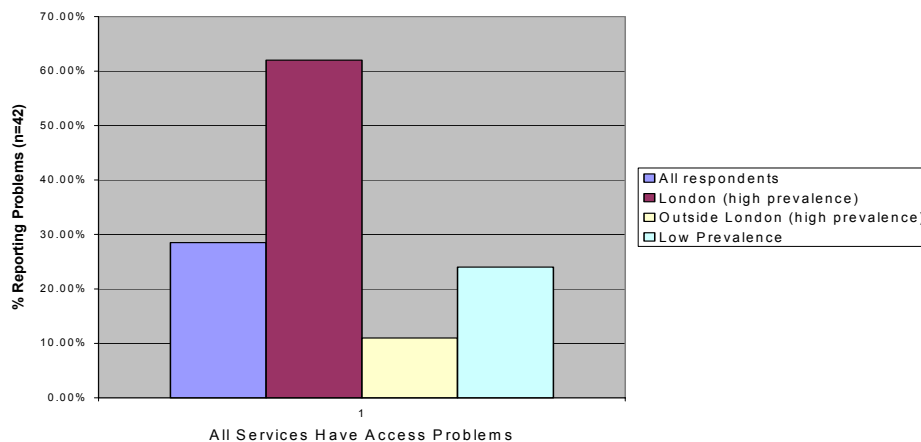
Table 2: Percentages reporting no issues with access to primary care services (n=42)



42 health authorities provided comments on access to primary care services, specifically dental care, podiatry and A&E. Figure 2 shows that access to services was variable, with only 23% of respondents overall reporting that

there were no issues of concern about access for rough sleepers to primary care services. 25% of London Health Authorities were satisfied with access to primary care services, however provision outside London was less satisfactory with only 11% of high prevalence areas responding that they had no issues of concern. 28.5% of all respondents indicated that there were access problems for all services for rough sleepers. (see Figure 3)

Figure 3: Access to Primary Care Services



There are particular issues surrounding provision of dental and podiatry services, identified throughout the literature on rough sleeping as major problems for those sleeping rough. The audit reflected this shortfall in dental provision for rough sleepers. 50% of respondents identified a problem, which broke down to 40% in low priority areas, 56% outside London, and 75% within London. The structure of dental services, being based on registration or provision of emergency clinics was felt to hamper access by the homeless. Podiatry services were also problematic in 40% of all areas. Poor access to podiatry services reflected their clinic based registration format. Accessibility of Accident & Emergency services was also an issue, either due to geographical inaccessibility or inappropriate use as a primary care service by

homeless people, therefore increasing pressure on these often overstretched services.

Identified Good Practice

Some areas have found innovative ways of overcoming access to dental and podiatry services, which include drop in podiatry and dentistry services or sessions for podiatry and dentistry provided on a monthly basis at day centres, hostels, or rough sleepers accommodation.

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 the homeless. In Dorset provision of dental care by a mobile unit is already available.

3. DRUGS AND ALCOHOL

Current provision and emerging trends

Provision of drug and alcohol support services for rough sleepers varies across health authorities. In most areas, community drug and alcohol teams are the main service providers. 20(39%) of respondents overall had dedicated drugs and alcohol workers for homeless people. This was more common in high priority areas, with 80% provision in high priority areas outside London, 78% provision within London.

In other areas more specific provision, such as an alcohol link initiative for those who would not attend normal services, had been developed. The availability of detox facilities varied widely. Three health authorities reported a total lack of services.

Respondents were asked to comment on the types of detox services available for those sleeping rough, specifically whether the services were specific for their needs or part of general provision. No respondents felt that all or no needs were being met but two thirds (67%) said facilities only met some rather than most needs.

Good practice

Ways in which some health authorities have made alcohol and drug detox services accessible to rough sleeper/homeless populations are:

- an open access clinic at a GP practice supported by a drug dependency unit session worker
- GP and specialist detox facilities in the community and hostel centres
- fast tracking of hostel residents in the community drug service
- alcohol and drug support at residential centres and units

4. Mental Health

Current provision and emerging trends

In most areas, current provision for a mental health service for homeless people involves specific workers with a dedicated remit population. Models include CPNs, mental health social workers, housing project officers and GP cover for voluntary sector emergency accommodation. Several respondents reported active multi-agency groups specifically looking at homelessness issues. In other areas the public health department provided advice to local authority housing departments and committees. However this type of inter-agency working was not reported in all areas, being more common in areas targeted by HMII funding.

A few respondents reported future plans to improve current provision, such as, provision of an assertive outreach service and plans to work with the prison service.

A commonly reported area of difficulty is access to mental health services by non-health agencies.

Figure 4: Description of Access of Non-health agencies to MH Services

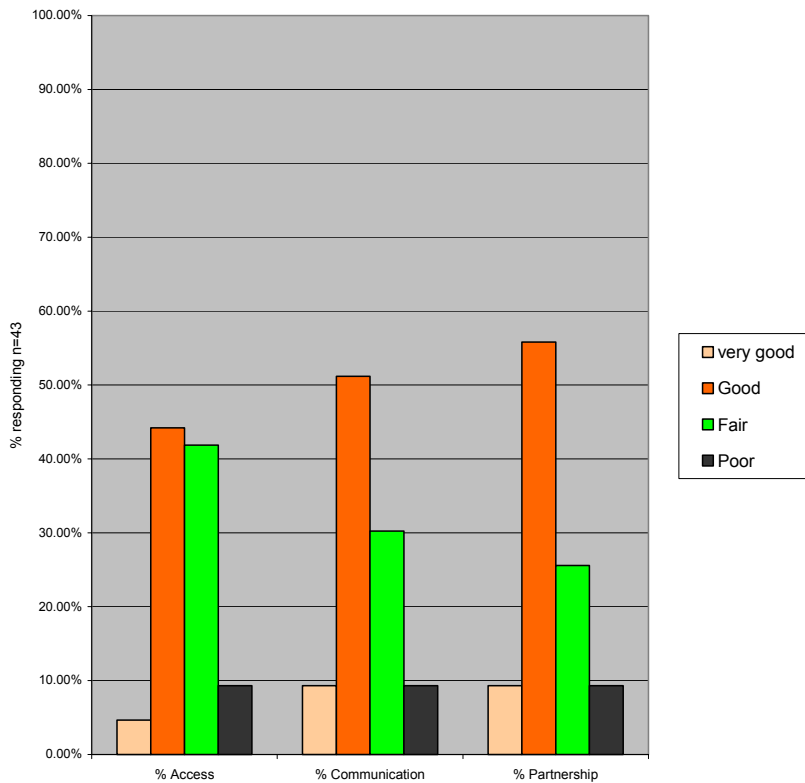


Table 4 shows the views about access to mental health services for non-health agencies. 49% of respondents replied that access was good or very good, with 60% believing that communication with mental health services was very/good, and 65% believing that partnership was very/good. This audit did not address the question of whether this reflected the views of the non-health agencies.

5. Prevention

Some examples of work being undertaken to prevent the health problems of rough sleepers were reported. These include:

- the health promotion service working with local hostels for young homeless to provide life skills training to enable them to maintain tenancies when found
- health promotion work on access issues, including housing advice.

Other areas on which Health Authorities were asked to comment were:

a. Shortfall in provision

Three main issues were raised regarding local problems hindering effective prevention strategies. These were:

- a shortage of low cost rented accommodation
- engagement of probation/prison services
- differences in access/communication between hostels

b) Effect of national policies

Comments on the impact included:

- the missed opportunity for homelessness and social exclusion to be highlighted in the NHS Plan, which meant that some providers do not always see this service as a priority.
- uncertainty surrounding the change to national asylum seeker policies and the impact this would have on homelessness issues.
- complexity of meeting the needs of this group

- the need for responsive and accessible services which were sensitive to their needs.
- Opportunities provided by Local Strategic Partnerships (LSPs) and homelessness strategies

c) Communication and multi-agency involvement

- The importance of multi-agency involvement and good inter-agency communication.
- Need for good communication between agencies such as prison discharge, hospital discharge and housing departments and the benefits agency to enable the needs to be met.
- NHS activity alone is inappropriate.
- Need better links with prisons and probation

Discussion:

This survey was undertaken in advance of the changes in Shifting the Balance of Power. However, its findings are relevant to Primary Care Trusts, particularly Directors of Public Health and the public health teams.

The level of provision for the health needs of rough sleepers/homeless people varied considerably across health authorities in England, in part reflecting the size of these populations and the perceived need for such services. In some areas, access to services was only available via mainstream services which were available to all. However, some areas had very specialist

provision available to rough sleepers/homeless people. The opportunities for developing new and creative ways of meeting needs will increase with the opportunities provided by PMS and primary care modernisation.

Summary

Healthcare provision for rough sleepers varies across the country, with service innovation reflecting the size of the rough sleeper population and investment by the RSU. However, podiatry and dental services are difficult to access in some areas, although innovative approaches have overcome these problems for some health authorities.

Inappropriate use of and accessibility to Accident and Emergency services among the homeless population is a common problem. Access to primary care services varies between availability via mainstream services to provision of specialist primary care. Out of hours primary care provision was reported to be mainly provided by GP co-operatives, walk-in centres and primary care centres

In most health authorities, alcohol and drug support for rough sleepers/homeless people is only available via mainstream provision through community drug and alcohol teams. Current provision for a mental health service for homeless people involves specific workers with a dedicated remit

for the homeless population in most areas, rather than a separate mental health service for the homeless.

Several health authorities reported future plans to improve accessibility of primary care services and alcohol and drug support to rough sleepers/homeless populations through greater outreach work.

Supporting rough sleepers/homeless people was considered a complex issue, because different sub sections have of the homeless population have different needs and this group require considerable support to enable them to maintain tenancies. Problems faced in providing this support vary across the country

Overall, although progress in meeting needs is being made all health authorities recognised the need for improvement.

Conclusion:

This audit demonstrated the need to ensure the needs and health of rough sleepers receive more consideration from statutory providers. There are gaps in provision across the country and a need to improve local partnerships to ensure the best use of existing resources and expertise as well as targeted services where appropriate. Communication and clear shared strategies with all agencies signed up will improve the often fragmentary and ad hoc availability of health care to homeless people. The role of GPs and primary care teams working with local partners is crucial, particularly with the current structural changes to health care services. The responsibilities of PCTs

include not only ensuring health care provision within the NHS, but also responsibility for working in partnership to ensure the wider health needs of this vulnerable group are met.

Rough Sleeper Health Audit

Analysis of the written content of the rough sleeper health questionnaire

**Prepared for the Rough Sleepers Unit, DETR by
Dr Carol Dumelow
Independent Research Consultant**

February 2001

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1. INTRODUCTION

This report provides a summary of the written content of a rough sleeper health questionnaire which was returned by forty-one Directors of Public Health as part of the rough sleeper health audit. It focuses on examples of best practice, emerging trends and shortfall in healthcare provision for rough sleepers/homeless populations in health authorities in England.

About two-thirds of respondents completed the open-ended questions of the questionnaire. *Framework* qualitative analysis method¹ was used to analyse these responses. Following study of the responses from the open-ended questions, a thematic framework was constructed based on the aims of the audit and the recurring themes. The thematic framework was applied systematically to the questionnaires to enable reorganisation of the data by category. Each individual's response relating to the categories was transferred from the questionnaire and written on to charts. The reorganised data was examined which enabled patterns and associations to be identified.

Findings are summarised under five key sections; policy, services, alcohol and drugs, mental health prevention and overall comments.

2. POLICY

Respondents were asked to comment on the inclusion of the health needs of their rough sleeper population in their health authorities policies/strategies. There were few specific comments made in this section. However, those respondents who said that their authority's HIMP did not include specific mention of the health needs of rough sleepers reported that they had only a small population of rough sleepers locally and did not perceive it to be a significant problem. Ten respondents reported that the health needs of rough sleepers were included either in their general homelessness strategy or under the housing and social inclusion sections of their HIMP.

3. SERVICES

3.1 Current provision and emerging trends

A range of specialist primary care provision was reported to be provided for rough sleepers/homeless people in various health authorities across England. The level of provision reflects the size of the rough sleeper population and many respondents reported low numbers of rough sleepers in their area. Current provision for rough sleepers/homeless people can be grouped in to two types:

- Outreach work - sessions in hostels, day centres provided by primary care staff (GP, health visitor, nurse, community mental health team staff)
- Drop-in/walk in centres; open access services

1.Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess RG (eds.) *Analysing Qualitative Data*. London: Routledge, 1994.

Both types of provision were equally common across health authorities. However, several respondents reported future plans to provide services to improve accessibility of services to rough sleepers/homeless populations. These include:

- a hostel support programme
- a mobile dental surgery
- a mobile medical surgery
- a chiropody clinic for the homeless
- a GP appointment system in Accident & Emergency

Out of hours primary care provision was mainly provided by out-of-hours GP co-operatives, walk-in centres and primary care centres. In some areas, the only out-of-hours service for rough sleepers/homeless people was the accident and emergency service, in others a specific primary care service was available within accident and emergency departments or dedicated sessions were provided in night centres and hostels for the homeless.

3.2 Good practice

The amount of provision for the health needs of rough sleepers/homeless people varied considerably across health authorities in England, which reflects the size of these populations and the perceived need for such services. In some areas, access to services was only available via mainstream services which were available to all. However some areas had very specialist provision available to rough sleepers/homeless people. Some reported examples of good practice are:

- a primary dental service with open access
- out of hours sessions run in a homeless night centre
- GP appointments in A&E
- mobile medical surgeries for people in housing need
- dedicated primary care staff input to hostels, days centres
- mobile dental unit
- dedicated primary care sessions provided in rough sleepers accommodation
- hostel support programme to enable unregistered clients to use GP based services

3.3 Shortfall in provision

In many areas, the main shortfall in primary care provision for rough sleepers/homeless people is access to dental and podiatry services. Registration and access was reported to be difficult because either podiatry services are clinic based; dental care is provided by registration only or emergency dental care is geographically difficult. A second problem in some areas is accessibility of Accident & Emergency services which are either geographically difficult to access or are used as a primary care service by homeless people, therefore increasing pressure on these services.

Some areas have found innovative ways of overcoming access to dental and podiatry services, which include drop in podiatry and dentistry services or sessions for podiatry and dentistry provided on a monthly basis at day centres, hostels, or rough sleepers accommodation. 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 the homeless. In Dorset provision of dental care by a mobile unit is already available.

4. DRUGS & ALCOHOL

4.1 Current provision and emerging trends

Provision of drug and alcohol support and detox services for rough sleepers/homeless people varies across health authorities. In most areas, only mainstream provision for all via community and drug and alcohol teams is available. In other areas more specific provision, such as an alcohol link initiative for those who would not attend normal services, is available. These tend to be provided in areas where there is a high rough sleeper population such as, Ealing, Hammersmith and Hounslow, where a large range of services to rough sleepers and street drinkers are reported to be available.

Several authorities reported plans to improve current services by making them more accessible to rough sleeper/homeless populations through greater outreach work.

4.2. Good practice

Ways in which some health authorities have made alcohol and drug detox services accessible to rough sleeper/homeless populations are:

- an open access clinic at a GP practice supported by a drug dependency unit session worker
- GP and specialist detox facilities in the community and hostel centres
- fast tracking of hostel residents in the community drug service
- alcohol and drug support at residential centres and units

4.3 Shortfall in provision

Three types of problems concerning alcohol and drug provision for rough sleepers/homeless people were reported in a few areas:

- the need for GP registration for access to Alcohol and Drug agencies
- the long waiting time for assessment and to start alcohol and drug detox
- finding accomodation for rough sleepers after detox is complete

In one area, some of these problems have been overcome by providing some fast tracking of hostel residents to community drug services.

5. MENTAL HEALTH PREVENTION

5.1 Current provision and emerging trends

In most areas, current provision for a mental health service for homeless people involves specific workers with a dedicated remit for the homeless population, rather than a separate mental health service for the homeless. This includes CPNs, mental health social workers, housing project officers and GP cover for voluntary sector emergency accommodation. However, several respondents reported active multi-agency groups specifically looking at homelessness issues. In other areas the public health department provide advice to local authority housing departments and committees. However this type of inter-agency working was not reported for all areas.

A few respondents reported future plans to improve current provision, such as, provision of an assertive outreach service and plans to work with the prison service.

5.2 Good practice

Examples of work being undertaken to prevent homelessness and rough sleeping include:

- the health promotion service working with local hostel for young homeless to provide life skills training to enable them to maintain tenancies when found
- health promotion work on access issues; night shelter and housing advice issues

5.3 Shortfall in provision

Three issues were raised by a few respondents regarding local problems they were facing in preventing homelessness and rough sleeping. These were:

- a shortage of low cost rented accommodation
- engagement of probation/prison services
- differences in access/communication between hostels

6. OVERALL COMMENTS

Some respondents commented on the impact that both national policies and local issues had on health service provision for rough sleeper/homeless populations.

6.1 Effect of national policies

One respondent commented on the missed opportunity for homelessness and social exclusion to be highlighted in the NHS plan which meant that some providers don't always see this service as a priority. A second respondent highlighted the uncertainty surrounding the change to national asylum seeker policies and the impact this would have on homelessness issues.

6.2 Meeting the needs of rough sleepers/homeless people

Supporting rough sleepers/homeless people was a considered complex issue, both because different sub sections have of the homeless population have different needs and this group require considerable support to enable them to maintain tenancies. Problems faced in providing this support vary across the country; in affluent areas like Kingston and Richmond low cost housing is either not available or taken up by a student population, in more rural areas like Cornwall the numbers of rough sleepers are less obvious because they are sleeping in barns and fields rather than streets.

One respondent highlighted the importance of ensuring quick access to services for this population.

6.3 Communication and multi-agency involvement

The importance of multi-agency involvement and good inter-agency communication was highlighted by a few respondents. Good communication between agencies such as prison discharge, hospital discharge and housing departments and the benefits agency was considered imperative to enabling the needs of rough sleepers/homeless people to be met.

7. Summary

- Healthcare provision for rough sleepers/homeless people varies across the country and reflects the size of the rough sleeper population
- Podiatry and dental services are difficult to access in some areas, but through innovative approaches these problems have been overcome by some health authorities
- Inappropriate use of and accessibility to Accident and Emergency services among the homeless population is reported in some areas. Schemes to overcome this problem are in place in some areas
- Access to primary care services is only available via mainstream services in some areas. However other health authorities provide specialist primary care provision for rough sleepers/homeless people
- Out of hours primary care provision was reported to be mainly provided by GP co-operatives, walk-in centres and primary care centres
- In most health authorities, alcohol and drug support for rough sleepers/homeless people is only available via mainstream provision through community drug and alcohol teams
- Current provision for a mental health service for homeless people involves specific workers with a dedicated remit for the homeless population, in most areas, rather than a separate mental health service for the homeless.

- Several health authorities reported future plans to improve accessibility of primary care services and alcohol and drug support to rough sleepers/homeless populations through greater outreach work
- Supporting rough sleepers/homeless people was considered a complex issue, because different sub sections have of the homeless population have different needs and this group require considerable support to enable them to maintain tenancies. Problems faced in providing this support vary across the country

Appendix 3

Royal College of General Practitioners Editorial

Developments in the provision of primary health care for homeless people

In 1952, Aneurin Bevan suggested that no society can legitimately call itself civilised if a sick person is denied medical aid because of lack of means.ⁱ Homelessness represents poverty in its most extreme form. No-one is immune. Accurate prevalence statistics are elusive, complicated by problems of definition and legislative loopholes. However, it has been shown that up to 4.3% of all current head of households in England have experienced a period of homelessness in the past decade.ⁱⁱ

The Royal College of General Practitioners has stated that all people must have equity of access to health care.ⁱⁱⁱ However, homeless people often experience difficulty in gaining access to quality primary health care.^{iv} Primary care registration rates vary between 24% and 92% for homeless people, the former described in a study of rough sleepers^v and the latter in families in bed and breakfast accommodation.^{vi} Barriers to care are poorly researched; however, limited work from a GP perspective suggests that lack of training, concerns over time-costs, and negative attitudes towards homeless people are significant issues.^{vii} Homeless people themselves report perceived reluctance from the primary care team and personal competing priorities as barriers to registration and care.^{viii} Yet this is a population with very significant health needs. In 1992, Crisis reported that the average age of death of 86 identified rough sleepers in London was 47 years.^{ix} A follow-up study, using records from the London Coroners' Courts from 1 September 1995 to 31 August 1996, found that 74 deaths of rough sleepers had been recorded and that life expectancy was 42 years,^x compared with the national average of 74 years for men and 79 years for women.

Twenty years ago, the Acheson Report on primary care in inner London noted that mainstream primary care provision in London at that time was not engaging with the health needs of homeless populations.^{xi} One of the Report's many recommendations was that alternative provision should be made for providing primary care to homeless people. As a result, a number of new primary care services were set up around the country, including specific salaried GP posts, house doctor schemes and mobile GP surgeries, whose role was to provide primary health care to the homeless population. In 1996, a report for the Department of Health (DoH) noted that there were 13 dedicated primary care homelessness centres in England.^{xii}

PMS pilot schemes have led to a dramatic increase in the number of dedicated primary care homelessness centres. In guidance from the DoH, prior to the call for applications for first-wave PMS schemes, homeless people were specifically mentioned as a target group for PMS projects.^{xiii} There are currently 25 primary care centres around the country, which are under PMS contracts and specialising (or with a special interest) in the health care of

homeless people. There are also several other specialist homelessness centres around the country that have contractual arrangements other than PMS.

It is important that specialised homelessness centres working under a PMS contract are not seen as a panacea for homeless people. Their obvious strength is that they overcome the time-cost disincentive to GPs working with homeless people. PMS contracts have the potential to replace or complement the capitation system of payment, which forms a significant proportion of GP independent contractor pay. The obvious limitations of specialised services are that they may effectively absolve local GPs from providing primary care services and at worst may serve to ghettoise homeless people, rather than encourage their integration back into mainstream primary care. Limited research in this area shows that homeless people value specialised services.^{xiv} Anecdotally however such value can act as a barrier to homeless people moving into mainstream primary care practices once they have become re-housed. Although PMS contracts are subject to local and national evaluation, it is questionable whether such evaluation will be sensitive or specific enough to address these issues.

Segregation of homeless people through PMS, however well meaning, is unlikely to resolve the health inequalities of homelessness. A better model might be inclusive service provision that combines specialised and mainstream primary care services. This would offer homeless people – for example, rough sleepers – the opportunity of registering with a specialised homeless practice when they are in crisis. Once their urgent needs have been met by the specialist skills available in such services, they could then be helped to permanently register within mainstream general practice. This model creates a bridge between separation and integration, opening up access to mainstream care for the majority of homeless people and also providing immediate transitional primary health care and social care services through interested GPs.

Primary care trusts, with their dual remit to work more closely with social services departments (supported by the potential provision of unified budgets for health and social care) and to commission primary health care for large populations, could be pivotal in organising and supporting this service model. New services would need to be guided by the views of service users underpinned by training, for example, to dispel the persistent barrier-inducing myths of mobility and registration regulations; and rigorously evaluated, since there is a paucity of conflicting research into the appropriateness and feasibility of such models.^{xv xvi} Central policy developments around extending the nurse role in primary care also have potential to significantly improve the health of homeless populations. Nurse practitioners working alongside general practitioners in their practices could play a central role in supporting mainstream primary care, ensuring smooth transition of homeless people from specialised primary care centres to mainstream general practice, making links to community resources, and enabling effective networking with housing and social care. Such progress towards mainstream health provision for the

majority of homeless people may well take us a step closer towards Bevan's civilised society.

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