

**HIDDEN HOMELESSNESS:**

# Lost Voices

The invisibility of homeless people with multiple needs



HELP

**CRISIS**

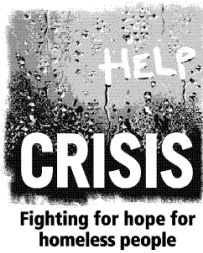
**HEALTH ACTION**

**Fighting for hope for  
homeless people**

**HIDDEN HOMELESSNESS: Lost Voices**

The invisibility of homeless people  
with multiple needs

**Clare Croft-White**  
**Georgie Parry-Crooke**



Crisis is the national charity for solitary homeless people.

We work year-round to help vulnerable and marginalised people get through the crisis of homelessness, fulfil their potential and transform their lives.

We develop innovative services that help homeless people rebuild their social and practical skills, join the world of work and reintegrate into society.

We enable homeless people to overcome acute problems such as addictions and mental health problems.

We run services directly or in partnership with organisations across the UK, building on their grass roots knowledge, local enthusiasm and sense of community. We also regularly commission and publish research and organise events to raise awareness about the causes and nature of homelessness, to find innovative and integrated solutions and share good practice.

Crisis relies almost entirely on donations from non-government organisations and the public to fund its vital work. Last financial year we raised £5m and helped around 19,000 people.

Much of our work would not be possible without the support of over 3,700 volunteers.

Crisis was founded in 1967 and has been changing the lives of homeless people for 36 years.

Crisis  
64 Commercial Street  
London E1 6LT  
Tel: 0870 011 3335  
Fax: 0870 011 3336  
Email: [enquiries@crisis.org.uk](mailto:enquiries@crisis.org.uk)  
Website: [www.crisis.org.uk](http://www.crisis.org.uk)

Crisis UK (trading as Crisis)  
Charity no 1082947. Company no 4024938

© Crisis, February 2004  
Cover photo: © Crisis/Andy Sewell  
Design: Ingrid van der Gucht



Crisis Health Action is a specialist team within Crisis. It aims to improve homeless people's access to the full range of quality health and social care services. It produces reports, practice guides, leaflets and a newsletter to promote awareness of new solutions and share good practice.

### **Other Crisis Health Action publications**

***Understanding the new NHS – A guide to the new NHS for voluntary homeless*** (May 2003) this free publication is also published by Crisis Health Action.

This guide explains what the new NHS structures are and how they work. Its purpose is to enable frontline staff in voluntary homelessness organisations to have a good understanding of the new local structures and services available and to secure improvements in health service delivery to homeless people. This is available free of charge from the Crisis website at [www.crisis.org.uk/downloads](http://www.crisis.org.uk/downloads)

# Contents

<b>Foreword</b>	<b>1</b>
<b>Executive summary</b>	<b>2</b>
<b>1. Setting the Scene</b>	<b>5</b>
1.1 Background to the research	
1.2 Health and homelessness	
1.3 The range of health services available to homeless people with multiple health needs	
1.4 Distinguishing multiple health needs from the other needs of homeless people	
1.5 Overview of the research approach	
1.6 The structure of the report	
<b>2. Who are the Homeless People with Multiple Health Needs?</b>	<b>11</b>
2.1 Service user characteristics and trends	
2.2 Needs assessment: learning about homeless people with multiple health needs	
2.2.1 The effectiveness of needs and risk assessment processes	
2.2.2 The use of assessment forms	
2.2.3 Using paperless assessment processes	
2.2.4 Securing specialist assessments	
2.2.5 Undertaking risk assessments	
2.2.6 Reducing the number of needs and risk assessments	
2.2.7 Developing common assessment processes	
2.3 Key considerations	
<b>3. Front of the House: Gaining Access to Health Services</b>	<b>17</b>
3.1 Factors affecting homeless people and their use of services	
3.2 Availability of services	
3.2.1 Flexibility of services	
3.2.2 The provision of appropriate care	
3.2.3 Non-prejudicial treatment	
3.2.4 Support and advocacy	
3.2.5 Information for the service user	
3.3 Key considerations	

<b>4. Behind the Scenes: Supporting Access to Health Care Services</b>	<b>26</b>
4.1 Working towards good practice	
4.1.1 Coordination	
4.1.2 Joint working	
4.1.3 Training and support for staff	
4.2 Key considerations	
<b>5. Turning Practice into Policy and Policy into Practice</b>	<b>30</b>
5.1 Primary care organisations	
5.2 Local consultation	
5.3 The Welsh perspective	
5.4 The Scottish perspective	
5.5 Moving forward to a new scenario	
5.6 Recommendations	
<b>Appendix: Research Methods</b>	<b>37</b>
<b>Bibliography</b>	<b>44</b>
<b>Acknowledgements</b>	<b>45</b>
<b>About the Authors</b>	<b>46</b>
<b>Abbreviations used in the report</b>	<b>47</b>
<b>Other Crisis publications</b>	<b>48</b>

# Foreword

At Crisis we believe that solving homelessness is about more than providing people with a roof over their head, that homelessness manifests itself as personal crisis as well as housing shortages and economic poverty. Yes we need to provide people with housing and work, but in the meantime many face a far more pressing and immediate problem, and it is essential that we provide solutions in both the immediate and long-term future.

That homeless people suffer from terrible ill health is a fact that is neither new, nor indeed surprising. What is shocking though is that despite the work of so many good people, specialist projects, campaigns and research reports, homeless people continue to suffer in a manner that should be unacceptable in 21st century Britain. If we are serious about tackling homelessness then this must change. This report exposes the scale and nature of the health problems facing homeless people and will prove essential reading to health & homelessness specialists seeking to solve this problem.

A handwritten signature in black ink that reads "Shaks Ghosh". The signature is written in a cursive, slightly slanted style.

Shaks Ghosh  
*Chief Executive, Crisis*

# Executive Summary

## Introduction

Multiple health needs are prevalent in the lives of single homeless people. These individuals are among the most vulnerable in our society. In addition to ever-present health concerns they are faced with ongoing difficulties related to poverty and discrimination. Services targeting the homeless are not able to sufficiently address the array of issues facing this population, leaving them largely un-served. In this report we examine the lives of single homeless people with multiple health needs, investigate issues related to access to care and services, and look toward the creation of meaningful solutions to the gaps and barriers that currently exist.

## Who The Report Is For

*Lost Voices: The invisibility of homeless people with multiple needs* explores the characteristics and life experiences of individuals struggling with competing health issues and critical life situations. These accounts include the lives of people impaired by poor health, chaotic lifestyles, and limited opportunities. This report draws upon the experiences of people who are or have been homeless, health service providers, and providers of homelessness services. This work is critical reading for anyone seeking to understand and address the issues of multiple health needs among homeless persons. Program developers, services providers, and policy makers will find this especially helpful as they strive to create meaningful solutions to complex situations of need amongst the most vulnerable people within their communities.

## Case study: Annie

Annie had been using local mental health services for some time. She was also described as having a personality disorder; had been self-harming for a number of years and had an eating problem. Sometimes she took drugs, which led to several overdoses. Her liver damaged, Annie had requested a detox. She had received considerable support from the local community mental health team over the years and had been using day services but she also had a reputation of being disruptive. Annie had lived in a

shed sometimes staying in hostels but losing her space because of her behaviour. She moved to a B&B after all services had broken down and was known to sit in her room, despondent, drinking or taking drugs. Her psychiatrist had told her they could no longer work with her because her mental illness was not sufficiently severe. She had been going to other local hospitals because of self-harming but they too said they were exasperated by her behaviour. A local agency worker said, "*sadly she will be no more than a statistic at some point.*"

## Homeless people with multiple health needs

Multiple health needs are pervasive in the lives of single individuals who are homeless. Persistent health problems include severe psychiatric conditions, ongoing substance abuse issues, and learning disabilities. These often co-occur along with an array of physical health difficulties that are frequently under-diagnosed and untreated. As a result they experience considerable difficulties in accessing appropriate services.

Multiple health needs are further exacerbated by stigma, poor social and life skills, and limited opportunities. In our study we found that those individuals who sleep rough are over-represented within this population, making them especially vulnerable. Individuals with multiple health needs are plagued with an array of complex problems and few resources. Stigma and discrimination only serve to exacerbate these issues, compounding the nature of their health problems and acting as barriers to effective service use and delivery.

*"Our clients with multiple health needs find it difficult to access health services as they have the experience of knocking on doors and being turned away."*  
(Day centre worker)

## Accessing Healthcare

Homeless people experienced considerable difficulty in obtaining information, accessing services and receiving any coordinated response. Staff also revealed a considerable level of frustration at their impotence to

resolve the tension between sometimes-inflexible structures within the system of provision and the very real needs of their clients. Service providers identified a range of obstacles that prevented homeless people with multiple health needs from using health, social care and housing support:

- I **Availability** of services continues to be problematic for homeless people with multiple health needs. Only a few examples emerged where health service providers (including GPs) had successfully addressed problems about the availability of services for homeless people with multiple health needs
- I **Flexibility** or lack of it presented a further hurdle to homeless people with multiple health needs. Inherent within the provision of health services to homeless people with multiple health needs was the tension between the desire to provide flexible services and the practical realities of delivering services within traditional but sometimes rigid structures
- I **The provision of appropriate** care had been addressed by some agencies particularly where dedicated health services had been able to visit and deliver a service within homelessness agencies where service users often felt more comfortable. However, there continued to be gaps in appropriate care including the need for comprehensive check-ups and health screening which could be carried out in any location. A further area of concern was the lack of drug detox services and the inconsistent ways in which some services were offered, for example methadone prescribing in hospitals
- I **Non-prejudicial treatment** was an issue for some homeless people. Some services have identified ways of working in a non-prejudicial way. Others, however, were perceived as holding negative attitudes towards homeless people, thereby discouraging their use of services. Concerns were raised about how this might lead to depriving people of necessary health services
- I **Support and advocacy** were seen as important by both staff and homeless people. For some, this took the form of helping them to access mainstream services. For others, it was to provide a degree of consistency and stability to someone whose life was already chaotic. Some staff from voluntary sector agencies were concerned that the non-medical, non-professional advocate was discounted as an untrained 'amateur'. Conversely, some specialist health service staff found that they were more likely to act as an advocate than in the professional role to which they had been appointed
- I **Information** was clearly important for service users and providers in relation to single and multiple health needs. Basic education about harm reduction, health and illness was needed to help people take responsibility for themselves. In addition, information was needed about how to access services and about what individuals could expect to receive
- I **Structural hurdles, lack of resources, resistance to change**, and at times prejudicial attitudes further isolated this client group, which discouraged services from working with them. What emerged most clearly was the need for dedicated health and homelessness services that have the capacity to go out to people in hostels and other venues. There was concern that individuals often received inappropriate, inadequate, and sometimes no treatment due to prejudicial attitudes and 'buck-passing' between healthcare professionals. Due to the diversity of need and the often transitory and elusive lifestyle of many homeless people with multiple health needs, healthcare services should be creative and opportunistic in their design and delivery.

## **Recommendations**

The broad findings of this research and recommendations for the future include:

- I Develop appropriate tools for assessment that are comprehensive in their definition, including a

## HIDDEN HOMELESSNESS

spectrum of conditions such as undiagnosed learning disabilities, and personality disorders

- | Reduce barriers between agencies and professional domains, towards a framework of 'joint working' and services that are inclusive rather than exclusive
- | Improving elements of care through the recognition of specialised needs (e.g. dual disorders)
- | Improving the infrastructure, and promoting co-ordinated care; providing appropriate and comprehensive training to service providers in order to enable them to implement appropriate evaluation and care.

The full research report concludes with 10 recommendations based on the findings. These recommendations are likely to be of general application especially since the research found consistency of experiences and views across the four case study areas. Prioritisation, however, will need to be addressed in the light of local policy, planning and resources.

# 1. Setting the scene

This report explores the experiences of single homeless people (without dependent children) who have multiple health needs in their quest for accessible and acceptable health services. It tells of the experience of staff working in specialist and mainstream health services and in other agencies providing for this group of homeless people. Building on the learning from four case study areas, it highlights the factors which help and hinder individuals as they navigate their way into and through services, and examines the impact this has on the services which seek to support them. Within the four case study areas, the research found no examples of specialist health services that were dedicated *solely* to homeless people with *multiple health needs*, although this patient group was often strongly represented and likely to be demanding of staff time and resources.

## 1.1. Background to the research

In 2003, the national homelessness charity *Crisis* commissioned this research about the experiences of single homeless people (without dependent children) who have multiple health needs in their quest for accessible and acceptable health services. Conducted through the use of questionnaires and interviews in four geographical case study areas with people who were or had been homeless, health service providers, specialist health services for homeless people, and homelessness services, the research examined the nature of homelessness experienced by vulnerable, single people with a complex set of needs; assessed the range and type of current health service provision available to them; explored the ways in which they accessed (successfully or otherwise) these health services; and identified barriers to and gaps in provision.

A recent report commissioned by *Crisis* estimated that there were between 310,000 and 380,000 single homeless people without dependent children in the UK. This includes people sleeping rough, staying in hostels, bed and breakfast accommodation or in other 'precarious' accommodation, including the 'hidden homeless: people living in unsuitable accommodation or sleeping on friends' and families' floors'.<sup>1</sup> Many of these homeless people will have experienced a complex

range of difficulties associated with their homelessness and a range of health issues, including related problems in accessing and using appropriate services.<sup>2,3</sup>

Existing literature on 'homelessness and health' provides an important context for understanding the complexity of issues that face single homeless people and the ways in which individuals and agencies collaborate to ensure greater and improved access to appropriate service provision. It is widely acknowledged that single homeless people experience higher than average levels of mental health problems; have difficulty accessing mainstream services; and gaining access to primary care services.<sup>4</sup>

Both *Crisis*<sup>5</sup> and Pleace<sup>6</sup> et al noted that on a countrywide basis, access to healthcare for homeless people was uneven. It is encouraging where it works well. However, where it does not, *Crisis* commented that:

*"considerable gaps exist resulting in health needs not being addressed further locking homeless people into cycles of ill-health and social exclusion".*

This research set out explicitly to explore the impact of 'multiple health needs' on homeless people (without dependent children) in finding accessible and acceptable health services to meet their needs. It examined the nature of homelessness experienced by vulnerable, single homeless people who have a complex set of health needs; assessed the range and type of current health service provision for them; and looked at the ways in which they accessed (successfully or otherwise) these health services, thus identifying barriers to, and gaps in, provision. By doing so, it aimed to increase understanding among readers that single homeless people have differing health and support needs, and that these need to be addressed in policy and planning structures.

## 1.2 Health and homelessness

The undisputable link between health and homelessness has been well documented in the plethora of research reports that have appeared in recent years. They have emphasised the need for those

## HIDDEN HOMELESSNESS

agencies and organisations that have the ability to influence the direction and development of health services in the UK to address the problems that many homeless people have in accessing acceptable and appropriate healthcare. Whilst much of the literature has highlighted the various and different health needs of homeless people, little has focused specifically on those with multiple health needs.<sup>7,8,9</sup>

What the literature has done, however, is to identify that the barriers to primary and secondary healthcare services become increasingly higher each time an additional problem is added to the homeless person's 'portfolio' of needs. For example:

- | The rough sleeper: *"Despite the huge health problems faced by the majority of rough sleepers, they often cannot or do not seek help... (There are) strong financial disincentives for GPs to register rough sleepers"*<sup>10</sup>
- | The homeless drug misuser: *"Research shows that up to 80% of homeless people are misusing drugs; many homeless drug users experience problems in registering with a GP and with having their prescribing needs addressed"*<sup>11</sup>
- | The homeless person with mental health problems: *"less than a third of single homeless people with mental health problems receive treatment"*<sup>12</sup>
- | The homeless person with a dual diagnosis: *"The incidence of mental illness and its association with alcohol and substance misuse is identified as a rationale supporting the unwillingness of GPs to register homeless people"*<sup>13</sup>
- | The homeless person with a personality disorder: *"A recent study in Edinburgh... found that homeless people with personality disorders rarely receive a diagnosis and have erratic service use histories, with more care contacts in different care locations than other homeless people with mental health problems."*<sup>14</sup>

Ultimately, what about the homeless person with multiple health needs?

*"At the sharp end of health and addictions are the many homeless people who have multiple needs. These complex and interwoven issues often prevent vulnerable people from accessing health care, drug detoxification and housing support."*<sup>15</sup>

While the link between health and homelessness has been well documented, research that has focused on multiple health needs and homelessness has been negligible. In 2002, Homeless Link, a membership organisation of 700 agencies working with homeless people across England and Wales, raised the profile of homeless people with multiple needs through a survey of its member agencies. The response from 155 (16%) agencies helped increase their own and others' understanding of multiple needs by developing a definition, which has now been widely adopted. This survey demonstrated that well over three-quarters of member agencies were working with people who met the criteria<sup>16</sup> whilst homeless people with additional needs and problems have always existed within the homeless population, this survey established a working definition of the term of 'multiple needs' (with a clear spotlight on three or more identifiable independent presenting problems), which has been adopted by others, including the Department of Transport, Local Government and the Regions (DTLR).<sup>17</sup>

The definition is as follows:

*"This group of homeless people do not constitute a single, homogenous group, and individuals may have a varied combination of presenting issues. They are people with three or more of the following":*

- | mental health problems
- | misuse of various substances
- | personality disorder
- | offending behaviour
- | borderline learning difficulties
- | physical disability

- | physical health problems
  - | challenging behaviours
  - | vulnerability because of age and will not be in effective contact with services.
- ... and will not be in effective contact with services. If one presenting issue were resolved, the others would still give cause for concern."*

Analysis of the Homeless Link research findings demonstrated that:

- | 88% of the responding agencies worked with some homeless people who they considered met the Homeless Link definition
- | 48% of the agencies' service users had multiple needs
- | of those sleeping rough at the time (total 2,084), nearly 58% of those over 50 years old (total 1,981) and just over 53% of young people (total 2,533) had multiple needs.

### **1.3 The range of health services available to homeless people with multiple health needs**

Like the rest of the population, single homeless people have a right of access to appropriate health care services. They should be able to make use of *mainstream and generic services* that include GPs and other primary healthcare services such as NHS walk-in centres; accident and emergency (A&E) departments and hospital in-patient services. In common with other studies, this research found that, in reality, it was not always easy for homeless people to use these services even when presenting with a single health issue. Where multiple needs were present, professional boundaries frequently intervened, as a 'dispute' appeared to arise between healthcare specialists as to which need should be addressed first.

In many areas, health services treating *specific and specialist needs* – for example, statutory and non-statutory agencies working with people with mental health problems, drug and/or alcohol related problems

– may find a significant number of homeless people amongst their patient group. However homeless people with a range of additional health-related needs often find that these services are not willing to address the mental health and substance misuse problems simultaneously and, consequently, neither receive satisfactory attention.

In addition to the above services, in some areas *specialist health and homelessness services* exist which offer different models for the provision of healthcare to homeless people. These are invaluable for homeless people who are unable to register with a GP due to local shortages, or who may feel excluded or exclude themselves from mainstream services because they find them inflexible and not designed to meet their single or multiple health needs. Some of these services are NHS Personal Medical Services (PMS) pilot schemes. Where resources allowed, the specialist primary care services offered a patient-centred and flexible approach, with strong links to other health, social care and housing services, thus providing a holistic service that facilitated entry into the mainstream.

Following the implementation of the National Service Framework for Mental Health, a further type of specialist homeless and health service has been developed. Originally designed to provide for people with mental health problems who were erratic in their contact with agencies, mental health services have expanded their role to include assertive outreach, working with people who have mental health difficulties as well as monitoring those with substance misuse problems. The teams increasingly involved a multi-disciplinary staff including mental health nurses, social workers, counsellors, and psychologists.

### **1.4 Distinguishing multiple health needs from other needs of homeless people**

As part of this research, participants were asked to comment on the extent to which the Homeless Link definition (see 1.2. above) concurred with their own (or as used by their agency); on how useful they found it

## HIDDEN HOMELESSNESS

in their contact with this client group; and the ways in which an agreed definition could assist in supporting homeless people with multiple health needs in their access to and use of health services:

- 1 A key question was the extent to which it was useful or possible to distinguish between *multiple needs and multiple health needs*. Some agencies suggested that the concept of 'need' should be as broad as possible and should also embrace housing, resettlement, and benefits needs since these were inextricably linked to an individual's physical and mental well being, therefore agreeing with Homeless Link that the needs of this particular group of homeless people were wider than 'health' alone.

*"Lots of clients get bamboozled by paper work with lots of forms. They may have no housing benefit coming through or it's late and they have no income. The financial difficulty can lead to not eating, to depression, increased stress because they keep having to ask for help, leading to a which results in being taken to A&E."*

(Housing multiple needs worker)

The two terms were therefore used interchangeably but the essence was that within the 'envelope' of multiple needs, there were likely to be a number of presenting needs that were both health related and non health related which together resulted in a complex situation requiring thoughtful and creative solutions.

- 1 Others believed that all homeless people experienced some degree of emotional difficulty and required primary healthcare services for similar reasons as other members of the public. They may well be using drugs and/or alcohol in a problematic way; and were likely to have to face a variety of practical issues related to being homeless, for example, housing and benefit claims. Agencies used their assessment processes to identify wide-ranging needs, although often not specifically making reference to a 'multiple (health) needs' definition.

*"We need to address all aspects of health as most clients will have at least two of them (characteristics) yet there is no general acceptance*

*that, for example, drug users have mental health or emotional problems."*

(Overview interview)

- 1 Many agencies appeared to use the term 'dual diagnosis' to signify those service users with a variety of presenting problems. This term was typically applied when individuals presented with a combination of substance misuse and mental health problems, ranging from enduring mental illness, personality disorder, depression, panic attacks through to general anxiety. However, the need to address a range of associated issues (including current or past offending behaviour and other physical and psychological health-related needs) was recognised.

*"Dual diagnosis is the term we use. This means people who have been diagnosed with more than one illness. It could be dementia, mental health or other illness."*

(Hostel worker for older people)

Participants did not offer an alternative definition of 'multiple health needs' but interpretations of the 'criteria' within the Homeless Link definition may have differed due to staff experience, qualifications and training. For example, the Homeless Link survey of multiple needs identified that whilst 89% of the organisations had staff trained in substance misuse issues (and 84% in mental health), only 24% of the agencies had staff trained in working with borderline learning disabilities. This variation of interpretation and understanding has implications for the development of, for example, common assessment tools and partnership approaches to service provision. What one person saw as 'challenging behaviour' may have just been 'high jinks' to another.

In this report, we have tried to reflect the complexity of views represented above. At the same time we have, throughout, referred to homeless people with multiple health needs as those who meet the Homeless Link definition.

## 1.5 Overview of research approach

The focus of the research was the group of single homeless people with no dependent children who had multiple health needs. The Homeless Link definition was adopted here as a framework.

The research was carried out within four areas in England, Scotland and Wales. These case study areas were selected to include a range of services for homeless people, including dedicated health services, and those with more limited services targeting homeless people; a mixture of demographic make-up in terms of size and population density; and a spread across three countries. The research makes no claim that the findings from the four case studies enable generalisability to every town and city within England, Scotland and Wales. However, the striking similarity across these areas suggests the opportunity for wider application of the recommendations.

The research was based on the following methods: (further details can be found in Appendix A)

- 1 | *A review of relevant documentation* including national policies on homelessness especially in the way it affected homeless people with multiple health needs, frameworks which affect homeless people's access to health and related services; policy and strategy documents (from the four geographical areas) related to homelessness and health; and descriptive information from previous research studies
- 1 | *A consultation with health service providers, specialist health services for homeless people, and other related services.* A questionnaire was sent to all relevant services within the case study areas to elicit understanding about both the breadth and range of health and health-related services available to homeless people as well as the perceptions of service providers in relation to providing for homeless people. Response to the questionnaire was low for reasons that are explored in Appendix A. However, it usefully demonstrated the difficulty of obtaining reliable and comparable information about service use across a variety of services. It also facilitated the identification of appropriate providers for further contact
- 1 | *Interviews with the staff of selected services.* These included homelessness hostels (including foyers, hostels for young people, night shelters and longer-stay hostels), day centres for homeless people and for people with alcohol-related problems, advice services (including those for the Irish community and young people), specialist projects working with different client groups (including sex workers, and people with drug-related problems), health workers (employed in specialist health projects and in mainstream primary and secondary care services). The interviews explored a range of issues including perceptions of access to health services for homeless people with multiple health needs; of current local health service provision to this client group; assessment of local partnership arrangements and joint working; and what they considered to be the gaps in local health services to meet their needs
- 1 | *A consultation with key agencies that offered a homelessness overview position.* At a local level in the four case study areas, these included local authority housing and health services. At a national level the Homelessness Directorate (which covers England and Wales only) and homelessness agencies that could offer a strategic overview were consulted. The purpose of these interviews was to elicit and subsequently to describe at a strategic level the current and future provision for homeless people with multiple health needs
- 1 | *Interviews and case studies with current and previously homeless people* who were considered by local agencies to have multiple health needs. Their experiences, views and perceptions were central to this research and the interviews explored both met and unmet need; personal priorities in relation to their health; factors that helped or hindered them to access health services; and their perceptions of current local health service provision.

### 1.6 The structure of this report

During the course of this research, nine themes emerged which were identified as 'indicators of good practice'. They have been adopted to review the effectiveness of the structures that are in place to support the delivery of services and support to homeless people with multiple health needs.

Chapter 2 describes the characteristics of service users in the four case study areas. It also looks at how generic homelessness and health providers use assessment processes to identify the additional health needs of homeless people who presented at their doors.

In Chapter 3, the homeless person with multiple health needs is centre stage. It explores their experience of accessing and using health services; it draws on the views and opinions of individuals and agencies working with them; and looks at the extent to which they match up to six of the 'indicators of good practice':

- | availability of services
- | flexibility of services
- | the provision of appropriate care
- | non-prejudicial treatment
- | support and advocacy
- | information for the service user.

Chapter 4 goes behind the scenes and focuses on the work of the 'stagehands'. Their role is to make sure that all the supports and props are in place. The three 'indicators of good practice' are:

- | co-ordination
- | joint working
- | training and support for staff.

Finally, Chapter 5 looks towards the future and considers alternative or improved healthcare scenarios for homeless people with multiple health needs. In referring to how current practice relates to policy and policy to practice, this final chapter makes ten recommendations each with action points for consideration by agencies and policy makers concerned about this group of people.

## 2. Who are the homeless people with multiple health needs?

This research did not set out to calculate the exact number and proportion of homeless people within the four case study areas with multiple health needs; instead, it sought to understand the extent to which this group impacted on the work of different agencies. In order to build up a profile of homelessness and multiple health needs, the research gathered information from three sources: a review of existing literature, the questionnaire distributed to agencies in the four case study areas, and interviews with local professionals and service users. Mental health and substance misuse were found to be common characteristics. Many of the other characteristics, however, suggest that for services to work well with homeless people with multiple health needs, they need to be able to work well with any individual or group. The behaviour of some individuals has required a number of agencies to allocate additional resources to staffing, services and security systems in order to respond to their needs.

### 2.1 Service user characteristics and trends

From our research, a profile of homeless people with multiple health needs in the four case study areas emerged – a group whose characteristics gave much cause for concern. The key characteristics are identified below.

- 1 Mental ill health and illicit drug use appeared to be the most common coexisting issues identified within a multiple health needs 'diagnosis'
- 1 Many individuals' lives were made more vulnerable due to poor or limited life skills, and/or engaging in risky practices (such as sex work, or illicit drug use). Agencies in the three case study areas outside London expressed concern that their area was 'catching up' with London, and witnessing an escalation in the use of crack/cocaine, and cocktails of crack and heroin
- 1 Whilst the majority were men, those homeless women with multiple health needs frequently had more chaotic lifestyles than the men
- 1 A small proportion of the homeless people with multiple health needs were from black and minority ethnic communities
- 1 Homeless people with multiple health needs were typically – but not exclusively – found within the 'younger' range of homeless people. It would appear that there was an increasing number of young female drug users manifesting additional health issues associated with multiple health needs
- 1 Many of the homeless people with multiple health needs were sleeping rough.
 

*"Those left on the streets are hard to help, have more complex needs and often relapse and return to the streets after being helped into accommodation. Consequently we now spend a longer time dealing with slightly fewer patients as they have multiple needs."*  
(Specialist primary care service worker)
- 1 Begging and sex work were two key ways in which homeless individuals, who used drugs, raised the money to pay for their drug habit. One agency working with female sex workers identified that well over three-quarters of the sex workers operating in one of the case study areas were using crack; at least a third were homeless and frequently slept in crack houses.
 

*"Many don't sleep, don't wash, are malnourished, are either depressed or have more severe mental illness, have been through the care system, and often have a history of family or sexual abuse."*  
(Project worker)
- 1 Self-harming was a frequent occurrence in young homeless people with multiple health needs who were fewer than 25. Many of these people were victims of abuse within the family and had experience of the care system
- 1 Many were thought by the homelessness agencies to have undiagnosed or untreated issues such as learning disabilities (although it was difficult to access a detailed assessment, as discussed later in this report):

## HIDDEN HOMELESSNESS

*"We have a lot of people with learning disabilities. It seems like a hidden problem and in its widest sense may be dyslexia. It's important to recognise in relation to skills training and what people are capable of achieving. Others may take the micky out of them, they're less able to make choices, many more homeless are autistic and they can be very vulnerable. If learning disabilities are there with mental health problems they are even more vulnerable."*

(Day centre worker)

- I Their lifestyle had brought many of them into contact with the criminal justice system. One agency working with alcohol users reported that over half their service users (most of whom were homeless and many of whom had received treatment for a mental illness) had been charged with an offence (with many having multiple offences), for which, over three-quarters had received a custodial sentence
- I Many individuals had poor social skills, which had the knock-on effect that it made it difficult for some to form relationships, and for others to resist peer pressure. As one worker said:
 

*"Relationship breakdowns form a major trigger – these can be parental relationships or relationships in later life. This impacts on individuals' abilities to develop and maintain 'appropriate' relationships. This could be having good 'working relationships' with staff or service providers, as well as entering into what might be perceived as destructive or dysfunctional relationships with peers."*
- I The level of educational achievement was low and the level of illiteracy was high
- I Some individuals – and often the younger women – presented with aggressive behaviour. This was thought to be associated with their drug use
- I The tolerance level of many individuals was often very low and their frustration at the lack of immediate availability of services or support frequently erupted into disruptive and verbally abusive behaviour
- I Acts of vandalism (for example, broken windows and toilet seats) were often a response to

individuals' frustrations

- I Many demanded a level of support from services that was unrealisable and some became frustrated when it was not forthcoming
- I Many were not in regular touch with any helping agency. This may have been a result of 'falling through the net' between different helping agencies, or through individuals choosing to shun contact, often through fear of officialdom.

A small number of 49 participating agencies in the current research felt that none of their clients had multiple health needs. Just over a quarter (14) were not able or prepared to give any estimate at all of numbers or percentages. Their hesitancy may be due to a number of reasons:

- I For some agencies, it may indicate a relatively low number of clients in this group and therefore a minor impact of this group on their work. This was indeed given as a reason for not returning the questionnaire by some of the generalist agencies
- I For others, it may reflect the reluctance to work with this client group due to staffing levels. For example, some night shelters within the case study areas operated with single cover overnight
- I For some projects, the role of the staff in relation to their clients was limited:

*"We are not looking to cure (the residents), we are here to house them. We know people need a lot of support but is it our job to do it?"*

(Hostel worker)

- I Some projects were anxious not to assume that their clients had multiple health needs simply on account of their behaviour:

*"We have to be careful not to label too freely as some people with the characteristics do not have multiple health needs."*

(Day centre worker)

- I Lack of training also prevented some projects from working with this group:

*"(Housing) support workers are often not trained..."*

*(they are) paid peanuts and see themselves as receptionists and cleaners. Yet they need to be trained and paid (appropriately)."*

(Local Authority housing worker)

Few of those who responded to a question about the number and proportion of clients with three or more of the multiple health needs associated with the Homeless Link definition were able to give exact information rather than 'guesstimates'. This further highlights the complexity around interpretation and explains the wide variation in contributors' assessments of evidence of multiple needs within their agencies' client group.

Although many agencies reported working with an increased number of homeless people with multiple health needs, it should be questioned as to whether this was in fact the case, or simply that awareness of the needs of this group has intensified in the last few years. As one health worker said:

*"There is no great change in the numbers, but we are just more attuned to the problems. For example, we are now more aware of people with learning difficulties and the need to refer them to special services."*

The ways in which agencies appeared to be 'more attuned' were reflected in the type and range of modifications that had been introduced to enable them to work with homeless people with multiple health needs. Most common were staff training and the employment of additional specialist staff. Modifications were also made to agency premises with the installation of additional security including CCTV and panic buttons. Personal alarms were also given to staff and visitors, and there was an increase in security staff on the premises.

### **2.2 Needs assessment: learning about homeless people with multiple health needs**

Despite the likelihood that the assessment of multiple health needs was affected by individual interpretation rather than a pre-defined set of measures or checklist of criteria, some homelessness agencies had given

considerable time to the development of assessment procedures, which aimed to encompass and better understand such needs. Below we describe some of those used to assist workers in identifying the support needs of clients and the risk factors that they believed require consideration.

#### **The effectiveness of needs and risk assessment processes**

Most agencies said they were satisfied with their needs and risk assessment processes when used in combination with other in-house policies, guidelines and support systems, including staff supervision. A number of non-statutory agencies drew attention to their lone-working guidelines; and statutory health agencies had Risk Management Policies and integrated Health and Social Services Policies, which included comprehensive risk assessment procedures.

However, some agencies were less confident. They noted that both experience and intuition were needed and this took time within the job to acquire. No local training had been identified to facilitate the process of risk assessment.

Staff in one agency commented that they had established a detailed risk management procedure, which included the provision of a mobile phone and alarm for staff, who were also required to be explicit about their whereabouts within the office diary when visiting clients. But this system had been found only to be as reliable as the staff – who sometimes failed to complete these formalities.

It was further noted that many assessments had a short life span and were only accurate on the day it was undertaken. Its 'quality' was also dependent on the client's contribution to the process.

*"The tool is only as good as the response we get from the client and we are therefore currently reviewing the form to see how it can be developed. We have to realise that nothing is static and clients' needs fluctuate."*

(Day centre worker)

## HIDDEN HOMELESSNESS

### The use of assessment forms

The assessment forms that were reviewed as part of this research showed a common practice of collecting information on clients' physical and mental health, their medication, their alcohol and illicit drug use. A small number recorded evidence of challenging behaviour through exploring a history of verbal or physical violence – and particularly whether this was influenced by alcohol; whether it had led to criminal convictions; intimidation of other clients; or acts of vandalism. Other agencies also explored a history of suicide attempts, self-harm, depression, or other behaviour that might be associated with a personality disorder.

One agency working primarily with homeless people with alcohol problems has developed a 'triage' structure of assessment. The first interview was intentionally short and was used to collect very basic information as well as to gauge the individual's ability to sustain a 15-minute conversation. Following this, a full assessment took place, which was used to engage more 'deeply' with the client and to explore issues that were relevant to the support that may be offered to them.

A day centre for homeless people described the way they worked with a tiered approach. Following a 'warm welcome' and access to hot food, clothing, showers and laundry, staff said they worked towards establishing a relationship with service users to identify what else they might need. Only at this point, did they commence an assessment which was intended to help people access appropriate services – often within the centre itself. The third tier assessed users in relation to housing and resettlement and they then worked with them as an individual moved towards independent living.

### Using paperless assessment processes

The use of assessment forms was not always appropriate either due to the setting in which contact was made, or the nature of the client group. The staff of one accommodation provider used their own observations and discussion with a visiting health practitioner to make an assessment. They would then

liaise with other agencies including social work and psychiatric services. They noted that:

*"We are not professional health workers and liaise with other specialist agencies to support the health needs of our residents. We also rely on referring professionals not to inappropriately send unsuitable people to us."*

For other agencies, paper assessments were avoided at least during early contact with those individuals who were unlikely to respond positively to what might be regarded as an interrogation. Agencies which made contact with their clients in informal settings were more likely to attempt to engage the individual in conversation in order to begin the process of building up trust and of learning about their lifestyle and most pressing support needs.

Paperless assessments were typically used on the street. Providers of mental health and homelessness services were clear that it was entirely inappropriate to use formal assessment procedures at least during initial contact. One mental health team worker described how their team operated:

*"It's possible to build up a profile as there are ways around (assessment) to find creative ways of working, to come to a diagnosis. We might go out with park staff, for example, and the psychiatrist would follow to chat informally maybe over two to three weeks. It's still an assessment which can lead to a clinical plan."*

In recognition of the problems of working with this group of homeless people, agencies had developed other approaches to gather the type of information required both to develop a picture of presenting needs but also to facilitate a risk assessment. These typically included structured observation, discussion with colleagues within project team meetings or in inter-agency meetings, and the collection of reports from other agencies.

### Securing specialist assessments

One of the purposes of a comprehensive needs assessment process was to enable the assessor to identify where further expert input was required.

Sometimes this could successfully be gathered from other agencies through telephone contact or a request for written reports. However, workers identified three problems; firstly in identifying the most appropriate agency; secondly, in persuading professionals to undertake an assessment of a homeless person who clearly manifested more than one health problem (for example the co-existence of drug and mental health issues); and thirdly, in obtaining an assessment within an acceptable timescale.

Homeless people with learning difficulties proved a particular challenge to homelessness agencies. One team working on an outreach basis found there were:

*“A number of difficulties in providing a service to those individuals either known to have learning difficulties or unproven learning difficulties. In either getting an assessment or a service via Social Services there is an awareness that services are designed for people that have generally settled lifestyles and need help in functioning in the community. (Our clients... tend to be a distance away from the level of stability needed for them to engage with learning difficulty services as available now.”*

Case study: Thomas

Thomas was evicted from his mother's home. He was 16 and had considerable learning difficulties. He had to leave because of his incontinence (for which he was awaiting surgery) and poor personal hygiene. He had just left his school where he had been supported by a children's learning disability team and had been seen by a support worker from a project that worked with young single homeless people. They found Thomas a hostel place. Whilst there, his support worker contacted the local Community Learning Disability Team as well as Care Management but both showed some reluctance to get involved. As he was 16 and had left school, he was no longer able to ask for support from the children's team yet it would take six weeks before his records could be transferred to the adult team. Despite his support worker, he was evicted from the hostel again because of his incontinence, poor hygiene and now anti-social behaviour. Finally, social services became involved – he was given a flat within

10 days and a support package was put in place.

### **Undertaking risk assessments**

Most agencies undertook a client risk assessment either simultaneously or subsequent to the client needs assessment process. Sometimes these were combined into one form.

However, there were different interpretations of 'risk', and consequently different formats for assessment were identified. For some, 'risk assessment' meant the safety of the worker in making contact with an individual. Others focused almost exclusively on the risks presented by the individual to himself or herself and concentrated on their particular 'risky' symptoms and behaviour. Yet others attempted to combine the potential risk to client and to staff.

The risk assessment form used by one day centre for homeless people contained a checklist of 18 areas where the client may have experienced problems in the past year; they ranged from risk of self-harm, risk of violence towards others, risk of accidental harm from careless smoking or falling, through to the risk of damage to property including arson. The assessor then classified the client's risk category (as high, medium or low) in relation to any history of aggression, violent incidents, suicide attempts, and mental ill health. Where a client was classified as 'medium risk', the instructions were that *“this risk must be specifically managed through a support plan, e.g. no lone working, harm minimisation”*; and 'high risk' implies *“allocation of service to be discussed with Director, additional support services may be sought, and risk to be managed through support plan, e.g. specific boundaries within which work may proceed”*. In this last circumstance, the form had to be signed off by the director.

### **Reducing the number of needs and risk assessments**

Standardised forms for needs and risk assessment have helped to streamline referral procedures and agencies recognised that they had helped to improve inter-agency communication. They had also simplified – and therefore speeded up – the client's access to care pathways. There was evidence elsewhere that efforts

## HIDDEN HOMELESSNESS

were being made to reduce the number of assessments that the client needed to endure. For example:

- I In one area, a Community Mental Health Team for homeless people and local statutory drug treatment agency had adopted a single assessment process. Not only did this eliminate the requirement for a second assessment for many clients, it also enabled the early identification for the need for a rehabilitation service that caters for people with both mental health and substance misuse problems.
- I A referral form had been developed in one case study area that all the agencies were able to use. It had been designed to be user friendly and accessible to the client: *“This (form) belongs to the individual, therefore the information does not have to be extracted over and over again”*. (Young person’s project worker)

### Developing common assessment processes

Two of the case study areas have developed a standard assessment form to be used by all the agencies working with homeless people. In one of these areas, there was concern about the high number of exclusions and ‘bannings’ from direct access hostels. Many of those who were banned probably had multiple health needs as evidence of challenging behaviour was very prevalent – they were being excluded due to their inability or unwillingness to work with staff to address their identified needs, and the reluctance or resistance of staff to work with them. As a result a standardised assessment form was introduced to ensure a consistency throughout the area and minimise negative outcomes.

## 2.3 Key considerations

This research revealed a variety of methods for assessing the needs of clients. However, despite a wide-ranging set of assessment processes, none of these agencies appeared to use them as a way to pull together the different elements in order to identify ‘multiple health needs’. As one respondent said: *“our assessment form pre-dates the multiple needs agenda and does not combine them (together)”*. (Homelessness agency worker)

No one perfect assessment method or tool emerged. Given the complexity of needs of this client group and their contact with services, it would be both unrealistic and inappropriate to assume a ‘one size fits all’ approach. Nevertheless, participants identified the need to reconsider the type and level of analysis they brought to assessment in order to address increasingly complex situations. Some said they would welcome guidance or a template assessment tool (which could be adapted to individual agencies) to support their work. This was not to introduce yet another (perhaps unhelpful) label but as a means of identifying the best next step for a homeless person in need.

In order to provide appropriate services to homeless people with multiple health needs, it was essential to know more about the client group. Increasingly, agencies were working with people with multiple health needs and the development of effective needs assessment was therefore crucial.

## **3. Front of the House: gaining access to health services**

This chapter highlights the key issues raised in the four case study areas in relation to the principal actors – homeless people with multiple health needs – and their ‘front of house’ experience on the receiving end of service provision. Using six of the key themes outlined in Chapter 1, it describes their experience and explores ways in which services have identified methods for improving access and use as well as the barriers which continue to face homeless people with multiple health needs. Homeless people said they experienced considerable difficulty in obtaining information, accessing services and seeing any coordinated response. Staff also revealed a level of frustration at their impotence to resolve the tension between the sometimes inflexible structures within the system of service provision and the very real needs of their clients.

### **3.1 Factors affecting homeless people and their use of services**

Across the range of homeless people and service providers who participated in the research, there was a consistent set of themes that underpinned the success – or otherwise – of health-related services addressing the multiple health needs agenda. Whilst there were many examples of innovative practice to ameliorate a hitherto problematic situation, there were as many that suggested there were still barriers to overcome. This chapter addresses six of the key themes seen to be essential tenets of appropriate service provision: availability of services; flexibility within services; the provision of appropriate care; non-prejudicial treatment; support and advocacy; and information for the service user.

Service providers identified a range of obstacles that prevented homeless people with multiple health needs from using health, social care and housing support. Of 16 agencies responding to the questionnaire, almost all noted the likelihood that this client group did not believe services could help them; did not have sufficient knowledge of what was available and lacked self-confidence in approaching services. Many felt that long waiting times presented a major obstacle, as did the homeless person’s inability to recognise that a service

could be of benefit to them. Distances to services were sometimes too great and in some areas, there were concerns that services might be culturally inappropriate particularly where someone’s first language would not be understood.

#### **Availability of services**

Few examples emerged where health service providers had successfully addressed problems about the availability of services for homeless people with multiple health needs. Indeed, even the dedicated health and homelessness services were sometimes not able to offer a uniformly accessible service because they could not always go out to patients due to perceived health and safety and risk problems in environments such as day centres and hostels. However, a number of initiatives were underway. Two, which appeared to be working well, included a drug and alcohol partnership and a health service team for homeless people.

- 1 A drug and alcohol partnership agency established a Homeless Team for young people aged 16 to 25. It was based in a newly opened ‘one-stop shop’ where a range of services was being developed, including substance misuse advice. It was hoped that the centre would host primary health care services in the future. Its opening had a very positive impact on the local outreach team which worked with hard-to-reach chaotic drug users, many of whom were homeless and with multiple health needs. For the first time, the team felt it was able to recommend a service that was *“a street level, easy access, one-stop shop that is flexible, not 9–5, user-friendly, client-centred, with an appropriate attitude and approach”* and which was able to pick up the ‘reins’ where the outreach left off
- 1 A Health Service Team for Homeless People offered a range of services including a GP, a community nursing team where a specialist nurse performed an outreach role, and a travelling dentist and chiropody service. They applied for future PMS funding to expand this service to include two GPs providing five sessions per week to homeless people, a full time nurse practitioner offering a walk-in service and a peripatetic service.

## HIDDEN HOMELESSNESS

Homelessness workers in the case study areas said that the typical inner-city problem of GP registration was exacerbated for homeless people, and especially those with additional health needs. In their experience, the majority of local GPs refused to register homeless people without a fixed address or refused saying they were 'family doctors'. This clearly contravened the Royal College of General Practitioners' (RCGP) expectation that its members should provide a "welcoming and sensitive service to homeless people"; to register them as permanent patients; and to encourage local agencies to "develop shared protocols and operating procedures that aid integrated working and co-ordinated care for homeless people".<sup>18</sup>

For homeless people with multiple health needs the barrier became even higher.

*"Our clients with multiple health needs find it difficult to access health services as they have the experience of knocking on doors and being turned away."*  
(Day centre worker)

Where problematic drug and/or alcohol use was one of the presenting problems, the barrier was almost insurmountable, with only a handful of GPs in each of the case study areas being prepared to register this group of clients. This was consistently highlighted as a major obstacle to the care of this client group.

### Case study: Maria

Maria is a 25-year-old IV drug user staying at a hostel for single homeless people. She had been removed from her present GP's practice list. Maria has numerous abscesses on her arms and legs from injecting which require regular dressings. She also has Hepatitis B and C, has been in hospital recently with deep-vein thrombosis and has failed to comply with daily injections of anti-coagulant. Maria tried to register with a mainstream GP but after four attempts at four different practices was still unsuccessful. At one, the receptionist said they do not take on drug users. At another, they said they do not take homeless people because there is a GP for them. A third, the nearest to the hostel where she was staying, made it clear that they would not register hostel residents and suggested

she use the GP for the homeless. In the end, she was allocated a GP by the PCT – and it was one that had previously refused her registration.

Some homeless people found themselves making use of A&E departments for a variety of medical problems, and often to overcome the problem of not being able to register with a GP. Many found the waiting times very difficult particularly where they were already anxious and leading a chaotic life. The senior staff nurse at an A&E department in one of the case study areas said:

*"If they are local, they may have had a GP. But usually there is a substance misuse problem and therefore they have been struck off. So we act as a GP – and we are prepared to do this. We don't turn people away. This is the policy agreed by our consultant."*

Workers recognised the necessity to 'seize the moment' and to exploit any 'window' of motivation. But this opportunity was often perilously short-lived and they were often thwarted by the waiting times for many treatment services. In all of the case study areas, homeless people had to wait many months for drug treatment services, with often over six months elapsing between assessment and access. During this time the individual typically continued to use street drugs and experienced the physical health problems associated with chaotic and unpredictable use.

The National Treatment Agency for substance misuse, which has the remit to ensure that substance misuse services are available to homeless people in England, states that drug treatment services are:

*".... particularly successful where access can be flexible and provided quickly, and is developed alongside wider support to ensure that the person's housing, health and welfare issues are also addressed."*  
(NTA website)

In order to increase access, it suggests that mainstream services should be adapted "so that they are accessible to homeless people and provide them with efficient treatment", adding that new specialist services should

be established where warranted. It has set targets that waiting times in England for services should not be longer than four weeks between referral and in-patient treatment, and the same time lapse for accessing a GP prescribing service.

Whilst no definitive solutions were identified to overcome these problems, a number of participants pointed out that increased resources could result in greater availability of staff thus facilitating a reduction in high case loads and long waiting lists. Others suggested that there should be a reconfiguration of roles and activity, resulting in:

*“a more appropriate balance between staff undertaking contact and initial assessment, and those actually providing the service that was identified through the assessment.”*

(Hostel manager)

Inherent within the provision of health services to homeless people with multiple needs was the tension between the desire to provide flexible services and the practical realities of delivering services within traditional but sometimes rigid structures. Most services which took part in this research argued that, in addition to the need for flexible access routes into services, the provision itself needed to be responsive, to work with the multiple health needs patient at the centre and to acknowledge that the provision of flexible services was an important method for tackling the inequalities agenda.

For example, primary care services needed to recognise the irregular lifestyle and attendance patterns of homeless people. Workers recounted occasions where GPs refused to see homeless patients when they were late for their appointments and where their clients were removed from GP lists simply for non-usage for a couple of years.

*“People can’t get care if they have no GP. But if they go to the day centre, they’ll get them registered. On the downside, if they register with the ‘homeless GP’ they can’t get a mental health or in-patient service. There’s no way to use in-patient psychiatric services, as there is no CPN attached to the homeless GP. So mainstream GPs*

*become the gatekeepers to mental health services for this client group.”*

(Specialist health and homelessness worker)

Both homelessness service providers and users welcomed the flexibility that was offered by health services brought directly to them. The key advantage to these approaches was that they maximised the opportunity to build up trust between the service user, key worker and professional, thus demonstrating that this person would not have to jump through hoops in order to use a service. Service providers said that users also appreciated being able to access the support and treatment they needed ‘under one roof’ and that they, the providers, were able to establish a relationship and work more closely with health services because they were on site on a regular basis.

*“The biggest factor which encourages take up is when the service comes to the client.”*

(Hostel worker)

Even in these circumstances, dedicated services were often unable to provide more than one session per week, which reduced their flexibility to the homeless person’s needs.

Service users were also in favour of a dedicated homelessness and health service even if they had to travel to it. Such services existed in three of the four case study areas and their workload had not reduced despite decreases in the numbers of people sleeping rough.

#### **Case study: Jim**

Following a successful assessment, Jim was hopeful that he would be offered a second chance of entering a methadone programme to help him withdraw from heroin. However, this was dependent on him being registered with a local GP. This should have been no problem as he had been registered with the same GP for most of his life. He had an appointment to see the doctor at 9.10 am but he failed to keep it. As a result he was struck off the GP’s list – which meant that he was taken off the waiting list for the methadone programme. His address changed every week and the “homelessness doctor” told him that he would need a

## HIDDEN HOMELESSNESS

permanent address before he could get on the list of another GP – which he needed to get the methadone. And then he would most likely need to wait a year due to the waiting list. Each day, Jim had the intention of going to the Housing Department council to find out about permanent housing options, but he found his need for heroin was greater. *“If I had a script it would change everything. I could get my act together and get myself somewhere to live.”*

Inflexible professional boundaries created a further problem. Hostel managers expressed their frustration when the local community mental health team often refused to see residents (many who had multiple health needs) as they were officially registered with a GP in another area (although they may not have visited the surgery for several years). These reports of ‘passing the buck’ between mental health and substance misuse services are highlighted elsewhere in this report.

Appointment systems were also problematic when homeless people attempted to access services that operated a waiting list. As one day centre worker said:

*“How can the homeless person be informed of the date if they have no postal address? Many of our clients have mobile phones but few have any credit on them.”*

### Case study: Annie

Annie had been using local mental health services for some time. She was also described as having a personality disorder; had been self-harming for a number of years and had an eating problem. Sometimes she took drugs, which led to several overdoses. With a damaged liver, Annie had requested a detox. She had received considerable support from the local community mental health team over the years and had been using day services but she also had a reputation of being disruptive. Annie had lived in a shed sometimes staying in hostels but losing her space because of her behaviour. She moved to a B&B after all services had broken down and was known to sit in her room, despondent, drinking or taking drugs. Her psychiatrist had told her they could no longer work with her because her mental illness was not sufficiently severe.

She had been going to other local hospitals because of self-harming but they too said they were exasperated by her behaviour. A local agency worker said, *“sadly she will be no more than a statistic at some point.”*

Not all stories were like Annie’s, and both staff and service users told of the positive experiences. Many of the issues about availability and flexibility identified above appeared to be partially resolved by specialist healthcare teams for homeless people. Whilst homelessness agencies welcomed visiting health professionals to treat the homeless person who – for physical health or psychological health reasons – could not access mainstream health services, a significant number in the case study areas reported that the service was being withdrawn – or was under threat – unless space was adapted to become a dedicated ‘health’ room with appropriate panic-alert systems.

- i A small voluntary drop-in centre for homeless people in one case study area recognised the need to facilitate access to healthcare for those who were the most reticent to use mainstream services. At some considerable expense, they converted a room expressly for this purpose – and said that the visiting primary healthcare practitioners would use it for one session per week
- i A well-established primary healthcare team in another case study had been visiting the local homelessness hostels and day centres on a regular basis. However, in recent months this had become more problematic when guidelines on personal risk were introduced. Members of the team were only able to visit projects – and work with patients – in environments where costly security systems had been installed. The level of flexibility was further reduced, as the health worker was no longer able to drive the patient to appointments. One identified solution to this problem was to introduce joint working between health worker and host agency project worker, so that two professionals were present with the patient at all times.

Despite the good intentions and the many innovative activities, in relation to more general health issues,

services commented on a number of notable gaps in appropriate care:

- I There was a need for comprehensive check-ups and health screening. Yet the way in which people presented at surgeries combined with overburdened GPs meant that this service was not provided. This type of screening could be carried out at any location and specialist homeless and health services working in satellite locations often conducted general health assessments
- I There was a paucity of well-women, pregnancy and sex education provision for both drug using and other homeless people
- I There was a need for issue specific counselling not just the generic counselling usually offered via primary care services.

One strategy to support homeless people with multiple health needs was to support them to move from specialist healthcare services into those in the mainstream. A recent framework for the provision of primary healthcare for the homeless was put forth by Lester and colleagues:<sup>19</sup>

*“A 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 through interested GPs”.*

In terms of appropriate care, and in addition to waiting lists and other access issues, both users and providers raised concerns about the lack of drug detox services and the problematic and inconsistent ways in which methadone prescribing was provided. In all areas, it

was difficult to find GPs who were prepared to prescribe methadone. In some areas, hospitals had a policy not to provide methadone to in-patients at all, irrespective of whether they were currently in receipt of a prescription. In other areas, hospitals prescribed methadone but at a reduced dose compared to local GPs’ practice. This frequently resulted in people leaving hospital prematurely with serious medical problems.

#### **Case study: John**

John was a rough sleeper who was prescribed heroin by a local GP. One day he was found by the local outreach team and was taken to hospital as he was clearly overdosing. He said that the hospital was the worst he had ever stayed in. He was extremely ill because of the overdose. He asked for a painkiller and for some methadone. He was refused both. When he told the consultant that he was ‘rattling’, the consultant said he could leave if he wished. He told John that he had brought the problem on himself. As a result, he has been put off hospitals and would think twice before going again. But what he could not understand is why the consultant would not give him methadone when he was on a bona fide script from a local NHS GP.

Other difficulties for homeless people who were drug users included locating GPs who were prepared to prescribe; locating pharmacies prepared to dispense and the need for walk-in, easy-accessible detox services.

*“For those with alcohol and drug related problems, we refer to other services but many are orientated to appointments for people motivated to abstinence – often quite pointless so we monitor people ourselves.”*

(Specialist health/homelessness agency)

#### **Case study: Joan**

Joan was about 35 years old. She had either slept rough or stayed in a squat. Joan had contacted a voluntary drugs project – she was an IV heroin, crack and methadone user, which was injected for her by other people. She had been physically and sexually abused in the squat and had DVTs, septicaemia, malnutrition and many other physical problems. She weighed less than six stone at the time. The voluntary

## HIDDEN HOMELESSNESS

agency workers were naturally concerned and took Joan to hospital. There, they failed to find a vein for antibiotics so she had no drugs for these various infections. Nor was she prescribed any methadone so discharged herself and literally crawled out. Three days later, the same process was repeated, she received the same poor treatment and took the same action – discharged herself as no methadone was prescribed. After a further week, Joan contacted one of the workers who took her to a different hospital. She was admitted immediately but discharged the next day because; we were told, of difficulties establishing a patient/doctor relationship. By this time Joan could hardly walk. The worker persuaded her to go back and she did staying for two weeks although still never given antibiotics. A worker there identified her need for housing and made an application as she was fleeing from domestic violence. On discharge, a flat was available; she got a regular methadone script. Joan was talking about making contact with her children.

A further context in which appropriate care needed to be considered was in relation to hospital discharge. In one area, a service provider commented that local hospitals pushed people out quickly, even if they had no guarantee of finding a bed. In another, hostel staff said that their residents had been discharged in the middle of the night – prematurely, in their opinion. Early discharge often involved ward staff rather than social workers or other specialist staff. They did not assess whether the individual had somewhere to go or whether they had the ability to sustain their tenancy. Discharge planning is encouraged as good practice with NHS hospitals, but the reality appears to be that priority is given to the discharge of older people given the lack of staff availability – and in one area only patients over the age of 65 had access to a social worker on the wards. It was perhaps therefore not a surprise to find that little attention was given to the discharge of homeless people with multiple health needs.

An area for consideration was how to support homeless people with multiple health needs through to move-on accommodation. One suggestion was to

develop a District Nurse role with specialist knowledge of working with homeless people and alcohol problems. This could overcome the problem that GP home visits can be difficult to arrange. It would also mean that a healthcare professional was available to assess health need, to take people to hospital if necessary, and to check that individuals' health is not being undermined by other factors such as alcohol, drugs or the environment. Such a role might be particularly useful for homeless people with learning disabilities who may only be in contact with social services if they have a high level of difficulty. Agency staff described them as more often vulnerable; at risk of abuse from drug dealers; and whose general health is more likely to be poor.

Some services described how they aim to provide non-judgemental services to homeless people, including:

- | working to reduce stigma by ensuring that staff and other users see that people's behaviour may be an expression of symptoms of being unwell
- | working with generic health services to ensure that not all homeless people are seen as a problem
- | avoiding punitive responses to people with drug and alcohol problems.

Negative attitudes from healthcare staff were both actual and perceived. For example, one agency described a situation where a member of its staff had contact with a local psychiatrist, who was writing a court report for a client. The psychiatrist said that they did not want to be too involved with the client, as *"they did not want people following them around wanting a script"*. The agency representative added that their clients *"were always accused of being manipulative and always threatening suicide"*.

Many homeless people with multiple health needs feared that their 'label' impacted on the response they received and made them fearful of accessing their services. One worker from a housing project for people with multiple needs said that residents were reluctant to go for help for less desirable conditions such as sexually transmitted diseases and HIV, self-harm and

mutilation, or eating disorders. *“They probably had a hard time from health professionals in the past and don’t want to be judged”*. Other workers felt that they were often barred from services even before they presented as *“their reputation preceded them”*.

A project described working with female sex workers, the majority of whom were homeless, and bore the ‘scars’ of multiple health needs. Each weekday it provided a non-identifiable dedicated drug treatment service, which was open to any female sex worker. On a weekly basis, this service was supplemented by a no-appointment, no-questions-asked GUM service for the same client group. In addition to consultation with a GUM consultant, the women could access on-the-spot HIV testing, Hepatitis C vaccinations, counselling and a full range of family planning services.

Pregnant women were often reluctant to attend antenatal appointments as they felt doubly prejudiced against for being without a male partner and for their assumed (and often actual) lifestyle as a homeless sex worker with additional health problems.

Attitudes were seen as negatively affecting homeless people in two key ways:

- 1 There were concerns about the way in which prejudicial treatment resulted in depriving homeless people with multiple health needs of necessary health services. This included treatment (or often more accurately, the lack of treatment) at A&E because a patient was known to be homeless and perceived as looking for a bed; and exclusion of homeless people from methadone programmes and detox because they had been struck off a GP’s list within a preceding three month period. Both community mental health services and in-patient services were identified as demonstrating a lack of sensitivity towards homeless people with multiple health needs. This, one homeless service provider noted, often culminated in a refusal to work with ‘complex’ cases where there was drug and/or alcohol use, and an absence of hospital discharge planning. One homeless person said:

*“Nurses shouldn’t judge but the staff in one hospital made me feel like dirt on a shoe. They were clearly not interested in me and made me feel as if everything was self-inflicted. But in another hospital, everything was absolutely fine and I felt treated like an equal.”*

- 1 Some specialist homelessness mental health and drug and alcohol services were concerned about the way in which staff in homelessness agencies treated people with multiple needs. They were aware that staff were employed as support workers – and not as specialists – but that they too needed training and support in their roles with what, to some, appeared to be a growing client group with complex needs. This affected assessment and the extent to which they were supporting their clients in accessing health services.

Workers in a range of different settings (statutory or voluntary, specialist or generic) felt that an important role for them was to advocate for homeless people with multiple health needs. For some, this meant assisting them to access mainstream health. To others, it was a ‘hand-holding’ operation that gave a little stability in a consistent way to people whose lives were often chaotic. The following scenarios provide examples where advocacy, and the support of a professional, was felt to be particularly beneficial and welcome to the homeless person with multiple health needs.

- 1 An agency working with sex workers frequently attended an ante-natal clinic appointment with a pregnant client:

*“The attitude of hospital staff affects the service: many of them look down on sex workers and think of them as ‘dirty women’. There is a lot of buck-passing, and there is no-one there to advocate for them”*.

- 1 Staff accompanied clients to hospital A&E departments whenever possible, especially if the client was a drug user:

*“We often have to stay with them to check they don’t get shoved to the back of the queue; and even when they see the doctor we need to make sure they get the treatment they need, which*

## HIDDEN HOMELESSNESS

*might mean a hospital bed or a script.”*  
(Outreach worker)

- I Some workers were obliged to stay with patients when they saw their GP as s/he was not prepared to see a homeless person with multiple health needs unless an advocate from a helping agency was also present.
- I An accompanying member of staff was also often helpful in ‘negotiating’ with the surgery receptionist, especially if the homeless patient arrived a little late for the appointment, was unkempt or smelling of alcohol.

### Case study: Paul

Paul’s experience illustrates the frustration of workers as well as the effect on the service user when basic coordination, advocacy and information are not in place. Paul was in his fifties and had made several suicide attempts. He had a whole range of physical health problems (including incontinence), learning disabilities and was hyperactive. Paul had an alcohol problem and had undergone one recent residential detox programme. However, the staff had found him very demanding of their time, as he needed a nurse to sit with him constantly due to his agitation, hyperactivity and anxiety. He only lasted six days of the programme. Paul had said that when he used medical services, he was treated with respect but he needed someone to come and advocate on his behalf. He found it difficult to use services when he had been drinking, and frequently missed appointments. Most hostels had asked him to leave because of his disruptive behaviour; and although he was currently staying in a hostel, he acknowledged he was there *“by the skin of his teeth”*. A major difficulty identified by hostel staff was that no one would take the lead to coordinate his care. One worker was trying to arrange another detox for Paul but believed that what would be more useful would be a thorough assessment, as he had never had one. The worker said, *“I am at a loss to know where to go to get Paul a proper service”*.

Several members of staff from voluntary sector

agencies described how the non-medical and/or non-professional ‘advocate’ was frequently discounted as an untrained ‘amateur’, especially by the mainstream medical services. They felt obliged to ‘flaunt’ their professional nursing or social work qualifications in order to gain respect. A day centre worker said:

*“When working with external agencies, there are issues of legitimacy. I am a nurse and when advocating I will use this even though I don’t often tell other people.”*

Conversely, nursing staff in specialist health-related agencies often found that their role was more akin to advocacy than to the professional role to which they had been appointed. For example, the primary care nurse was frequently the advocate who ‘opened doors’ to other services for the homeless person with multiple health needs:

*“People are not interested in the nursing side – I go and sit and chat until people know me. So I am not known as the nurse but more as a counsellor/advocate. I can help them get... past receptionists. But this means I am an expensive receptionist who gives emotional support; I can be the gatekeeper and get them to deal with real health issues.”*

(Specialist healthcare nurse)

Both providers and users needed information and knowledge on the range of health difficulties that affect homeless people. In one agency (a wet day centre), it was noted that many drinkers did not comply with medication, often had unresolved fractures and preferred not to attend A&E because they feared being treated badly. The agency identified a real need for basic education at a level that all users would understand about harm reduction, health and illness so they were better able to take responsibility for themselves. They said:

*“In part this could be about health awareness, first aid so that people can help their mates. We had some training from a substance misuse team – they know about drinking but not about alcohol”.*

There was a need to ensure information was provided about access to agencies as well as about what users

could expect to receive within the content of specialist and generic services. All too often, workers reported posters being hidden on notice boards as new ones were added. One health and homelessness worker said it was important to check on every visit that information about services was still available and visible.

Other service providers were concerned with the need for useful advertising of services (that were displayed in an accessible way) and the provision of leaflets about a range of health issues in formats that are easily understood. Although there was an increasing use of technology, including mobile phone and texting among homeless people, it was unlikely that on-line resources could be effectively used with this particular group of people.

### **3.2 Key Considerations**

This chapter has aimed to unpick the variety of potential enablers but more often barriers that homeless people with multiple health needs face when hoping to access and use health care services. In the views of some service providers, the combination of structural hurdles, under-resourcing, resistance to change and at times prejudicial attitudes conspired to push this client group further into a situation where few will be able to work with them. What emerges most clearly are the following key messages (further addressed in Chapter 5):

- | There is a need for dedicated health and homelessness services that have the capacity to go out to people in hostels and other venues
- | Homeless people with multiple health needs often use A&E services when they are not able to register with a GP or when the specialist health services are not available
- | There is concern that they often receive the inappropriate, inadequate, and sometimes no treatment due to prejudicial attitudes and 'buck-passing' between healthcare professionals
- | Due to the diversity of need and the often transitory and elusive lifestyle of many homeless

people with multiple health needs, healthcare services should be creative and opportunistic in their design and delivery.

## 4. Behind the scenes: supporting access to health care services

This chapter continues to explore the key themes that were identified in all four of the case study areas. Whilst the previous chapter looked at aspects of healthcare that impacted directly on the homeless person with multiple health needs, this chapter goes behind the scenes and focuses on the work of the 'stagehands' who need to work together to ensure all the supports and props are in place. The three 'indicators of good practice' addressed here are coordination; joint working; and training and support for staff.

### 4.1 Working towards good practice

A common theme from the four case study areas was that homeless people with multiple health needs required an approach that reduced the likelihood of them 'slipping through the net'. What emerged was a range of generic and specialist services which, to a greater or lesser extent, were identifying opportunities to strengthen the links between them so that the holes in the net were smaller, thus making it harder for the homeless person with multiple health needs to slip through. Although there were examples of effective joint work, most participants in the research acknowledged that a more united approach would be facilitated by greater coordination and joint working, and that more opportunities for training and support would further empower those working with this particular challenging group of homeless people.

For many homeless people with multiple health needs, contact with helping agencies was often fleeting as they were regularly barred from day centres and hostels due to their anti-social and unacceptable behaviour. They were often 'here today and gone tomorrow' and this limited the opportunity to implement a care plan and to provide sustainable 'key work' support. Robust systems that reliably monitored the well being of this transitory group of homeless people, who were often out-of-touch with services, were not greatly in evidence within the case study areas.

#### Case study: Frank

Frank, homeless for 15 years, was sleeping rough. He was assessed as deeply disturbed, often depressed,

emotionally damaged and with an alcohol problem. He also had behavioural problems. No agency had been able to sustain regular contact with him and even annual monitoring had proved difficult. The different agencies which had fleeting contact with Frank felt at a loss as to how to offer him meaningful support. For example, the community mental health team had closed his case as they said they could not help him due to his poor attendance. However, others were anxious to maintain some form of 'damage limitation' and to keep Frank somewhere in their sight. One agency, which Frank frequented from time to time, struggled to find a solution as to how to engage with Frank but felt frustrated by his unpredictability. Even so, they acknowledged that it was important to keep Frank on their books and to hold a watching brief.

Staff from all types of agencies recognised that a more coordinated approach was needed to support them. However, one manager said that coordinated work was hampered by the 'parochial' and 'protectionist' attitudes of some agencies which were, it appeared, fearful of 'losing ground' through working too closely with others:

*"Each piece of the jigsaw is like a castle that enjoys the view from it. Some castles don't know that others exist. Each one fights its corner for services and there is no discipline across services. What has been lost is a voice across the city for this client group."*  
(Day centre worker)

There was a need for more opportunities for multi-disciplinary meetings to discuss common business, including the needs of mutual clients; the process of referral between agencies; waiting times; and pressures on services. It was acknowledged that such meetings would have the additional benefit of improving knowledge and understanding of each others' services, and would enable agencies to develop a 'voice' that could be fed into local strategic consultations and planning processes.

There were some examples of such meetings taking place. In one case study area, regular case reviews were held with all the agency staff working with particularly

chaotic clients. This facilitated joint decision-making and provided the opportunity to develop strategies to make contact and support the individuals. As one regular participant said:

*"This shares the load and makes sure everyone is kept informed. It is also good to tell the client that we share information so they know who else has an interest in their well being. It boosts their morale – and also means there is less chance of manipulation. But professional perspectives can cause a blockage as some agencies are unhappy about talking about a client without them being present."*

Although the advantage of regular information-exchange between agencies was highlighted, the involvement of the client was also important. To overcome many homeless people's fear and distrust of 'officialdom', workers said it was essential that the client's consent was sought before approaching each different service. This helped ensure that a relationship built on trust and honesty was established and maintained with the client. Where such protocols were in place, the research did not hear of any instances of client refusal or breaches of confidentiality.

In the absence of these meetings, a number of workers stressed the importance of being proactive and of regularly asking to attend the staff meetings of different projects in order to inform new staff about the service (since many projects have a high staff turnover), remind 'older' staff of its continuing existence, and to explore ways of working together to ensure a coordinated service for those vulnerable and chaotic clients who were most likely to suffer from a break in the continuity of support.

A further strategy to enhance greater understanding between agencies – and to provide a regular service to the most vulnerable – was through joint working. In one case study area, joint outreach sessions had been established between the rough sleepers' outreach team, a homeless intervention team (from a mental health trust) and a specialist service for drug-using people who were sleeping rough. This partnership work facilitated homeless people with multiple health needs to gain easy access to an initial assessment for both

their mental health and substance misuse; to get onto the first rung of the 'health ladder'; and to have support from the same group of workers who actively looked for them on the streets; and to make it easier for them to access the different services.

A prerequisite for effective joint working and coordination was honesty between agencies. Relationships had sometimes been soured by agencies being 'economic' with the truth when making referrals. Many projects were prepared to accept residents with multiple health needs, provided they came with additional support from other agencies with greater knowledge and expertise in relevant areas. The development of common referral and assessment processes was offered as one solution that might encourage transparent and clearer referral pathways. This could ensure that the on-going support that was promised at the referral stage was forthcoming. For example, one housing project that prioritised housing for people with multiple health needs refused to accept any new resident until a formal contract with other agencies had been signed which specified the on-going support to be provided.

One model that has demonstrated some success is the *Crisis Winter Watch* model. This aimed to work intensively with the most vulnerable, challenging and excluded rough sleepers to help them move away from the streets and rebuild their lives. It typically provided additional direct access beds, increased key working, daytime activities and outreach work between December and March. In one of the case study areas, such a project was set up, offering a five-week programme that enabled individuals to have regular contact with a wide range of different professionals who focused on different aspects of their life. Those involved said that the turning point for many people was their first opportunity to access to a local GP who not only prescribed a course of methadone but also treated their physical health needs. As a result of this intensive input, ten people moved off the streets and nine moved into their own tenancies. One shelter user said:

## HIDDEN HOMELESSNESS

*"I stayed in the shelter for five weeks. I got to see a GP. I couldn't have got more help – help with everything. But you have to trust people. At first I was wary with everyone and I felt guilty asking for help as I had left my drug using friends on the street. At first I was held back from getting help because of this feeling of guilt."*

The research identified a number of examples of training which targeted both generic and specialist staff involved in the support of homeless people with multiple health needs. For example:

- | A specialist homelessness mental health team provided training in dual diagnosis and personality disorder, either responding to requests for one-off training sessions, consultation sessions that used a particular client with multiple needs as a case study, or through the provision of more formal multi-disciplinary training courses
- | A Foyer in one area organised training on health, alcohol and drugs for both staff and residents. The feedback was that although the staff valued the opportunity for increased knowledge, they would have welcomed more practical advice on developing 'tools' to support their day-to-day work with challenging clients
- | 'Health and homelessness' courses took place, including one where a nurse provided joint sessions with a previously homeless person. Participants included trainee GPs, pre-registration nurses, health visitors and district nurses. Although typically brief, feedback had shown they were useful for raising awareness even if, as one person said, *"they only skim the surface"*.

However, such courses and training opportunities were not to be found in all the case study areas and many had to forego training due to cost – not just of the training, but also in the provision of locum cover and travel to the venue. Managers stressed the importance of setting realistic training budgets that calculated the 'true' cost of training and not just the registration fee.

Training gaps in relation to working specifically with homeless people with multiple health needs were also

identified. Staff in some homelessness agencies, particularly hostels and other temporary accommodation, were often expected to undertake a supportive role with clients – an increasing number of whom had multiple health needs – but their training did not necessarily include topics such as physical health, mental health or drug and alcohol related problems.

Staff also felt that they needed training and information on issues such as benefits and housing so that they could provide basic advice to those clients who might get 'lost' if they were referred on to another agency. They also felt that training was important to remain in touch with the needs of a changing client group, and of tried and tested ways of meeting these needs. Participation provided an opportunity to unpack prejudice, to raise awareness, and to find out what was happening elsewhere in the homelessness field.

The need for training was also an issue where homeless people with multiple health needs constituted just a small part of the patient or client group. The lack of sensitivity of some health professionals highlighted in the previous chapter may well be due to the lack of training and support in this area:

*"It is not the role of nurses to be judgmental. Let's face it; we all do risky things in our lives. But I cannot guarantee that some are not judgemental. We have not had any training in this area and none of us are involved in any forums."*

(Senior staff nurse, A&E)

Additionally their frustration in relating to this patient group may have been exacerbated by a lack of knowledge of services appropriate to them:

*"We need access to more information. We need to know what services exist and how to make referrals to them. Many nurses don't know and so people are falling through the net. Maybe a telephone Information Line would help."*

(A&E nurse)

The A&E nurses in the hospital in one of the case study areas had formed into a number of teams to ensure that the needs of different patient groups were appropriately met. One of these teams, with five or six

nurses, focused on homeless people. It met regularly and part of the discussion focused on particular homeless patients who were regular attendees and were causing concern. A Directory of Local Services had been developed and occasional meetings were held with the staff from local specialist homelessness agencies. This approach identified the need to 'tag' homeless people on the patient database so that they could be easily identified when they presented at A&E.

Training in itself was not considered by everyone to be the only answer to improving services for homeless people with multiple health needs. Indeed, a small number of services felt their time and resources were better spent in other ways. One accommodation provider argued that homeless people were unlikely to spend more than a few weeks with them, and therefore a lot of 'technical' knowledge was unnecessary. Their role was to provide support, not to offer specialist skills. Others said that resources would be more effective if used to employ more workers:

*"Training is a luxury for staff, not for the clients. What we need is more staff to bring down the waiting times; we need more staff actually doing the work and less doing the assessments."*  
(Homelessness worker)

Some workers felt that impact and value of training was lost as there was insufficient support within the agency to ensure new learning had an influence on practice. For example, workers referred to the growth of interest in the use of Cognitive Behaviour Therapy with homeless people with multiple health needs, but feared that their managers were not always able to provide the supervision necessary to support staff.

## **4.2 Key considerations**

This chapter demonstrates that, despite the best intentions, providing for homeless people with multiple health needs will continue to be as difficult as ever due to the absence of local strategies, which emphasise the need for coordination and partnership in particular. There is clearly a need for agencies to come together on a regular basis to share information and consider how best to deliver a coordinated service to this client

group – even where this is simply a matter of 'holding' or 'monitoring'. Increased coordination would be facilitated by improved knowledge of local provision and individual clients as well as by staff who, through supervision and support, would feel more confident in their ability to not just work with homeless people with multiple health needs but also to make appropriate decisions about referral and care.

# 5. Turning Practice into Policy and Policy into Practice

The NHS Plan (2000) – legally binding in England and Wales – states:

*“Healthcare is a basic human right... [and] the NHS will not exclude people because of their health status or ability to pay... [It] must be responsive to the needs of different groups and individuals in society, and challenge discrimination on the grounds of age, gender, ethnicity, religion, disability and sexuality... [It] will treat patients as individuals, with respect for their dignity... [It] will develop partnerships and co-operation at all levels of care – between patients; between the health and social care sector; between the public sector, and voluntary organisations. It will work with others to reduce health inequalities.”<sup>20</sup>*

The previous chapters have looked at the current practice of delivering healthcare to homeless people with multiple health needs, identifying within them examples of what works as well as some of the barriers to the access and use of services. We now look at how and where policy interfaces with practice. Responsibility for the provision of healthcare to homeless people with multiple health needs falls ultimately on the shoulders of NHS services.

## 5.1 Primary care organisations

At a local level, it is the English Primary Care Trusts (PCTs), Welsh Local Health Boards (LHBs) and Scottish NHS Health Boards (HBs) – collectively known as Primary Care Organisations (PCOs) – which have the lead in ensuring there is access to primary care services for all their residents. The most recent statement from the Royal College of General Practitioners (RCGP) on ‘Homelessness and Primary Care’<sup>21</sup> highlights the central role of primary healthcare services in the care of homeless people. It suggests, *“in view of the impact of homelessness on health, homelessness issues should be recognised as part of the core PCT agenda”*.

Since July 2003, all PCOs have been required to identify a named individual to promote and oversee the needs of homeless people.

Two PCOs within the case study areas have employed a Social Inclusion Manager who has specific responsibility

for ensuring the needs of homeless people are met. Following a review of local services in one of these areas, the Manager identified that *“health services for homeless people have fallen behind levels of provision available in other cities with similar homeless populations”*. The PCO board has been asked to consider a ‘Hub and Spoke’ model of care which would be a fully operational medical unit offering a range of services associated with a mainstream general practice. This would be based in a hostel in the city centre and accessible to those without transport.

Another PCO has considered establishing an Intermediate Care Service, which would be based in a voluntary agency. It intends to offer a multi-disciplinary approach to the care of homeless people involving both healthcare and social care professionals. Within this framework, GPs will be able to treat and prescribe for this client group whilst ensuring there is a focus on other aspects of the homeless patient’s life. In order to facilitate this, a number of local GPs have already become General Practitioners with a Special Interest (GPwSI), which required undergoing training in substance misuse.

General practitioners are central to the provision of primary healthcare in the community. The RCGP expects its members to provide a *“welcoming and sensitive service to homeless people”*; to register them as permanent patients; and encourages local agencies to *“develop shared protocols and operating procedures that aid integrated working and co-ordinated care for homeless people”*. Yet this research has highlighted a number of problems that homeless people with multiple health needs have experienced in accessing an appropriate and acceptable service. The research also identified a number of approaches that were being taken to improve the current situation.

The delivery of primary healthcare via Personal Medical Services (PMS) pilots is one way in which efforts have been made to improve the primary healthcare of homeless people. PMS pilots offer a more flexible way of providing primary health care to a local population and by allowing the practice specifically target those local

people who have been disadvantaged in healthcare terms. Leading primary care researchers have noted:

*"PMS pilot schemes have led to a dramatic increase in the number of dedicated primary care homelessness centres. In guidance from the DH, prior to the call for applications for 1st wave PMS schemes, homeless people were specifically mentioned as a target group for PMS pilots."*<sup>23</sup>

However, as the editorial points out:

*"The obvious limitations of specialised services are that they may effectively absolve local GPs from providing primary care services and at worse may serve to ghettoise homeless people, rather than encourage their integration back into mainstream primary care."*

## **5.2 Local consultation**

The *Homelessness Act 2002* required every local authority in England and Wales to undertake a review of homelessness and, by July 2003, to produce a strategy for addressing the prevention of homelessness. Future funding from ODPM would be linked to the targets identified in the local strategies. In the guidance from the ODPM, the need to engage with those agencies that would be responsible for the delivery of the strategy was stressed, although no specific mention was made of health-related agencies. Similarly, it did not specifically require that the health needs of homeless people should be addressed within the strategy. In Scotland, the *Housing (Scotland) Act 2001* introduced a similar statutory duty on local authorities.

This research was undertaken when the four local authorities were in the process of drawing up and completing their plans. The level of involvement of specialist voluntary sector and health agencies varied but local consultation was seen as important in the case study areas. In some areas this has focused on the health needs of the local homeless population. For example, in one case study area, a workshop which formed part of the consultation exercise focused on health and homelessness. Whilst the discussion did not specifically address the needs of homeless people with multiple health needs, themes emerged in common

with the findings of this research. The problems of securing an appropriate service from local GPs, the lack of methadone prescribing on certain hospital wards, unplanned and uncoordinated hospital discharges, counselling and other services for homeless people with low level mental health issues or learning disabilities were all discussed.

Integral to each strategy is an action plan with strategic objectives. Further research is needed to identify the extent to which the health and health-related needs of homeless people are addressed within these action plans.

## **5.3 The Welsh perspective**

Local Health Boards (LHBs) were introduced in Wales in April 2003 in the slipstream of the English PCTs, which were established between 2001 and 2002. The 22 LHBs are similar as coterminous with unitary authorities, holding responsibility for improving the health of the community, for developing primary and community health services, and for ensuring that local commissioning of secondary healthcare services meets local need.

The LHBs contain a strong emphasis on partnership where primary healthcare is just one important element in addressing local health and social care needs:

*"Partnership working has been written into the new strategic documents. The guidance on preparing health, social care and well-being strategies clearly identifies the duty that falls on local health boards and local authorities alike to co-operate with voluntary sector interests in formulating and reviewing local strategies."*<sup>24</sup>

In March 2003, the Welsh Assembly Government published its *National Homelessness Strategy*.<sup>25</sup> One of its strategic objectives is to:

*"ensure that vulnerable groups have access to specialist services, e.g. domestic violence, alcohol, drugs and mental health services, and that services can be provided in a joined-up way for people with multiple needs."*

*National Homelessness Strategy (p.7)*

## HIDDEN HOMELESSNESS

The *Action Plan*, which accompanies the *Strategy*, identifies a range of 'commitments' that address the health of homeless people. They include the requirement on LHBs to produce Health, Social Care and Wellbeing Plans, which will include strategies to address the health needs of homeless people; the promotion of good practice initiatives for developing accessible front-line services for homeless people; an emphasis on planned hospital discharge to appropriate housing; and the aim to secure access to substance misuse treatment services for all homeless people. This is to be achieved through:

- | additional funding being made available under the Flexibilities Grant Programme to LHBs working jointly with local authorities in developing projects that improve access to healthcare for homeless people
- | making additional funding available for substance misuse projects working with homeless people
- | issuing guidance on the discharge of patients from healthcare services
- | a survey of the views of homeless people and practitioners on issues regarding access to health services
- | consideration of the recommendations of research, commissioned by the Welsh Assembly, on access to health services for homeless people in Wales.<sup>26</sup>

### 5.4 The Scottish perspective

During the 1990s the number of homelessness applications in Scotland from those deemed to be unintentionally homeless and in priority need remained static. However, since 2000 there have been significant changes in legislation. For example, the *Housing Bill*, introduced into the Scottish Parliament in December 2000, brought the following recommendation into effect:

*"That additional duties be placed on local authorities to draw up homelessness strategies and to secure that advice about housing and other services is available free of charge to any persons who consider themselves to be at risk from homelessness."*<sup>27</sup>

Subsequently, the *Housing (Scotland) Act 2001* made a

recommendation to the Scottish Parliament that the concept of 'priority need' should be extended and ultimately removed to allow all those who believed themselves to be 'in need' to have the right to access housing services. The Scottish Executive acknowledged that such change needed to be introduced gradually in order to enable local authorities to plan for additional services and accommodation. However, since autumn 2002, the impact has become more strongly felt, and local authorities are currently under pressure to provide for increasing numbers of homeless people. In 2001-02, there was a 24% rise in applications to local authorities under the new legislation, representing a total of 46,380 applications in that year.<sup>28</sup>

Against this background, the Scottish Executive announced two other initiatives, which were underpinned by a commitment to partnership and joint working. First, in September 2001, the Scottish Executive Health Department issued guidance<sup>29</sup> to NHS Boards on the importance of "*engaging with homeless people in order to ensure that their services are indeed reaching those for whom they are intended*" (p.3). Local NHS Boards were required to develop health and homelessness action plans and in drawing them up they were supported by the appointment of a Health and Homelessness Coordinator and a Steering Group with responsibility for overseeing the new arrangements. The representation of individuals from government, health, local authorities and the voluntary sector helped to ensure they were closely linked to Local Authority plans. The Guidance states very clearly that it requires NHS Boards to:

*"Develop a Health and Homelessness Action Plan as an integral part of the Local Health Plan, in partnership with local authorities, the voluntary sector and homeless people. This Action Plan will be effective from April 2002 and will have been agreed with the Scottish Executive."*

Secondly, Local Authorities were also being required to conduct local needs assessments of homelessness and subsequently develop a Homelessness Strategy in the light of such assessment and changes in Scottish legislation. As in England and Wales, these needed to

be prepared by March 2003. At the time of this research, Health and Homelessness Action Plans had not been implemented.

The *Homelessness (Scotland) Act 2003* further strengthens the rights of homeless people. It allows for a gradual expansion of the 'priority need' category outlined in the *Housing (Scotland) Act 2001*, and will have an immediate impact on some homeless people with multiple health needs as 'priority need' now includes homeless people:

- | with a chronic illness
- | who have suffered a miscarriage or undergone an abortion
- | who have been discharged from hospital
- | who run the risk of sexual exploitation or involvement in the serious misuse of alcohol, any drug (not necessarily controlled under the *Misuse of Drugs Act 1971*), or any volatile substance.

### **5.5 Moving Forward to a new Scenario**

This research focused on homeless people with multiple health needs. However, many of the responses to their health needs and views about these practices were equally relevant to those homeless people with single or simple needs or, indeed, to the population as a whole. What is different here is that the research aimed to identify the factors that particularly affected homeless people with multiple health needs. In an ideal world, healthcare provision would meet the needs of all individuals and groups. In a world that is not ideal, some suggestions for approaches and improvements to the existing situation seem appropriate and the following are offered for consideration.

The concept of dedicated healthcare for homeless people with multiple health needs through outreach services or one-stop-shop models were clearly welcomed by homeless people and services alike, although not without some problems of their own. This report has described examples of some specific services that have proved popular to both homeless people with multiple health needs as well as with staff. The reasons

for their popularity may have been because the services were intrinsically good (this research did not have a remit to evaluate individual services). However, this popularity may also have been the result of situations where alternative, mainstream options tended to fall short of meeting the needs of this group of people and homeless people more generally.

If specialist healthcare services for homeless people represent one way forward, what factors need to be taken into consideration?

***What needs to be in place at the outset?*** The findings here suggest that the following are essential to support the development of a dedicated service:

- | an urban location with a critical mass of potential users
- | explicit commitment within local strategies and planning, including funding to resource it within the mainstream budget
- | commitment of other agencies including mental health and substance misuse counselling, and housing advice
- | an holistic approach
- | links to and ways of enabling and promoting access to mainstream healthcare.

***What does this approach offer homeless people with multiple health needs?*** Chapters 3 and 4 detail the key indicators of good practice to emerge as themes in our findings. Many of these suggest what are likely to be the most important aspects of this approach:

- | flexibility: overcoming appointments systems and professional boundaries
- | positive attitudes: reducing fear of being labelled
- | availability: ability to access when needed
- | appropriateness: through a dedicated service for homeless people
- | advocacy: building trust and opening doors to other services
- | coordination: with named workers on site from a full range of services.

## HIDDEN HOMELESSNESS

**What are the disadvantages?** Three principal difficulties were identified in the research:

- | although the local PCO has a responsibility to ensure equity of access to healthcare services, the priority to commit new money to services for homeless people with multiple health needs may be low
- | specialist services may encourage dependency
- | they can limit access to and use of mainstream healthcare either as a result of patient dependency or because mainstream services seen no further need to take responsibility.

Developing specialist services will not always be either feasible or appropriate. We highlight other approaches throughout the report that could also be adopted and adapted to meet local needs within local contexts.

### 5.6 Recommendations

This research has identified nine 'indicators of good practice'. They are:

- | availability of services
- | flexibility of services
- | the provision of appropriate care
- | non-prejudicial treatment
- | support and advocacy
- | information for the service user
- | coordination
- | joint working
- | training and support for staff.

These 'indicators' have influenced the ten recommendations that are suggested below to conclude this report.

The development of services and support for homeless people with multiple health needs was partly hampered by guesstimates, varying interpretations and different assessment procedures. Further work is required to ensure that the numbers and needs of homeless people are consistently recognised, acknowledged and shared

between local agencies. There are three practical activities associated with this recommendation.

#### **Recommendation 1 – Developing common**

**assessment processes:** Opportunities to undertake a needs assessment of a homeless person with suspected multiple health needs are frequently hampered by their transitory lifestyle; the unsuitability of the location to conduct a confidential discussion; and their inability to fully engage in the process due to their physical and/or mental health. The development of a common assessment process, which requires one assessment that could be shared between agencies, would have advantages both to the individual and to local agencies. Partnerships or forums of interested agencies should explore the potential for a common assessment process to be developed locally. One example is given within this report and suggests that funding would only be available to those agencies that adopted the procedures outlined below:

- | A comprehensive 'Standard Needs and Risk Assessment' process was in place to encourage hostels (and other homelessness services) to properly assess referrals and to develop structured Care Plans
- | A standard Application for Direct Access Accommodation was developed. This was a simple two-page form and included a tick-box section to highlight the areas where additional support needs had been identified. Many of these areas are now associated with 'multiple health needs' including self-harm; physical health; disabilities; aggression/violence; substance abuse; arson convictions; mental health; and alcohol misuse
- | Agencies were required to ensure that their exclusion policies contained a review process to facilitate 're-access', and that there were mechanisms for the sharing of information in an open and honest manner with other agencies
- | Record logs were to be signed off by senior managers to ensure client files were regularly reviewed and updated.

**Recommendation 2 – Developing a shared language to facilitate the collection of statistical data:**

Although the Homeless Link definition of ‘multiple needs’ was accepted by participating agencies, the research identified that there are still varying interpretations and understandings of the different terms. This is partly because few agency staff are expert or trained in the ‘presenting issues’ that combine to constitute a ‘multiple needs’ diagnosis, and also partly due to an unwillingness to label service users. An outcome of the variation in interpretation is the inability to quantify with confidence the number of homeless people – both locally and nationally – with multiple health needs. *The development of a common assessment process* (see Recommendation 1) will facilitate this. *This should be supported by the further promotion of the Homeless Link definition, together with the provision of training and information sheets on the needs of homeless people with multiple health needs.*

**Recommendation 3 – The needs of homeless people with undiagnosed disabilities:**

Many agencies raised their concerns that homeless people with multiple health needs were not receiving the full range of services due to the problems of accessing a timely needs assessment. This consequently affected the identification of the required services. One client group that was causing particular concern was those with learning disabilities. *Links with the local services that undertake local needs assessment should be strengthened. In particular, local Learning Disability Services need to be brought into the ‘frame’ and their participation in local partnerships and forums should be encouraged.*

This research identified that access to healthcare by homeless people with multiple health needs can be hampered by inflexible rigid professional boundaries, blinkered vision and ‘buck passing’ due to ‘disputes’ as to which of many health issues is the primary presenting problem. This results in individuals ‘falling through the net’ and not receiving the services they require.

**Recommendation 4 – Joint working:** Dedicated services for homeless people already operate in areas

where there is a critical mass of homeless people. These take place in agencies frequented by homeless people with multiple health needs as well as on the street. *Where possible, the ‘teams’ offering these services should be multi-disciplinary and involve workers from different organisations, both specialist and mainstream.* In addition to specialists in mental health and substance misuse, *the teams should include nurses and other primary healthcare specialists.*

**Recommendation 5 – Getting homeless people onto the mainstream primary healthcare agenda:**

The NHS Plan and other recent government policies emphasise the need to improve access to healthcare and to break down health inequalities. Local primary care organisations (PCOs) have the responsibility to make this happen and ‘responsible officers’ have been identified. *Where access to primary healthcare services by homeless people with multiple health needs remains a problem, local agencies or forums should make contact with the responsible officer.* Examples of different ways in which services involving local GPs have been developed are identified in this report, as well as in the previous reports produced by *Crisis*<sup>30</sup>.

**Recommendation 6 – Awareness training:** This research identified a number of examples of uninformed attitudes and understanding of homeless people with multiple health needs. *Local primary care organisations – in partnership with specialist agencies working with homeless people – should ensure that short, accessible training courses are organised for mainstream primary healthcare staff, including GPs, practice nurses and reception staff.* Where appropriate, accreditation for attendance and payment of locum staff should be used in order to encourage uptake.

**Recommendation 7 – Improving hospital**

**discharge:** The research reported examples where homeless patients with multiple health needs were discharged prematurely, often due to the patient being unable to ‘establish a relationship with the nursing staff’ (in other words, not complying with the proposed treatment). It also heard of examples where the patient was discharged onto the streets or back to a hostel in the middle of the night. In order to improve

## HIDDEN HOMELESSNESS

hospital discharge policies for homeless people, *liaison should be established between relevant hospital consultant, the discharge nurse, and the responsible official within the local PCO. Local specialist homelessness agencies should also be involved to ensure a smooth process is established.*

### **Recommendation 8 – The treatment of drug users:**

This research suggests that a significant number of homeless people with multiple health needs were using heroin. Access to methadone prescribing was extremely limited in all the case study areas, partly due to the paucity of prescribing GPs and partly due to the long waiting lists for treatment from specialist drug treatment agencies. One of the barriers to this patient group accessing and accepting in-patient hospital treatment was the inability to access methadone whilst in hospital, irrespective of their previous source being prescribed by a GP or being ‘the street’. This report contains some case studies of the impact of the withdrawal from this source. It recommends that:

- | *Hospital consultants should be encouraged to continue methadone treatment* where evidence is provided of previous prescribing by a GP or statutory drug treatment service
- | *More GPs should participate in substance misuse training* to increase the availability of prescribed methadone in the community. They may be further inclined to register drug users as patients where ‘shared care’ arrangements are developed with specialist drug agencies. In this scenario, the homeless patient is provided with additional support to help them address their continuing drug use
- | *The National Treatment Agency guidelines on waiting times should be adhered to* in order to increase access to treatment for those drug users who seek it.

**Recommendation 9 – ‘Holding the ring’:** The transitory lifestyle of many homeless people with multiple health needs requires a coordinated approach to their care. *Systems that can ‘track’ individuals in this patient group are required to ensure that appropriate*

*care from appropriate professionals is available at ‘crisis points’.* In the future, computerised systems – which quickly share knowledge between local agencies – may be put in place; but in the meantime, *regular meetings of key personnel should be scheduled to share information on those homeless people who are the most vulnerable. The identification of a ‘key worker’ to ‘hold the ring’ and to be the recipient and broadcaster of new information on an individual should be considered.*

### **Recommendation 10 – Improving skills,**

**information and knowledge:** The referral of homeless people with multiple health needs between agencies was, at times, inhibited by lack of information of local services, as well as skills in making a thorough assessment of their needs. In order to improve this, a number of strategies for local consideration are recommended:

- | *A local directory of services should be produced* containing details of eligibility (and exclusion) criteria for acceptance; how to make a referral; range of services provided; typical waiting lists; costs (if any); staff qualifications. This needs to be regularly updated to ensure accuracy. A paper and a web-based version should be considered
- | The research suggests that there is a paucity of training courses that focus on ‘multiple health needs’, rather than different individual elements that make up the definition. *The development of courses that address the full range of issues relating to ‘multiple health needs’ should be considered*
- | Whilst supervision is available to most workers in contact with homeless people with multiple health needs, there may be advantages in exploring different forms of support and supervision that enable worker to introduce different ways of working with this group of homeless people; for example, the use of Cognitive Behaviour Therapy has proved valuable but requires appropriate supervision to support its delivery.

# APPENDIX: Research Methods

## 1. Background to the Research Design

### 1.1 Overall design

The research design included five key components:

- | a review of relevant documentation
- | a questionnaire for health service providers, specialist health services for homeless people, and other related services within four selected case study areas
- | interviews with selected health service providers, specialist health services for homeless people, and other related services within four selected case study areas
- | interviews with key agencies that have a homelessness overview position including local authorities and voluntary sector providers
- | interviews and case studies with current and previously homeless people who have multiple health needs.

It was conducted within the four geographical areas of Aberdeen, Scotland; Wrexham, Wales; Birmingham and the London Borough of Islington, England. The four case study areas were selected, in collaboration with *Crisis*, to provide the research with as comprehensive coverage as possible of the ways in which the multiple health needs of homeless people are both identified and addressed. These areas were chosen on the basis of agreed criteria, which included:

- | levels of identified homelessness in towns and cities of differing sizes
- | a range of facilities and services for homeless people
- | opportunities for homeless people with multiple health needs to access health-related services of different kinds.

On receipt of Multi-Site Ethics Committee approval in April 2003 (see 1.2 below), fieldwork was carried out in the four areas with presentation of the final report in October of the same year.

The fieldwork included the following: (details provided in separate sections below):

- | 24 interviews with men and women with multiple health needs and experience of homelessness
- | 49 interviews with representatives of health services, homelessness and other relevant agencies
- | 12 interviews with key overview agencies.

### 1.2 Ethical approval for research involving staff and users of health services

The NHS Research Governance Framework for Health and Social Care<sup>31</sup> requires that any research conducted within the NHS and involving individuals must seek approval from a relevant local research ethics committee. From April 2002, this further included NHS staff as well as service users. Although this research project was not exclusively conducted within NHS settings (it involved other statutory and non-statutory agencies, staff and users), it was still necessary to seek approval in order to gain access to services as and when appropriate.

Application was made to the Scottish Multi-Site Research Ethics Committee (MREC). Since the research was to be conducted in four separate areas, this was the simplest option for gaining approval. With no need to seek approval for a 'local researcher', the multi-site approval was deemed adequate to meet the needs of all areas. On receipt of approval, we provided the local research ethics committees with all the relevant documentation and a copy of the research protocol. In three of the four local areas, we received acknowledgement and were asked to submit the final report on completion. In one of our case study areas, the requirements were more stringent and we learned that in order to undertake even a minimum of interviews with staff only, we were required to seek temporary, honorary contracts with the trusts concerned (including submitting references and meeting occupational health standards) prior to conducting any research. In the absence of this contract due to time constraints, we abandoned a discussion with staff of one key service (having been

invited some time earlier to use part of a regular staff meeting) with much regret. Interestingly, other trusts within the same research ethics committee area did not ask the same of us.

The research ethics process rightly serves the interests of research participants, be they staff or service users. The Scottish MREC was able to respond within a reasonable time-period – once we had been accepted on to the list of applications for consideration. They provided some extremely useful and thoughtful feedback, which we believe, improved the proposed methods. This experience was in striking contrast to the subsequent demands placed upon us by one local research and development department (responsible for research ethics) and which we fear may have adversely affected the quality of the data generated. It would seem that this approach acts to prevent rather than enable good research practice, the ethos that we believe is at the core of any research ethics approval process.

## 2. The Methods

### 2.1 Document review

A preliminary review of databases and other sources demonstrated that much of the research about homelessness and health was produced prior to the latter part of the 1990s. Since then it would appear that there had been fewer research studies which reflected the relationship between health and homelessness in a changing political and social climate. The document review addressed issues of particular significance to single homeless people with multiple health needs and how and why they might differ from other homeless people. It included the following:

- | *Government policy on homelessness* especially in the way it affected homeless people with multiple health needs, e.g. *Homelessness Act*; the *Health and Social Care Act 2001*; and policy documents from the Homelessness Directorate/DETR

- | *Frameworks which affected homeless people's access to health* and related services, e.g. from PCT strategy documents; A&E guidelines and specific reports such as the *Dual Diagnosis Good Practice Guide*<sup>32</sup>
- | *A review of policies and strategy documents* (from the four geographical areas) which addressed PCT/Local Health Board priorities, provision and social inclusion
- | *Descriptive information* from previous research studies, needs assessment studies
- | *Local statistical data* about the volume and nature of general and targeted health services available to single homeless people with a focus on the four geographical areas selected

The review of documentation provided a backdrop to the research and was useful in determining the overall approach and research design.

### 2.2 Questionnaires to service providers within the four case study areas

The research required different types of data to enable a full understanding of both how service providers understood multiple health needs and whether or not they considered homeless people with these needs to be significant in both number and demands on their services. On that basis a postal questionnaire was sent to all agencies identified that provided health or other services to single homeless people in the four selected locations. In addition in-depth interviews were conducted as described in 2.3 below.

This twofold approach aimed to elicit understanding about both the breadth and range of health and health-related services available to homeless people in the selected areas as well as the perceptions of service providers in relation to providing for homeless people. It was hoped that the questionnaire would enable exploration of opportunities to make contact with service users who were happy to contribute to the research through describing their experience of using local health services (see 2.5).

The postal questionnaire set out to elicit the following:

- | detailed information on the activities of agencies
- | information to facilitate the identification of the level of multiple health and associated problems within the local homeless populations
- | description of the existing links between generic health, specialist mental health; substance misuse and specialist health agencies for homeless people that addressed the needs of individuals with multiple health and associated problems
- | needs assessment conducted within the area with reference to existing health needs assessment tools (if any).

The agencies targeted included:

- | the statutory health services (specialist and generalist)
- | the statutory mental health services (specialist and generalist)
- | primary and secondary health care services having significant contact with this group
- | local substance misuse services
- | organisations that provided residential and day services to homeless people
- | the providers of health care services within homelessness agencies

- | teams (paid and volunteer) that provided outreach services on the street.

A total of 87 questionnaires were sent out.

These included advice, drug and alcohol and ex-offender organisations

The questionnaire sought information on:

- | the aims and activities that were relevant to the homeless population
- | demographics of the homeless client group (if known) in terms of numbers and individual characteristics
- | the number and/or percentage of their homeless clients with multiple health and associated problems (estimates only)
- | the support (if any) that was given within the agency/service to these clients
- | typical referral patterns where the agency/service was not able to respond to clients' health needs
- | partnership arrangements within the area and their views of how these worked in practice
- | perceived strengths and weaknesses in the support that was available to individuals with multiple health and associated problems
- | any unmet need and their suggestions for improvement.

**Table 1:** Survey of relevant agencies (n=87)

<b>Case study area</b>	<b>Health Services</b>	<b>Homelessness &amp; housing agencies</b>	<b>Other agencies*</b>	<b>Total</b>
Aberdeen	2	8	1	11
Birmingham	5	14	10	29
Islington	5	15	6	26
Wrexham	6	5	8	19
Other	1	0	1	2
<b>Total</b>	<b>19</b>	<b>42</b>	<b>26</b>	<b>87</b>

\* These included advice, drug and alcohol and ex-offender organisations

## HIDDEN HOMELESSNESS

The questionnaire was designed to have a quick ‘turnaround’ with follow up by telephone where a response was not received by the deadline. The response to the questionnaire was, however, extremely disappointing and in total, we received only 16 – less than a quarter of those sent out.

Despite a minimum of three, and sometimes more, follow-up telephone calls many agencies did not return the questionnaires within the original and subsequently extended deadline. We tried to find out what difficulties they had encountered and their reasons often included feeling already overwhelmed by the demands of providing services without the additional requirement to complete ‘yet another’ questionnaire. More interestingly (from a research point of view), an additional yet common reason was that both health and homelessness service providers questioned the relevance of this research to their client/patient groups. During follow-up conversations and in-depth interviews it emerged that many did not perceive that they were working with homeless people with multiple health needs; they did not have in-house systems for monitoring whether they did or did not have these clients; and they did not feel confident to offer even a ‘guesstimate’ of numbers of homeless people who fitted the definition adopted for this research. This feedback we took to represent an important finding for the research and is further addressed within the body of the report.

### 2.3 In-depth discussions with key agencies

We had anticipated that a review of the responses would enable us to identify key agencies in each geographical area, which would be invited to take part in a follow-up interview to explore some of the questionnaire issues in more detail. Due to the poor response to the questionnaires, we contacted as many agencies as possible directly to arrange interviews with them as well as seek their advice on where else to go. The framework for these interviews was the six evaluative ‘qualities of healthcare’<sup>33</sup> – accessibility, equity, appropriateness, effectiveness, acceptability and efficiency. The issues agreed to be most relevant here included:

- | perceptions of access to health services for homeless people with multiple health needs
- | assessment of how and why homeless people do, or do not, make use of available health services with an examination of their relationship to organisational/agency barriers as well as individual motivation to make to make themselves known
- | factors that help or hinder homeless people to access such services
- | perceptions of current local health service provision to homeless people
- | perceptions of gaps in health services
- | assessment of any partnership arrangements

**Table 2:** Response to the questionnaire (n=16)

	<b>Number sent out*</b>	<b>Number returned</b>	<b>Promised</b>	<b>Refused as ‘innappropriate’</b>	<b>Refused for other reasons</b>
Aberdeen	11	4	2	1	0
Birmingham	29	4	2	1	0
Islington	26	6	2	2	2
Wrexham	19	0	1	2	0
Other	2	2	1	0	0
<b>Total</b>	<b>87</b>	<b>16</b>	<b>8</b>	<b>6</b>	<b>2</b>

- factors that help or hinder homeless people with multiple health needs in accessing housing and resettlement.

Intensive visits were arranged to the case study areas and approximately 100 individuals participated in 49 discussions.

These interviews not only elicited the depth of information, perception and views we hoped for, they also allayed our concerns about the low return of questionnaires. Some interviews were conducted with agencies that had not sent the questionnaire back and it was here that we learned about their understanding and perceptions of whether their agency worked with homeless people with multiple health needs.

**2.4 Consultation with key agencies with a local or national strategic overview**

In order to fully understand the profile of homeless people with multiple health needs and the ways in which services addressed these needs, a further series of 12 interviews were conducted with representatives of agencies with an interest in this field. At a local level in the four areas, these included local authority housing and social services departments and Primary Care Trusts. At an English national level we met with representatives of the Homelessness Directorate and homelessness agencies that offered a strategic overview.

The purpose of these interviews was to elicit and subsequently describe at a strategic level the current provision for homeless people with multiple health needs as well as perceived visions for the future. The content covered topics similar to those outlined above but with a view to the 'broader picture' as it was affected by local and national contexts.

**2.5 Consultation with homeless people with multiple health needs**

It was essential to include the experiences, views and perceptions of homeless people with multiple health needs in this research. Their perspective has augmented those provided by service providers and offered an opportunity for cross-analysis. We aimed to identify people who were willing to contribute through the follow-up interviews with providers. Unsurprisingly, we quickly became aware that very often, homeless people with multiple health needs were those least likely to be in contact with services. As a result, we were limited in the pool of potential participants. However, some individuals came forward and we were also provided with case studies to augment our empirical data. A contribution of £10 was offered to each participant.

By inviting individuals to tell their recent 'life story', we gained an opportunity to ask them to amplify on their experience as relevant to the research. The content of these discussions mirrored the previous interviews with service providers and included the following:

**Table 3:** Interviews with key agencies (n=49\*)

<b>Case study area</b>	<b>Health Services</b>	<b>Housing &amp; homelessness</b>	<b>Strategic &amp; policy</b>	<b>Other</b>	<b>Total</b>
Aberdeen	2	6	3	0	11
Birmingham	3	4	3	3	13
Islington	2	6	1	2	11
Wrexham	5	5	1	3	14
<b>Total</b>	<b>12</b>	<b>21</b>	<b>8</b>	<b>8</b>	<b>49</b>

\* This represents the number of interviews not individuals. Some discussions were held with two or more people including staff 'groups' of up to six.

## HIDDEN HOMELESSNESS

- | exploration of met and unmet need from their perception
- | description of their priorities and how far these were met through existing or future services
- | views on access and barriers to both health and related services.
- | perceptions of access to health services when faced with multiple health needs
- | assessment of how and why they did or did not make use of available health services
- | factors that helped or hindered them to access such services
- | perceptions of current local health service provision
- | perceptions of gaps in health services.

We were concerned that people who were or had been recently homeless may experience a variety of emotional and practical difficulties (in addition to health problems) that leave them feeling vulnerable. In order to make their inclusion in the research meaningful to them and acceptable to staff, we suggested the following ground rules as a means of addressing concerns that may arise.

- | That participants and agency staff were provided with a written statement outlining the purpose and conduct of the research with proposals for feeding back findings to these groups
- | That participants understood the confidentiality guidelines which regulated the research, e.g. that all data would be confidential to the researchers, that the data would be provided to *Crisis* in either an aggregated form or anonymised and that no individual would be identifiable from the report
- | That the interviews were conducted in an environment and location where both parties felt safe and comfortable
- | That some reward or incentive for participation was agreed
- | That some homeless people would be reluctant to

offer criticism or suggestions for change due to a sense of powerlessness over their personal situation

- | That a range of people would be included to enable participation from different people in relation to sex, age, ethnicity, length of homelessness, experience of health difficulties and support needs
- | That *appropriate responses would be provided* to participants who raised queries or concerns.

**Table 4:** Characteristics of homeless people interviewed (n=24)

	Characteristics	Number
Sex	Male	16
	Female	8
Age	20 and under	1
	21 – 25	6
	26 – 35	6
	36 – 45	4
	46 – 55	3
	56 – 65	3
Ethnic group	66 and over	1
	White British	14
	Irish	4
	African Caribbean	2
	Mixed race	3
	Other	1

### 3. Data Analysis

The data were analysed to provide both descriptive and explanatory, illustrative material. The analysis was undertaken from the interviews on a thematic basis from which a series of charts were prepared on which all comments and views were summarised.<sup>34</sup> This analysis provided a systematic profile of experiences, views and perceptions from providers and users of services, those involved in strategy and policy and those with a broader overview of the needs of homeless

people on each of the principal themes central to the research. This approach allowed for repeated and contrasting experiences and views to be identified both within and across the different participant groups.

Given the previously noted limitations of the questionnaire data, these were charted in a similar way and added to the qualitative data, which provided the core learning for this research.

#### **4. Project Reference Group**

A project reference group was established for the life of this research that acted as a resource throughout the process. At the outset of the research, the group helped to undertake the following:

- | setting the scene and establish the context
- | agreeing the process for the research
- | agreeing the definitions and parameters for the research
- | identifying the four geographical locations
- | providing some 'signposting' for us.

On the basis of an agreed timetable, the group met at least four times during the research period. Members of the group were on hand to offer guidance, read draft reports and see the project to completion.

Further information on primary healthcare services for homeless people and the role of primary care organisations in their delivery can be found in three comprehensive reports published by Crisis Health Action in 2002/2003:

- | *Critical Condition: Vulnerable Single Homeless People and Access to GPs*: a policy brief promoting the important role of primary healthcare in delivering care to homeless people
- | *Understanding the new NHS – A guide to the New NHS for Voluntary Homelessness Organisations*: a guide for homelessness agencies to understand the new structures for the delivery of healthcare so championing the healthcare needs of homeless people

- | *Guide to Models of Delivering Health Services to Homeless People*: a practical document for PCOs, local authorities and voluntary agencies to assist the planning of health services for homeless people. Plus models for delivering services in different ways to different groups of homeless people, many of which are appropriate to those with multiple health needs.

These can be downloaded for free from [www.crisis.org.uk/downloads](http://www.crisis.org.uk/downloads)

# Bibliography

1. Kenway, P. and Palmer, G. (2003) *How many? How Much? Single Homelessness and the Question of Numbers and Cost*, Crisis and The New Policy Institute, London.
2. Croft-White, C. and Parry-Crooke, G. (2001) Rosa's story: the burden of ill health when homeless in Mason, T et al (Eds) *Stigma and Social Exclusion in Healthcare* Routledge
3. Bines, W. (1994) *The Health of Single Homeless People* Centre for Housing Policy, University of York
4. Pleace, N. and Quilgars, D. (1996) *Health and Homelessness in London: A Review* The King's Fund
5. Crisis Research Brief (2002)
6. Pleace, N., Jones, A. and England, J. (2000) *Access to General Practice for People Sleeping Rough*, Centre for Housing Policy University of York
7. Bines, W. 1994) *The Health of Single Homeless People* Centre for Housing Policy York.
8. Pleace, N. and Quilgars, D. (1996) *Health and Homelessness in London: A Review* The King's Fund.
9. Shardlow, S. et al, (2003) *Homeless People's Access to Medical, Care and Support Services* Salford University
10. Griffiths, S. (2002) *Addressing the Health Needs of Rough Sleepers* Homelessness Directorate ODPM
11. Gorton, S. (2003) *Guide to Models of Delivering Health Services to Homeless People*, Crisis London
12. Anderson, I., Kemp, P.A., and Quilgars, D. (1993) *Single Homeless People* London HMSO
13. Shardlow, S. et al, (2003) *Homeless People's Access to Medical, Care and Support Services* Salford University
14. Pleace, N. and Quilgars, D. (1996) *Health and Homelessness in London: A Review* The King's Fund
15. Office of the Deputy Prime Minister (2003) *More Than a Roof: A Report into Tackling Homelessness* ODPM, London.
16. Bevan, P. and van Doorn, A. (2002) *Multiple Needs: Good Practice* Briefing Homeless Link
17. Department of Transport, Local Government and the Regions (2002) *Homelessness Strategies: A Good Practice Handbook* DTLR, London.
18. Royal College of General Practitioners (2002) *RCGP Statement on Homelessness and Primary Care*.
19. Lester, H., Wright, N., and Health, I. (2002) *Developments in the provision of primary health care for homeless people*, (Editorial), British Journal of General Practice, Volume 52 (2), pp: 91-92.
20. Department of Health (2000) *The NHS Plan: A Plan for Investment; A Plan for Reform* Department of Health.
21. Royal College of General Practitioners (2002) *RCGP Statement on Homelessness and Primary Care*
22. Royal College of General Practitioners (2002) *RCGP Statement on Homelessness and Primary Care*.
23. Lester, H., Wright, N., and Health, I. (2002) *Developments in the provision of primary health care for homeless people* (Editorial), British Journal of General Practice. Volume 52 (2) pp: 91-92.
24. Dobson, A. (2003), *Out with the old*, *Care and health Journal*, Issue 43, pp 24 – 25.
25. Welsh Assembly Government, (2003) *National Homelessness Strategy*
26. Shardlow, S. et al, (2003) *Homeless People's Access to Medical, Care and Support Services* Salford University
27. Scottish Executive (2001) *Helping Homeless People*.
28. Scottish Executive (2002) *Operation of the homeless persons legislation in Scotland*, quarters ending 31 December 2001 and 31 March 2002.
29. Scottish Executive Health Department (2001) *Health and Homelessness Guidance*.
30. For additional materials visit the *Crisis Research Bank* at [www.crisis.org.uk](http://www.crisis.org.uk)
31. Department of Health (2001) *NHS Research Governance Framework for Health and Social Care*
32. Department of Health (2002) *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide*, DOH, London.
33. Royal College of General Practitioners (1997) *Measuring Quality* RCGP.
3. Ritchie, J. and Lewis, J. (2003) *Qualitative Research Practice* Sage Publishers, London.

## About the Authors

This research was carried out by Clare Croft-White and Georgie Parry-Crooke during 2003. Clare and Georgie have worked collaboratively and independently on research and evaluation projects that focus on the needs of homeless people in a variety of situations and circumstances – homelessness and mental health, drug and alcohol problems and women’s experience of homelessness.

Their collaborative work includes Double Exposure: Addressing the Needs of Homeless Women with Mental Illness (1996), a study of staff and women’s views and experiences of direct-access accommodation in London for women with severe mental health problems for the Sainsbury Centre for Mental Health; an evaluation of the *Crisis*-funded ReachOut Programme (1998), a national initiative providing outreach services to homeless people with mental health problems; *Can’t See: Won’t See Revealing the Housing and Support Needs of Single Homeless Women in Central London* (1999) and *Equity of Access: the treatment of alcohol problems in primary care* (2001) on behalf of Camden & Islington Health Authority.

# Acknowledgements

We would like to thank everyone who participated in this research. We believe it has been considerably enhanced by the contribution of over 20 women and men who talked very openly about their experience of homelessness and their use of health services. We would also like to thank the staff of specialist and generic health services; homelessness agencies and other services who work with homeless people with multiple health needs. Over 100 individuals participated through a questionnaire (which was kindly piloted by Nora McLaughlin, Jo Williams and Charlotte Tomkins), interviews and discussions as well as by providing documentation about policies and practices that affect this group of existing and potential service users.

The research Steering Group gave us invaluable encouragement and support throughout. Special thanks to Pip Bevan, Homeless Link, for his thoughtful and considered comments at all times. The research only came into being as a result of work by Homeless Link which identified the ways in which homeless people with multiple needs often become more marginalized because of the way in which their needs are seen as too complex or difficult to deal with. Thanks are due to Sue Irving, Scottish Executive for offering her knowledge and experience of the Scottish situation and to Phil Timms, Consultant Psychiatrist (START) for his insights into the lives of homeless people who live on the margins. Tarig Hilal and Brenda Roche, *Crisis*, provided detailed feedback on draft reports for which we are very grateful.

Finally, thanks are due to *Crisis* for funding this research.

Clare Croft-White  
Georgie Parry-Crooke

November 2003

# Abbreviations used in this report

<b>A&amp;E</b>	Accident and Emergency
<b>CCTV</b>	Close circuit television
<b>CPN</b>	Community Psychiatric Nurse
<b>CMHT</b>	Community Mental Health Team
<b>DTLR</b>	Department of Transport and Local Regions
<b>GP</b>	General Practitioner
<b>GpwsI</b>	General Practitioner with Special Interest
<b>GUM</b>	Genito-urinary Medicine
<b>HIV</b>	Human Immuno-deficiency Virus
<b>LHB</b>	Local Health Board
<b>NHS</b>	National Health Service
<b>NTA</b>	National Treatment Agency
<b>ODPM</b>	Office of the Deputy Prime Minister
<b>PCO</b>	Primary Care Organisation
<b>PCT</b>	Primary Care Trust
<b>PMS</b>	Personal Medical Services
<b>RCGP</b>	Royal College of General Practitioners

## Other Crisis publications

### Homelessness Factfile

Tony Warnes, Maureen Crane, Naomi Whitehead, Ruby Fu  
ISBN 1 899257 51 9 2003 208pp £12.50

This second edition of the *Homelessness Factfile* provides comprehensive, accessible and up-to-date information about homeless people in the United Kingdom, and policy and service responses to homelessness and its prevention.

The *Factfile* is however more than a directory, for it also reviews the current scene, and critically examines some of the most vigorously debated current policy and practice development issues. It is an invaluable resource with links, references, case studies and sources for further research. There is plentiful information about homelessness in Scotland, Wales and Northern Ireland. Updated information that supplements the printed version, can be found in the Factfile Online at [www.crisis.org.uk/factfile](http://www.crisis.org.uk/factfile)

### Publications in the Hidden Homelessness series

There are hundreds of thousands hidden homeless people in Great Britain living in emergency hostels, B&Bs, squats or on friends' floors. A series of publications have been commissioned to map out their experiences and highlight their plight.

### Your Place, Not Mine

David Robinson with Sarah Coward  
ISBN 1 899257 50 0 2002 40pp £7.50

Efforts to tackle homelessness have focused on reducing the number of homeless people living in bed and breakfast accommodation and the number of people sleeping rough. Yet the vast majority of homeless people are living in alternative situations, such as squatting, staying with family and friends or living in hostel accommodation. Recognising and responding to this fact, this ground-breaking report profiles the incidence and experiences of homeless people staying with family and friends.

Drawing on interviews with over 150 homeless people, the authors reveal that staying with family and friends is a common homeless situation, in which the majority of homeless people find themselves at some point in time. The reasons why homeless people stay with friends and relatives are explored and staying with friends or family is revealed to be a highly insecure homeless situation characterised by unsuitable and hazardous living conditions. Recommendations are made about interventions required to limit the reliance of so many homeless people on family and friends, as well as how friends and relatives might be better supported to provide suitable and secure accommodation when able and willing.

*Your Place, Not Mine: Homeless People Staying with Family and Friends* is essential reading for anyone concerned with understanding homelessness in the 21st century – policy makers, housing and homelessness professionals, lecturers, teachers and students in housing and social policy.

### How Many, How Much?

Crisis and The New Policy Institute

The problem of single homelessness is not new and has its roots in the *Housing (Homeless Persons) Act 1977*. At its simplest it is about homeless single adults or couples without dependent children and how difficult it is to meet their needs.

Over the years Crisis has worked with, campaigned and lobbied on behalf of this group of people. However as is often the case with excluded populations, there has always been a lack of knowledge about the true scale and cost of single homelessness; in addition to this the introduction of new policy and legislation has created a degree of confusion over the status and rights of single homeless people.

*How Many, How Much?* sets out to close that knowledge gap.

## Home and Dry?

Samantha Howes

ISBN 1 899257 50 0 2002 40pp £7.50

Homelessness and substance misuse are two of today's most pressing social concerns. Both are clearly linked to social exclusion and are closely associated with one another. Despite this and the notable practical work that has been carried out there is still a serious gap in knowledge to guide service delivery and policy development. *Home and Dry?* fills these gaps by exploring the nature and causes of substance misuse and looks at some of the ways that we might begin to tackle these problems. Based on interviews with 389 homeless people and dozens of service providers it is a powerful and comprehensive piece of research, unflinching in its investigations, it has few qualms in drawing the necessary conclusions.

## Hidden but not Forgotten

Oswin Baker

ISBN 1 899257 49 7 2001 32pp £7.50

This ground-breaking report examines the life of over 50 hostel residents. By mapping their experiences not only within the hostel system but also before they became homeless, we have been able to build up what is perhaps the most detailed picture of hostel life today. The report will be required reading for anyone who wants to help shape the response to homelessness in the next decade.

## Publications in the New Solutions to Homelessness series

Crisis' New Solutions research programme is dedicated to identifying the major problems facing homeless people and suggesting innovative responses, designed to enable practical, long-term responses to homelessness.

## Trouble at Home: Family Conflict, Young People and Homelessness

Geoffrey Randall and Susan Brown

ISBN 1 899257 48 9 2001 58pp £7.50

Family conflict is the main immediate cause of homelessness amongst at least two thirds of homeless young people. *Trouble at Home* looks at the causes and the scope for intervening to prevent young people from becoming homeless. Based on case studies with 12 organisations and structured interviews with 150 young people this powerful report identifies opportunities for the development of crisis intervention services, highlighting the role that can be played by the government initiatives. The report goes on to look at the benefits of mediation services and calls for the implementation of a nation-wide network of family mediation services.

## Healthy Hostels: A Guide to Promoting Health and Well-being Among Homeless People

Teresa Hinton, Naomi Evans and Keith Jacobs

ISBN 1 899257 47 0 2000 40pp £7.50

This is the first guide to comprehensively explore health promotion work with homeless. It outlines how housing, resettlement and health workers can promote the health and well-being of homeless people and the most effective ways of working and what resources are needed. The report is a unique attempt to bring together the experience and knowledge gained through current work, with ideas for developing future work with this population. It contains a wealth of material and information and practical examples of health promotion activities. It also outlines the principles of good practice and offers valuable insights into how housing providers can gear up and become more effective in this area.

## Lest We Forget – Ex-servicemen and Homelessness

Scott Ballintyne and Sinead Hanks

ISBN 1 899257 46 2 2000 36pp £7.50

In 1999, up to one in five hostel residents and nearly one in three rough sleepers have been in the Armed Forces. What have the Armed Forces done to stop ex-squaddies put their training to sleep rough into

## HIDDEN HOMELESSNESS

practice? Have the dozens of ex-Service organisations been able to weave an effective safety net? And does the homelessness sector even recognise someone's background in the Forces as a relevant factor? Lest We Forget plugs this information gap and points the way ahead to close down, once and for all, one of the most well-recognised routes into homelessness.

### **Walk on By... Begging, Street Drinking and the Giving Age**

Simon Danczuk ISBN 1 899257 45 4 2000 34pp £7.50

Few issues spark controversy more than begging and street drinking. Should you give? Should you walk past? Should you feel guilty? Or scared? Or angry? When all is said and done, should people really think that they have the right to beg? Drawing on interviews with hundreds of beggars and drinkers, and on dozens of case studies from all over Britain, Walk on By shows how new and imaginative thinking can be translated into lasting solutions both for the community and for the people literally helped off the pavements.

### **Homelessness and Loneliness – The Want of Conviviality**

Gerard Lemos

ISBN 1 899257 43 8 2000 20pp £4.50

Homelessness is about many things – but it is isolation, loneliness and despair which perhaps leave the most damaging legacy. This report seeks to explore this overlooked area and proposes new ways to rebuild people's social networks through mentoring, befriending and family mediation. Ultimately it looks towards the establishment of 'the convivial life' as the key to any successful reintegration into society.

### **A Future Foretold – New Approaches to Meeting the Long-term Needs of Single Homeless People**

Gerard Lemos with Gill Goodby

ISBN 1 899257 35 7 1999 48pp £7.50

This influential report states that homelessness is the

symptom of a multitude of life problems rather than people not having anywhere to live. The author argues that, although homelessness is not a new phenomenon, its causes, characteristics and consequences change frequently and that work done by the Government, and voluntary agencies needs to reflect this changing landscape. The authors argue that multiple causes can make homelessness a future foretold for some people. It makes recommendations to address the barriers currently facing single people in housing need.

# Publications order form

An updated list of publications can be found on our website at [www.crisis.org.uk/publications](http://www.crisis.org.uk/publications). You can order all publications online through our secure payment system or by using the form below – post to: Crisis, 64 Commercial Street, London E1 6LT. Alternatively ring 0870 011 3335.

	Crisis code	Quantity	Price	Total
<b>Homelessness Factfile</b>	HFF/03/P/082	_____	£12.50	_____
<b>Hidden Homeless series</b>				
<b>Your Place, Not Mine</b>	YPN/03/P/082	_____	£7.50	_____
<b>Home and Dry</b>	HAD/02/P/082	_____	£7.50	_____
<b>Hidden but not forgotten</b>	HBF/01/P/082	_____	£7.50	_____
<b>New Solutions publications</b>				
<b>Trouble at Home</b>	TH/01/P/082	_____	£7.50	_____
<b>Healthy Hostels</b>	HH/01/P/082	_____	£7.50	_____
<b>Lest We Forget</b>	LWF/00/P/082	_____	£7.50	_____
<b>Walk on By</b>	WOB/00/P/082	_____	£7.50	_____
<b>Homelessness and Loneliness</b>	HL/00/P/082	_____	£4.50	_____
<b>A Future Foretold</b>	FFT/99/P/082	_____	£7.50	_____
<b>Leaving Homelessness Behind</b>	LHB/99/P/082	_____	£3.50	_____
<b>Prevention is Better than Cure</b>	PBC/99/P/082	_____	£6.50	_____

**Sub-total** \_\_\_\_\_

Bookshop discount\*

Post & packing\*\*

I would like to make a donation to help Crisis' work

**Total** \_\_\_\_\_

\* Please take off 35% discount (25% on single copy order)

\*\* Please add £3.00 post & packing for UK and £5.00 for overseas

Please debit my MasterCard/Visa/Amex/Switch/CAF Charity Card (*delete as appropriate*)

Card number ..... / ..... / ..... / .....

Expiry date (mm/yy)..... / Issue no. (Switch only) .....

Signature .....Date .....

OR

I enclose a cheque/postal order/charity voucher made payable to Crisis UK

OR

Phone the credit/debit card hotline on 0870 011 3335 with your order.

Title ..... First name..... Surname.....

Organisation .....

Position.....

Address.....

..... Postcode.....

Telephone (*please specify: home/business/mobile*) .....

E-mail .....

I would like to receive a complete Crisis publications leaflet; you may alternatively call 0870 011 3335 to request one or visit the Crisis website at [www.crisis.org.uk/publications](http://www.crisis.org.uk/publications)

I would like to be included on Crisis' mailing list to be invited to its conferences (annual Innovations Fair etc)

I do not want to receive information about other Crisis publications

## **HIDDEN HOMELESSNESS:** **Lost Voices**

The invisibility of homeless people  
with multiple needs

Homeless people suffer from extremely high levels of physical and mental ill health. Many are dealing with multiple health problems simultaneously, making them exceptionally vulnerable. However there are enormous obstacles preventing these individuals from accessing appropriate care. Service providers find themselves struggling to prioritise the myriad of competing difficulties. Ensuring care that is meaningful and appropriate is a difficult task across an often-fragmented system. In this research report we examine the lives of single homeless people with multiple health needs, investigate issues related to access to care and services, and look toward the creation of meaningful solutions to the gaps and barriers that currently exist.

This work is critical reading for anyone seeking to understand and address the issues of multiple health needs among homeless persons. Program developers, services providers, and policy makers will find this especially helpful as they strive to create meaningful solutions to complex situations of need amongst the most vulnerable people within their communities.

ISBN 1 899257 52 7

£7.50



**Fighting for hope for  
homeless people**

Crisis  
64 Commercial Street  
London E1 6LT  
Tel: 0870 011 3335  
Fax: 0870 011 3336  
Email: [enquiries@crisis.org.uk](mailto:enquiries@crisis.org.uk)  
Website: [www.crisis.org.uk](http://www.crisis.org.uk)

Crisis UK (trading as Crisis) Charity no. 1082947. Company no. 4024938