HOMELESSNESS AND HEALTH
A NEEDS ASSESSMENT IN THE GREATER GLASGOW HEALTH BOARD AREA
JULY - OCTOBER 1992

A report by
Diane Macmillan
Hilary Miller
Dr John Womersley

Health Information Unit, Department of Public Health,
225 Bath Street, Glasgow, G2 4JT - Telephone 041 248 7644
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SUMMARY

Homeless people form an extremely heterogeneous group - from children living with single parents in unsatisfactory temporary accommodation to traditional vagrants who have begun almost to accept their particular way of life. Between these extremes are older children or young adults who have left their parental home for some reason and who sleep rough or live with friends or relatives from time to time. Families living with other families or in a variety of other temporary accommodation comprise a large group, as do single homeless people living in hostels.

The health needs of these diverse groups are quite different. Highest priority must be given to the families with young children - some of whom are living in lamentable conditions which are likely to be permanently injurious to physical and mental health. Next must be older children, some of whom are pregnant, who are living with other families, or sometimes in hostels, and possibly occasionally sleeping rough. More younger people are now living in hostel accommodation and their needs must also be a priority. For all these groups the aim must be to secure more suitable accommodation as soon as possible, and to provide the support needed to rehabilitate them to a more normal and satisfactory way of life. Until this is achieved it is necessary to ensure that the health services available for people in more fortunate circumstances are not only available but accessible and used by homeless people in these various groups. This is difficult to achieve, particularly for homeless families and homeless children because they move around frequently; without help from other agencies (particularly housing and social work) they may be impossible to identify. Health visitors are almost certainly the most appropriate group to identify, assess the needs of and to act as advocates for these children.

Many hostel dwellers do not consider that they are homeless. Although they might not regard the accommodation as ideal, the company and facilities meet much of their needs. In the opinion of the community psychiatric nurse for hostels many hostel dwellers would benefit from active intervention to rebuild self-esteem and self worth, and to begin to absorb and possibly to discuss the options available for living elsewhere - for example in group tenancies with facilities for washing and laundry etc. In time residents begin to gain the confidence to speak to and eventually talk openly to the nurse. For some, particularly the older single people living in hostels, rehabilitation is unlikely to be successful and the main concern is ensuring adequate access to health care for both long-term and acute conditions when it is needed. These individuals however will only be identified by offering help to all. Because there is often a distaste among health professionals to providing it, the way in which services are delivered needs to be tailored to the particular needs of the group. This requires better understanding of the health care needs of the group and greater willingness to provide outreach services directly to hostels and other facilities used by single homeless people. Hostel dwellers should therefore be targeted by professionals who wish to improve both health and social outcomes. This is only likely to be achieved if the professional has a specific remit to hostel dwellers and would not be achieved if this client group was an element competing within an existing caseload, because their priority would most likely be low.
Methodology

The components of the assessment process were as follows:

1. Identification of locations of accommodation and facilities for homeless people from a wide range of sources.

2. Interview/questionnaire survey of 40 managers of hostels and other facilities for homeless people.

3. Identification by health visitors of 260 homeless families living in temporary accommodation and a survey of 72 of these.

4. Interview/questionnaire survey of the managers of two day centres and of temporary accommodation for rough sleepers.

5. Discussion with health visitors with a special interest in homeless families.

6. Discussion with a health visitor with a special interest in travelling people.

7. Analysis of statistics from the Scottish Office.

8. Analysis of statistics from Hamish Allan Centre.

9. Discussions with two consultant psychiatrists and one consultant in mental handicap followed by a written request to all consultants in mental illness and handicap for information about homeless people.

10. Discussions with the community psychiatric nurse with special responsibility for hostel dwellers under the age of 65 years living in hostels in East Glasgow.

11. Discussions of the research findings of one general practitioner.

12. Interrogation of the Community Health Index and Standard Immunisation Recall System in order to identify children living in Bed and Breakfast accommodation and determine the immunisation status and other characteristics of children living in Bed and Breakfast and other temporary accommodation.

Scale and type of homelessness

At the time of the survey (around September 1992) the numbers of people in the various categories of homelessness were as follows:

* Homeless families (housing department) at end of 1991 - 1,970
  (for detail see table overleaf)

* Hostel dwellers 2,085

* ‘Rough sleepers’ (approx) 150
* Abused women (with or without children) 40+
* Pregnant girls in special accommodation 10
* Travelling people (approx) 250

Number of homeless families (Housing Department) at end of 1991

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<tr>
<td>Single parents age 26-64</td>
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<td>Families with children age &lt;5</td>
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<tr>
<td>Families with children age 5+</td>
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<td>Families with children age 16+</td>
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<td>Single people age 16-25</td>
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<td>Single people age 26-65</td>
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<tr>
<td>Couples age &lt;65</td>
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<tr>
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<td>Others</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1,970</strong></td>
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Source: Anne Taylor, Strategy Group, Housing Department, Glasgow District Council.

**Particular local problems**

Overcrowded households, traditionally high levels of alcohol abuse and violence, high rates of unemployment and the very high and steadily increasing rate of illegitimate births all contribute to the extent and severity of the problem of homelessness in Greater Glasgow.

**Physical and mental health problems encountered**

**Homeless families**

In the majority of cases the living environment was unhealthy and unsuitable for bringing up children due to factors such as overcrowding (43% of households), inadequate heating, poor home safety, dampness, inadequate facilities or unreasonable behaviour on the part of a landlord. As a result many mothers were under stress, anxious and depressed and over 25% of children were said to have a behavioural disturbance. 76% of respondents smoked.

**Hostel dwellers**

The majority of hostel dwellers have health problems such as alcohol or drug abuse,
behavioural abnormalities or physical illness and disability. The prevalence of mental health problems (as distinct from alcoholism and drug addiction) is relatively low. Many of the reported behavioural problems are likely to be attributable to the environment rather than to the hostel dwellers themselves. Since those who can be rehabilitated are more likely to move out, the hostels are likely always to accommodate a hard core of people with severe problems. The survey of all residents at present being conducted in two hostels by John Atkinson will provide more accurate data for the prevalence of health problems in a few months time. This research should also identify the numbers of hostel dwellers who have been discharged from psychiatric hospitals.

Rough sleepers

The prevalence of mental and physical health problems is almost certainly greater than in the hostel population.

Young single homeless

Mainly problems with physical health, and pregnancy.

Initiatives taken

Health Service

Community psychiatric nurse for East sector hostels (65 years of age and under)

This is the most significant development. The aims of the service include identification of need, referral to and coordination of caring agencies, training staff in mental health, provision of advice and counselling and an advocacy role. Nine hostels were visited regularly by the community psychiatric nurse.

Consultant outreach work

One consultant psychiatrist holds consultations with individual clients and provides advice and support for staff at a hostel and at a day and night ‘drop in’ centre.

General practitioner outreach work

General practice surgeries are held in three locations (Kingston Halls accommodation for single homeless and rough sleepers, Calderbank House Hotel and the DSS Resettlement Unit). As a result there is no difficulty in obtaining routine or emergency general practitioner services, or in access to acute general hospitals in an emergency. However difficulties in accessing mental health services remain. Also, it was felt important to have a relatively small number of general practitioners on a duty roster so that some degree of continuity of care could be ensured.

District nursing/health visiting

District nurses visited hostels as required, although in five hostels regular weekly or even more frequent visits were made. Four hostels received regular visits from the health visitor,
usually to provide information and advice for groups of people. There may be a need for more counselling of individuals.

**Chest X-ray service**

A small proportion of hostel dwellers take advantage of the £5 food voucher scheme to encourage them to have a chest X-ray at the static unit in Cochrane Street. The mobile facility which visited hostels in the past has been disbanded.

**Other agencies**

**City Centre Initiative**

This is organised by Glasgow Council for the Single Homeless, YMCA, SRC Education and Social Work departments. Its aim is to help people mainly in the 15 to 25 year age group who have no accommodation.

**Talbot Association Supported Accommodation**

These are two projects for women with addiction and alcohol or drugs.

**The Red Cross**

Volunteers are provided to assist with bathing, haircutting, shaving and providing changes of clothing for residents of the Great Eastern Hotel.

**Monitored Dosing System**

This is a joint venture by the Talbot Association and Boots Pharmaceuticals to facilitate administration of the correct doses of drugs at the correct intervals.

**The Board’s involvement in inter-agency or interdisciplinary approaches**

The main and possibly sole inter-agency activity is the transfer of information about homeless families with young children between the housing department and community nurses, and between social work and community nurses. The objective is to try to ensure that children in homeless families receive the same level of services (e.g., immunisation, child surveillance and management of special needs) as other children. Unfortunately this information is often not passed for reasons of ‘confidentiality’, and as a result - as the small survey of children in temporary accommodation shows - their children ‘slip through the net’.

No examples of interdisciplinary working within the Health Board were identified.
Conclusions and recommendations

These are specified in more detail in section 11. In summary they comprise:

* Establishing a multidisciplinary health monitoring group.

* By greatly extending the health care input from community psychiatric nurses and consultant psychiatrists particularly those in hostels and those using facilities provided for rough sleepers. Homeless people with mental health problems require support, counselling and assistance with medication.

* Providing adequate training for hostel staff in the management of mental health problems.

* Giving specific health visitors in particular areas responsibility for assessing the health care needs of homeless and travelling people, for coordinating services and for advocacy purposes.

* Encouraging more general practitioners to provide consultation sessions in hostels and to help staff to deal effectively with health problems which arise.

* Establishing a satisfactory transfer of information between agencies about families with children who are homeless.

* Improving the attitudes of health service professionals to the problems and needs of homeless people.

Postscript

After the first draft of the report had been completed, a meeting was held of some of those who had contributed to the work:

1. John Atkinson - District Nurse Specialist in the homeless, Glasgow Polytechnic.

2. Alice Docherty - Community Psychiatric Nurse, Mental Health Unit, Eastern Sector.


4. Elaine Haddow - Hamish Allan Centre.

5. Diane Macmillan - Health Information Unit, GGHB Department of Public Health.

6. Hilary Miller - Health Information Unit, GGHB Department of Public Health.
Very early on in the meeting and throughout its progress a polarisation of views emerged. Some members were keen to provide services to homeless people, particularly hostel dwellers, as a special case. Others condemned this as 'ghettoisation'. This difference appeared to derive from differences in the philosophies of agencies concerned rather than being based on an objective appraisal of what was needed in a particular set of circumstances. One of the central aims of health and social services however is to identify, sensitively and fairly, groups of the population which have particular needs and to try to meet them. It is therefore their responsibility to ensure that as far as possible the needs of these groups are met, and sometimes it will be necessary to make special provisions in order to achieve this. This responsibility must not be obscured by ideological arguments.

Hostel dwellers should not however be regarded as a stable and different people for whom there is little hope and for whom the provision of special services may be seen as official recognition that theirs is a permanent and acceptable state. Rather efforts have to be made to ensure that they are included as recipients of all necessary services by sensitive assessment of needs, facilitating access and by creating appropriate networks of support. If this approach is adopted more rather than less opportunity will become available for hostel dwellers to transfer to more suitable accommodation elsewhere.
Section 1: INTRODUCTION

It is a popular conception that homelessness is an avoidable state which is chosen by the people it affects. However in reality homelessness can be caused by a great variety of problems including relationship breakdown, physical violence, sexual abuse, mental abuse, bereavement, financial problems, addictions or a combination of several of these. Other problems which can cause homelessness particularly in young people are failed tenancy (due to rent arrears, failure to maintain property etc), offences, or release from care, prison or hospital. Overcrowded, damp or otherwise unsuitable housing can also be the initial cause of losing a permanent home and the resulting state of homelessness can lead to further social, emotional and physical problems.

There are many situations in which people can be considered to be homeless. The most obvious is where people are roofless or have no fixed abode. Often these people are thought of as tramps and vagrants. However this group does not represent the majority of homeless people although they may be the most visible.

People who have a roof over their heads but who are homeless may be living in hostels for the single homeless, supported housing projects, caravans or in temporary facilities such as bed and breakfast accommodation or furnished flats. Another possibility which is harder to quantify is that of single people and families having to find shelter with relatives and friends, doing the rounds and staying as long as welcome. This cycle may be interspersed with periods of rough sleeping or seeking places in voluntary or council projects.

The term 'hidden' homelessness is used to describe those whose homelessness is not recognised as such. It is most often used in connection with women trapped in a violent or abusive relationship. Hidden homelessness also encompasses people staying 'care-of' friends or relatives.

The following report examines the problem of homelessness in Glasgow, including the help available for homeless people. It describes the particular health care needs of different sectors of the homeless population and considers the delivery of health services to them.
Section 2: PROFILE OF HOMELESSNESS IN GREATER GLASGOW

SECTION 2.1: Homelessness and the law

The Housing (Scotland) Act 1987 defines an applicant as homeless under the following circumstances:

.. He has no accommodation.

.. There is no accommodation which he
   (a) is entitled to occupy by virtue of an interest in it.
   (b) has a right or permission to occupy.

.. He has accommodation but
   (a) he cannot secure entry to it, or
   (b) it is probable that occupation will lead to violence from another resident, or
   (c) it is a mobile home and there is no place where he is entitled to place it or reside
       in it, or
   (d) it is overcrowded and may endanger the health of the occupants.

.. A person is threatened with homelessness if it is likely he will become homeless in 28 days.

However, being homeless or threatened as homeless is only the beginning for those who seek to be housed. Next they must be considered to be in priority need, ie:

.. a pregnant woman or a person with whom a pregnant woman resides, or

.. a person with whom dependent children reside, or

.. a person who is vulnerable as a result of old age, mental illness or handicap or physical
   disability or other special reason, or

.. a person who is homeless as a result of an emergency such as a fire, flood or other
   disaster.

If an applicant is not in priority need then the local authority is not bound to do more than offer help and advice in finding accommodation. Those in priority need must satisfy two further conditions - they must not be intentionally homeless (for definition see box 2a) and must have a local connection (for definition see box 2b).

Box 2a

A person becomes intentionally homeless if he deliberately does or fails to do anything in consequence of which he ceases to occupy accommodation which is available for his occupation.
A person has a local connection with a district

(a) because he is, or in the past was, normally resident in it and his residence in it was of his own choice, or
(b) because he is employed in it, or
(c) because of family associations, or
(d) because of any special circumstances.

Applicants who do not have a local connection may be referred to an authority with which they do have a connection. In a situation where the applicant is judged to be intentionally homeless the local authority is not obliged to provide permanent accommodation (although it may do so) but rather makes an offer of temporary accommodation (usually for a period of 7 days) until the applicant can make other arrangements.

When all conditions of unintentional homelessness, priority need, and a local connection have been met, the local authority has a statutory duty to rehouse.

2.2: Referral system for the homeless

A diversity of accommodation exists in Glasgow for those who find themselves homeless. These establishments are run by several organisations both statutory and non-statutory. Some of the charitable, commercial or independent organisations accept self-referrals or operate an open door policy. Referrals can also be made between organisations or by the Social Work Department.

A large proportion of places available for the homeless are within large hostels, eight of which are run by the Glasgow District Council. It is widely recognised that this is not a suitable environment for those who are vulnerable.

In recognition that advice and assistance on offer to single people was inadequate and that increasing numbers of young single people were being accommodated in large hostels which were clearly unsuitable, the Hamish Allan Centre was opened by Glasgow District Council in 1989. Its objectives were to:

.. ensure appropriate advice and assistance for all single homeless people.

.. refer people to appropriate agencies and accommodation.

.. establish a single entry point into the hostels.

.. consult with appropriate agencies re need and provision.
The Hamish Allan therefore provides a referral system for the council hostels and tries to ensure that placement is appropriate to the needs of each individual. This may mean referral to other agencies or placement in furnished emergency flats. The Centre has short term accommodation for 17 single people and a similar number of families. One of the council hostels, Bell Street, can be used as an open access hostel in emergencies.

2.3: Support Network

Due to the complicated nature of the problems of those who find themselves homeless, the system designed to cope with them should be both flexible and comprehensive. There is a large network of groups which fulfil certain functions. These include umbrella organisations such as the Glasgow Council for the Single Homeless, and the Strathclyde Poverty Alliance which raise the profile of the plight of homeless people. However there are a lot of gaps. The Social Work Department also have a strong involvement with the problem of homelessness and have a Homeless Team located in offices in Osborne Street. They provide advice and practical assistance (e.g., referrals to accommodation) to those who find themselves homeless.

One of the main provisions for the single homeless in Glasgow is in the form of hostels. Some of these are custom built or converted but others originated as working men’s hostels which were built when Glasgow was developing as an industrial centre. Over the years the clientele has changed and now the hostels have become home to a wide cross-section of people. It still includes some working people who are happy in this type of accommodation. However, the hostels main function is that of housing those who have nowhere else to go, or who would not wish to go anywhere else. In addition, hostels provide accommodation for those who are waiting for allocation to mainstream housing.

Within the hostel network there are some specialist enterprises. These have evolved because of the recognition that hostels were not an appropriate environment for certain vulnerable groups such as young people and those with special needs. There are residential projects providing accommodation with 24 hour staff cover and housing projects which would generally have a lower level of support. This supported accommodation tends to be on a smaller scale with a smaller staff/resident ratio. The aim of these projects is mainly rehabilitation into mainstream accommodation. There is also provision for homeless women with alcohol problems, e.g., the Simon Community has a house with a space for six women. This is not a ‘dry’ project but one which aims for damage limitation.

There are several types of organisations involved in the provision of accommodation for the single homeless: statutory, voluntary and commercial.
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Groups like The Salvation Army and The Talbot Association run soup kitchens for those who sleep rough and the City Centre Initiative offers advice and support to the young people who gravitate towards the centre of Glasgow. The Simon Community and The Wayside Club also contribute to facilities for this group. There are several mainstream groups which have a wider client group but encompass many homeless such as The Richmond Fellowship, The National Schizophrenic Fellowship Scotland, The Glasgow Council on Alcohol, The Glasgow Association for Mental Health, and The Red Cross.

2.4: Estimate of extent of homelessness in Greater Glasgow

In the absence of a comprehensive system of collecting information on homelessness it is very difficult to estimate the scale of the problem with any degree of accuracy. It is apparent however that for some groups there is more information available than for others. Statistics are collected on households which apply to local authorities as homeless and on single homeless people who present themselves as homeless at the Hamish Allan Centre. These figures are presented in (i) and (ii) below. The homeless people who are harder to quantify are single people living in hostels, rough sleepers, travelling people, people with mental health problems and women who are experiencing hidden homelessness. These are covered in (iii) to (vii) below.

(i) **Scottish Office Statistics**
Local authorities in Scotland submit two annual returns about homelessness to the Scottish Office. The Scottish Office Information Directorate publishes the figures for all areas of Scotland from which Greater Glasgow Health Board area statistics for 1990/91 can be derived as follows. (Note that rounded percentages were used to derive figures which were then rounded to integers. Thus discrepancies with totals may occur).

Of an estimated 381,750 households in Greater Glasgow, there were 10,669 households applying as homeless. Case returns were submitted to the Scottish Office in 9,786 cases.
6,379 households were assessed as being actually or potentially homeless. The reason for loss of accommodation given by the applicants are given in Table 2a.

Table 2A: Reasons for homelessness given by families applying to the local authority for accommodation

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<thead>
<tr>
<th>Reason</th>
<th>Numbers</th>
<th>Percentages</th>
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<td>Friends or relatives no longer willing or able to accommodate</td>
<td>4,492</td>
<td>46%</td>
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<tr>
<td>Dispute with spouse or co-habitee</td>
<td>2,999</td>
<td>31%</td>
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<tr>
<td>Court Orders (including mortgage defaults)</td>
<td>264</td>
<td>3%</td>
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<tr>
<td>Action by landlord</td>
<td>211</td>
<td>2%</td>
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<tr>
<td>Other reasons</td>
<td>1,767</td>
<td>18%</td>
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<tr>
<td><strong>Total</strong></td>
<td>9,733</td>
<td>100%</td>
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The type of households applying as homeless are as shown in Table 2B.

Table 2B: Types of homeless families applying for local authority accommodation

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<th>Age</th>
<th>Number</th>
<th>Percentage</th>
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<td>One Person</td>
<td>&lt;18 years</td>
<td>1,224</td>
<td>12%</td>
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<td>18-24 years</td>
<td>1,595</td>
<td>16%</td>
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<td>25-64 years</td>
<td>2,439</td>
<td>25%</td>
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<td>65+</td>
<td>293</td>
<td>3%</td>
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<tr>
<td>One Parent</td>
<td>&lt;26 years</td>
<td>1,069</td>
<td>11%</td>
</tr>
<tr>
<td></td>
<td>&gt;26 years</td>
<td>2,208</td>
<td>22%</td>
</tr>
<tr>
<td>Couple with Children</td>
<td>-</td>
<td>234</td>
<td>2%</td>
</tr>
<tr>
<td>Couple without Children</td>
<td>-</td>
<td>810</td>
<td>8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>9,872</td>
<td>99%</td>
</tr>
</tbody>
</table>

The largest groups were single homeless aged 25-64 and single parents aged over 26.

*There were 3,865 households assessed as being in priority need. Further details are shown in Table 2C.*
Table 2C: Type of priority applications of homeless families for local authority accommodation

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unintentionally</td>
<td>2,528</td>
<td>65%</td>
</tr>
<tr>
<td>Intentionally</td>
<td>298</td>
<td>8%</td>
</tr>
<tr>
<td>Potentially</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homeless</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unintentionally</td>
<td>947</td>
<td>25%</td>
</tr>
<tr>
<td>Intentionally</td>
<td>92</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>3,865</td>
<td>100%</td>
</tr>
</tbody>
</table>

Those households where homelessness or potential homelessness was unintentional comprised 90% of those in priority need.

The provision made for those in priority need is described in Table 2D.

Table 2D: Types of family in priority need which were found accommodation

<table>
<thead>
<tr>
<th></th>
<th>Permanent accommodation found</th>
<th>Short stay accommodation found</th>
<th>Neither</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single persons</td>
<td>546 (61%)</td>
<td>157 (17%)</td>
<td>194 (22%)</td>
<td>897</td>
</tr>
<tr>
<td>Single parents</td>
<td>1,776 (77%)</td>
<td>64 (3%)</td>
<td>471 (20%)</td>
<td>2,311</td>
</tr>
<tr>
<td>Couples</td>
<td>490 (74%)</td>
<td>33 (5%)</td>
<td>136 (21%)</td>
<td>659</td>
</tr>
</tbody>
</table>

Permanent accommodation was found for 61% of single persons, 77% of single parents and 74% of couples. It is not clear whether those who did not secure accommodation were in priority need or not.

(ii) Hamish Allan Centre Statistics
The Hamish Allan Centre is now ideally placed to collect statistics on homelessness in Glasgow. Data collected throughout 1991 and detailed in box 2c shows that there were nearly 9,000 "presentations" for accommodation in that year. "Presentations" is the word used to describe those who have been referred to the Hamish Allan Centre by housing, social work or self. This figure includes those who found themselves without anywhere to stay on more than one occasion.
Box 2c

<table>
<thead>
<tr>
<th>Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of presentations at Hamish Allan</td>
<td>6,229</td>
</tr>
<tr>
<td>Number of presentations at Bell Street</td>
<td>2,499</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8,728</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Under 18’s presentations</strong></td>
<td></td>
</tr>
<tr>
<td>First time presentations</td>
<td>617</td>
</tr>
<tr>
<td>Non-first time presentations</td>
<td>1,327</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,944</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Over 18’s presentations</strong></td>
<td></td>
</tr>
<tr>
<td>First time presentations</td>
<td>2,869</td>
</tr>
<tr>
<td>Non-first time presentations</td>
<td>3,915</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6,784</strong></td>
</tr>
</tbody>
</table>

Source: Hamish Allan Centre

Statistical breakdown is available for the first time presentations which totalled 3,486 in 1991.

Following interview, those presenting themselves at the Hamish Allan were categorised into the priority groups as shown in box 2d (not mutually exclusive).

Box 2d

<table>
<thead>
<tr>
<th>Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 16/17</td>
<td>603</td>
</tr>
<tr>
<td>Age 60+</td>
<td>112</td>
</tr>
<tr>
<td>Vulnerable</td>
<td>849</td>
</tr>
<tr>
<td>Separated from spouse</td>
<td>259</td>
</tr>
<tr>
<td>No priority</td>
<td>2,225</td>
</tr>
<tr>
<td>With local connection</td>
<td>3,030</td>
</tr>
<tr>
<td>Without local connection</td>
<td>276</td>
</tr>
<tr>
<td>Ex-offender</td>
<td>63</td>
</tr>
</tbody>
</table>

Source: Hamish Allan Centre

The remaining statistics are broken down by age - over 18 and under 18 being the two separate categories. The reasons for homelessness amongst the 3,486 were

<table>
<thead>
<tr>
<th>Description</th>
<th>18+</th>
<th>16/17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evicted by friends</td>
<td>304</td>
<td>28</td>
<td>332</td>
</tr>
<tr>
<td>Evicted by relatives</td>
<td>952</td>
<td>288</td>
<td>1,240</td>
</tr>
<tr>
<td>Released from hospital/prison</td>
<td>228</td>
<td>4</td>
<td>232</td>
</tr>
<tr>
<td>Fleeing violence</td>
<td>89</td>
<td>46</td>
<td>135</td>
</tr>
</tbody>
</table>
Separated from spouse 320 0 320
No Fixed Abode/others 287 100 387
Not homeless 270 4 274
Gave up accommodation 239 1 240
Financial 46 30 76
Evicted from hostel 128 0 128
Behaviour 4 113 117
Previously in care 0 1 1
Recently left care 0 0 0
Sexual abuse 0 2 2

The type of previous accommodation was also noted.

<table>
<thead>
<tr>
<th>Type of Accommodation</th>
<th>18+</th>
<th>16/17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private hostel</td>
<td>165</td>
<td>8</td>
<td>173</td>
</tr>
<tr>
<td>Private rented</td>
<td>319</td>
<td>4</td>
<td>323</td>
</tr>
<tr>
<td>GDC rented</td>
<td>835</td>
<td>1</td>
<td>836</td>
</tr>
<tr>
<td>NFA</td>
<td>86</td>
<td>8</td>
<td>94</td>
</tr>
<tr>
<td>Prison</td>
<td>129</td>
<td>0</td>
<td>129</td>
</tr>
<tr>
<td>Child care</td>
<td>0</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Hospital</td>
<td>50</td>
<td>0</td>
<td>50</td>
</tr>
<tr>
<td>Owner occupied</td>
<td>78</td>
<td>0</td>
<td>78</td>
</tr>
<tr>
<td>Parental home</td>
<td>616</td>
<td>374</td>
<td>990</td>
</tr>
<tr>
<td>Others</td>
<td>504</td>
<td>214</td>
<td>718</td>
</tr>
<tr>
<td>GDC hostel</td>
<td>86</td>
<td>1</td>
<td>87</td>
</tr>
</tbody>
</table>

Of all presentations during 1991, 5,484 (63%) were from Glasgow, 807 were from outside Glasgow and 221 were from outside Scotland. Intervention is required by the Hamish Allen only if there is a local connection.

(iii) **Single homeless people living in hostels**
A survey of the hostels (described in section 3) showed that there were 2,328 beds of which 2,085 (90%) were occupied. Some indications of the age and sex distribution of these homeless people can be obtained by analysis of data from the Community Health Index (see Appendix 1).

(iv) **Rough Sleepers**
Estimates on the number of rough sleepers vary (see Section 4), and the actual number will depend on factors such as the season. 150 might be a reasonable estimate of the average. The mobility and unpredictability of this group makes it very difficult for an accurate count to be taken. Locations (eg, Kingston Bridge area, Anderson Bus Station) frequently used by rough sleepers are known to outreach workers but there are others not known which may include derelict buildings or back alleys.

(v) **Travelling people**
Under the law travelling people are only homeless if they cannot find somewhere to ‘pitch’ their accommodation and in fact many would not view themselves as homeless. It has been estimated that there are probably 100-300 travelling people residing within the Greater Glasgow Health Board area at any one time. At present there is only one official site, at Kenmuirhill, Carmyle. This site has room for 20 families. During 1990 a health visitor made
regular visits to the site, at which time there were only 10 families there as 10 pitches were awaiting upgrading. These families comprised 15 adults and 32 children ranging from one year to 17 years of age. This is the most recent information available. Three new official sites are proposed which would result in the provision of space for 55 families in all - this being the target set by the Advisory Committee for Scotland's Travelling People.

(vi) People currently under the care of psychiatrists or consultants in mental handicap

One consultant psychiatrist, Dr Dallas Brodie, is currently undertaking a casesheet study of the mental health problems of 104 hostel dwellers who are under psychiatric care. Twenty-seven of these are on the caseload of the community psychiatric nurse for the East Sector. The cases had been identified by maintaining regular contact with hostel managers - as a result of which it was "possible gradually to get to know all the inmates, very few or none at all having hidden mental health problems". Dr Brodie felt that there is no significant hidden psychiatric need among hostel dwellers. What is needed is more trained staff to deal with the problems which have been identified.

A second consultant psychiatrist and a consultant in mental handicap were approached by Dr Womersley (Consultant in Public Health Medicine) to seek their assistance in identifying homeless people on their case lists. Both consultants worked in the East sector of Glasgow. Six individuals were identified by the former (5 men and one woman aged between 35 and 61 years) and four (all male) by the latter.

<table>
<thead>
<tr>
<th>Sex</th>
<th>Diagnosis</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>Schizophrenia/Mental Handicap</td>
<td>Sleeps rough, mostly Buchanan St Bus Station.</td>
</tr>
<tr>
<td>M</td>
<td>Schizophrenia</td>
<td>Calderbank (Talbot Association)</td>
</tr>
<tr>
<td>M</td>
<td>Schizophrenia</td>
<td>Kirkhaven (C of S Hostel)</td>
</tr>
<tr>
<td>M</td>
<td>Schizophrenia/Depression</td>
<td>Balfour Sclare House (GAMH)</td>
</tr>
<tr>
<td>M</td>
<td>Schizophrenia</td>
<td>Balfour Sclare House (GAMH)</td>
</tr>
<tr>
<td>F</td>
<td>Depression</td>
<td>Swanston St Caravan Site</td>
</tr>
</tbody>
</table>

Mental Handicap

One under a Guardianship Order at present in Riddrie Hostel; one sheltered at present by his mother; one in a homeless unit; and one who is homeless because of his wife throwing him out of the family home, and who had been admitted to the Royal Infirmary with a drug overdose.

Each consultant wrote to his colleagues in other sectors to ask whether they knew of further cases. Three other cases were identified in the West: one a thirty-eight year old man with a personality disorder and who is currently an inpatient in Gartnavel, a second who is also
an inpatient there (no age or diagnosis available), and a third who is a chronic schizophrenic of unknown age who sleeps rough in the grounds of Gartnavel Royal.

There are about 50 consultant psychiatrists and 6 consultants in mental handicap in Glasgow. If each had been approached on a personal basis rather than by letter many more cases would almost certainly have been identified.

These findings should be interpreted on the context of the recent report (1991) of the Mental Welfare Commission for Scotland on its visits to Glasgow.

"The visit to single homeless projects and to the association providing night shelter facilities illustrated a range of concerns about the relationship between mental disorder and homelessness, particularly for those discharged from hospital. A general lack of liaison with mental health services was reported, as well as an increase in 'new' mentally ill people using such facilities.

The position of people with mental disorders in hostel accommodation was regarded as precarious. They were felt to be at times open to exploitation, as well as being misplaced in terms of their long-term health and social care needs. In particular the lack of appropriately trained staff in housing and hostel facilities to deal with mental illness was noted.

At a residential resettlement unit providing 77 places, 11 residents with a history of mental illness were interviewed. Eight of the 11 had been in a psychiatric hospital during the last year and 7 of the 11 were taking medication. There was no community psychiatric nurse or Mental Health Officer/social work contact within the unit, and medical treatment was provided by a general practitioner. All 11 residents interviewed were homeless and few expressed any definite plans for rehousing.

Further discussions are being sought with the Special Needs Section of the Directorate of Glasgow District Council Housing Department".

(vii) Hidden homelessness

Hidden homelessness is even more difficult to quantify. Many of the hidden homeless are women who do not have their own tenancy and may as a result be trapped in a relationship. These women may not be accepted as a priority case or may be on a long waiting list for housing. The extent of the problem and the difficulties of the women it affects is explored in a study conducted by Sarah Webb for the Glasgow and Scottish Councils for the Single Homeless due to be published in October 1992. In this study a total of 5,400 women (with or without children) were awaiting Glasgow District Council accommodation because they were having to share with another household. In addition there were 90 with no fixed abode.

The presumably very small proportion of such women who have sought refuge from physical, mental or sexual abuse may seek help from organisations such as Women's Aid or SAY Women (Sexually Abused Young women). Women's Aid provides 'refuge' accommodation for about 50 single women or women with families in different parts of the city. SAY Women provides semi-supported accommodation for three young women in the age group 16 to 21 years for periods of up to two years; they may be self-referred, or referred by social workers, health visitors or general practitioners for example. Victims are helped to find their tenancy and to procure employment.
(viii) Health visitor survey of families in temporary accommodation
In a separate survey (Section 6) health visitors identified a total of 1,062 people living in temporary accommodation - 545 adults, 455 children and 62 of unknown age. These were mainly families with young children.

In all of the above groups the numbers given are unlikely to show the full extent of the problem as it is not easy to identify homeless people no matter which type of accommodation they are resident in.
Section 3: ASSESSMENT OF THE HEALTH CARE NEEDS OF THE SINGLE HOMELESS

3.1: Methodology

Information on health needs and access to services in all of the above types of accommodation was sought through a questionnaire (see Appendix 2). Because of time and the difficulties of obtaining this information directly from homeless people, a survey was conducted amongst the managers of hostels and certain other facilities. A survey is however being conducted of individual homeless people in two hostels at present by John Atkinson (see Section 8 for details). The word hostels will encompass both hostels and residential projects throughout this chapter.

The first step in the construction of the questionnaire was to find out which questions would be relevant. In order to do this those who work on a day to day basis with the homeless were approached for their perspective on the health care needs of their clients. Their knowledge and suggestions were pooled and incorporated into the questionnaire. This process had the added advantage that it afforded the opportunity to establish a link and mostly resulted in an agreement to participate in the health needs assessment. On the whole the managers were very enthusiastic and expressed great interest in the questionnaire.

In order to ensure a high response rate, a face to face interview was conducted. The act of going to visit the hostels also put the answers to survey questions into context. For one reason or another, however, it was not always possible to visit the hostels and on these occasions the questionnaires were sent by post. Understandably, a lot more useful background information was gained from the interviews.

3.2: The survey of hostels

Thirty-seven surveys were conducted between 4th August and 2nd September. Four postal surveys were not returned. The survey analysis here covers 34 hostels. Two returns from The Innocents and one from the Talbot Association (Kingston Halls) are considered separately, The Innocents because they deal only with pregnant women and the Kingston Halls because they are included in the section on rough sleepers.

The available beds totalled 2,328. During the survey 2,085 of these were in use. This is equivalent to a 90% occupancy rate but it must be remembered that the survey was conducted during the summer months.

The following organisations had hostels or projects included in the survey.

No. of survey returns

| Blue Triangle       | 5  |
| Church of Scotland | 1  |
| Civil Service      | 1  |
| Commercial         | 2  |
| District Council   | 9  |
Glasgow Council for Single Homeless 1
Independent 2
Queens Cross Housing Association 1
Salvation Army 3
Simon Community 3
Talbot Association 3
YMCA 3

TOTAL 34

66% of beds (10 hostels) were specifically for males, 7% (7 hostels) for females and 27% of beds (17 hostels) were in mixed hostels or projects.

The number of beds in the residences varied between 5 and 253.

(i) Registration with general practitioners
The hostel managers who filled in the questionnaire were asked about the hostel policy on registration of customers with general practitioners. In six cases there was no policy, usually where hostels were trying to rehabilitate residents back to independence. Managers did not feel that a policy would be appropriate because the residents were being trained for independent living. There was also an element of protection of their rights to have freedom of choice. In three hostels it was compulsory to register with a particular general practitioner and in two hostels it was compulsory to register with a general practitioner but it was up to the individual to choose which one. This usually occurred where managers wished to ensure that treatment would be available if an emergency situation arose. Twenty-three hostels actively encouraged residents to register and 18 of these recommended a particular general practitioner or health centre. Hostels usually recommended a health centre or general practitioner which was either nearby, easy to get to or known to be sympathetic towards the needs of their residents. In one particular place for young people some of whom worked, it was pointed out that the residents had a preference for a doctor who was more understanding than most with regard to sick lines.

(ii) Formal and informal links with general practice
Twenty-four (71%) of the hostels had a link with a certain general practitioner or health centre. These links were mainly unofficial although a few places had agreed levels of service from a local health centre or general practitioner. It was more common that a gradual relationship had built up between the hostel and the local health centre which the hostel managers had come to view as a link. The relationships had generally built up over a number of years. Of the 25 hostels which experienced no difficulty in registering clients with general practitioners, 19 had the kind of link described above. Seven hostels claimed that certain general practitioners resisted attempts to register some clients.

It was quite common for people to be registered as temporary patients. Reasons for this varied e.g. a person with a record of not keeping appointments or thought to be potentially abusive could encounter difficulty in becoming permanently registered. Some clients could not register because they were registered somewhere else even though the other general practitioner might be inaccessible. In these cases it was not always sensible to change the general practitioner as the client expected to move back to their own area. The general practitioner's payment for temporary registration is slightly higher than for a permanent registration.
(iii) Level of registration
Overall, 1,659 of the 2,085 people that the survey covered were registered with a general practitioner, an equivalent of 79.5%. The effect of the policy on general practitioner registration on the number of people registered is illustrated in Table 3A.

Table 3A: Effect of policy on general practitioner registration

<table>
<thead>
<tr>
<th>Policy</th>
<th>No. of residents</th>
<th>No. registered</th>
<th>% registered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compulsory to register with a particular GP</td>
<td>303</td>
<td>277</td>
<td>91.4%</td>
</tr>
<tr>
<td>Compulsory to register with a choice of GP</td>
<td>40</td>
<td>40</td>
<td>100 %</td>
</tr>
<tr>
<td>Encouraged to register with a particular GP</td>
<td>981</td>
<td>772</td>
<td>77.8%</td>
</tr>
<tr>
<td>Encouraged to register with own choice</td>
<td>580</td>
<td>447</td>
<td>77.1%</td>
</tr>
<tr>
<td>No policy</td>
<td>181</td>
<td>123</td>
<td>68 %</td>
</tr>
<tr>
<td>TOTALS</td>
<td>2,085</td>
<td>1,659</td>
<td>79.5%</td>
</tr>
</tbody>
</table>

The table shows that where there was an attitude of non-intervention, 68% were registered. The places where it was compulsory to register with a particular general practitioner or with a choice of general practitioner achieved registration rates of 91.4% and 100% respectively. The largest group were those who were encouraged to sign up with a local or recommended general practitioner and 78.7% of them were registered. It was pointed out that claims of registration are not always validated. For example, one man had stated that he was registered but his general practitioner turned out to be in Edinburgh. Another wished to continue with his general practitioner even though he had to travel to Lanarkshire.

The Community Health Index was used to identify hostel residents who were registered with a general practitioner. The proportion registered varied between 3% in short stay accommodation and 480%, with many hostels recording over 100%. Data for individual hostels are given in Appendix 1. Clearly many of the records on CHI relate to people who have left their recorded (hostel) address some time ago. The data probably does however give a reasonable indication of the age structure of the hostel population: 10% under the age of 20 years, 39% between 20 and 49 years, 37% between 50 and 69 years, and 13% aged 70 years and over.
(iv) **Visiting patterns of health professionals**

The hostel managers were asked about the visiting patterns of health professionals and social workers. The results are summarised in Table 3B, but these should be interpreted with caution as there is no way to gauge what would be an ideal visiting pattern. For example where rehabilitation is the principal aim, routine visits are not desirable.

<table>
<thead>
<tr>
<th></th>
<th>No. of hostels visited (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Routinely</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>3 (8%)</td>
</tr>
<tr>
<td>Health Visitor</td>
<td>4 (12%)</td>
</tr>
<tr>
<td>District Nurse</td>
<td>5 (15%)</td>
</tr>
<tr>
<td>Community Psychiatric Nurse</td>
<td>9 (27%)</td>
</tr>
<tr>
<td>Social Worker</td>
<td>18 (53%)</td>
</tr>
</tbody>
</table>

For those professionals who conducted routine visits, the following pattern emerged.

<table>
<thead>
<tr>
<th></th>
<th>No. of hostels visited</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GP</td>
</tr>
<tr>
<td>daily</td>
<td></td>
</tr>
<tr>
<td>weekly</td>
<td>3</td>
</tr>
<tr>
<td>fortnightly</td>
<td>1</td>
</tr>
<tr>
<td>monthly</td>
<td>1</td>
</tr>
<tr>
<td>less than monthly</td>
<td></td>
</tr>
<tr>
<td>not known</td>
<td>1</td>
</tr>
</tbody>
</table>
Where the district nurse normally visited routinely this was to change dressings or do follow-ups after hospital treatments. The visiting pattern of the three general practitioners was in the form of a surgery held in the establishment. Two of these were weekly and one was twice weekly. Apart from the social workers, the community psychiatric nurse was the most regular visitor to hostels. Further details of the community psychiatric nurse service are given in Section 8. The service was greatly appreciated by the managers of those hostels (in East Glasgow) which she visited.

(v) Accessibility of services
The managers were asked how much trouble they had getting access to emergency general practitioners, hospital accident and emergency and mental health services. Their replies are given in Table 3D.

Table 3D: Difficulty in accessing services

<table>
<thead>
<tr>
<th>No. of Hostels visited</th>
<th>Yes frequently</th>
<th>Yes occasionally</th>
<th>Yes unspecified</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency GP</td>
<td>1 (3%)</td>
<td>8 (24%)</td>
<td>-</td>
<td>25 (73%)</td>
</tr>
<tr>
<td>Hospital Acc &amp; Emer</td>
<td>1 (3%)</td>
<td>3 (9%)</td>
<td>1 (3%)</td>
<td>29 (85%)</td>
</tr>
<tr>
<td>Mental Health</td>
<td>4 (12%)</td>
<td>6 (18%)</td>
<td>1 (3%)</td>
<td>23 (68%)</td>
</tr>
</tbody>
</table>

Those who claimed not to require a service were counted as having no problem with access. Accessing an emergency general practitioner was especially difficult if the person was not registered. Some of the problems which arose with accident and emergency were caused by difficulties in getting an ambulance. Care staff have particular problems in cases of attempted suicide and have encountered reluctance on the part of the ambulance service to come out in these situations. Staff cannot always take people to Accident and Emergency and have sometimes resorted to describing symptoms in such a way that an ambulance is more likely to be sent.

Because of their client group some establishments required more mental health services. Problems highlighted included difficulty in accessing psychiatric assessment on an emergency basis, and after-care for those discharged from mental health institutions. Mental health issues are dealt with in Section 8.

(vi) General health of hostel dwellers
In order to try and get a 'snapshot' of the general health of the hostel population, managers were asked to consider the health of those resident on the day of the survey. The answers were based partly on medical diagnosis (if known) but more on the perception and knowledge of those working in the hostel on a daily basis. The figures are based on the 2,085 people covered by the survey.

The number of residents having an obvious physical disability or illness was 566 (27%). These included a range of illnesses for example, epilepsy, heart problems, ulcerated limbs,
diabetes, bronchial complaints. There were 883 people (42%) who were considered to have an alcohol problem and 155 (7.4%) who were known to have a drug problem (excluding smoking cannabis).

Eighty-one people required more than the normal change of bed sheets (3.9%). This was asked to indicate the level of incontinence. Many of these people were incontinent due to an excessive alcohol intake.

Hostel managers were asked to judge how many residents had anti-social, repetitive or withdrawn behaviour in order to see what the perceived level of mental health problems was. Five hundred and forty-three people (26%) were thought to have behavioural problems. Thirty-six residents (1.7%) were being seen by a community psychiatric nurse. This information is summarised in Table 3F.

Table 3F: Physical and mental health problems

<table>
<thead>
<tr>
<th>Physical illness/disability</th>
<th>566 (27 %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>alcohol problem</td>
<td>883 (42 %)</td>
</tr>
<tr>
<td>drug problem</td>
<td>155 (7.4%)</td>
</tr>
<tr>
<td>incontinence</td>
<td>81 (3.9%)</td>
</tr>
<tr>
<td>antisocial repetitive or withdrawn behaviour</td>
<td>543 (26 %)</td>
</tr>
</tbody>
</table>

(vii) Suggested improvements in health service provision
Hostel managers were given the opportunity in the form of an open-ended question to suggest ways in which the Health Service could improve the health care provision to their residents.

There were many comments both written and spoken, and recurring themes were:

.. routine visits from or regular contact with the following health professionals: chiropractor, community psychiatric nurse, health visitor and district nurse, with a need for a chiropractic service being most mentioned.

.. general practitioners to be more sympathetic.

.. a general practitioner to hold a surgery in the establishment on a regular basis.

.. better communication with general practitioners.
improvements in mental health after-care; for example
(i) improved communication with mental health institutions when they discharge patients from care,
(ii) easier access to psychiatric services for emergency assessment,
(iii) the community psychiatric nurse service to be extended to cover the over 65's,
(iv) greater provision of supported accommodation.

independent counsellors (psychiatric, alcohol, drug) with access on an emergency basis.

more advice/information/counselling from Family Planning Clinic.

development of preventative health/health education, well woman/man clinics;
the problem of apathy was acknowledged but care staff wished to do as much as possible to stimulate interest.

a speedier and more sympathetic response from ambulance service specifically in an overdose situation.

joint planning and initiatives between Housing Department, Social Work Department, Health Service.

Also mentioned were:

- General practitioners to be more accurate with prescriptions. This criticism was raised in a long-stay hostel where a surgery was held once a week. This was seen as generally helpful but there was no continuity of care as different general practitioners were involved in holding the surgery. As a consequence, not enough attention was given to each patient's past history and errors in prescribing were being picked up by the care workers. For example, a resident was prescribed medication that he had already been given in the past and which had recently been stopped.

- Improved specialist care facilities for the terminally ill, eg a hospice-based nurse.

- Additional aids for the elderly and infirm.

- A more flexible response from the community psychiatric nurse service.

- Better liaison with local-health centre.

- Better liaison with local casualty department.

- Hostel staff training on use/misuse of drugs, first aid, occupational therapy.
There were conflicting views as to whether there should be a health care team to deal with the needs of the homeless. Concern was expressed by some that this would lead to stigmatisation and a two-tier health service, while others felt this would be the road to take.

As mentioned earlier, The Innocents are not included in the above analysis. The following describes their role.

3.3: The Innocents

The Innocents provide shared accommodation for 15 homeless pregnant women at two locations in the city. Their main function is to provide pregnancy care, but they are increasingly taking referrals from the Social Work Department for assessment of ability to care for a baby where there are special needs.

Due to the nature of their client group, availability and access to health services posed no problems to The Innocents. There are links with the local health centres and all of their residents are registered with general practitioners. Consequently, general practitioner and health visitor services appropriate to pregnant women/mothers and babies are available. Input by Social Work Department is variable, but The Innocents have their own social worker.

On the day of survey, there were 10 women being accommodated plus 9 babies. None was considered to have an obvious physical illness/disability, or an alcohol or drug problem. Three (30%) were perceived to have antisocial, repetitive or withdrawn behaviour, and one (10%) was visited by a mental handicap nurse.

The staff were happy with the service from the Health Board. The only suggestion for improvement was the provision of a health professional to give parentcraft sessions on a regular basis, even on a one-to-one basis if necessary, as a number of residents do not take up the antenatal services that are available.

3.4: Summary

Two recurring themes emerged from comments from managers.

Firstly, levels of satisfaction with the health service varied immensely. Those who had a good service had developed this over a number of years by building up relationships with local primary care services. Some hostels had less success with this and were as a result receiving a relatively poor service. However, in saying this some felt encouraged by recent improvements.

Secondly, there were contrasting levels of health care provided by hostel staff in-house. Regardless of levels of health training of staff, a number of staff had not infrequently to deal with fairly serious crisis situations which should have been the responsibility of health service professionals. These included suicide attempts, acute psychiatric episodes and alcohol and drug abuse. Often, these situations were dealt with without back-up or support from relevant health services.

The hostel managers' survey provided an insight into the main issues of health for those living in hostels and gave an indication of the level of health service provision. The three
studies described in section7 discuss the health of three smaller groups of homeless people.

3.5: Glasgow Resettlement Unit, Bishopbriggs (DSS)

The Unit takes referrals from any source including self-referrals. Many clients are admitted repeatedly. Some are there as the only alternative to prison.

The Springfield Road general practice in Bishopbriggs provides a two hour surgery at the Unit twice weekly. It deals with all residents taking them on as temporary residents where necessary, and is also on call. The practice also provides a private service for which they are paid a salary.

The main problem at the Resettlement Unit is with mental health with an estimated 40% of residents having psychiatric difficulties. This has been increasing significantly in the past three years due to the lack of care available in the community. There are some residents who are virtually institutionalised and cannot cope in the community. They require the kind of support that the Resettlement Unit can provide such as work programmes, counselling, etc.

There is no regular psychiatric provision from the health service. The staff at the centre are left to assess the extent of each patient’s mental problems for which, by their own admission, they are not qualified. There is only one occasion on which a psychiatrist has visited the Unit and this was in order to refuse referral of a resident to psychiatric services. Whenever the staff identify a problem, referral to the health service is almost always impossible, and the process of certification of patients is increasingly difficult. There have been incidences in which residents have become violent and abusive and staff have had to cope with no support, transporting them to hospital in private cars. On arrival at hospital an injection may be administered and the person returned promptly to the Resettlement Unit. The “tolerance” level at the Unit is higher than any other agency as they accept cases which other hostels would not contemplate taking on. Staff commonly have to cope with epileptic fits, administering of regular medication and various kinds of suicide attempts. Most medications are stored under security as many of the drugs are marketable or stealable.

Last year the Mental Health Welfare Commissioner visited the unit but with no resulting improvement in services.

The Unit is in constant contact with many agencies and groups such as Alcoholics Anonymous, Social Work Department, etc and in about 3% of cases is able to rehabilitate the residents back into the community. However the lack of resources for follow-up means that they really require supported placements which do not exist. Thus even when placements are made the success rate is not good.

The residents at the Unit are quite open to receiving health care whilst living at the centre. At one time a mobile chest X-ray van visited regularly and the uptake of this was good but the services was terminated. It was later replaced by the introduction of a payment of £5 in the form of a food and shelter voucher to increase usage of a non-mobile service. The Unit hired a coach to take the residents for the X-rays. However the Resettlement Officers pointed out that as soon as residents leave the Unit their health immediately becomes of low priority - after money, shelter, etc. This means that often treatments are begun at the Unit but discontinued when on the streets. During the next spell of residency the treatment
must be started again from scratch and so on, with treatment never able to be completed.

This hostel is said to be due to close in 1996.

3.6 Queen’s Cross Housing Association - The Fire Station

This comprises 12 single flats for 16-25 year old males and females. There is limited support - not 24 hour staff cover. Referrals are made by the Social Work Department and hostels. Suitable residents are normally allocated tenancies with Queen’s Cross Housing Association. Individuals can stay for up to 2 years.

Health needs

The residents tend to be ill frequently, often with minor ailments. They frequently attend the general practitioners surgery - probably attention-seeking. They are prone to infections and ailments due to poor diet as a result of very low income. There are also stress-related illnesses and some mental health problems as many of the residents are from troubled backgrounds. This leads to small problems being blown out of proportion.

The staff occasionally arrange a visit by a health visitor to talk on for example contraception, but these meetings are poorly attended. The residents are encouraged to adopt a more healthy lifestyle, eg to give up smoking, to learn how to cook, to take exercise, but there is virtually no uptake of advice. Health information/promotion leaflets are available but not read. Hygiene is also a problem in some cases.

Residents are resistant to counselling due to perceived stigma. They find visits to the Family Planning Clinic embarrassing due to lack of privacy.

It is felt that the residents would welcome regular visits from someone like a health visitor to talk to individuals about their own health problems; this would relieve pressure on general practitioners.
Section 4: ROUGH SLEEPERS

This group are very difficult to assess due to the chaotic lifestyle of these individuals.

The reasons for rough sleeping vary from alcoholism to drug abuse, gambling, or inability to cope with finances. Once people become part of the 'skippering scene' they often get caught up in the prevailing lifestyle with likely development of alcohol and other problems if they are not already present.

The estimated number of rough sleepers varies from 30 to over 100. At the time of the 1991 census, 28 were accounted for but this is felt to be a gross underestimate as many 'disappeared' that night to avoid being identified. The following organisations had specialised knowledge of this group and the comments of managers and others involved were as follows:

The Salvation Army

The Salvation Army runs a centre where rough sleepers can visit during the day. In addition, it provides a "soup run" at night to locations where those who skipper (sleep rough) are known to frequent.

Increasing numbers of young people who have nowhere else to go are being seen; these are likely to be the "old-timers" of tomorrow. The older people sleeping rough tend to do so by choice.

When those who 'skipper' require medical attention they almost always seek help first from the staff at the centre rather than from the Health Service. This is because their dirtiness and other characteristics have often led to unpleasant experiences in the past and also because many of them wish to remain outwith the system. Most are not registered with a general practitioner or are still registered with their original general practitioner. In the past a particular general practitioner at Gorbals Health Centre was sympathetic and would register a patient whenever necessary to ensure that the required treatment was given, but he is now retired.

The most common health problems encountered are cuts and bruises, injuries from attacks and ulcers partly due to lack of attention to cuts. There is also a high incidence of epilepsy which can be attributed mainly to chronic alcohol abuse. Ninety five per cent of skippers have a drink or drug problem; others may be gamblers. Stress is also a problem as many have a fear of violence.

The care staff are trained in first aid and can deal with minor problems, but they are often called upon to deal with injuries or wounds which require treatment by trained medical staff.

Twice a year the men are bussed to Cochrane Street for chest X-rays for which the men are paid £5 in the form of a meal voucher (see section 8 for details).

Increasingly difficulties are experienced when attention is required for a mental health problem. Now this type of situation has to be dealt with without support from psychiatric
services. An ambulance can be requested but what tends to happen when this action is taken is that the patient is removed by the ambulance service, kept in an acute hospital overnight and discharged the following day, only to turn up at the centre.

The fact that Salvation Army care staff are the first port of call when medical attention is needed is as a result of the trust built up with this particular client group. Assistance from the Health Service in meeting their needs would be welcomed in the provision of a nurse to visit the centre on a regular basis, such as the Talbot Association has. They would like this to be carried out for a trial period of, say, a month to see whether this would work. A regular chiropody service was also felt to be a great need.

The Health Service is perceived as being two-tier - one for 'normal' people and another for skippers. An example was given of a woman attended to by the care staff in an alleyway, but her medical condition was such that she required proper medical attention. An ambulance was called but the driver reported that the patient could not be found; a second ambulance had to be requested and she was picked up and admitted to hospital. She was operated on for a neck abscess and was discharged within 4 hours of coming out of the anaesthetic.

The Wayside Club Day/Evening Centre

The services provided by the Day Centre are part of the overall service offered by the Wayside - a lay group within the Roman Catholic Church.

The aim of the Centre is to provide day care for homeless men. They provide specific help regarding, eg alcohol abuse, drug addiction, psychiatric problems, accommodation etc. They also provide a range of activities both within and outside the Day Centre, eg arts and crafts, hillwalking. There is a café within the centre which provides hot lunches. In addition there is a shower and the provision of clean clothing. Attendance is about 100 during the day and 140 at night.

The physical and mental health problems encountered by the Day Centre staff are mostly those associated with longterm alcohol and drug abuse and homelessness, eg untreated wounds, limb ulcers, heart problems, diabetes, nutritional problems, feet problems (they have the services of a chiropodist on a voluntary basis).

The Centre uses mostly voluntary or private organisations for the purposes of alcohol and drug rehabilitation, but uses the Health Service provision at Parkhead Hospital for those who have mental health problems. A community psychiatric nurse from the hospital visits the centre every two weeks and they have a link with Dr Dallas Brodie, Consultant Psychiatrist who visits the centre routinely, attends staff meetings, etc. Most of the men are registered with general practitioners. Staff can occasionally have problems when encouraging the men to register due to previous difficult experiences, eg having caused trouble at the health centre in the past due to being under the influence of alcohol.

They see the number of young single homeless people on the increase due to, eg family breakdowns. They feel the situation is exacerbated by Government policy on benefits to young people.

Accessibility of the Health Service is a problem for the centre in an emergency situation.
General practitioners tend to request that the Accident and Emergency Department is used, and vice versa. However, once the case is accepted by one or the other the service is first class.

They feel progress would be made in dealing with the needs of the homeless if there was joint planning and initiatives between the various agencies involved. Reports, Strategies, Missions have been made, but at policy level. This is not always filtered down to grass roots but often there are initiatives going on at this level anyway, eg the link with Dr Brodie from the Mental Health Unit.

A big gap in services is perceived in respect of mental health after-care needs. The Community Care policy is a concern as most of their men do not have families to care for them and will end up back in such places as The Great Eastern Hotel which is not a suitable environment for those who are vulnerable. They feel the needs of these people would be met by providing more supported accommodation such as that provided by the Richmond Fellowship, and the Archdiocese (who bought houses in Easterhouse and provide back-up support).

They would also like to see a change of attitude towards this client group.

The Talbot Association - Kingston Halls

The Kingston Halls provides accommodation for 25 people as an alternative to rough sleeping, in addition to 65 permanent places.

The care staff encounter a diversity of both physical and psychological problems. Common conditions amongst their clients are: respiratory conditions, cardiovascular problems, gastrointestinal conditions, skin complaints, frequent and acute episodes of symptoms linked to withdrawal from alcohol, a wide range of psychiatric disorders with acute episodes as well as chronic states including Korsakoff's psychosis. They also meet with various health problems attributable to old age including differing degrees of dementia.

The staff have established links with the local health centre, and they encourage their clients to register with a particular general practitioner there. They have not experienced any difficulties in registering clients. Daily visits are made by a general practitioner on a roster basis to the halls, and a community psychiatric nurse visits on a monthly basis. No problems have been encountered when requiring access to an emergency general practitioner or to hospital Accident and Emergency services. However, the staff frequently experience difficulties accessing Mental Health Services.

It was felt by the care staff that the most valuable contribution which the Health Board could make towards improving the health of long-term single homeless people within Kingston Halls would be the allocation of one General Practitioner to

1) Provide a health service to the clients and
2) To coordinate all other essential and specialist services viz psychiatric, geriatric, etc.

Although they had a good service and were grateful they felt that there was a lack of continuity of care due to the large numbers of doctors on the roster.
The feeling was expressed that the individuals dealt with by the staff at the Kingston Halls go around the health and social care system receiving virtually no health care apart from emergency service.
SECTION 5: TRAVELLING PEOPLE

The different agencies involved in the care of Travelling People have no coordinated policy relating to their health and social welfare. Assistance is given intermittently on an ad hoc basis as crises occur. During the autumn of 1989 there were 36 adults and 59 children residing at the various sites within Glasgow.

Strathclyde Regional Council employs four full time Liaison Officers to work with travelling people. Together with the Social Work Department, Health Services personnel and the Police the Liaison Officers communicate with one another on the whereabouts of itinerant families as they become known.

It is difficult to plot the pattern of movement of travelling people because to a large extent this is determined by economic considerations and "external pressure" (e.g., social security officers, police and attitude of local residents).

The constant movement of these families makes any assessment extremely difficult. This applies not only to health and social welfare needs, but also to the continuing care and general health surveillance of children who appear to be at risk. This is especially true for those living in "squatter sites" with no basic amenities such as sanitation, water or electricity. Many travelling people are not registered with general practitioners: when necessary they use the accident and emergency departments of hospitals and sometimes health centres that are in close proximity to their camp sites. Others are registered with several general practices, which obviously makes continuing surveillance and care very difficult.

Environmental Health Officers help when it comes to refuse collection and the provision of skips. Poor sanitation has led to an increase in rat infestation which is being controlled by the EHOs responsible for the areas concerned.

For a time a health visitor, Gail Bell, took - at her own initiative - a special interest in travelling people at the official site in Carmyle. She visited the site each week, often with a peripatetic teacher or other professional. The following report is based on her work, and illustrates how effectively an individual who is given or takes responsibility for a specific client group can be in developing services, engendering enthusiasm amongst other professionals and as an advocate. Ms Bell has unfortunately left and no-one appears to have taken over responsibility for the health care of travellers from her.

The use of services
Travelling people need to be encouraged to use services - otherwise they will only seek help as a last resort. This is partly due to fear of what is unfamiliar to them, partly to an unwillingness to be subjected to any form of regimentation, and partly because they are afraid that treatment might be unpleasant or even involve them being taken away. These fears must somehow be allayed, and regular visits by a friendly and sensitive health visitor can be an effective way of achieving this. It is important to persuade travelling people to seek advice or treatment as soon as possible when they - and particularly their children - become ill. It is obviously necessary however for these preventive and treatment services to be available and delivered in a manner which is acceptable. Somehow those responsible for organising these services need to be made aware of the special characteristics and needs
of travelling people, and encouraged to make their services more available to them. Again the health visitor is very well placed to achieve this.

Promoting integrated care
Care is much more likely to be effective and acceptable if its component parts are carefully coordinated, and this is particularly true of travelling people. This means that the health visitor, teachers (including a peripatetic teacher to provide teaching at nursery level), general practitioner and clinic services (for example for immunisation, child surveillance, family planning, well woman - including cervical cytology, and breast screening) must be coordinated and organised sensitively in order to ensure that travelling people are given the maximum possible opportunity to benefit from educational and health services. Again, this is a role which the health visitor is adequately trained and experienced to adopt.

The aims of care
To encourage children to receive (a) full courses of immunisation and (b) regular surveillance by a doctor and health visitor.

To continue child surveillance throughout schooling.

To ensure that the children receive adequate nursery, primary and secondary schooling.

To ensure adequate antenatal care for all pregnant mothers.

To encourage attendance at well women and family planning clinics.

To identify illnesses and disease at as early a stage as possible so that suitable preventive measures may be taken.

To promote good health for all travelling people by whatever means possible.

Process measures
Willingness of a general practitioner to register travelling people or to accept them as temporary residents.

Availability of a female doctor for wives and children.

Willingness of the general practitioner to accept consultations without appointment.

Visits to site at least weekly, in order to
(i) identify new travellers
(ii) identify new problems, and take appropriate action.

Joint assessment of need with the peripatetic nursery teacher.

Liaison with primary and secondary school teachers in order to maximise the effectiveness of teaching.

Identification of and provision of care for travellers at other sites.

Establishing a suitable health record for the health visitor and parents.
Establishing and maintaining links with the appropriate SRC Liaison Officer and others with special interests or responsibility for travelling people (e.g., other health visitors, sign-post, charities, specialist health visitors in other areas and Mr Collier of Ruchill Hospital).

Define additional needs of travelling people.

Monitor the various professional inputs.

Publish an annual report on the health and health needs of travelling people.

Prepare a 'charter' for use by travelling people and professionals.

Develop an advocacy role.

Encourage interest in travelling people among doctors, social workers and others.
Section 6: FAMILIES IN TEMPORARY ACCOMMODATION

The assessment of those families living in temporary accommodation was thought to be most appropriately carried out by health visitors in view of their involvement with the care of pre-school children.

The health visitors in Greater Glasgow Health Board were therefore asked for their assistance in carrying out a survey to identify any homeless families on their caseload.

6.1 Identification of families in temporary accommodation

Over the week from 24 August to 28 August the health visitors were asked to identify any families they knew of in temporary accommodation (including flats, bed and breakfast accommodation, guest houses, hotels, supported accommodation and half-way houses). Hostels were not included in the remit. Others to be identified included older children "boarding out" with people other than their own parents and those families sharing inappropriate accommodation with other families.

270 forms were distributed one to each health visitor; 144 were returned. A further 15 were returned after the deadline. These were included in the estimation of numbers but not in the sampling process. It is thought that health visitors who had no homeless families nearby did not return the form but the extent of this is not known. There were seventy nil returns and 89 returns with data.

The health visitors identified 260 addresses where homeless people were living. 545 adults, 455 children and 62 other people of unknown age were living at these addresses. Some of these were two or three families living together, homeless families living with relatives or friends or individuals sleeping rough.

There are 4 bed and breakfast establishments (Bellahouston Guest House, Hamilton House Hotel, Arkway House and Dunvegan Hotel) used by Glasgow District Council but only when all other options have been explored.

6.2 Health questionnaire

(A copy of the questionnaire is shown in Appendix 2)

Those health visitors who had identified at least one address where homeless people were living then took part in a more detailed health questionnaire. A sample of 141 addresses was chosen randomly and questionnaires for each were sent to the sector nurses for distribution.

Most of the survey questions were suggested by a group of health visitor representatives based on discussions they had had with other health visitors involved with the homeless and the investigators. The questions were restructured to facilitate analysis.
It would have been interesting to have carried the questionnaire out over a longer period of time as this would have allowed follow-up of those families who moved on between identification and interview. However the time period allowed for questionnaires to be returned was limited and health visitors did not have time to trace these families.

Of the 141 questionnaires distributed, 72 were returned completed, 41 were returned blank and 28 were not returned. The reasons for the blank forms were as follows:

<table>
<thead>
<tr>
<th>Reason</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family moved away</td>
<td>6</td>
</tr>
<tr>
<td>Family now housed</td>
<td>6</td>
</tr>
<tr>
<td>Unable to contact family</td>
<td>11</td>
</tr>
<tr>
<td>Family claim not to be homeless</td>
<td>3</td>
</tr>
<tr>
<td>Client refused to participate</td>
<td>1</td>
</tr>
<tr>
<td>Client removed from caseload</td>
<td>1</td>
</tr>
<tr>
<td>Situation too dangerous for Health Visitor</td>
<td>3</td>
</tr>
<tr>
<td>Health Visitor on holiday</td>
<td>3</td>
</tr>
<tr>
<td>Health Visitor did not have time</td>
<td>2</td>
</tr>
<tr>
<td>Other reasons</td>
<td>2</td>
</tr>
<tr>
<td>No explanation</td>
<td>3</td>
</tr>
</tbody>
</table>

The questionnaire was answered by the ‘caring adult’ of the homeless family. In the 72 households visited there were 200 adults and 143 children and of these 112 adults and 120 children were homeless. The 72 homeless adults interviewed had a total of 115 dependent children.

The following information was derived from the analysis:
(Please note that where percentages do not add up to 100, there was missing data on the forms).

i) **Type of tenure**

Only 2 of the families interviewed were living in Bed and Breakfast accommodation. Thirty-five families were sharing with friends or relatives, 26 were in local authority temporary accommodation, and four lived in private rented housing four lived in some other kind of accommodation: three were young mothers staying at The Innocents homes and one was a bought house which belonged to creditors.

ii) **Reasons for homelessness**

The factors which had contributed to homelessness were indicated on the form. In some cases there were several factors.

Overcrowding contributed in 28% of cases, relationship breakdown in 42%, eviction by family or friends in 25%, physical abuse in 6%, mental abuse in 11% and poor housing conditions in 8%. There were 20 instances in which other reasons were given. In 4 of these crime was the contributing factor and in 3 it was the presence of drug abusers in the area; 3 families were homeless because they had returned to live in Glasgow; 3 families were being accommodated by relatives. In one case neighbours had requested that the family
be removed; another family living in a caravan was rendered homeless when the owner sold the caravan 3 weeks prior to their baby being born. Harassment by neighbours, repossession of the family home, eviction, end of lease were cited by others as the reason for homelessness.

iii) Distance from proper home

Thirty-two per cent of families were living within walking distance of their home. Twenty-one per cent could get there easily by public transport and 26% found it very difficult to access. Thirty-six per cent of families did not have relatives or friends nearby.

iv) Number of moves and length of time in accommodation

The number of moves in the previous year varied from zero up to six. Sixteen families had moved 3 or more times with 3 moving four times and 3 moving five times.

On average homeless people had been in their accommodation for just over 5 months. Thirteen had been resident less than one month and thirteen had stayed for more than a year.

v) Emotional effects

The effect of homelessness on the feelings of those interviewed was investigated. Thirty-three (46%) were relieved to have some kind of accommodation, 16 (22%) were glad to be away from violence and 10 (14%) were glad to have left their own area. Twenty-five or 35% felt isolated. Other feelings expressed were anxiety; frustration; helplessness; desperation; fear and uncertainty about future home; the need to have a place of one’s own; weariness with moving from one place to another; sadness at being away from own area; relief at being away from partner; fear of being thrown out on the street where someone was staying illegally.

vi) Home safety

The home safety in temporary accommodation was described as adequate in 53 cases (74%). Fifteen people (21%) said that home safety was inadequate and three said that it was non-existent. Comments on home safety included:

- lack of fireguard
- broken or no catches on windows
- unsafe sockets
- no child gates on stairs
- dangerous fire surround
- fire hazards due to overcrowding
- gas leaks
- high pile of furniture in room
veranda railings - can put head through
electric fire blown
oven not working
handles falling off doors
vulnerability in all-female flats.

Almost all of those who made these comments had young children.

vii) Problems with temporary housing

Almost half of the temporary accommodation was described as overcrowded (43%). 11% claimed not to have adequate cooking facilities and 7% inadequate toilet facilities. Dampness was a problem in 8 residences (11%) and laundry facilities were not adequate in 13 places (18%). Other problems were lack of privacy, poor water pressure and a washing machine that damaged clothes. Lack of bed space was a problem in two cases. In the first the mother and two children were sleeping on a settee in the living room. In the second the mother, father and two children shared a bed settee with the baby in a pram at the side. This family have lived there for six months with 4 other adults and another baby.

viii) Heating

Nineteen of the 72 houses were difficult to heat for financial or other reasons. Some houses did not have central heating and only had one room with a heater in it. The expense of heating water was mentioned by one and another said that heating was too expensive as powercards cost £15 a fortnight. One family had central heating that they had no control over and one mother claimed that the dry heat from the electric heating was causing asthma in both her children.

ix) Area lived in

In order to judge how satisfactory the situation of temporary accommodation was, people were asked what they thought of the area of residence. 29% found it desirable while 53% found it acceptable but not ideal. Ten people (14%) thought the area was unacceptable and the reasons specified were mostly related to intravenous drug users in the close, needles left in closes, crime, violence and vandalism.

x) Additional problems

Other problems cited by people as the consequences of living in temporary accommodation were: a family of 5 sleeping in one bed; another person’s bed was in the lounge and relatives stayed up till 4 am; one child was not able to be toilet trained as owners of the property insisted on nappies being used; others had to report to a warden when entering or leaving the premises.

6.3: Health of caring adults

The health of the caring adult before and since moving to the present accommodation was noted.
i) Health before and after moving

Thirty people were experiencing difficulty sleeping, 16 of whom had no trouble with this in their previous accommodation. However sleep patterns had improved for 13 people.

There were 21 people who had suffered weight loss or gain since moving, sixteen of whom had never had the problem before. Eleven people had had weight loss or gain but found that the new accommodation had helped this problem.

Chest infections were less common with only 12 people who had ever suffered. However it must be remembered that the survey was done at the end of the summer. For five of these the infections occurred for the first time after moving and three people had suffered continually.

Overall 50 people had suffered depression, half of whom admitted to being depressed before and after their last move. For 11 people the move had helped to relieve their depression but for 14 it had helped to cause it.

The incidence of stress was high with 58 people suffering. Twenty-one of them had begun to feel stress after moving into their new accommodation while 16 felt their stress relieved.

ii) General health

Each interviewee was then asked to assess their general health before and after moving into the present accommodation, rating it good, acceptable, not very good and poor. Twenty people felt that their health had declined and thirteen thought that it had improved. Thirty-two people did not consider their health to be any different. There were seven missing values. Nine people described their present health as poor and 14 said it was not very good. Twenty-five said it was acceptable and 17 thought their health was good.

iii) Smoking

76% of the sample said that they smoked. The number smoked daily was given:

<table>
<thead>
<tr>
<th>Number of cigarettes</th>
<th>No of people</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 or less</td>
<td>14</td>
</tr>
<tr>
<td>11 to 20</td>
<td>32</td>
</tr>
<tr>
<td>21 to 40</td>
<td>7</td>
</tr>
<tr>
<td>60</td>
<td>1</td>
</tr>
<tr>
<td>100</td>
<td>1</td>
</tr>
</tbody>
</table>

Health visitors felt that smokers may have 'scaled down' the number of cigarettes smoked daily.

iv) Uptake of services

It was felt that homeless families could be receiving a second-rate service and that this could affect their willingness to seek help. Table 6A shows how often help was sought from various professionals and whether the response was satisfactory (where specified).
### Table 6A: Uptake of services and whether satisfied

<table>
<thead>
<tr>
<th>Service</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>47</td>
<td>17</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>63</td>
<td>4</td>
</tr>
<tr>
<td>Health Visitor</td>
<td>53</td>
<td>10</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>62</td>
<td>0</td>
</tr>
<tr>
<td>Other Nursing</td>
<td>10</td>
<td>7</td>
<td>5</td>
<td>4</td>
<td>38</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>Baby Clinic</td>
<td>30</td>
<td>11</td>
<td>4</td>
<td>9</td>
<td>13</td>
<td>55</td>
<td>0</td>
</tr>
<tr>
<td>Community Medical Officer</td>
<td>7</td>
<td>9</td>
<td>2</td>
<td>8</td>
<td>36</td>
<td>25</td>
<td>1</td>
</tr>
<tr>
<td>Family Planning Clinic/Well Woman</td>
<td>11</td>
<td>15</td>
<td>4</td>
<td>4</td>
<td>31</td>
<td>32</td>
<td>1</td>
</tr>
<tr>
<td>Hospital Accident &amp; Emergency</td>
<td>6</td>
<td>7</td>
<td>4</td>
<td>11</td>
<td>36</td>
<td>19</td>
<td>7</td>
</tr>
<tr>
<td>Social Worker</td>
<td>13</td>
<td>8</td>
<td>7</td>
<td>1</td>
<td>37</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>Welfare Advice</td>
<td>10</td>
<td>5</td>
<td>6</td>
<td>3</td>
<td>44</td>
<td>18</td>
<td>4</td>
</tr>
<tr>
<td>Voluntary Services</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>56</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Environmental Health</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>59</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

**Code:**
1 - Within last month
2 - Within last 6 months
3 - Within last year
4 - Over a year
5 - Never

The above table shows that there was a high level of contact with general practitioners and health visitors. 89% of those asked had seen their general practitioner within the last 6 months and 87% had seen their health visitor in that time. However nearly half had never seen any other community nurse or doctor. The usage of accident and emergency was of note as 50% had presented there at one time or another, although a third of these had not presented within the last year. There were 11 families who had used casualty within the last month. Of the 36 people who had used this service, 7 had expressed dis-satisfaction. 43% had never attended the Family Planning Clinic/Well Woman Clinic, but the general practitioner may well provide the same services.

### v) Health checks and advice

People were asked how long it was since they had received the following health checks or advice.
Table 6B: Health checks and advice

<table>
<thead>
<tr>
<th></th>
<th>Within last month</th>
<th>Within last 6 months</th>
<th>Within last year</th>
<th>Over a year</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure Check</td>
<td>19(26%)</td>
<td>30(42%)</td>
<td>11(15%)</td>
<td>9(13%)</td>
<td>3( 4%)</td>
</tr>
<tr>
<td>Smear Test</td>
<td>6( 8%)</td>
<td>13(18%)</td>
<td>20(28%)</td>
<td>24(33%)</td>
<td>7(10%)</td>
</tr>
<tr>
<td>Advice on Smoking</td>
<td>21(29%)</td>
<td>12(17%)</td>
<td>9(13%)</td>
<td>6( 8%)</td>
<td>21(29%)</td>
</tr>
<tr>
<td>Advice on Exercise</td>
<td>11(15%)</td>
<td>16(22%)</td>
<td>11(15%)</td>
<td>6( 8%)</td>
<td>25(35%)</td>
</tr>
</tbody>
</table>

Most people had received the above services if they were relevant. This is probably because it is likely that they have received ante-natal care recently.

The services provided by other agencies did not appear to be highly utilised. Just over half stated that they had never seen a social worker and 12 of those who had were not satisfied with the service. Environmental Health had only been involved in 18% of cases. Twenty four people had received welfare advice.

vi) Levels of stress and depression

The caring adults were asked to describe how often they experienced stress and depression.

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Occasionally</th>
<th>Mostly</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress</td>
<td>5( 7%)</td>
<td>28(39%)</td>
<td>23(32%)</td>
<td>14(19.4%)</td>
</tr>
<tr>
<td>Depression</td>
<td>8(11%)</td>
<td>33(46%)</td>
<td>21(29%)</td>
<td>8(11%)</td>
</tr>
</tbody>
</table>

6.4: Health of dependent children

Information was analysed on 92 children. Several children had been excluded as they were newly born or had always lived at the same address as a result of which the forms had not been filled in.

It emerged that 57% (52 children) were fully immunised, 35% (32 children) were partly immunised, and 2 children were not immunised at all (possibly new born babies).

One child had begun to suffer from bed-wetting since becoming homeless while 4 had stopped. There were 3 children who had continually suffered.

Behavioural disturbances were recorded with some interesting results. There were 27 children who had had behavioural disturbances since becoming homeless, 16 of whom had developed the problem for the first time after becoming homeless. One child's behaviour had improved.
There was a high incidence of children having disturbed sleep patterns, 36 in all. For 22 of these children homelessness was the cause of disturbed sleep while the condition improved for 9 children. Five had experienced continuing problems.

Fourteen children suffered from asthma at some point, seven of whom had developed it since becoming homeless. Thirteen had received treatment. Eight children had sickness or diarrhoea and for all it was an ongoing problem.

Eighteen children had developed chest infections since becoming homeless. Of the 25 children who had had chest infections, 20 had been treated.

A variety of other problems were identified, for example:

- Twins both on nebulizers for asthma, one attending child psychiatry (aged 3).
- Child development behind due to being strapped in a chair because furniture and ornaments belong to householder.
- Inability to access speech therapy as child’s school in another area.
- Family of 3 children, all under 4 years - one admitted to hospital at 2 weeks with gastroenteritis, one with frequent nits and scabies, will not eat and cannot get out of cot to walk, one three year old not toilet trained with persistent stomach bugs and nits.
- Child cries a lot since moving.
- One case of possible developmental delay.
- Difficulty in toilet training, lack of routine.
- General behaviour of one child affected by overcrowding.

One mother who was relieved to move away from her own area felt a closer bonding with her child since moving and found that the child was sleeping better.

6.5: Data recorded on the Standard Immunisation Recall System (SIRS)

Ten preschool children living in bed and breakfast accommodation were identified from the Community Health Index (CHI). A further 455 preschool children were identified by the health visitors and for a sample of 115 of these children identification details were obtained from the health visitors for the purpose of the analysis described above (Section 6.4). These identification details also permitted immunisation and other information for each child to be extracted from SIRS. These details were extracted for 17 children. The results were as follows:
Table 6C: Comparison of immunisation and other data for preschool children living in different types of temporary accommodation

<table>
<thead>
<tr>
<th></th>
<th>Preschool children living in bed &amp; b/fast accommodation</th>
<th>Preschool children identified from HV survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of preschool children</td>
<td>10</td>
<td>17</td>
</tr>
<tr>
<td>No. not recorded on SIRS</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>No. with SIRS record</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>No. fully immunised (for age)</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>No. missing measles/MMR only</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>No. missing 3rd DTP/Po only</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Breast fed</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>No. &lt;2,500g birthweight</td>
<td>-</td>
<td>5</td>
</tr>
</tbody>
</table>

Preschool children living in bed and breakfast accommodation

The health visitors and others identified four 'hotels/guest houses' where homeless families with children were thought to be living.

Children living at these addresses were then identified from CHI: 10 preschool children and 4 aged between 6 and 16 years. This is likely to be a very considerable underestimate of the number of children living in such accommodation because some addresses will not have been identified and - probably more importantly - most families living in such accommodation will not be recorded on CHI (the accommodation being temporary and parents being likely not to have registered with a local doctor).

Of the 10 preschool children identified 5 were not recorded on SIRS. This suggests that these children have not been immunised, unless they have moved into the Greater Glasgow Health Board area from outside. Only two of the children had been fully immunised. One child had been breast fed and one was low birthweight (<2,500 g).

Preschool children living in other temporary accommodation

A sample of 17 preschool children was selected from the 115 children identified in temporary accommodation. Only two were not recorded as SIRS. Of the remaining 15, 11 (73%) were fully immunised. Five (33%) were low birthweight and only two (13%) were breast fed.
6.6: Case studies

The health visitors knew of many interesting cases which involved homelessness. The following case studies illustrate some of the problems encountered. Names have been changed to preserve confidentiality.

Case study 1

During an 8 year tenancy, Mary developed a relationship with John who moved in with her. When Mary became pregnant they married and Mary transferred the tenancy to John. Their relationship deteriorated, and in addition John was not contributing financially to the upkeep of the house. Mary's health suffered during her pregnancy due to anxiety and stress, and she developed severe back pain which did not respond to painkillers.

Once her baby was born, Mary moved out of the family home to stay with relatives as her relationship with John did not improve. Her health had not improved since the birth of baby Andrew, and she was having difficulty lifting and handling him. She applied for a house in the Cardonald area as this was where she had been born and brought up. Also her extended family were there and could help with the baby. Meanwhile Mary was referred by her general practitioner for investigation of her severe back pain but no physical problem was found.

The Housing Department offered Mary a house in West Drumoyne which she would not accept as it was damp and in a deprived area which she considered to have a drug problem. She continued to lead a nomadic existence staying a few days with relatives until she had outstayed her welcome and then moving on to another household. Andrew was developing normally but he had become overweight as Mary tended to feed him as soon as he whimpered so that he would not disturb relatives.

Her original housing association offered her a house but this was near her husband who had created problems regarding access to Andrew. As a result she felt unable to accept their offer. Mary's name had been on the waiting list of another housing association and she was unexpectedly offered suitable accommodation with them. The improvement in Mary's health and general well-being once she was housed was clearly evident.

Case Study 2

Mrs G is 42 years old and of below average intelligence. She had her own tenancy when she became pregnant. After the birth of her baby she spent most of her time at her unemployed boyfriend's flat. He shared the tenancy of this with his brother who was in employment. Her boyfriend made no contribution to the rent.

Mrs G gave up her tenancy after 6 months to move in with her boyfriend but 3 months later the family was served with an eviction notice as the working brother had not been paying his share of the rent. The Housing Department offered Mrs G and her baby 2 nights at the Hamish Allan Centre, then 7 days bed and breakfast. In that week Mrs G had to find private rented accommodation, or find a relative willing to take them in, and was told that her child would be put in care if she failed to do so. The Health Visitor involved with this family felt that this situation could have been avoided if the Housing Department had been more understanding of the reason for non-payment of rent. This lady will not be considered by the Housing Department for rehousing for one year.
Case Study 3

An eviction order was served to this girl because of her dirty house and unattended garden. She had been given the opportunity by her factor to amend the situation but failed to do so. She was therefore evicted with her 2 children - a handicapped daughter and an older son. At that time she was placed in homeless accommodation on the south side with her daughter, her son staying locally with his grandmother. She has had various addresses over the summer period but is now reasonably stable, staying with a cousin in 1-bedroomed accommodation in her original area. She has to be based there because of transport to school for her daughter. This situation poses a problem regarding stability, play facilities and schooling, but this girl will not be rehoused by the Housing Department.

Case Study 4

A woman, married with 3 children (2 to her husband, one to her boyfriend), living in family home in a private estate. She is going through a divorce and has no money and no employment. Her children attend the local secondary school and she wishes them to remain there. She has never been on the housing waiting list and the Housing Department have only offered her accommodation in poor areas. She met with a Welfare Rights Officer and was subsequently placed in temporary accommodation - a homeless flat - and is awaiting the offer of housing.

6.7: Comments on survey results

Health visitors remarked that they had seen improvements over a number of years for example in condition of accommodation. However, they felt that abuse of the benefits system by some people in the past has resulted in a gradual reduction in financial assistance for some groups. As a consequence of this some homeless families now find that benefits which they received previously are no longer available and this is reflected in a decline of their standard of living.

The health visitors offered tentative suggestions about how services to families could be improved.

. Closer liaison in each area between Housing, Social Work and Health Visitors.

. Liaison Health Visitor based at Hamish Allan Centre.

. Named Health Visitor in each area whose remit it was to liaise with named person in Hamish Allan Centre and local housing.

. Printed list of baby clinics, family planning clinics to be made available at Hamish Allan Centre to be given to each homeless family.

. ‘Information Pack’ in each homeless flat giving name of contact Health Visitor for each area.
Development of family centres with play therapists, social workers, health visitors and psychologists available in each area of the city (by having daytime family centres perhaps people would seek help before making themselves homeless).
Section 7: SPECIAL STUDIES OF HEALTH PROBLEMS IN THREE GROUPS OF SINGLE HOMELESS

Data on the health of the single homeless is here derived from three distinct sources - one specifically dealing with single males living in hostels, one dealing with young vulnerable homeless living in supported accommodation and one survey on residents of hostels.

Section 7.1 describes the study carried out by Dr Patrick McGuigan in his year as a trainee general practitioner in Bridgeton in 1991. During his traineeship Dr McGuigan became interested in the number of male patients living in hostels and made them the subject of his project.

Section 7.2 describes the work of the Glasgow Council for Single Homeless Stopover’s work with young homeless. It details the reasons for homelessness as collected routinely and describes the results of a study carried out especially for this needs assessment by the Stopover to assist in this health needs assessment.

Section 7.3 outlines the results of a Glasgow Council for the Single Homeless study of self-reported health status.

7.1: Single homeless males in hostels

Dr McGuigan was interested in finding out the special needs of this population. Prior to the study his preconceptions were of a dependent population with a high number of attendances, a high prescribing rate and a high proportion of patients claiming sickness benefit. In addition the population was thought to have high morbidity (especially psychiatric illness, alcohol abuse and minor ailments) and to display aggressive and demanding behaviour.

Dr McGuigan conducted a study in which he compared 63 hostel residents to an age-sex matched control group. This was done by identifying those living in hostels from their address on the records and choosing the patient from the general practice population who was closest to that person in age and who was of the same sex. This gave a set of 63 matched pairs on which a statistical analysis was carried out at the Health Information Unit. The study included patients living in 15 different hostels in the vicinity of Bridgeton.

The information about patients was gathered retrospectively from the medical records at the Health Centre. The variables used were: age; number of general practitioner attendances in 1991; medical history (recorded diagnoses); number of regular medications; issue of Form Med 3 (Sickness benefit) certificate for longer than 26 weeks.

The hostel residents were found to be aged between 18 and 87 with the majority being in their fifties and sixties. There were twelve men over seventy. The hostel residents are here described as ‘cases’ and their age-sex matches as ‘controls’.

The number of general practitioner attendances in 1991 can be summarised as follows:
<table>
<thead>
<tr>
<th>Number of attendances</th>
<th>Cases</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>33</td>
<td>17</td>
</tr>
<tr>
<td>1</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>2-5</td>
<td>10</td>
<td>23</td>
</tr>
<tr>
<td>6-10</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>&gt;10</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

The hostel dwellers had 184 attendances overall compared to 120 for the controls. The greatest discrepancy between the two groups is in the number who did not attend at all. Nearly twice as many hostel dwellers did not attend the general practitioner throughout the year. However when the cases and controls were considered as pairs and a paired t-test was applied there was no significant difference between the two groups at the 5% level.

The majority of both cases and controls were not on any regular medication at all but more hostel residents were not on medication (75%) than controls (57%). A paired t-test was again used and it emerged that there was a significant difference between the two groups with those living in hostel accommodation taking less medication.

Twelve of the hostel dwellers and thirteen of the control group were in receipt of a Form Med 3 certificate.

What was most interesting about Dr McGuigan’s findings was the morbidity. The hostel group showed a significantly higher incidence of alcohol abuse, schizophrenia, epilepsy and strokes. However, they showed a significantly lower incidence of arthritis, hypertension and peptic ulcers. There were no significant differences between the two groups with regard to drug abuse, chronic obstructive airways disease, pulmonary TB, fractures/traumas, anxiety/depression, skin conditions, gout and ischaemic heart disease.

These results are summarised below:

(63 hostel dwellers, 63 controls)

<table>
<thead>
<tr>
<th></th>
<th>Hostels</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug abuse</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Peptic ulcer</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Stroke</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Ischaemic Heart Disease</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Fractures/trauma</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>Anxiety/depression</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Skin condition</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Gout</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Hypertension</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Arthritis</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>22</td>
<td>8</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Chronic obstructive airways disease</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Pulmonary tuberculosis</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>
It emerged from the study that preconceptions about homeless single males are not necessarily true. As shown above the hostel residents did not have higher attendance records when compared with their age-sex match although they had a higher number of attendances overall and in fact had lower prescribing rates. Also they were not more likely to receive sickness benefit.

7.2: Young single homeless - GCSH Stopover

One of the provisions for young single homeless people is the Stopover on Pollokshaws Road which is short stay accommodation run by the Glasgow Council for Single Homeless. It caters for 14 people between the ages of 16 and 21 who can be either self or agency referred. Support is given on a round-the-clock basis and the hostel is nearly always full. The Stopover does not hold a waiting list and admittance depends in the first instance on whether a bed has just been vacated at the time of referral. The number of young people being referred to the project in 1991 was 20% higher than that in 1990 which in turn had increased 20% since 1989 according to the GCSH Annual Report 1991.

The factors which contribute to the client group’s homelessness are many and varied. The information given to the Stopover when a referral is made is routinely recorded and stored on a database. It includes such details as sex, age, reasons for homelessness, number of times referred and also brief notes on the history of each prospective admission. Dave Hewit of the Stopover produces summary statistics on an annual and six-monthly basis.

The figures shown here are in two categories - admissions and referrals (the referrals include admissions). The details for those admitted are more full and accurate as information is more forthcoming from the young people while they are living at the hostel. Those referrals who are not admitted either because there is no space or because they are not suited to the service offered must try to find accommodation elsewhere.

There were 601 referrals in 1991 and 121 admissions. In the first half of 1992 the number of referrals was 306 while there were 65 admissions. The factors contributing to the homeless state of the 601 people referred in 1991 are shown in Table 7A below (reasons not mutually exclusive).

<table>
<thead>
<tr>
<th>Reason for Homelessness</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Problems</td>
<td>120</td>
</tr>
<tr>
<td>Drug Abuse</td>
<td>100</td>
</tr>
<tr>
<td>Employment</td>
<td>75</td>
</tr>
<tr>
<td>Domestic Abuse</td>
<td>50</td>
</tr>
<tr>
<td>Other</td>
<td>75</td>
</tr>
</tbody>
</table>

47
Table 7A: Factors contributing to homelessness GCSH Stopover

<table>
<thead>
<tr>
<th></th>
<th>Referrals in 1991</th>
<th></th>
<th>Admissions 1991</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Total</td>
<td>Male</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>24</td>
<td>48</td>
<td>72(12%)</td>
<td>10</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>6</td>
<td>25</td>
<td>31 (5%)</td>
<td>2</td>
</tr>
<tr>
<td>Financial</td>
<td>88</td>
<td>47</td>
<td>135(22%)</td>
<td>33</td>
</tr>
<tr>
<td>Failed tenancy</td>
<td>37</td>
<td>32</td>
<td>69(11%)</td>
<td>12</td>
</tr>
<tr>
<td>Offences</td>
<td>140</td>
<td>26</td>
<td>166(28%)</td>
<td>50</td>
</tr>
<tr>
<td>Violence</td>
<td>39</td>
<td>11</td>
<td>50 (8%)</td>
<td>13</td>
</tr>
<tr>
<td>Step-parents</td>
<td>22</td>
<td>19</td>
<td>41 (7%)</td>
<td>8</td>
</tr>
<tr>
<td>Parents split</td>
<td>49</td>
<td>32</td>
<td>81 (6%)</td>
<td>19</td>
</tr>
<tr>
<td>Parent addictions</td>
<td>23</td>
<td>18</td>
<td>41 (7%)</td>
<td>13</td>
</tr>
<tr>
<td>Alcohol</td>
<td>26</td>
<td>12</td>
<td>38 (6%)</td>
<td>10</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>63</td>
<td>29</td>
<td>92 (15%)</td>
<td>16</td>
</tr>
<tr>
<td>Psychological</td>
<td>23</td>
<td>6</td>
<td>29 (5%)</td>
<td>6</td>
</tr>
<tr>
<td>Pregnant/has child</td>
<td>11</td>
<td>30</td>
<td>41 (7%)</td>
<td>1</td>
</tr>
<tr>
<td>Overcrowding</td>
<td>14</td>
<td>14</td>
<td>28 (5%)</td>
<td>6</td>
</tr>
<tr>
<td>Eviction</td>
<td>183</td>
<td>123</td>
<td>306(51%)</td>
<td>53</td>
</tr>
</tbody>
</table>

The most common reason for homelessness is eviction from a tenancy with 51% experiencing this. Financial problems and offences also figured highly with 23% and 28% respectively.

Drug abuse contributed in 15% of the cases, a parental split to 14% of cases, physical abuse to 12%, failed tenancy to 12% and violence to 8%. The other contributing factors and their incidence were sexual abuse (5%), stepparent problems (6%), parents addictions (7%), alcohol (6%), psychological problems (5%), overcrowding (5%) and pregnancy (7%).
For the 121 admissions in 1991 the corresponding figures are: eviction 64%; offences 52%; financial difficulty 38%; parental split 24%; drug abuse 21%; physical abuse 21%; violence 15%; parental addictions 15%; failed tenancy 17%; sexual abuse 12%; alcohol 13%; stepparent problems 11%; overcrowding 9%; psychological problems 7%; pregnancy 5%.

It can be seen from the referrals that women were affected by physical abuse in twice as many cases and by sexual abuse in four times as many cases as men. Offences and violence as causes of homelessness were much more common for men than women as were eviction, psychological problems, drug addiction and alcohol abuse.

The study carried out by the Stopover took place over two weeks at the end of September. It consisted of finding out what conditions any of the referrals were suffering from.

There were 32 referrals over the fortnight and information was gained about 22 of them from the young people themselves or from the agency referring them. Eleven had no known conditions. The other 11 suffered from a variety of ailments. Three people had asthma, one of whom was 5 months pregnant. One person complained of poor general health and one had an eating disorder. One of those referred had recently had a termination, one was on medication for depression following a suicide attempt. There were 3 cases stemming from violence - one slashed arm, one fractured cheek bone from an assault and one where the person had been attacked with an iron bar. Finally someone had had a heart condition since age 5 and received regular check-ups.

As can be seen from above, the young single homeless suffered from very different problems from their older counterparts.

7.3 Survey by Glasgow Council for the Single Homeless (1990)

A survey of the self-reported health status of 277 men and 65 women living in hostels was conducted during 1988 as part of a study of single homelessness and housing need in Glasgow (Glasgow Council for the Single Homeless, 1990) The results were summarised as follows:

1. Over 50% of male respondents and 60% of female respondents reported health problems. One-third reported chronic or serious health problems. About 9% of respondents were severely disabled. Comparison of the GCSH survey's health-related data with the findings of the General Household Survey demonstrated that hostel residents' health is markedly poorer than the health of the working population in Britain.

2. The health of some client groups appeared to be particularly poor. Among female respondents the most unhealthy groups were established residents, middle-aged women (45 to 60 year olds) and the younger, longer-term residents (women aged 25 to 44). Among male respondents the group in poorest health was the 45 to 64 year olds.

3. The survey results confirmed the existence of a substantial level of care and support needs in Glasgow's hostels for homeless people. There was a close association between poor health and extended hostel residence. The rehousing programme
almost automatically selects, or is selected by, the more able residents because these applicants are best equipped to move into mainstream tenancies; it therefore contributes to an accumulation of less fit residents. Permanently sick, disabled and otherwise vulnerable residents tend to regard hostel residence, whether by choice or necessity, as the appropriate or only housing solution.

4. Residents’ responses on GP consultations raised doubts about the adequacy of access to community-based primary health services. Residents’ health was found to deteriorate with age and length of stay without a corresponding increase in GP consultations.

5. 60% of all respondents stated that they attended a local doctor. 40% did not. Many of the latter group explained that they normally consulted a doctor close to a last address.

6. Further questions about residents’ health and about the quality of health care available to hostel residents were raised by the apparently excessive use made of hospital services.

7. Many residents received practical assistance with a variety of tasks from other residents and from hostel staff. No formal structures exist to target assistance according to need. The levels of informal support and assistance available appeared to vary much more than the difference in care and support needs.

8. Gender differences and hostel conditions (including scale and staffing levels) appeared to interact, to promote a climate conducive to informal practical support in the women’s hostels. The inference is that the men’s hostels could be made more conducive to group living.
SECTION 8: INITIATIVES

8.1: Local Authority

Statutory agencies such as the Glasgow District Council Housing Department and the Strathclyde Regional Council Social Work Department have an obvious and vital part to play in trying to solve the problem of homelessness and what causes it. Their initiatives are structured to address these aims. The Housing Department is currently implementing a Youth Housing Strategy funded by the Scottish Office which aims to provide furnished flats for 16 and 17 year olds. It is also developing an Adult Homelessness Strategy to help match up homeless with high quality bedsits and self-contained flats.

The Social Work Department has a team which works specifically with the homeless and provides a social work service where appropriate to hostel residents. However, in response to the recognition that there is a need for long term and intensive support for those hostel residents with serious or chronic health problems a specialist group called the Hostel Care Team was set up within the homeless section of the Social Work Department in 1991. The mission of the team was to provide services that allowed elderly and infirm residents to maintain a reasonable level of functioning by giving help with washing, dressing and toileting on a daily basis and by accompanying them to doctors, hospitals, social security and so on. The service is still in place and serves to fill part of a large gap in practical healthcare support within the hostels.

At present the team of 8 workers are seeing 80 cases who require varying degrees of support. Most of the hostels they visit, with the exception of the Salvation Army hostels, have managerial rather than care staff and the leader of the hostel care team felt that this limited the team's effectiveness as care is only given while the team worker is there. The team operates office hours on the assumption that anyone who requires a higher level of support should not be living in a hostel.

8.2: Greater Glasgow Health Board

The Greater Glasgow Health Board also has schemes which encompass the homeless and more recently has begun to develop services specifically for certain groups of homeless for example mentally ill people living in hostels. These are described in the following sections.

(i) Chest X-ray Service

Perhaps the longest running project managed by the Health Board is operated by the Chest X-ray Service under the supervision of Dr K R Patel, Consultant Physician. It was established in 1970 and has undergone various developments and changes since then.

The Chest X-ray Service in Glasgow has long carried out X-ray examinations of residents in model lodging houses, night shelters and common hostels as part of its role of surveillance of pulmonary tuberculosis in the community. However, the rate of tuberculosis in the hostel population was found to be consistently higher compared to other groups and indeed was nearly 34 times higher than that detected in those working in heavy industry. At the same time the uptake of X-rays for those living in hostel-type accommodation was less than 15% leading to the conclusion that incidence of tuberculosis was perhaps even higher than recorded.
Following the 1973 Crofton Report, Greater Glasgow Health Board established a system whereby incentives were given to encourage a higher uptake of X-rays amongst the homeless. The incentives were in the form of food vouchers which could be exchanged for food or money at hostels. The proportion of those being X-ray examined subsequently rose to 47% and the number of cases of tuberculosis being detected also increased. The service was operated through a mobile unit which visited hostels twice a year.

The incentive scheme is still in place and at the moment the value of the food voucher stands at £5. However, the mobile units no longer operate and although the surveillance of the single homeless population continues, all X-rays take place at the static unit at Cochrane Street. This has obvious implications for the uptake of the service as most of those who live in hostels or similar accommodation have no transport. Those who are ill would be even less likely to attend.

This decline in the service can only have a detrimental effect on the health of those living in hostels. Dr Patel suggests that the mobile units should be re-instated and that other health promotion could be carried out by these units.

If Glasgow follows the same trend of an increase of tuberculosis among the homeless as some large American cities then this service will become even more vital.

(ii) Eastern sector community psychiatric nursing - Hostel Project

A major advance has just been made by the Health Board with the introduction of a community psychiatric nurse who is solely involved in hostels working with those under 65 years of age. The nurse in post, Alice Docherty, describes her work as follows:

The hostel community psychiatric nurse post was created in response to an expressed need identified within the community. Service had previously been reactive rather than proactive. In previous years Housing Department Hostel staff had expressed their concern about 'mental health cases' within the homeless population in this sector and the fact that the addition of homelessness compounded any existing problems. In the summer of 1992 an experienced community psychiatric nurse was therefore released to work with the hostel population in the Eastern Sector. Contact was made, and links established, with the various agencies involved in provision for the homeless including the Hamish Allan Centre. This helped to create an awareness of the needs and problems of the client group living within the hostels. Following this, it became evident that some kind of training of staff in 'mental health awareness' was necessary and this was undertaken with the approval and assistance of the management of the Hamish Allan Centre.

An open referral system was established by the community psychiatric nurse which allowed hostel staff to identify those clients which they knew had mental health problems or suspected that problems may exist.

To facilitate the development of provision the community psychiatric nurse decided to take over the clinical nursing responsibility of any existing clients within the hostels. These included those clients who attended a depot clinic for medication administration. This numbered 25 clients over 8 hostels. While establishing a service for these clients new referrals were being received at a steady pace. This number increased as seminars were commenced. People were more aware of why the community psychiatric nurse was there,
what she did and what the correct criteria was for a mental health problem. She felt that referrals from the Local Authority Hostels were very appropriate and that they had realistic expectations as to feasible outcomes.

Interest in similar seminars was expressed by the voluntary and private sectors which resulted in a joint seminar being run to cater to their needs. Again this had the effect of clarifying the referral criteria, and removing some of the frustration often expressed in relation to service shortfalls. Explanation of the Mental Health Act, its application, and access to psychiatric services created a better understanding and platform from which to work than had been previously available.

The aims and objectives are:

To establish a service for those clients known to be living within the hostel population.

To identify those persons requiring a service within the hostels.

To refer to other agencies as appropriate:

- Medical Officer - general practitioner, psychiatrist
- Services for mentally handicapped
- Social work
- Community psychiatric nurse for the elderly
- Other relevant agencies.

Mental Health Education - for clients, workers and other professionals.

Reduction in illness rates.

Provision of a variety of interventions at point of access.

Monitoring treatment and administration of medication.

Advice and counselling where needed.

Improvement in quality of life where possible and maintenance when no improvement possible.

Hygiene issues addressed. Coordination of bathing and clothing provision through statutory and voluntary agencies.

Improvement of integration with the community - use of facilities, clubs and services.

Advocacy - housing, finance and judicial issues addressed when necessary.

The project should be flexible and increase in size in response to proven need. It should be evaluated after one year to assess its validity.
Problems that have been encountered to date include:

Limitations on service provisions due to geographical limitation (3 large hostels outwith the Eastern Sector).

High incidence of elderly within the hostels. Clear need for a community psychiatric nurse within the 'Elderly Mentally Ill' team to work specifically in the hostels.

High incidence of mental handicap within the Hostels - clear need for a community mental handicap nurse within the team or affiliated to it through mental handicap service provision.

Due to the type of work and the poor compliance of the client group, a mixture of grades of staff to address specific aims.

Confidentiality issues raised due to the inability to share relevant information with the other agencies who are most involved in the care of the client - eg housing staff, hostel care staff, hostel managers. Communication often one-way from the referrer but feedback can be difficult.

Inappropriate referrals from a district nurse involved in a separate study in one of the large commercially run hostels. The problem would seem to be the perception of mental illness.

(iii) Other mental health outreach activities
Another outreach initiative has come from the Mental Health Unit. Dr Dallas Brodie, a Consultant Psychiatrist has regular meetings at The Wayside Club. This came about through the recognition that many vulnerable people with mental health problems could be identified through this source. At the meetings Dr Brodie is able to give advice on mental health and make appropriate referrals.

Dr Brodie also makes regular visits to the Talbot Association's Women's Centre. There he has consultations with individual residents and provides welcome support and advice to staff.

(iv) Notification system for homeless families
A health board scheme which aims to improve care of homeless families consists of a notification system. This is operated through the Hamish Allan Centre who notify the health centre in the family's new area. However the system is not effective due to incomplete or out-of-date information.

These schemes are the only major Health Board initiatives which were discovered during the period of fact-finding. However there are many professionals at the primary care level who seek to deliver the same standard of service to the homeless as they would to any other patients, despite the difficulties. This is a strong foundation on which to build a more equal service for the homeless.

8.3: Voluntary and other agencies

(i) City Centre Initiative
The City Centre Initiative has been in existence for approximately 18 months. It involves an inter-agency partnership between Glasgow Council for Single Homeless, YMCA (Glasgow)
and the Education and Social Work Departments of Strathclyde Regional Council. The CCI is in the process of identifying and compiling issues which affect vulnerable young people who converge on the city centre because they have nowhere else to go.

In their first year of operation (the 12 months to April 1992) the CCI made contact with 412 individuals ranging in age from 8-25 years, most of them being aged between 15 and 21. 38% were women and 71% came from Glasgow. 42% had experienced homelessness and 23% had experienced sleeping rough.

The health of these young people in general is poor as a result of poor nutrition or alcohol/drug abuse. There is also the problem of sexually transmitted diseases. Mental health problems are also encountered. Additionally these young people are at risk of being caught up in prostitution.

As a lot of these youngsters do not have an address, they do not have access to services. As a result they do not know where to go for health care. Consequently, very often a health problem is dealt with only when it has reached an acute stage.

The project workers aim to continue responding directly to young people's needs.

(ii) Talbot Association Supported Accommodation
In response to the urgent need to provide a stable environment for those who experience frequent crises, The Talbot Association is building a new facility funded by Scottish Homes with residential, social and therapeutic facilities. The running costs deficit will be met by the Mental Health Specific Grant. The Association's aim is to improve the lives of an 'often-forgotten' group of people. It is hoped that the project will open in early 1993.

(iii) Glasgow Council for Single Homeless
The GCSH runs two projects for women concerning mental health and alcohol and addictions. Both groups are well attended. The work aims to promote a better attitude to health and GCSH is working with the women to produce a health information pack geared to those it is trying to reach.

(iv) The Red Cross
The Red Cross has a group of volunteers who make regular visits to the Great Eastern Hotel providing basic health care services to elderly and disabled residents in the form of bathing, haircuts, shaves and changes of clothing.

(v) The Monitored Dosing System
One suggestion which was welcomed throughout the Talbot Association's hostels and residential projects came from the private sector - Boots the Chemist. The Talbot and Boots are now working together to implement the Monitored Dosing System (MDS) for administering medication.

The system has been introduced by Boots who own the rights to it. MDS originated in Canada but has been operating successfully in England for some time. The system is loaned to residential homes and operates as follows.

The prescriptions are either posted to Boots or uplifted by the home, depending on the
A study on men living in a commercial hostel

The project will present a general description of hostel provision and their facilities for the 1,100-1,400 Single Homeless men in Glasgow.

A questionnaire asks the residents of the Great Eastern (about 170 men) and a comparison group in another hostel about their lifestyle and health experience.

A District Nurse research assistant is assessing as many residents of the Great Eastern Hotel as possible using validated tools and nursing assessment. Over 50 men have needed treatment and referral to health services. The role of nursing advocacy is also being examined.

After referral medical and nursing practitioners will be interviewed and asked about their action and its rationale.

A selection of 6-10 anonymised cases will be presented to a panel of six district nurses from another health board to establish what action they would have taken.

In conclusion quantitative analysis will be made of the data from the subject group juxtaposed with general information about this client group. Morbidity amongst the subject group, nursing and medical referrals and action taken will be analysed. A qualitative analysis of the residents cases linking themes and comparison with the panel's report will be made. Recommendations will be made regarding future nursing practice (and liaison with other agencies) towards this client group.

Individual volunteers

Help from individual volunteers has been steady over the years with people including health professionals giving up spare time to provide services to rough sleepers and hostel dwellers. These small scale 'projects' have included such people as chiropodists who have seen a need and used their skills and own time to try and meet it.
Initiatives on this personal level are much appreciated by such groups as the Salvation Army and the Talbot Association, but they can never hope to meet the level of need encountered. Volunteers are unable to spend unlimited time and cannot always be available so more help is always required.

8.4: Comments on initiatives

This section has outlined initiatives undertaken by the Greater Glasgow Health Board and other groups. The overwhelming impression was of a lack of innovation on the part of the Health Board. The introduction of the community psychiatric nurse service for the hostels in the Eastern sector is a major step forward and has been met with a positive response. Within the voluntary sector projects continue to be developed with the most recent one being the provision of supported accommodation for homeless people with mental health problems.

Each Unit General Manager of Greater Glasgow Health Board was contacted by letter and given the opportunity to highlight any initiatives within their own area. No further initiatives were brought to attention.

Summary of initiatives

<table>
<thead>
<tr>
<th>Health Initiative</th>
<th>Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest X-ray incentive scheme</td>
<td>Greater Glasgow Health Board (Chest X-ray service)</td>
</tr>
<tr>
<td>Hostel Community Psychiatric Nurse</td>
<td>Greater Glasgow Health Board (Eastern Sector Community Nursing)</td>
</tr>
<tr>
<td>Notification scheme for homeless families</td>
<td>Greater Glasgow Health Board/ Hamish Allan Centre</td>
</tr>
<tr>
<td>City Centre Initiative (health advice and support to young homeless people)</td>
<td>(Glasgow Council for Single Homeless, YMCA, Strathclyde Regional Council Social Work and Education)</td>
</tr>
<tr>
<td>Supported accommodation</td>
<td>Talbot Association</td>
</tr>
<tr>
<td>Health promotion and information</td>
<td>Glasgow Council for Single Homelessss</td>
</tr>
<tr>
<td>Basic health care for elderly and disabled residents of the Great Eastern</td>
<td>The Red Cross</td>
</tr>
<tr>
<td>Monitored Dosing System, for medication in communal establishments</td>
<td>Boots the Chemist</td>
</tr>
<tr>
<td>Study on men living in a commercial hostel</td>
<td>John Atkinson, Glasgow Polytechnic</td>
</tr>
</tbody>
</table>
There may be other initiatives within Greater Glasgow Health Board and the voluntary sector which did not come to light during this needs assessment.
Section 9: DISCUSSION

In order to put the results of this report into context it is important to consider the underlying issues in health care of the homeless. The following discussion seeks to summarise the important points which perhaps did not come out in the data analysis.

There were mixed reactions to this assessment of the needs of the homeless. Those in the front line of caring for the homeless welcomed the interest of the Health Board and were keen to participate. However there was a degree of cynicism as many felt that the problems of the homeless had not been addressed in the past. In fact some had already undertaken their own health initiatives to fill what they perceived as large gaps.

There is a diversity of people who are homeless but one factor is common to all and that is poverty. Whether living in temporary accommodation or hostel accommodation or sleeping rough the living conditions are not conducive to a healthy lifestyle. In addition many single homeless people find their problems compounded by alcohol addiction.

A growing problem is that of the young single homeless population. One reason cited as contributing to this is the change in Government policy on benefits to young people. The special needs that arise should be borne in mind throughout the discussion.

It was widely felt that the health service treatment of homeless people is not what it should be. Some expressed the opinion that there is a two-tier system which disadvantages those with no home.

There were two causes for this. Firstly the attitude of health service staff could be affected by their pre-conceptions. This may mean that they view the homeless as a troublesome group of people who can at times be difficult, demanding or aggressive. In addition it could be thought of as work which is not rewarding. Secondly the system itself can work against the homeless. Instances of this include the impossibility of registering with a general practitioner without an address, the difficulty in frequently changing general practitioners when constantly moving around and the problems encountered in trying to access health care without a general practitioner.

Stereotyping of hostel dwellers and rough sleepers can be based on past experiences of dealing with this group of people. Often it is not unfounded as many do exhibit 'difficult' behaviour especially if they are seeking health care after excess drinking. Drunken and aggressive behaviour upsets other patients and may lead to expulsion and police intervention. Obviously the health problem which prompted attendance in the first place will remain untreated. There can be other lingering effects. For example one man refused to return to hospital to complete his treatment after having been ejected for abusive behaviour previously.

Other groups of homeless also felt that their problems were not treated sympathetically. Hostels where young people lived mentioned that quite often general practitioner attention was sought for minor complaints as a means of attention seeking. One example was given of a girl who complained of a painful ear and insisted that she needed to see a doctor. However further investigation revealed that the problem was simply that her glasses were ill-fitting.
A major problem in delivering health care to homeless people is that they are not always receptive to services. Some people do not want to be helped. For others it is difficult to maintain treatment when they live from day to day. Courses of medication may go unfinished until the problem becomes acute and the healing process must be recommenced. Also for a large number, health is not a priority as they have many more pressing concerns. One consequence of this may be that they appear to have a casual attitude towards their health. When there is little money to cover grocery bills or heating bills it is unlikely that such things as nutrition will be considered important. Problems are compounded by lack of self-esteem and prior negative experiences which both lead to low expectations of the health service.

Thus the health service is not always good at delivering and the homeless are not always good at receiving health services and there are many problems which need to be addressed. Two areas in particular are the health of young people and the mental health problems which exist in the homeless population. Both are discussed more fully below.

Young People
It is of growing concern that the number of young people who are homeless is on the increase. With this new wave of homeless people comes a different set of problems. Many are from a very unstable background or have suffered a traumatic childhood or have a history of care. Young people who come to the city with no money or place to stay are vulnerable to becoming involved in crime or exploitation. The City Centre Initiative has highlighted cases of alcohol and drug abuse and both male and female prostitution. Again poverty is a key factor with lack of nutrition and poor general health being common. The aim of the City Centre Initiative is to provide advice and information about health and other issues but the young people must access services themselves. The matter of how these young people break out of their damaging lifestyle needs to be urgently addressed.

Young homeless people who have managed to secure a place in temporary accommodation are also not without their problems. An example was given of a teenage boy who had an alcohol problem. After a drinking bout he spent the night sleeping on the streets. On returning to his supported accommodation it was observed that he had a wound on his forearm. On close inspection this was found to be a human bite mark but he had no recollection of any incident. Suicide attempts are not uncommon.

Also of importance is the matter of family planning for young people. One care worker pointed out that the open waiting room at the health centre made it very embarrassing for young girls to state the reason for their visit when attending for pregnancy tests, smear tests or contraception. At another supported housing project the local general practitioner refused to prescribe contraception for anyone including married women and so girls had to go to another health centre. Difficulties arose with regard to who should be allowed in the consulting room. Some young people felt the need for the support of care workers when attending the general practitioner but general practitioners sometimes objected to this. Conversely there were instances where girls were accompanied by a friend when receiving pregnancy test results. Health centre staff failed to appreciate the need to maintain confidentiality in this type of situation. Also in a hostel environment lack of privacy means that everyone would know about the pregnancy before the girl had a chance to consider her options. A more flexible approach to all these problems would be helpful.
Mental Health Problems

It is important to realise that homelessness will probably compound any existing mental health problems. The environment in which single homeless people live is largely unsuitable for those with mental disorders. Feelings of isolation or despair may be exacerbated by hostel living and the condition can go unnoticed until a crisis situation develops. Even then treatment may be inappropriate. Examples were given of suicide attempts or self-abuse in which the physical symptoms were treated but not the underlying cause. One particular example was that of a resident who became violent and abusive. Attempts to get an ambulance failed and two care staff used their own transport to take the man to casualty. Upon arrival his behaviour was such that three people were required to hold him down. An injection was administered to calm him down and he was returned to the hostel. There are also those whose behaviour is withdrawn and they are unlikely to get the attention they need - “the worst cases get the least attention, the most extreme cases get the most attention”.

Problems have arisen as a result of a difference of opinion over what mental illness is. The term “personality disorder” is used in Scotland to describe cases which are not amenable to intervention or treatment as they do not fit into any diagnostic category. Situations have arisen where acute episodes have occurred and the only recourse is to utilise the Accident & Emergency service. Assessment has then been carried out and the label “personality disorder” attached as a result of which no treatment is made available. Return to ‘the community’ follows soon after. Scotland differs from England in this respect as in England a personality disorder is considered to merit treatment. In Scotland the system of definition results in vulnerable people slipping through the net of care.

A cycle can begin for those people who do not receive help. Their challenging behaviour may mean that they are banned from District Council and some other hostels. A spiral begins with people going from the hostel to the street, causing a breach of the peace and being arrested and perhaps spending time in prison. Upon release the cycle begins again. The DSS Resettlement Unit recognise this problem and have tried to break the cycle by being willing to provide accommodation as an alternative to going through the judicial system.

In addition to these problems there has been difficulty in obtaining emergency psychiatric assessments. Often this is needed to decide the suitability of an individual for a certain type of accommodation. Without an assessment the person may end up with inappropriate or no accommodation. Follow-up assessments were not easy to obtain either.

There are two distinct needs with regards to mental health care. Those who have been discharged from long term psychiatric care are mostly well provided for with regard to follow-up and support in the community. It was not the case that psychiatric wards were discharging long term patients with nowhere else to go as the Health Board purchases suitable supported accommodation for these patients. The concern lies with those who have had acute admissions for whom follow-up is often inadequate or non-existent. Sometimes this is due to ex-patients moving on without anyone knowing where to.

Another problem has been proved to exist by Alice Docherty, Community Psychiatric Nurse. In her first month working in the hostels she had 15 referrals. Of these, 6 had no previous contact with psychiatric services. Five of these 6 were described as psychotic (which may include people who have a severe behavioural problem but may be classified as having a personality disorder). There were no previous long-term residents in this caseload.
The service provided by Alice Docherty is for those who are under 65 years of age. There is no such provision for the elderly hostel residents who are spread across the caseloads of five other community psychiatric nurses. One of these community psychiatric nurses has six on her caseload who are living in the Great Eastern Hotel, and another has about 12 on his caseload.

There also appears to be some difficulty with regard to confidentiality. Although care workers give information to the psychiatric services when making referrals, confidentiality means that they get little feedback. This one-way flow of information disadvantages the care workers and thus the person in their care.

It is probable that the mental state of hostel residents will be adversely affected by the living conditions - as one resident of the Great Eastern Hotel said when asked how he was, "Alright considering I live here". John Atkinson's referrals from the Great Eastern (which were considered inappropriate by Alice Docherty) were assessed for depression using a scoring mechanism which does not take into account the surroundings. The community psychiatric nurse feels that a number of the referrals were depressed solely because of their surroundings.

It is thought that there are many people with mental health problems (particularly those who are withdrawn) living inappropriately in large scale hostels. These people would benefit from living in some type of supported accommodation but there is a lack of provision for this.

More in-depth research has been carried out by Isla Laing for GCSH, The Richmond Fellowship and Glasgow District Housing Department into mental health and homelessness. Her results are awaiting publication.

Concluding Remarks
In common with others, this report concludes that there is a clear relationship between homelessness and poor health. The question of how to tackle the problems endemic in the homeless population is a matter which has been considered by many. There has been a variety of ideas on how to address health concerns.

One approach which has been suggested is the setting-up of a health care team whose remit would be to deliver health care exclusively to the homeless. This would hopefully ensure that no-one 'slips thought the net'. However there have been objections to this on the basis that this would create a separate and second-class health service. It also goes against the aim of rehabilitation into the community.

Those who oppose this scheme suggest that help should come from within the existing structure. This would require that within each speciality there would be one health professional with the particular aim of ensuring delivery of services to the homeless.

It would appear that any future initiatives for the homeless should be based on the recognition that they have special needs. Planning should be done in partnership with the other voluntary and statutory agencies involved. A comprehensive and co-ordinated approach is required for each type of homelessness and the recommendations in the following section should be taken into consideration.
In anticipation of the implementation of the Community Care legislation in April next year there has been much concern expressed with regard to its effect on the homeless. Since the new concept is based on care in the home and the community questions have been asked about where care can be given to those who have no home. How the homeless will be incorporated into the community health strategy remains to be seen but it is of vital importance.

Homelessness is unlikely to go away as increasing numbers of homeless young people show. Second generation unemployment is already a problem which contributes to homelessness. Where both parents are unemployed and children reach the age of 16 without securing employment or a place on a training scheme tension can arise in the household. It may become impossible for the child to remain at home or they may be told to leave. Unless the young person has a place to go this may lead to homelessness. This second generation unemployment is bound to be on the increase.

The staff of hostels have noticed the rise in numbers of young residents and realise that they must adapt to this new client group. Young people have brought a new set of problems including drug abuse and it is difficult for staff to cope with these.

One final comment is that those working with the homeless showed a great deal of commitment to helping this group. They saw this needs assessment as an opportunity to highlight both the shortcomings and the more positive aspects of the Health Board's input and in doing so contributed greatly to this report. The knowledge is now there and the need has been identified - some imagination and expansion of successful initiatives are what the Health Board now needs to take progress further.
Section 10: SUMMARY OF HEALTH PROBLEMS OF EXISTING SERVICES AND OF SUGGESTIONS FOR IMPROVEMENT

A - HOSTEL DWELLERS: THE SINGLE HOMELESS SURVEY OF MANAGERS OF 34 HOSTELS (1,555 MALE AND 183 FEMALE AND 695 MIXED PLACES)

1. Estimated prevalence of health problems
   42% alcoholism.
   27% physical disability (e.g., respiratory/heart disease, diabetes, ulcers).
   26% behavioural abnormality.
   7.5% drug addiction.
   4% incontinence.

2. Support from primary care
   Ranged from very good where cooperation had developed over time to very poor
   where no such links had been established - hostel dwellers often being refused as
   patients or only accepted as temporary residents. Some hostels insisted on
   registration of all clients with a general practitioner (usually a specified doctor)
   whereas others merely encouraged registration or had no policy. On average about
   80% of hostel dwellers were registered with a doctor.

   Eighteen of the 34 hostels were regularly visited by a social worker, 9 by a community
   psychiatric nurse, 5 by a district nurse and 4 by a health visitor.

3. Difficulties experienced in obtaining health services
   About 25% of hostel managers experienced difficulty at least occasionally in obtaining
   emergency general practitioner help, and 32% experienced difficulty in obtaining
   psychiatric assistance. Specific problems identified included after-care of patients
   discharged from mental hospitals; lack of a chiropody service; the need for regular
   visits by a district nurse/health visitor or community psychiatric nurse; lack of
   sympathy from some general practitioners; the need for drug or alcohol counselling;
   the need for preventive health services, including family planning; speedier and more
   sympathetic response from the ambulance service; lack of care in prescribing
   medication.

4. Suggestions
   a) Training of hostel staff in dealing with psychiatric and other crises, the use/
      misuse of drugs, first aid and occupational therapy.
   b) Establishing effective links between each hostel and specified general practices,
      mental health services and community nursing services.
   c) Encouraging a more sympathetic attitude from health service staff to this client
      group.
   d) Provision of a chiropody service.
B - SHARED ACCOMMODATION FOR HOMELESS PREGNANT WOMEN SURVEY OF MANAGERS OF TWO HOSTELS RUN BY THE INNOCENTS (15 PLACES)

1. Estimated prevalence of health problems
   No obvious problems with physical health, but three of the 10 residents had antisocial, repetitive or withdrawn behaviour, and one other person was visited by a mental handicap nurse.

2. Difficulties experienced in obtaining health services
   None. Resident however often fail to attend regularly for antenatal care.

3. Suggestions
   Visits from a midwife to provide antenatal care.

C - ROUGH SLEEPERS; SURVEY OF MANAGERS OF TWO DAY CENTRES (SALVATION ARMY AND WAYSIDE CLUB: ABOUT 100 DAY ATTENDERS)

1. Estimated prevalence of health problems
   95% alcoholism and/or drugs; otherwise mainly cuts, bruises and other physical injuries due to accidents and violence; stress due to fear of violence.
   Epilepsy (? associated with alcoholism)
   Acute psychiatric disturbance.
   Nutritional and feet problems.

2. Difficulties experienced in obtaining health services
   Salvation Army: psychiatric help very difficult to obtain. Even if client is admitted to hospital, he/she is almost always discharged the following day with no follow up.
   Wayside Club: has regular visits from and active involvement with community psychiatric nurse and consultant psychiatrist. General practitioners are usually reluctant to visit the centres in an emergency.

3. Suggestions
   Regular visits from community psychiatric nurse or other mental health professional (cf Talbot Centre).
   Chiropody service for Salvation Army (Wayside Club has chiropodist attending on voluntary basis).
   Provision of supported accommodation for this group (cf that provided by Archdiocese in Easterhouse, and the Richmond Fellowship).
   Encouraging a more sympathetic attitude towards this client group.

D - SURVEY OF TEMPORARY ACCOMMODATION FOR ROUGH SLEEPERS IN KINGSTON HALLS: 25 TEMPORARY PLACES (PLUS 65 PERMANENT PLACES)

1. Health problems
   As for rough sleepers generally (C above). Also some with Korsakoff’s psychosis and dementia.
2. Support from primary care
   Daily visit from general practitioner (on roster). Monthly visit from CPN.

3. Difficulties experienced in obtaining health services
   None for general practitioner or acute hospital services. Frequent difficulty however
   in accessing mental health services.

4. Suggestions
   Single general practitioner to provide and coordinate services - including psychiatric
   and geriatric services. Roster has too many doctors for any continuity to be
   established.

E - YOUNG (16-21 YEARS) SINGLE HOMELESS: SURVEY OF GCSH STOPOVER (14
SHORT STAY PLACES)

1. Health problems
   Half of 22 persons referred over a two-week period had ailments. These included
   asthma (3), injuries resulting from violence (3), depression, a recent termination,
   pregnancy, ‘poor general health’ and an eating disorder.

   Of 601 referrals during 1991, 40% were women; 121 were admitted, (43% women).
   Drug abuse contributed to 15%, parental addictions to 7%, pregnancy also to 7%,
   alcoholism to 6%, and psychological problems to 5%.

2. Difficulties in obtaining health services
   Ambulance difficult to obtain in overdose situation.

3. Suggestions
   Funding of this project is about to end. Efforts should be made to enable this project
   to continue.

F - FAMILIES IN TEMPORARY ACCOMMODATION

Health visitors identified 260 addresses where homeless people were living: 545 adults, 455
children and 62 people of unknown age. A sample survey of 72 families was then conducted
by the health visitors. 35 families shared accommodation with friends or relatives, 26 lived
in temporary local authority flats etc, 4 in privately rented houses, 2 in bed and breakfast
accommodation and 4 in other types of accommodation.

The 72 homeless families included 115 dependent children.

1. Health and related problems
   Anxiety, fear, weariness and depression were common - mainly due to uncertainty
   and unsatisfactory living conditions - but sometimes there was relief at being away
   from violence etc. 20% of respondents said that they were always under stress and
   11% that they were always depressed. The following problems were also identified:
Inadequate home safety (21%).
Overcrowding (43%).
Dampness (11%).
Inadequate toilet (7%) and laundry facilities (18%).
Mother and children sharing a settee in two instances.
Inadequate heating (26%).
Unacceptable neighbourhood (14%).
Unreasonable behaviour by landlord or other families (6%).
76% of adult respondents smoked; 29% said that they had never received any advice or encouragement to give up smoking.

27% of the 92 children for whom information was recorded were reported to have behavioural disturbances - in most cases these becoming evident only since the family became homeless. 26 children had disturbed sleep patterns - again mainly since becoming homeless. Other conditions which were unusually prevalent were asthma (14 children) other chronic chest infections (25 children), chronic sickness and diarrhoea (8).

2. Difficulties in obtaining health and other services
Over 85% had seen the general practitioner and health visitor within the six months prior to the survey. Only four families were dissatisfied with the services received from the general practitioner; seven were dissatisfied with the hospital accident and emergency department and 12 with the social worker.

The main difficulties suffered by these families - and contributing to their relatively poor health - concerned the condition of the house, the type of area and the numbers and behaviour of those occupying the same premises.

3. Suggestions
a) Named health visitor in each area to be responsible for collating information about homeless families, for liaising with a named person both on the local housing department and in the Hamish Allan Centre, and with social work.
b) Health visitor based at Hamish Allan Centre.
c) Health visitors to visit homeless families as a priority.
d) Provision of better advice facilities in order to try to prevent families becoming homeless.
SECTION 11: RECOMMENDATIONS

1. A small group of professionals should be established to consider the findings of this report and to assess the validity and feasibility of the recommendations. This group might comprise a community psychiatric nurse, a consultant psychiatrist, a general practitioner, a consultant in public health medicine, representatives from social work, housing and voluntary organisations, and the authors of this report.

2. The service provided by the single community psychiatric nurse to 12 hostels in the East sector for hostel dwellers under the age of 65 years should be evaluated with a view to reinforcing and extending it. The limitations of the service to people under the age of 65 years who are mentally ill, leaves other categories of people (the mentally handicapped and elderly) with as yet no service. Community psychiatric nurses also need to be able to access resources.

3. The provision of a psychiatric assessment facility in the emergency placement unit at Bell Street hostel resulted in some people being allocated more appropriate supported accommodation rather than being transferred to a hostel. This facility should be extended to other areas.

4. Consideration should be given to employing a community psychiatric nurse specialist for alcohol addiction.

5. The service provided by the consultant psychiatrist to the Wayside Club and Talbot Association women’s centre should be evaluated, also with a view to extending it.

6. There should be a greater input by the district nursing service to the hostels, as there is a great need for assistance with physical health problems especially among the single males.

7. A health visitor should be identified in each health centre and community nursing ‘base’ who would take responsibility (on a part time basis) for collating information about all homeless families in the area, for assisting in negotiations with the local housing office(s), for liaison with the Hamish Allan Centre, and for ensuring that homeless families are visited as a priority.

8. In those areas where there are travelling people a health visitor should be given responsibility for assessing the needs of this group, for coordinating services and as an advocate.

9. A motivated health visitor (or preferably two people, each working part time) should be appointed on a trial basis to the Hamish Allan Centre in order to help develop support networks for homeless people who are referred to and/or placed by the centre. This would also foster collaboration between the housing department and community nursing.

10. Information about the whereabouts of homeless families with young children should be passed from the housing and social work departments to the health visitors with responsibility for the welfare of these children unless there is a clear reason for not
doing so. These children are extremely vulnerable and it is most important that health
visitors are assisted in every way possible to maintain contact with these families and
to ensure that they receive all possible support and help.

11. Health visitors attending families with young children should identify, and be able to
call on support and advice for, cases where there is a risk of homelessness. They
should also act as advocates for families whose living conditions are clearly unsatis-
factory.

12. Ways should be sought of improving the attitude of health service professionals to the
needs of homeless people. These might include study days or half days for general
practitioners, symposia, project work by trainee general practitioners etc. The
recently appointed general practice audit facilitators might assist in this process.

13. Hostel staff should be provided with more training in the management of mental
health problems and in 'health awareness' (particularly in relation to drugs) with
subsequent follow up support. This will enable staff more readily to identify people
'at risk' and to take appropriate action in the case of emergencies.

14. The possibility of a midwife attending The Innocents hostel occasionally should be
explored.

15. The possibility of providing occasional chiropody services at day centres for 'rough
sleepers' and hostels should be explored.

16. The doctors providing general practitioner clinics in certain hostels and at Kingston
Halls should be approached with a view to improving continuity of care (ie, by having
a specific doctor or pair of doctors rather than a large roster). For other hostels cover
should be negotiated from a specified practice for each hostel for emergencies with
possibly a weekly surgery to reach those individuals who will not actively seek a
general practitioner.

17. Information packs about health (and social) service facilities should be made available
at the Hamish Allan Centre and in homeless flats.

18. Efforts should continue to make hostels less stressful places to live in. Reducing noise
levels, and particularly trying to eliminate the need to house people in hostels
temporarily whilst waiting more suitable accommodation would help greatly in this
respect. The more 'permanent' hostel dwellers appear to dislike people with housing
problems who are seen as just 'passing through'.

19. Homeless people have considerable health and social care needs and will usually be
living under stress. The problems are greater still if children are involved. Professional
workers should understand that this is a group of people which requires help above
almost all others, and if adequate help is not provided for them then there is little point
in focusing effort on families with fewer or no problems.
20. Although homeless people have considerable need for health care and do in fact consume significant health service resources, the health needs of this very heterogeneous group have not previously been analysed as a whole. This present analysis is by no means definitive, but requires ongoing data collection and analysis in order to validate and extend the conclusions and recommendations.

21. The Health Board should be represented on the local liaison committee for travelling people.

22. The five District Councils within the GGHB area should provide permanent sites (with water and toilet facilities and a site manager) for the numbers of travelling people recommended by the Advisory Committee for Scotland's Travelling People.

23. A summary of this report and the recommendations should be sent to all those who participated in the surveys for their comments and possible discussion.
SECTION 12: SUGGESTED RESPONSIBILITIES OF HEALTH CARE PROFESSIONALS FOR HOMELESS PEOPLE

A) Monitoring Group (See recommendation 1 above)
   i) Continue assessment of the health care needs of homeless people on an ongoing basis.
   ii) Establish liaison with housing and social work representatives at appropriate levels.
   iii) Attempt to improve the attitude of health care and other workers towards the problems of homeless people - for example in training programmes, seminars and by providing information.
   iv) Facilitate links between hostels and other facilities used by homeless people and (a) general practitioners, (b) mental health services.
   v) Attempt to determine (by means of trial projects etc) the most suitable form of input by community nurses (community psychiatric nurses, district nurses and health visitors), chiropodists and others into hostels and other facilities for homeless people.
   vi) Collate information about the needs of all groups of homeless people and to develop an advocacy role on their behalf.

The group might meet three times in the first year, and twice yearly thereafter.

B) Health Visitors with specific responsibility for homeless people
   It is suggested that one health visitor in each health centre or community nursing base should be given responsibility on a part time basis for assessing the health needs of homeless people in the area and for ensuring that as far as possible these needs are met. It is envisaged that all health visitors should take on an additional part time responsibility such as this (eg for disabled people, children with congenital anomalies, the elderly etc) and that there would be no additional resource requirement. The duties of health visitors with a special responsibility for homeless would include:

   i) Collating information about homeless people and families from health visitor and district nursing colleagues operating from the same centre.
   ii) Establishing an effective working relationship with (a) named individual(s) in the local housing office.
   iii) Making general practitioners, social workers, housing personnel and others more aware of the health needs of homeless people.
   iv) Identifying and coordinating sources of support for homeless people.
   v) Acting as advocates for improvements in services.
   vi) Ensuring that as far as possible no children have their future health jeopardised by unsatisfactory living conditions.

C) Health visitor for the Hamish Allan Centre
   Two health visitors, each working on a half-time basis, should be based at the Hamish Allan Centre for a trial period in order to establish a more effective working relationship between the homeless unit, local housing officers and the health visitors with special responsibilities for homeless people.
D) Community nursing input in hostels

Discussions should take place between the community psychiatric nurse with special responsibility for hostels in the East sector, and representatives of local health visitors and community nurses in order to determine appropriate input to hostel accommodation.

E) Health visitors with specific responsibility for travelling people

It is suggested that in those areas where there are travelling people a health visitor should be given special responsibility (among her other duties) for assessing the needs of travellers, for co-ordinating services and as an advocate. The objectives are illustrated in Chapter 5.
ACKNOWLEDGEMENTS

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APPENDIX 1

Analysis of records on the Community Health Index for residents of hostels

In an attempt to ascertain more details about the homeless people in Greater Glasgow Health Board, Paul Sinclair, a summer student at the Health Information Unit, conducted an analysis using the Community Health Index (CHI) which is a computerised file of all residents in the Greater Glasgow Health Board area who are registered with a general practitioner.

This analysis involved using the unit postcode of each of 34 hostels to extract the names, sexes, ages and addresses of those people living at that unit postcode. The people whose addresses did not correspond with that of a hostel were eliminated from the analysis. The results are summarised as follows:

Age sex breakdown from CHI (From 34 hostels)

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<th>Female</th>
<th>Total</th>
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<td>77</td>
<td>98</td>
<td>175 (10%)</td>
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<td>196</td>
<td>80</td>
<td>276 (15%)</td>
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<td>151</td>
<td>32</td>
<td>183 (10%)</td>
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<tr>
<td>40-49</td>
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<td>311 (17%)</td>
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<td>135</td>
<td>28</td>
<td>163 (9%)</td>
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<td>&gt;80</td>
<td>49</td>
<td>21</td>
<td>70 (4%)</td>
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<tr>
<td></td>
<td>1,424 (79%)</td>
<td>373 (21%)</td>
<td>1,797</td>
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The Greater Glasgow CHI has an inflation rate of approximately 10-11% due to factors such as movement out of the area and deaths not being notified to the board. Thus information about homeless people who move about a lot is likely to be out of date.
<table>
<thead>
<tr>
<th>Unit</th>
<th>Data</th>
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<td>900</td>
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Note: The table above represents data for different units with corresponding values.
QUESTIONNAIRE FOR HOSTEL MANAGERS

HOSTEL __________________ ORGANISATION __________________

TYPE OF ACCOMMODATION __________________

MAIN CLIENT GROUP __________________

(Please write in box)

1. How many customers can your hostel accommodate in any one day?

2. What is the hostel policy on General Practice registration of customers?
   (Please circle)
   A  Compulsory to register with a particular GP
   B  Compulsory to register with own choice of GP
   C  Encouraged to register with a particular GP
   D  Encouraged to register or remain with own choice of GP
   E  No policy (non intervention)

3. Does the hostel have a link with a particular GP, practice or health centre?

   Yes      No      (Please circle)

4. What is your experience of trying to register customers with a GP? (Please circle)

   A  No difficulty
   B  Some difficulty
   C  Extreme difficulty
   D  Impossible
5. What are the visiting patterns of the following health professionals? (Please circle)

General Practitioner  Routinely  When Called  Never
Health Visitor        Routinely  When Called  Never
District Nurse        Routinely  When Called  Never
Community Psychiatric Nurse  Routinely  When Called  Never
Social Worker         Routinely  When Called  Never

6. If the named health professionals visit routinely, please state how often.
   How often

   General Practitioner
   Health Visitor
   District Nurse
   Community Psychiatric Nurse
   Social Worker

7. Do your customers have trouble getting access to the following? (Please circle)

   (a) Emergency General Practitioner  Yes  No
      If yes, then is it  1 Frequently or  2 Occasionally (Please circle)

   (b) Hospital Accident and Emergency  Yes  No
      If yes, then is it  1 Frequently or  2 Occasionally (Please circle)

   (c) Mental Health Services  Yes  No
      If yes, then is it  1 Frequently or  2 Occasionally (Please circle)

SURVEY OF CUSTOMERS  CONFIDENTIAL  NO NAMED DATA REQUIRED

Please answer the following based on the numbers on the stated day.

DAY ___ August 1992 (Please write in box)

8. What is the number of customers today?
9. What number of your customers are registered with a General Practitioner?  

10. What number have an obvious physical illness/disability?  

12. How many customers in your opinion have an alcohol problem?  

13. How many of your customers have a drug problem?  

14. How many of your customers have antisocial, repetitive or withdrawn behaviour?  

15. How many of your customers are visited by a Community Psychiatric Nurse?  

16. How many of your customers require more than the normal change of bed sheets?
17. What suggestions do you have about what facilities the Health Service should provide to improve the health of the customer in your care? Please give more than one, if able.
CONFIDENTIAL

Year of Birth 19....

1. a) How many people live in this house Adults □ Children □
    b) How many are classed as homeless Adults □ Children □

2. How many dependent children do you have ......................

3. Type of present tenure □
   1 - Bed and Breakfast
   2 - Sharing with friends/relatives
   3 - Local authority temporary accommodation
   4 - Mobile home
   5 - Private rented
   6 - Squat
   7 - Other*

* If Other please specify ........................................

4. Which of the following factors contributed to you being in temporary accommodation (tick any which contributed)

Overcrowding
Relationship breakdown
Family or friends unwilling/unable to accommodate
Physical or sexual abuse
Mental abuse
Inability to pay rent or mortgage
Accommodation in poor condition
Other (please specify) ..........................................

5. Which area are you from ........................................

6. Where do you consider your real home to be ..................

7. How far is temporary accommodation from home

(Enter code number in box) □
   1 - Within walking distance
   2 - Easily accessible by public transport/car
   3 - Difficult to get to

Do you have any friends or relatives nearby Yes □ No □
8. How many months have you been at your present address (if less than one month write zero) .......... Months

9. How many times have you moved in the last year (if at present address for more than one year write zero) .........................

10. Which of the following feelings have you had since you became homeless (tick more than one if appropriate)

   - Relieved to be housed  
   - Glad to be away from violence  
   - Isolated  
   - Relieved to be away from own area  
   - Other (please specify) ..........................................................

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Other (please specify) ..............................................................

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13. Are there problems heating your house
(for financial or other reasons)  Yes ☐  No ☐

Other reasons (please specify) ..............................................................

..............................................................

14. Do you consider your present area of residence to be
(Enter code number in box)

☐  1 - Desirable
2 - Acceptable but not ideal
3 - Unacceptable

If unacceptable please state why (eg, people, environment etc)

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Health of Caring Adult
(See separate sheet for health of children)

15. Have you experienced any of the following

<table>
<thead>
<tr>
<th></th>
<th>Before moving in to present accommodation</th>
<th>Since moving in to present accommodation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty sleeping</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Weight loss/gain</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Chest infection</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Depression</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Stress</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Others (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
16. Do you feel depressed (tick one box only)
   Never □
   Occasionally □
   Most of the time □
   All the time □

17. Do you feel under stress (tick one box only)
   Never □
   Occasionally □
   Most of the time □
   All the time □

18. How would you rate your general health before moving in to your present accommodation (tick one box only)
   Good □
   Acceptable □
   Not very good □
   Poor □

19. How would you rate your general health since moving in to your present accommodation (tick one box only)
   Good □
   Acceptable □
   Not very good □
   Poor □

20. Are you a regular smoker Yes □ No □
    If yes, how many cigarettes do you smoke each day ........................
Access to Health Care

21. When did you last seek help/contact with the following. Please indicate in column (b) whether or not satisfied with service.

1 - Within last month
2 - Within last six months
3 - Within last year insert number in column (a)
4 - over one year ago
5 - Never

Insert either Y - Yes or N - No in column (b)

<table>
<thead>
<tr>
<th>Service</th>
<th>Satisfied with service</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td></td>
</tr>
<tr>
<td>Health Visitor</td>
<td></td>
</tr>
<tr>
<td>Other Nursing</td>
<td></td>
</tr>
<tr>
<td>Baby Clinic</td>
<td></td>
</tr>
<tr>
<td>Community Medical Officer</td>
<td></td>
</tr>
<tr>
<td>Family Planning Clinic/Well Woman</td>
<td></td>
</tr>
<tr>
<td>Hospital Accident &amp; Emergency</td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
</tr>
<tr>
<td>Welfare Advice</td>
<td></td>
</tr>
<tr>
<td>Voluntary Services</td>
<td></td>
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<tr>
<td>Environmental Health</td>
<td></td>
</tr>
</tbody>
</table>

Please elaborate on any problems with access to the above services

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22. When did you last receive

Blood pressure check
Cervical smear test
Advice about smoking
Advice about exercise

1 - Within last month
2 - Within last six months
3 - Within last year
4 - Over one year ago
5 - Never
23. Which housing departments (including the Hamish Allan Centre) have you been in contact with and how would you rate your treatment (answer for each housing department separately)

<table>
<thead>
<tr>
<th>Housing Department/Association</th>
<th>1 - Good</th>
<th>2 - Acceptable</th>
<th>3 - Poor</th>
<th>4 - Very poor</th>
</tr>
</thead>
<tbody>
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Please add any comments with regard to Question 23

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Health of any dependent children

Child 1 (2, 3 etc) Date of Birth ....../..../. ....
CHI No ..................

1. As far as you know is your child immunised - Fully □
   (tick one box only)
   Partly □
   Not at all □
   Not known □

2. Please indicate by ticking the appropriate boxes whether the child has experienced the following and whether treatment has been given

<table>
<thead>
<tr>
<th></th>
<th>Prior to Homelessness</th>
<th>Since Homelessness</th>
<th>Been\ Being Treated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enuresis</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Behavioural disturbances</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Disturbed sleep patterns</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Sickness/diarrhoea</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Asthma</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Chest infection</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Others (please specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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