GREATER GLASGOW
HEALTH BOARD

HEALTH GAIN COMMISSIONING TEAM FOR HOMELESS PEOPLE IN GLASGOW

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EXECUTIVE SUMMARY

This report on health services for homeless people differs from the other 'health gain' reports in that there are no models of proven effective practice, and current service provision for homeless people is so limited that any redeployment of existing resources could produce at best only a marginal and almost certainly unmeasurable improvement on health. Additional resources will therefore have to be spent on this client group if health gain is to be achieved.

Another problem is that although there is a considerable literature on the health gain of various groups of homeless people there is very little documented local information apart from one recent study of residents of two Glasgow hostels. There is therefore no good baseline data for assessing the benefits of new interventions and so it will be necessary to develop recording and information systems in order to determine whether new interventions are worthwhile.

Because of the absence of evidence of the effectiveness of interventions the best approach will be to try a number of developments in a variety of settings for a limited time period (say one year) and to evaluate each of these carefully. Those which are successful can then be continued and probably extended while the remainder would be discarded. Service improvements could then evolve on a planned incremental basis, with careful evaluation of each stage.

A final point is that the specialised services which are needed for homeless people should be a bridge to mainstream services rather than a permanent service for individuals. This is important for homeless people themselves, who should be encouraged and helped to transfer from specialised to mainstream services; but it is also important for the health service because without such transfer the specialised services will become progressively more overloaded and unable to cope.

Recent improvements in health service provision

- A small number of GPs offer voluntary **medical support to rough sleepers.** This includes street consultations at night by at least one GP, and others who offer 'ad hoc' consultations on direct referral by voluntary agencies. This work is unsupported, relying on the GPs dedication and goodwill.

- A small number of practices offer **outreach surgeries in hostels.** In some cases the general practitioners register the patients as Temporary Residents and claim a fee (£8.60 or £12.90 depending on length of stay). Other GPs accept the responsibility for hostels in their areas as 'part of the territory'.

- A number of community nurses have provided support for the homeless on their own initiative, particularly in identifying and offering support to lone children and homeless families in B&B and temporary accommodation.

Some other problems with services, including access

- **The psychiatric nursing hostel team** operates only in the East Sector of the GGHB area, and only with younger hostel residents. There is no specialist hostel provision outwith the East Sector, and within the East Sector responsibility for hostel residents aged 65 years and over is shared between five community psychiatric nurses.

- **The out-of-hours service at Carswell House** is not directly accessible to people in crisis, and in fact is restricted to people who are registered with a GP and who are already on the CPN caseload.

- Health care needs in relation to **sexual health** are not met.

- Health services are required which provide **continuity of care** as well as crisis services.

- Health services should be provided for **those with overlapping needs** - eg drugs/alcohol problems, mental health/alcohol problems.

- **Co-ordination of information** is required on what is available for people who are homeless and how they can access and comment on services.

Suggested innovations for 1995/96

i) **Hostel psychiatric nursing team and out-of-hours service**

a) Extension of the present hostel psychiatric nursing team to include all hostel dwellers (i.e. not restricting responsibility to those under the age of 65 years in the East Sector).

b) Extension of the out-of-hours CPN service from Carswell House to all those with emergency psychiatric problems, including those who are not already on a CPN caseload and even to those not registered with a general practitioner. This will require general practitioner involvement - in order to make a diagnosis (which may not be mental illness or even any medical condition, but an alcohol, drug or family problem) and then referral to the CPN service; social work or other agency. This development will require careful planning and considerable inter-agency collaboration.

ii) **Hostel district nursing team**

Establish a hostel district nursing team (complementary to the psychiatric nursing hostel team) to run minor ailment treatment 'surgeries'; to identify conditions such as incontinence and other illnesses for which residents are reluctant to seek help; and to undertake health surveillance, preventive work and make any necessary referrals (eg for drug/alcohol counselling, family planning). Referrals to general practitioners would encourage the development of closer working relationships.

v) **Appointment of a Conciliator**

This is a proposal currently being developed by Mr Norman McGregor Edwards, Practitioner Services. The idea is to appoint an enthusiastic, proactive and committed individual to establish effective communication between individual homeless people, Practitioner Services at Belvidere Hospital and individual general practitioners, in order to:

- assist in developing a network of G.P's who are interested in improving services for homeless people and who are willing to provide general medical services for them.
- assist individual homeless people to become registered with a general practitioner and to gain access to other medical services if necessary.
- provide an interface between primary care providers on one hand, and the homeless and their organisations on the other.
- act as an intermediary who the homeless or their advocates/supporters could ask to intercede with the Board, primary care providers or other agencies.
- conciliate between professionals and 'difficult' patients, educate professionals on the needs of the homeless, liaise between the Board and other agencies on a day-to-day basis, and co-ordinate provision of general medical services.
- promote the interest of homeless people among health visitors, district nurses and other professionals.
- develop an advocacy function.

vi) Extend the provision of **outreach general medical services** on a case by case basis to meet the needs of hostel residents and other groups. It is unlikely that a single model will be appropriate, so sessional GPs/nurses, hostel clinics based on Temporary Registration, special clinics and clinic times for the homeless, and practices 'hosting' hostels/homes are all possible.

vii) **Establish and support a network of G.Ps** prepared to offer specific facilities for, and establish long term relationships with, homeless people. Formelise support for the G.Ps and others who have been providing voluntary support.

viii) Wherever travelling people are located arrange for a **health visitor** to have specific responsibility for ensuring and encouraging:

- childhood immunisation and health surveillance
- adequate schooling (nursery, primary and secondary)
- adequate ante-natal care
- attendance at well women and family planning clinics
- early identification of illness and disease with prompt treatment
- promotion of good health

John Womersley, Consultant in Public Health Medicine, GGHB, Health Info Unit

REF: JW/TC-158 (19 December 1994)

SCALE AND TYPE OF HOMELESSNESS (estimated as of September 1992)

(1) **Number of homeless families at end of 1991**
(Source: Ann Taylor, Strategy Group, Glasgow District Council Housing Dept)

Single parents age 16-25	197
Single parents age 26-64	373
Families with children age <5	79
Families with children age 5+	35
Families with children age 16+	64
Single people age 16-25	414
Single people age 26-65	652
Couples age <65	12
All-adult households	98
Single elderly	38
Elderly couples	1
Others	7
TOTAL	**1,970**

(2) **Individual homeless people (excluding families)**

• 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
TOTAL	2,535

N.B. A single count on one night will substantially undercount the number of people for whom rough sleeping is part of their normal experience. This number will be considerably more than 150; it could be one thousand or even more over the course of a year.

REF: JW/TC-167 (06 January 1994)

II: HEALTH SERVICES FOR HOMELESS PEOPLE

OPPORTUNITIES FOR 'HEALTH GAIN'

Among the various groups of homeless people the opportunities for improving health gain and for preventing ill health are greatest for children (who may be living in various types of temporary accommodation with one or both parents or on their own, and the children of travelling people). The health of the parent(s) is also of vital importance, because physical, social and psychological disfunction in the adults will inevitably have an adverse for their children.

The opportunities for health gain will in general be least for people who are permanently resident in hostels or permanent rough sleepers, because these individuals are older, tend to biologically older still than their chronological years, and they often suffer from multiple causes of ill health: the stock of health 'capital' with which they were born has usually dwindled to a very low level compared with people of similar age who live in more fortunate circumstances. However, there is a moral commitment to meet the social and health needs of these people, and perhaps because hostel dwellers are a well defined group and reasonably few in number considerable achievements have recently been made in improving their living conditions and access to health services.

The following sections summarise the main health problems associated with the various groups of homeless people, together with suggestions for meeting their health needs - i.e. for achieving 'health gain'.

(i) HOMELESS FAMILIES

Health risks to the children - Increased susceptibility to mental and physical illness, behavioural disturbance.
Disordered mental, physical and social development.
Sleep disturbance, inadequate home safety.

Health risks to the parents - Stress, emotional and mental disturbance.
Anxiety, fear, weariness and depression.

Associated adverse factors - Overcrowding, dampness, cold, unsatisfactory environment.

Health care needs of the families - Effective procedures for identifying these vulnerable families.
Sensitive appraisal of needs.
Thorough understanding of all possible sources of help.
Assistance in obtaining necessary services, funding and other sources of help.
Emotional support.
May need counselling and advocacy.

(iii) HOSTELLERS AND ROUGH SLEEPERS

Health risks -	Mental illness, alcoholism, physical disability, T.B. genitourinary disease, drug addiction, substance abuse, HIV infection, incontinence, epilepsy, malnutrition, pregnancy, intercurrent diseases, premature death.
Health care needs -	Primary care services, including district nursing and chiropody on site. Counselling services (e.g. for alcohol, drug and sexual problems). Access to more sympathetic professionals. Reduction of stigma applied to the homeless by health professionals through better information and increased contact.
Difficulty in accessing services -	Difficulties in registering with a G.P. (if no permanent address or perceived to be a 'problem' patient). Entry to other services provided by primary care team often barred as a result. Difficulty in obtaining emergency health services. Little opportunity for promoting good health or preventing disease. Benefits not claimed due to inability to obtain medical certificates for those eligible.
Prevention of homelessness -	Designated GP's who are happy to take on homeless people. Health promotion sessions Well man/woman sessions

(iv) TRAVELLING PEOPLE/FAMILIES

Health risks -	Failure to take up preventive services (immunisation, cytology, surveillance etc). Intercurrent disease.
Health care needs -	Continuing surveillance and care very difficult/impossible. Develop trust so that advice and treatment is sought as soon as possible when (particularly the children) become ill. Services delivered in an acceptable manner.
Difficulty in accessing services -	Many not registered with G.P's; some registered with several practices. Reluctance to use preventive and treatment services.

The Attitude of Health Professionals

a) Homeless people are often reluctant to use health services because they do not expect to be treated well or with respect.

b) Many doctors, psychiatrists, and to a lesser degree CPN's, do not accept the importance of other agencies input with homeless people, and do not work well with the Voluntary Sector in particular.

c) Often a worker from this sector is close to and trusted by the homeless person and could be used as a key worker, contact person. (Any problems about confidentiality can be overcome by written permission from patient).

d) Representatives accompanying homeless people for appointments with doctors and others are often totally excluded from proceedings - in spite of the patients wishes. Again doctors etc fail to understand/accept the vital role of these supports for good overall health care to be possible in the absence of other carers.

Other Comments

a) For homeless people, and particularly young people, health frequently is not an issue until it becomes an emergency.

b) Sector/district boundaries are artificial and result in inequities in provision and discontinuity of care.

c) It is difficult to assess preventive services - often unawareness of importance/availability of this.

d) Homeless people regularly use casualty departments instead of general practitioner services; this results in lack of access to aftercare.

e) Health care needs in relation to sexual health are not met at present.

f) Better links are required with Charing Cross clinic (for alcohol addiction)

g) Health services are required which provide continuity of care as well as crisis services.

h) Inadequate services for female homeless.

i) Health services should be provided for those with overlapping needs - e.g. drugs/alcohol problems, mental health/alcohol problems.

j) Excessive waiting time for a chiropody appointment.

k) Feedback from users should be encouraged and utilised creatively.

IV: RECOMMENDATIONS FOR SERVICE DELIVERY TO HOMELESS PEOPLE

I HOMELESS FAMILIES (parents and children)

(1) Appoint a health visitor to collate information about homeless people in order to assess needs; to co-ordinate services; to act as an advocate for homeless people and to explore opportunities for preventing homelessness (appointment made October 1994).

(2) Provide additional service to address the crisis element for families who present as homeless.

(3) Arrange for all family health visitors to have a specific responsibility for identifying families with children who are homeless or at risk of becoming so, assessing their needs and helping to provide access to funding and other sources of help, providing emotional support, and for exploring opportunities for preventing homelessness.

(4) Arrange for one health visitor in each health centre or nursing base to take responsibility (as part of her normal workload) for collating information about all homeless families in the area, for assisting in negotiations with local housing offices, for liaison with the Hamish Allan Centre, for establishing measures to prevent homelessness and for assisting parents and children to register with a general practitioner.

(5) Establish a liaison health visitor service for the Hamish Allan Centre to record and act on information about homeless families and other homeless people who may have health care needs. This service must operate throughout the day, and particularly from 16.00-22.00h. Regular personal contact is needed, as well as continuous 08.00-22.00h telephone availability.

(6) Consider provision of a drop-in health centre which would be staffed by GP, District Nurse and Community Psychiatric Nurse offering advice and practical help and treatment.

(7) Ensure that information about the whereabouts of homeless families with young children is 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. The following improvements are desirable:

(a) extending health visitor notifications by the Hamish Allan centre to include 5-15 year olds (at present it is restricted to children up to the age of 5 years), and families with children who have been allocated Bed & Breakfast accommodation.

(b) ensuring that the appropriate health visitor does always receive this information.

(4) Provide a choice of accommodation, for example supported lodgings and individual flats, which can be 'experimented' with on a trial basis. Care leavers may have great difficulty in adjusting to living alone; placements in unsupported housing therefore often breakdown with resultant homelessness.

(5) Establish specialist leaving care provision, building on and extending existing support networks. Individual leaving care plans, setting out educational, personal care and health needs are vital to ensure proper transition to adulthood.

(6) Attempt to provide access to housing, training, employment and if necessary financial help.

IIIa HOSTEL DWELLERS

(1) Expansion of existing Hostel Community Psychiatric Team to provide a service to areas outwith the East Sector.

(2) Expansion of services for those with mental health problems to include the elderly by the appointment of an additional CPN with a specific remit for elderly people in hostels.

(3) The out of hours CPN service should be extended to other services, for example drugs and alcohol, social work and primary care services. This would involve creation of a multi agency response team, which would be

a) accessible directly to people in crisis.
b) open to those who do not have a GP or address.
c) include social work, health and voluntary agencies.

General practitioner involvement would be required - in order to make a diagnosis (which may not be mental illness or even any medical condition, but an alcohol, drug or family problem) and then to refer on to the CPN service, social work or other agency. This development will require careful planning and considerable inter-agency collaboration.

(4) Improve follow up after discharge (including self-discharges) from acute psychiatric care.

(5) Expansion of addiction services to specifically target hostels and homelessness as a priority group for both drug and alcohol abuse.

(6) Establish a complementary Hostel District Nursing Team to run minor ailment treatment 'surgeries', and to identify conditions such as incontinence and other illnesses for which residents will not seek out their G.P's; physical morbidity could thus be treated before it becomes chronic or even life threatening. The district nurse(s) would also undertake health surveillance, preventive work and make any necessary referrals (e.g. for drug/alcohol counselling, family planning). Closer working with G.P's would ensue as the district nurse(s) referred patients on for permission to treat.

(18) Improve specialist care facilities for the **terminally ill** and for the elderly and infirm who prefer or need to remain in their hostel rather than be transferred for hospital or hospice care.

(19) Hostel staff require better **feedback of information about their residents** from the professionals to whom they have referred clients. This requires development of a partnership between those responsible for the care of people in hostels and an understanding of what information should properly be disclosed to those responsible for their day to day care.

(20) A **more sympathetic attitude** is needed from health service, social work and civil service staff dealing with the homeless.

IIIb ROUGH SLEEPERS

(1) Establish on a trial basis an evening clinic in one or more of the existing facilities for rough sleepers (Gorbals Salvation Army Centre, the Wayside Club, Glasgow City Mission, East Campbell Street Mission, the Simon Community, St Vincent de Paul soup kitchen). The clinic should be staffed by a district nurse, GP, chiropodist and CPN (families unlikely to be rough sleepers therefore not health visitor, and more likely to be mentally ill therefore CPN required). The health gains achieved, and the most appropriate professional mix, should be determined by careful evaluation. It may be that a district nursing service only is required, and that referrals can be made to a general practitioner or other sources of help as necessary.

(2) Improved services by psychiatrists in the East is now extended to Salvation army hostel within the East, with Psychiatrists making hostel visits. Easier referral to psychiatrist would be an additional improvement and make it nearer to the service previously offered to the waysiders club.

(3) Extend CPN services to the Hostels in the South of the City not currently covered. e.g. Salvation Army, Kingston Halls and Local Authority Hostel. This could be done from the creation of new Resource Centres in the South and West by specifically targeting these areas.

(4) Create a supported accommodation project that will accept rough sleepers and work to move them on to other accommodation and involve other agencies in the planning of care.

IV TRAVELLING PEOPLE/FAMILIES

(1) Encourage pre-school children to receive (a) full courses of immunisation and (b) regular surveillance by a doctor and health visitor.

(2) Continue child surveillance throughout schooling.

(3) Ensure that the children receive adequate nursery, primary and secondary schooling.

APPENDIX 1

THE ORGANISATION OF HEALTH SERVICES FOR HOMELESS PEOPLE

(1) No models of proven effective practice, and current service provision for homeless people is so limited that any redeployment of existing resources could produce at best only a marginal and almost certainly unmeasurable improvement on health. Additional resources will therefore have to be spent on this client group if health gain is to be achieved.

(2) Although there is a considerable literature on the health gain of various groups of homeless people there is very little documented local information apart from one recent study of residents of two Glasgow hostels. There is therefore no good baseline data for assessing the benefits of new interventions and so it will be necessary to develop recording and information systems in order to determine whether new interventions are worthwhile.

(3) Because of the absence of evidence of the effectiveness of interventions the best approach will be to try a number of developments in a variety of settings for a limited time period (say one year) and to evaluate each of these carefully. Those which are successful can then be continued and probably extended while the remainder would be discarded. Service improvements could then evolve on a planned incremental basis, with careful evaluation of each stage.

(4) Specialised services which are needed for homeless people should be a bridge to mainstream services rather than a permanent service for individuals. this is important for homeless people themselves, who should be encouraged and helped to transfer from specialised to mainstream services; but it is also important for these health service because without such transfer the specialised services will become progressively overloaded and unable to cope.

(5) Planning services to meet the needs of homeless people should be a specific responsibility both of the Health Board (Priority Services Planning Group) and of a team of individuals within the Community/Mental Health Unit.

(6) The most basic requirements for preventing homelessness and for improving the health of homeless people are the development of housing policies to ensure the provision of good quality and secure housing, and of fiscal policies to ensure that families and individuals can afford this. The management of the problems of homeless people is the responsibility mainly of the housing and social work departments, but many other organisations, particularly voluntary bodies, are also involved. For these reasons the health service can achieve little improvement in health acting on its own: a high level of inter-agency communication and collaboration is essential.

(14) Registration with general practitioners is important, not only for obtaining any necessary treatment, but also as a means of access to other primary care services such as nursing and family planning. Homeless families and lone children will usually find little difficulty in registering with a general practitioner, but frequent changes in address may mean that the general practitioner is too distant to provide general medical services. Hostel dwellers, rough sleepers and even travelling people often have the additional difficulty of being perceived to be undesirable or simply require and unreasonable amount of attention, and it appears that some general practitioners remove such patients from their lists with little provocation, refuse to register them in the first place, or rapidly remove them from their lists if they are assigned. Homeless people may be afraid to use general practitioner services because of fear of being 'struck off'.

(15) There is a variety of ways in which medical care could be provided in hostels and in facilities for rough sleepers. These include temporary registration, outreach surgeries in hostels, provision of services on a seasonal or salaried basis and provision of additional general practitioner sessions. It is not clear which is the most appropriate method. In any case it is likely that for a given input of resources, greater health gain will be achieved from provision of community nursing and other services than from a **special** general practitioner service, and it is quite possible that community nurses could establish an effective bridge to mainstream general practitioner services. general practitioners may be less reluctant to take on homeless people as patients if they knew that district nursing and other specialist services are available to provide support.

(16) Information about individuals in the various categories of homelessness should be collated, analysed and fed back to those in the Health Board and in the Community/Mental Health Unit who are responsible for purchasing and providing services for homeless people.

REF; JW/TC-133

II: LONE CHILDREN

About 46% of young people who end up 'on the streets' have been in care (32% direct from care, 14% formally in care). About one third of care leavers are 16 and another third are 17 years old. Other homeless children have become estranged from their families and may be sleeping in unsatisfactory accommodation with relatives or friends or sleeping rough on the streets. These children lack family support and often have many problems and therefore have to fend for themselves from a very early age. These children do not have parents, teachers and others to act as advocates and make sure they come to the attention of agencies. Failure to provide adequate help for them in the short term is likely to result in far greater expenditure later in terms of mental health and criminal justice systems.

In response to the increasing problem of homelessness among young single people the District Council established a Young Single Persons Section to deal with homeless 16 and 17 year olds; because of the large numbers of young people and the severity of the related problems, it has never been possible to extend the service to the age of 21 years as was originally planned. The rise in unemployment in young people, together with a reduction in the benefits to which they are entitled are now exacerbating the problem.

GDC rehouses a large proportion of young people in its own stock, with support where appropriate from the Social Work Department. many voluntary organisations have also been encouraged to make specialist provision. The District Council itself has been committed toward increasing the availability of a range of supported accommodations in sheltered flats to access to support and assistance as required.

IIIa - HOSTEL DWELLERS

There are about 34 hostels within the GGHB area (mainly in the East), with about 2400 residents.

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 service provided by the psychiatric nursing hostel team (based at Carswell House comprises a project leader, two staff nurses and two health care assistants) to residents of twelve hostels in the East sector who are under the age of 65 years. . This service is currently available seven days a week and has access to the East sector wide 24 hour on call service for known clients. Drop-in facilities together with Friendship Clubs have been created. Staff monitor treatments/medication and side effects; facilitate continued attendance at out patient clinics; and advise the responsible medical officer of mental health status or changes. Close links with other agencies allows staff to co-ordinate other services for their clients. Team members act as advocate for clients in areas such as housing, finance and judicial aspects. Improvements in daily living skills, personal hygiene and socialisation aspects are actively sought by the help of Health Care assistants and the

Travelling people need to be encouraged to use these services - otherwise they will only seek help at 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 treatment might be unpleasant or 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 pursued 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 an manner which is acceptable. Somehow those responsible for organising these services need to be made aware of the special characteristics and needs.

Care is much more likely to be effective and acceptable if its component parts are carefully co-ordinated, and this is particularly true of travelling people. This means that the health visitors, 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 co-ordinated and organised sensitively in order to ensure that travelling people are given 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. Her responsibilities might include:

- Encouraging general practitioners to register travelling people or to accept them as temporary residents.

- Providing access to a female doctor for wives and children.

- Visiting sites at least weekly in order to identify new travellers and identify new problems, and take to appropriate action

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

- Establishing a suitable health record for the health visitor and parents.

* Both adults and children in Bed and Breakfast accommodation are malnourished. There is a high incidence of weight loss in adults and of low birth weight in babies. Most hotels lack adequate cooking and refrigeration facilities and some have none. Families often have to vacate the accommodation between 10 am and 4 pm. These factors add to the difficulty of maintaining proper nutrition.

* Research carried out as part of a joint study by the Maternity Alliance, Shelter, the London Housing Aid Centre (SHAC) and the London Food Commission indicates that pregnant women living in Bed and Breakfast accommodation were more than twice as likely to have problems in pregnancy as women who become homeless after the birth of their baby. Homeless women are also more likely to be admitted to hospital during their pregnancy. Homeless children too have a high rate of hospital admission.

* Up-to-date information about local health services must be easily available for homeless families. Access to such information should not depend only on health visitors. One way of conveying information could be by putting leaflets and posters into temporary accommodation, translated into appropriate languages where necessary.

* Homeless families who hope that their situation is temporary might well give registering with a GP a lower priority than the more immediate problems of food, warmth and basic immenities. They tend to be unfamiliar with the local GP's and their surgery arrangements, and may be unaware of the function or existence of the FPC, let alone its address. Homeless families from ethnic minorities may have the added problem of language differences which impair their appreciation of how to gain access to a GP. In such circumstances, homeless families often resort to accident and emergency departments of local hospitals or child health clinics. But this is not an appropriate way to use such services and is no substitute for the continuing care of a GP.

Recommendations

* Accurate and up-to-date information on homeless families is needed to ensure effective health care. Health care, particularly for children and pregnant women, may be needed at an early date, so the local authority homeless persons unit should notify to the Health Board within one week of families being placed.

* The essential information required is: name, date of birth, sex, previous address, the address where the family is to be temporarily housed, and any transfers between establishments. These data include confidential personal information and consent of the individuals concerned is needed before information can be transferred. Most homeless families will give consent if they are counselled at the homeless persons unit about why they data are needed. The efficient transfer of such information along these lines is crucial to any scheme designed to improve the access of homeless families to primary health care services. Other forms of referral, such as a form accident and emergency units, social workers, other health visitors, etc, should be seen as a supplementary to this primary source of notification.

(b) A Study of District Nursing Intervention with single homeless men from a private hostel in Glasgow. J Atkinson (1994); Glasgow Caledonian University

A study has recently been completed by John Atkinson of 106 men in the Great Eastern Hotel, using the Barthel Index of Physical Functions, the Hospital Anxiety and Depression Scale, an alcohol use questionnaire and a detailed nursing assessment protocol. 50 men were referred to a nurse or general practitioner. Significant levels of physical and psychiatric morbidity were found, including possibly treatable biogenic depression (although in no case was this fact treated).

The research assistant, a qualified district nurse, demonstrated the benefits of a proactive role in actively making initial assessments, followed by relevant treatment of immediate physical emergencies and/or referral or advocacy to social and health agencies. Health gains were clearly demonstrated in that the research assistant undertook a total of 38 immediately necessary nursing treatments.

Most of the morbidity in this sample was identified within a relatively short time, indicating that a regular monitoring visit to such hostels by a district nurse, who could become known to the men, has considerable potential for finding "cases" of ill-health or people in need of nursing care. The researchers proposed that each health centre might be asked to identify hostels and other similar establishments within this area, and replicate the case-finding and assessment methods used in this study, with a view not only to testing out the methodology and tools with different groups, but to assessing health and nursing needs and improving the quality of life for many people hitherto rather than marginal to main stream health care provision - including those living in nursing and residential homes.

Some service providers held preconceptions about homeless people, for example, that residents were not interested in their health, would not comply with a treatment regime, or would not answer honestly any answers concerned with their health. However many of the men were in fact interested in their health, had treatable conditions such as biogenic depression, and were prepared to attend appointments and take treatment, for example in one case for newly diagnosed tuberculosis.

It was also found that some service providers were prepared only to address a client's presenting complaint, without seeking further information by assessment, and without considering ongoing monitoring. Others appeared not to follow up referrals from the District Nurse, although they acknowledged that these referrals were appropriate.

REF: JW/TC-160

Alcohol Problems

* Many single homeless people who were suffering from mental health problems also had alcohol-related problems; this applied to almost a third of people in hostels and B&Bs and almost half of those sleeping rough.

* Heavy drinking or alcohol-related problems were found to be less of a problem among people in hostels and B&Bs than among people sleeping rough. Heavy drinking appeared to be a recurrent problem for two fifths of those who reported alcohol problems at the time of the survey. Only a third of people in hostels and B & Bs and even fewer people sleeping rough were receiving treatment for their alcohol related problems. Overall, 7% of people on hostels and B & Bs had been in an alcohol unit and at least twice as many people sleeping rough had done so.

Drug Problems

* Less than one in ten single homeless people said they were suffering from a dependency on drugs other than those prescribed by a doctor. This was a health problem predominately reported by young people. Three out of four people with a dependency on drugs were not receiving treatment for this.

Access to a general practitioner

The survey of single homeless people showed that though the majority (80%) of hostel and B&B residents were registered with a doctor, fewer people sleeping rough were registered (60%). The majority of single homeless people knew of a doctor to whom they could go if feeling unwell.

Accommodation & support

The majority of single homeless people said they would prefer to have their own home than any other type of accommodation and this equally applied to those with physical and mental health problems. For many, however, accommodation on its own was not enough - seven out of ten homeless people with health problems said they would need at least one type of support in their preferred accommodation. A high proportion of single homeless people had multiple health problems and the more health problems they reported the more likely they were to say that they would need support in accommodation.

One in ten people sleeping rough who reported 'fits and loss of consciousness' said this health problem caused them difficulties in finding or keeping accommodation.

Few single homeless people said they had been discharged from a psychiatric hospital directly in to hostel or B&B accommodation, or said they had been sleeping rough immediately following discharge from a psychiatric hospital. This suggests that the important issue is less to do with the outcome of immediate discharge from psychiatric hospital but of adequate long-term care and support in the community.

(d) Housing, Homelessness and Health. The Standing Conference on Public Health. Working Group Report. The Nuffield Provincial Hospitals Trust, London. 1994.

It is easy for even caring professionals to see the problems associated with homelessness as intrinsic to the person (who then becomes a problem patient). An alternative view suggests that it is the inflexibility of our primary care services that poses a range of special problems for homeless people when they try to exercise their right to health care.

Unless staff are well-informed about the availability of the resources in the community that can provide primary or community care, assist with housing and offer various kinds of continuing support, homeless people have very little chance of gaining access to these services.

A national survey of temporary accommodation showed that a substantial proportion of bed and breakfast hotels provided unsuitable accommodation, with an average of 16 people sharing a bath or shower and 20 people sharing one WC. 26% of the hotels were found by Environmental Health Officers to be lacking or inadequate in the provision of drinking water, food storage and cooking facilities. A survey in London found 61% of bed and breakfast accommodation to be overcrowded, with two or more people to a room. Almost half posed a risk of fire with inadequate escape routes. Both children and adults are at greater risk of accidents, particularly burns and falls, in such accommodation. Bed and breakfast accommodation is unlikely to provide any play space for children other than that of the living and sleeping accommodation itself, which is often one room.

Good communication between health providers and providers of housing services is vital. Often the housing role of health providers begins and ends with referral for rehousing, and the best they can do is to get a household accepted as homeless. If their role could proceed to advocacy to prevent loss of housing or promote access to appropriate housing, it might help prevent the homeless trajectory which is so catastrophic to people with special needs.

Access to health care for the homeless is recognised to be poor and it seems reasonable to conclude that whatever health problems may have existed prior to homelessness, the additional health hazards posed by having no home are likely to exacerbate existing conditions, to delay recovery from illness and give rise to new medical problems. In particular, the long-term effects on children's health give cause for concern.

There are undoubtedly a number of reasons why homeless people may not have access to good health care. Perhaps the two most important are:

the (often enforced) mobility of homeless people; and

unsympathetic, and occasionally hostile, reactions from the providers of health care.

Improving inadequate housing

Some 4.6% of occupied dwellings fall below tolerable standards. In some areas, such as Glasgow, the figure is closer to 20%. Unfortunately the Government's commitment to a national strategy to improve health does not include adequate resources for improving these conditions. In particular, the availability of housing renovation grant-aid is woefully inadequate.

Improving bedsit and hostel accommodation (HMOs)

According to the Department of the Environment there are more than 340,000 houses in multiple occupation (HMOs) in England and Wales, providing homes for about 2.4 million people.

It is recommended that the Government should introduce an HMO licensing system immediately which would require compliance with standards prior to the owner opening the property for business. The licensing system should require local authorities to inspect properties regularly, at least annually, to ensure continuing good management and the maintenance of means of escape systems and the regular inspection of gas and electrical appliances.

Recommendations

* Homeless people should have unrestricted access to a health service of the same quality as that enjoyed by the general population. If special services dedicated to homeless people are required, they should aim to assist access to mainstream services.

* Details of services for homeless people should be publicised in places where homeless people are likely to see them.

* Providers should monitor the utilisation of their services by homeless people, to measure both level of use and quality of service. This information should be used to inform service development. A clear operational plan for services for homeless people should be developed with quantifiable aims for measuring performance.

* Services should be developed in partnership with FHSAs so that homeless people have good access to primary care. These services should be co-ordinated with local authority housing and social service departments, voluntary organisations, housing associations, day and drop-in centres, advice agencies and any other bodies with relevance to homeless people. Homeless people themselves should have the opportunity to influence the way health services are organised.

APPENDIX 4

HOUSING PROVISION FOR HOMELESS PEOPLE 1993/1994

There are currently new developments within the homeless field which will impact on the level of health for this group. Recent developments include:

Inequalities in Health Project

This project is currently targeting homelessness and health promotion.

Great Eastern Hotel

The purchase of the Great Eastern Hotel by the Lorretto housing associating in collaboration with Scottish Homes and Milnbank housing will have a huge impact on the present extremely poor facilities, and high levels of health and disability.

The hotel is being refurbished over a five year period with about 50% of residents moving into higher quality hostel accommodation, and the others transferring to supported accomodation provided by the Loretto Housing Association. Care staff, cooks, project leaders, and a project co-ordinator have already been employed and the standard of hygeine has greatly improved. The provision of meals for residents is part of the improvements with three meals a day being offered, and residential care status being given to the project.

The hotel will eventually be taken over completely by Milnbank housing association and turned into residential flats.

Midway House

New projects such as Midway House due to commence in the new year will address the problem of 'Blocked Acute Hospital beds' for those who become homeless and often self discharge before their accommodation needs are met as their illness has resolved.

Midway will provide a 12 week placement in a scatter flat provided by the Housing Dept, on a temporary lease with housing support built in the form of a support worker. There will be close inter agency working with those who are awaiting permanent placement from these flats. With appropriate placement at the end of the 12 week period. Referral will be from the Acute Wards in Psychiatric Hospital and a Community Care Assessment will have been done to assess level of need.

SUBMISSION FROM MRS AILSA MORRANT
CONSULTANT IN DENTAL PUBLIC HEALTH/CADO

.In the suggested innovations for 1995/96 list, I think that oral health and primary dental care services could very easily be integrated as follows:

i) **Hostel district nursing team**

Proposal - include oral health in district nurse remit for advice, prevention and referral.

Cost for training, resource development, evaluation and dental support £?

ii) **City centre outreach clinic: the City Mission**

Proposal - include a community dental officer/general dental practitioner in the primary health care refuge centre team.

Cost of CDO/GDP, nurse, equipment, approximately £8,000.

iii) **A service for young, single, roofless people: the City Centre Initiative**

Proposal - include CDO/GDP in young homeless city centre initiative.

Cost approximately £9,949.

iv) **Appointment of a Conciliator**

Proposal - include oral health/GDP network liaison in the remit of the primary care liaison officer/conciliator.

Training, resource development, evaluation and dental support £?

In summary, I think that oral health and dental care could be included as described above. To provide this expertise and support to other initiatives, it perhaps would be more appropriate to consider the establishment of either a salaried dental practitioner with this particular remit in primary care, or to purchase the services of a community dental officer from the Community and Mental Health Services NHS Trust, dedicated to develop and evaluate this service. However, whether such a post could be filled if it was only available for a year is another problem which would need to be discussed prior to this initiative being pursued.

ref: GM/DOCS/HOMAM.DOC

ORGANISATIONS CONSULTED

Title	FirstName	LastName	JobTitle	Company	Address1	Address2	City	PostalCode	WorkPhone
Ms	Alice	O'Flynn		Barnardo's	16 Sandyford Place		Glasgow	G3 7NB	
Ms	Val	Surgeoner		Talbot Association	344 Paisley Road		Glasgow	G5	
Ms	Ann	Thomson		Outreach Team Ruchill Counselling Clinic	Ruchill Hospital	Bilsland Drive	Glasgow		
Ms	Dorte	Pape		GAMH	15/23 Cadogan Street		Glasgow	G2 6QQ	

Index	Ogsation	Residence	Address	Pcode
	INDEPENDENT	LINK HOUSING ASSOCIATION	COWCADDENS	
1	SALVATION ARMY	WALLACE OF CAMPSIE HOU	30 EAST CAMPBELL ST	G1 5DT
2	SALVATION ARMY	HOPE HOUSE HOSTEL	14 CLYDE ST	G1 5JQ
3	BLUE TRIANGLE	DUMBARTON ROAD PROJEC	73 DUMBARTON RD	G11 6PW
4	TALBOT ASSOCIATION	BELMONT ST	1 BELMONT ST	G12 8EP
5	COMMERCIAL	HILLHEAD HOUSE	13 HILLHEAD ST	G12 8PU
6	GDC	SOUTHDEEN TENANCIES	64 SOUTHDEEN AV	G15 7RN
7	GDC	JEAN MORRIS HOUSE	218 BATH ST	G2 4HW
8	BLUE TRIANGLE	HOLLAND ST PROJECT	150 HOLLAND ST	G2 4NG
9	SIMON COMMUNITY	MARYHILL PROJECT	9 CALDERCUILT RD	G20 0AE
10	UNKNOWN	CHYP	171 WILTON ST	G20 6DF
11	ARCH OF GLASGOW	DE PAUL HOUSE	67 WILTON ST	G20 6RD
12	YMCA	BRANSTON COURT	71-95 PANMURE ST	G20 7SJ
13	YMCA	DAVID NAISMITH COURT	33 PETERSHILL DRIVE	G21 4QQ
14	QUEENS X HOUSING	THE FIRE STATION	509 ST GEORGES RD	G3 6JX
15	TALBOT ASSOCIATION	WOMANS CENTRE	122 HILL ST	G3 6UA
16	UNKNOWN	RIDDRIE HOUSE HOTEL	2 RIDDRIE CRES	G3 7AW
17	BLUE TRIANGLE	DOROTHY MCCALL HOUSE	2 SOMERSET PLACE	G3 7JT
18	BLUE TRIANGLE	BLUE TRIANGLE HOUSE	30 GRAY ST	G3 7TY
19	GDC	LAIDLAW HOUSE	95 CHEAPSIDE	G3 8BH
20	INDEPENDENT	ELPIS CENTRE	30 GRACE ST	G3 8DH
21	CHURCH OF SCOTLAND	KIRKHAVEN	176 DUKE ST	G31 1JH
22	SIMON COMMUNITY	DENNISTOUN COMMUNITY H	11 ONSLOW DRIVE	G31 2LY
23	GDC	BENGAIRD ST HOSTEL	BENGAIRN ST	G31 3QR
24	TALBOT ASSOCIATION	GOOD SHEPHERD HOUSE	1920 LONDON ROAD	G32 8XG
25	YMCA	CLAYPOTTS PLACE	16 CLAYPOTTS PL	G33 3QT
26	BLUE TRIANGLE	BORTHWICK ST	22 BORTHWICK ST	G33 3UT
27	COMMERCIAL	GREAT EASTERN HOTEL	100 DUKE ST	G4 0UW
28	SRC	WEST PRINCES ST HOSTEL	123 WEST PRINCES ST	G4 9BY
29	GDC	PETER MCCANN HOUSE	22 KYLE ST	G4 OJD
30	GDC	JAMES DUNCAN HOUSE	331 BELL ST	G4 OTJ
31	COMMERCIAL	MONTEITH HOTEL	14 MONTEITH ROW	G40 1AY
32	COMMERCIAL	BELLGROVE HOTEL	607 GALLOWGATE	G40 2PG
33	GDC	ROBERTSON HOUSE	260 BROAD ST	G40 2TR
34	GDC	NORMAN ST HOSTEL	93 NORMAN ST	G40 4JS
35	THE INNOCENTS	RACHEL HOUSE	503 BALTIC ST	G40 4SG
36	GCSH	STOPOVER	189 POLLOKSHAWS RD	G41 1PS
37	ARCH OF GLASGOW	GLENGOWAN HOUSE	196 NITHSDALE RD	G41 5EU
38	UNKNOWN	MACARTHUR HOUSE	15 ST JOHNS ROAD	G41 5QP
39	GDC	INGLEFIELD ST HOSTEL	19/21 INGLEFIELD ST	G42 7AY
40	SIMON COMMUNITY	CASTLEMILK PROJECT	ARNPRIOR RD	G45 9HD
41	GDC	CASTLEMILK HOUSING PRO	9/11 BALLANTAY QUAD	G45 ODY
42	TALBOT ASSOCIATION	KINGSTON HALLS	344 PAISLEY RD	G5 8RD
43	SALVATION ARMY	WILLIAM HUNTER HOUSE	70 OXFORD ST	G5 9EP
44	THE INNOCENTS	MERRYLAND ST	41 MERRYLAND ST	G51 2QG
45	BLUE TRIANGLE	KINNAIRD HOUSE	55 ELDER ST	G51 3PE
46	DEPT SOCIAL SECURITY	DSS RESETTLEMENT	200 CROSSHILL RD	G64 2PZ
47	TALBOT ASSOCIATION	CALDERBANK HOUSE	MUIRHEAD ROAD	G69 7UJ