Haringey Council

Adults and Health Scrutiny Panel – MENTAL HEALTH AND ACCOMMODATION EVIDENCE SESSION

MONDAY, 3RD FEBRUARY, 2014 at 18:00 HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, LONDON N22 8LE.

MEMBERS: Councillors Adamou (Chair), Bull, Erskine, Stennett and Winskill

CO-OPTEES: Helena Kania (HFOP), Healthwatch (tbc)

AGENDA

1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. URGENT ITEMS

The Chair will consider the admission of any late items of urgent business. Late items will be dealt with under the agenda item where they appear. New items will be dealt with at the end of the agenda.

3. DEPUTATIONS

To consider any requests received in accordance with Part 4, Section B, paragraph 29 of the Council's Constitution.

4. DECLARATIONS OF INTEREST

A member with a disclosable pecuniary interest in a matter who attends a meeting of the authority at which the matter is considered:

(i) Must disclose the interest at the start of the meeting or when the interest becomes apparent, and
(ii) May not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Members' Register of Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure.

Disclosable pecuniary interests, personal interests and prejudicial interests are defined at Paragraphs 5-7 and Appendix A of the Members' Code of Conduct.

5. HEALTH NEEDS ASSESSMENT OF HOMELESS IN HARINGEY (PAGES 1 - 24)

To receive a presentation from Sarah Hart, Commissioning Manager, Public Health on the health needs assessment of homeless in Haringey.

6. THE ROLE OF CARE CO-ORDINATORS

Attending:
Leigh Saunders, Assistant Director, Psychosis
Gerard Comey, CRHT Night Manager/Trust-wide Bed Management

7. FEEDBACK FROM EXTERNAL MEETINGS

To receive feedback from the scrutiny officer on meetings undertaken to inform the project.

8. NEXT STEPS, PRELIMINARY CONCLUSIONS AND RECOMMENDATIONS

For the Panel and attendees to discuss/identify:

- Themes
- Preliminary draft conclusions
- Preliminary draft recommendations and
- Areas where further information and work is required to inform the project.

9. NEW ITEMS OF URGENT BUSINESS

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Health needs assessment of homeless in Haringey

Key findings from a report by Dr Ruth Watt

Haringey 2013

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“Absolute poverty – a lack of the basic material necessities of life – continues to exist, even in the richest countries of Europe. The unemployed, many ethnic minority groups, guest workers, disabled people, refugees and homeless people are at risk. Those living on the streets suffer the highest rates of premature death.”

(Wilkinson & Marmot, 2003:16)

Introduction

Aim was to explore the health needs of rough sleepers and those living in hostels in Haringey

Purpose was to make recommendations for consideration by housing and health commissioners

Objectives:

- Identify the population that are rough sleeping or in hostels in Haringey and their demographics
- Identify the priority health needs for this group
- Identify usage of emergency and acute services
- Identify any barriers to health services
- Identify the services out there already improving access to health services
- Identify areas of best practice

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Why 50 homeless men are sleeping in a Tottenham church

New Economics Foundation report pinpoints how cuts are hitting England's most deprived wards, in London and Birmingham

Amelia Hill
The Guardian, Monday 19 November 2012 15.00 GMT

Article history

Society
Homelessness · Poverty · Benefits · Charities · Voluntary sector

UK news
Tottenham · London

Series
Breadline Britain

More from Breadline Britain on

Methodology

Expert views

- Interviews with staff and managers at local hostels, dual diagnosis and alcohol treatment services

Epidemiological evidence

- Literature review
- Best practise
- Analysis of local data, e.g. GP registrations database, National Drug Treatment Monitoring System

Benchmarking

- Benchmarking data from health services i.e. prevalence and service use data

Adapted from: Stevens, A., & Rafferty, J. (1994, 1997).

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Who do we mean by homeless

Conceptual Category	Operational Category
Roofless	**Living rough**
	In emergency accommodation
Houseless	**In accommodation for the homeless**
	People in women's shelters
	People in accommodation for immigrants
	People due to be released from institutions
	People receiving linger-term support (due to homelessness)
Insecure	People living in insecure accommodation
	People living under threat of eviction
	People living under threat of violence
Inadequate	People living in temporary/non-conventional structures
	People living in unfit housing
	People living in extreme overcrowding

Source: Adapted from FEANTSA. European Typology of Homelessness and housing exclusion

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Homeless in Haringey – an overview

494

Statutory homeless in 2010/11

60% of households with dependent children

41% from black ethnic groups

(compared 19% in Haringey - Census 2011)

Half lone parents (From accepted households)

Source: Community Housing Service, 2012.

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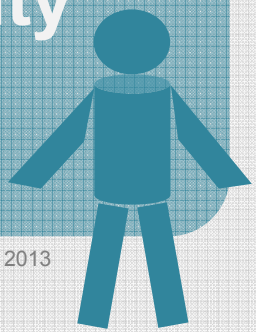
Rough sleepers in London

Vast majority single men



Source: Chain, 2013

Half of all rough sleepers in England located in London

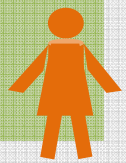
Estimated

6,437

Source: Brodie, 2013

12%

women



Source: Chain, 2013

58%

aged 26-45

Source: Chain, 2013

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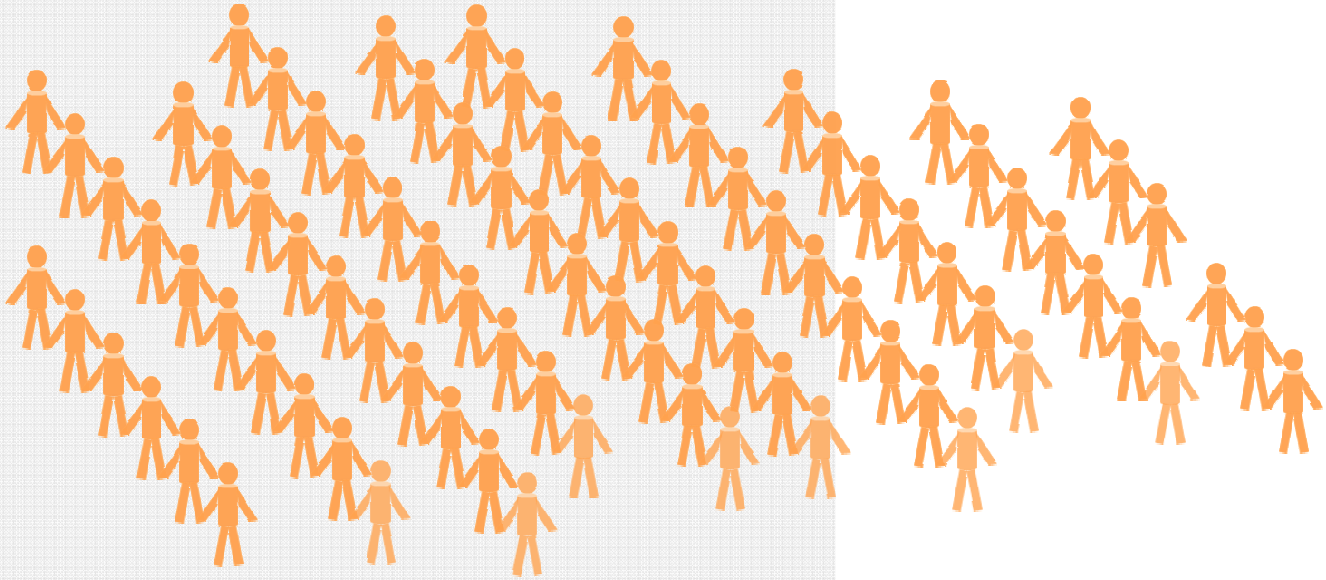
Rough sleepers in Haringey

85 people sleeping rough

at least once in Haringey in 2012/13, with 76 being new individuals.

Source:CHAIN, 2012).

London Fire Brigade concerned about people sleeping in derelict buildings, garages and sheds in Haringey.



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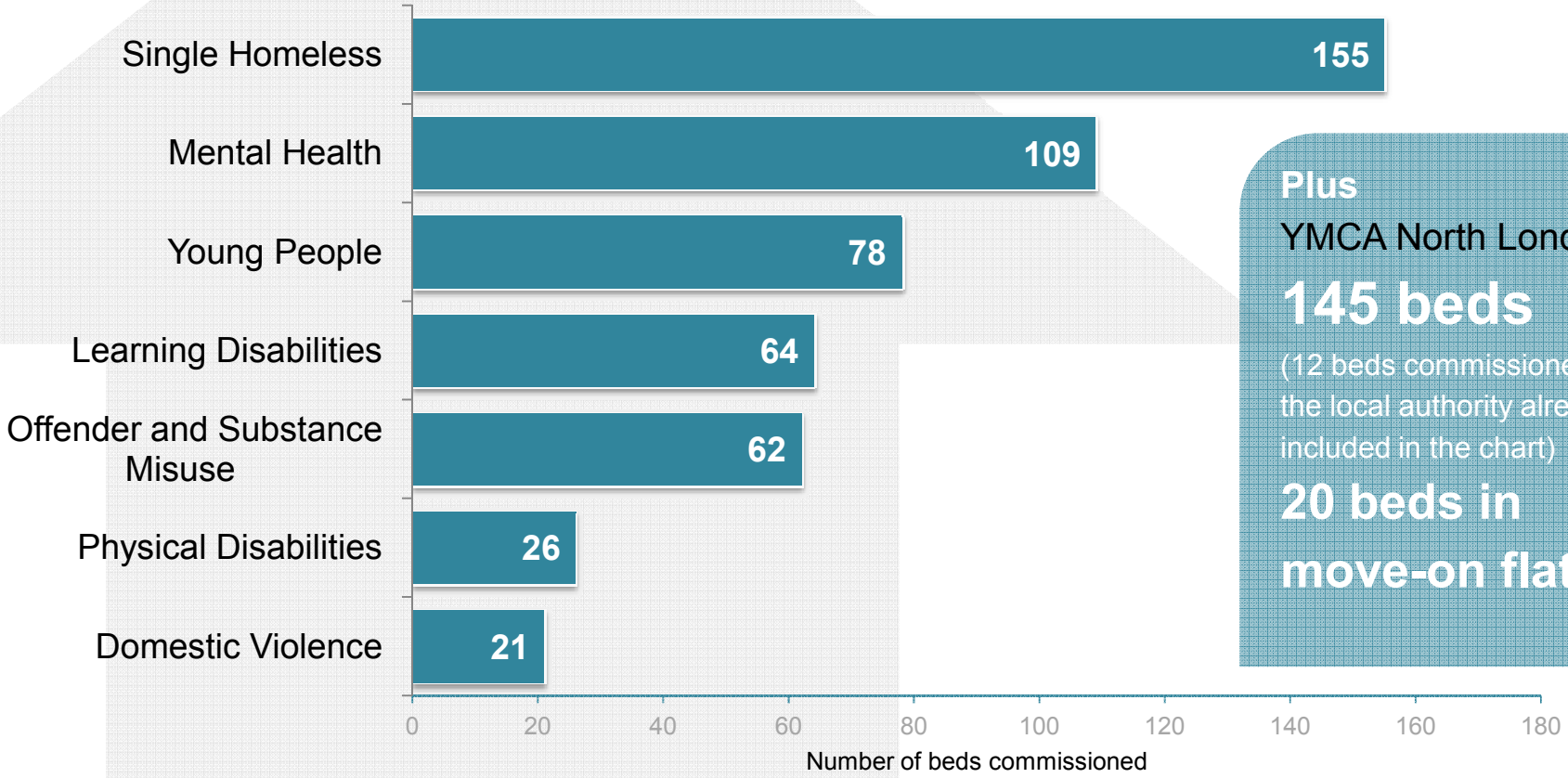
Hostel dwellers and rough sleepers in Haringey: Housing Related Support commissioned bed spaces 2012/13



Plus

YMCA North London

145 beds

(12 beds commissioned by the local authority already included in the chart)

20 beds in move-on flats

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Homelessness and health

People without safe, secure affordable shelter experience more health problems than the general population

Short term conditions	Life style factors	Infectious diseases	Mental ill health	Long term physical conditions
Physical injuries and wounds	Drug dependence	Infections (HEP B/C, HIV)	Depression	Heart and circulation problems
Dental	Smoking	TB	Psychotic disorder	Physical trauma
	Alcohol misuse	Inflammatory skin conditions	Dual diagnosis	Respiratory illness
	Poor nutrition			Physical trauma

Source:

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Prevalence of risk life style factors

SMOKING

85% rough sleepers

68% hostel clients

28% General population

Source: Crosier, 2004; Ash, 2003

Over half

of hostel clients use drugs

Source: Homeless Link, 2010

Nearly

1 in 3

regularly eat less than 2 meals per day

Source: Homeless Link, 2010

32%

with alcohol dependency

Source: Bilton, 2008

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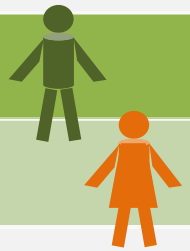
Impact on health

LIFE EXPECTANCY

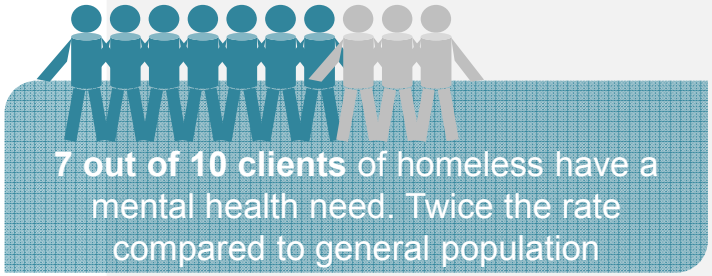
Rough sleepers	41
General population men	79
General population women	83



Source: Brodie, 2013, ONS, 2013

Many die of treatable medical conditions

MENTAL HEALTH



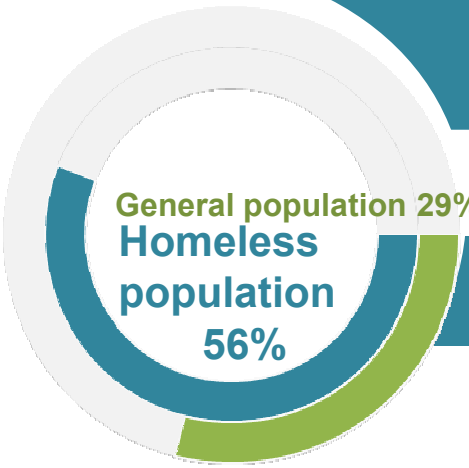
7 out of 10 clients of homeless have a mental health need. Twice the rate compared to general population

General population

Source: Homeless Link, 2010

PHYSICAL HEALTH

80%
with physical health needs



long term conditions

Source: Homeless Link, 2010

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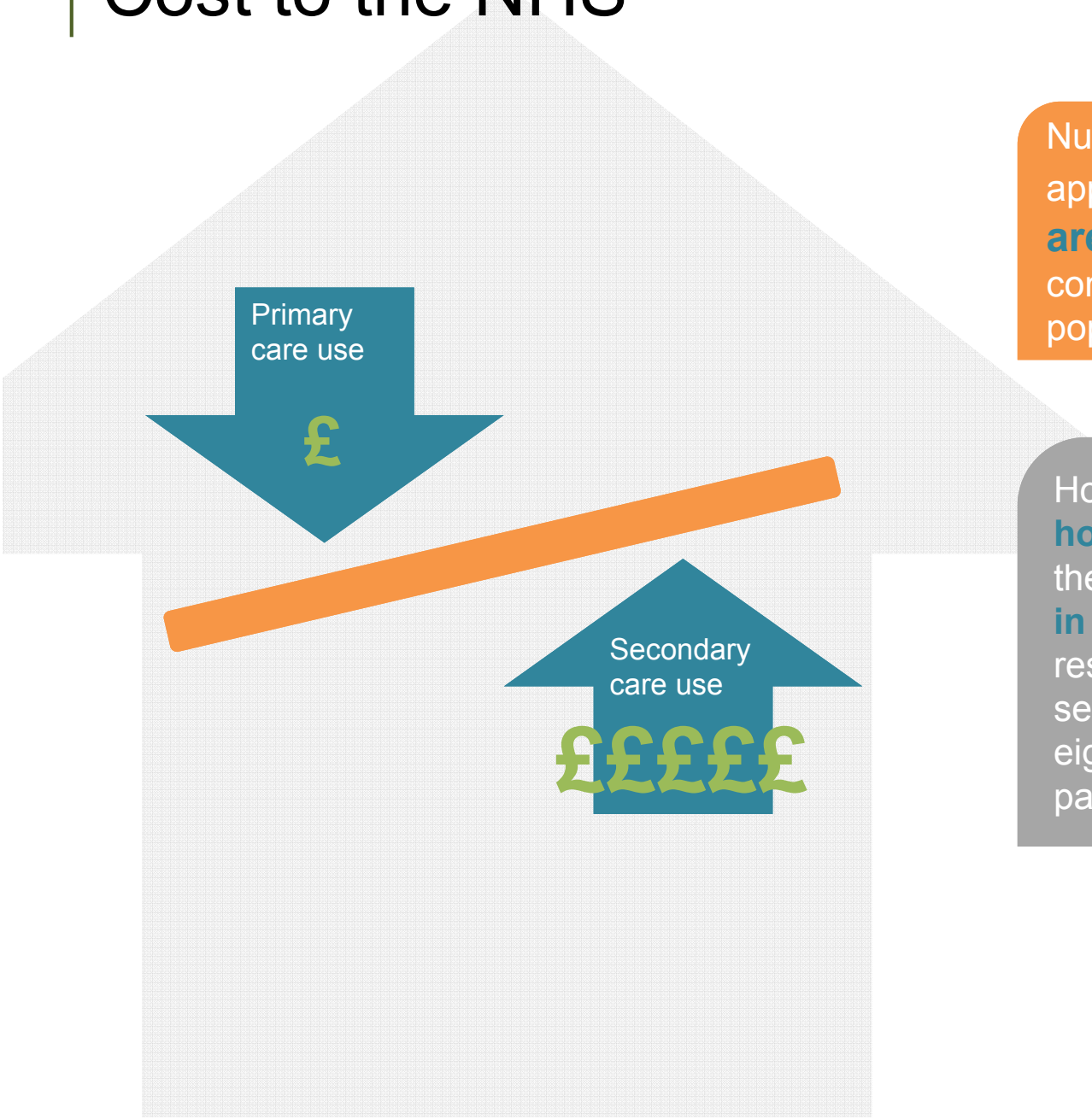
Cost to the NHS



Numbers of hospital outpatient appointment "**did not attends are seven times higher**" compared with the general population.

Source: Perera & Rabee, 2013

Homeless people are **admitted to hospital four times as often** as the general population and **stay in hospital three times as long** resulting in unscheduled secondary care costs that are eight times higher than for patients who are not homeless.

Source: Department of Health, 2010

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Local barriers to health services

27%

of rough sleepers have a NHS number, according to study by Inner North West London (INWL)

Source: Perera & Rabee, 2013

- **Registration with a GP-** proof of residency and photo ID – limited local guidance for health practitioners.
- **Getting homeless people to attend appointments**, poor experience of medical care and unreceptive environments, less capacity to get people to appointments
- **Lack of knowledge of the UK healthcare system**, e.g. Polish
- **Mental health services** - Regional PH Group for London (2010) found specific issues with access to mental health services: waiting times and rigid eligibility criteria. Findings corroborated by local reports from hostels.

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Local issues

- **Availability** – A lack of provision for complex single homeless people, discharges from acute and mental trusts problematic when patients have nowhere to go
- **Access for homeless people** – Homeless providers report barriers getting clients though housing advice to the Vulnerable Adults Team , is it the way customers present?
- **Pathways** – Poor communication and therefore continuity of care between specialist health and homeless services
- **Services** – Inadequate in-reach services regarding cannabis, counselling and IAPT services
- **Mental health services** - Queenswood Medical Centre report difficulties when referring homeless clients to mental health services
- **Role of faith organisations** – Some faith groups are offering shelter in churches to homeless people independently of VAT and these have no input from health
- **Polish encampment** – people with no resource to public funds

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Local services

- HRS -Single homeless projects with specialism's including substance misuse and mental health problems
- Street Rescue service one night per week, has access to a ‘crash pad’ then the above
- VAT sit on St Anne’s discharge meeting
- Substance misuse service have minimal residency requirements, which also providing training and in reach into hostels
- Dual diagnosis service for clients with mental health and substance misuse issues
- TB van, mental health first aid training, health checks, smoking cessation , CAB
- Queenswood Medical Centre – close to YMCA hostel and praised for its work with homeless patients

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Future projects for 2013

- Housing is redesigning its HRS pathway, includes a review of access to the VAT
- St Mungo's new provider of a substance misuse recovery service and will open the college part to all HRS residents
- Queenswood, satellite service from DASH, with a target on Cannabis use.
- The Dual Diagnosis to provide a peer led substance misuse services based in a local hostel
- Haringey Borough Commander of the London Fire Brigade will conduct a street count of all derelict buildings in the borough.
- North Middlesex hospital setting up a homeless discharge team.

....but no coherent unified strategy for health promotion, in primary, secondary or mental health services specifically looking at the needs of homeless people in Haringey

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Recommendations – we need health to work with housing

Qualitative study (Hinton, 2000) identified a number of factors they felt were negatively affecting health of the homeless:

- sharing space and the strains of communal living in hostels
- lack of daytime occupation
- lack of health information
- limited access to food and cooking
- and little resident involvement in the management of the hostel which fosters the feeling of powerlessness

Improving living conditions in hostels and providing housing support may be the most effective intervention for better health outcomes

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Recommendations

Strategic structures

- **Develop a local primary care model** for delivery of health and wellbeing for rough sleepers and hostel dwellers with key stakeholders, include community providers in the planning of services. (Next slide for models)
- **Develop mechanisms for commissioners and providers in housing, NHS and public health –** to develop joint commissioning, planning and training

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Four models of homelessness primary care

Models developed by Professor McCormack ranges from mainstream and outreach services to fully integrated primary care:

Mainstream practices providing services for the homeless – for example a GP from a mainstream practice holds regular sessions for homeless people either in a drop-in centre or in his or her surgery.

Outreach team of specialist homelessness nurses – for example an outreach team of specialist nurses providing advocacy, support and relevant health care treatments, and sign-posting to dedicated GP clinics

Full primary care specialist homelessness team – for example a team of specialist GPs, nurses and other services providing dedicated and specialist care, either located in a hostel or a drop-in centre

Fully co-ordinated primary and secondary care – for example a team of specialists spanning primary and secondary care providing an integrated service including intermediate care beds and in-reach services to acute beds

Source: Office of the Chief Analyst, 2010

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Recommendations

- **Exploit existing resources** – include health in housing pathway retendering, up-skill staff at hostels for health promotion activities, arrange health satellite services at hostels and Haringey winter shelters (church based rolling shelters).

- **Explore peer led options –** Groundswell have a Homeless Peer Advocacy project which aims to improve the health of homeless people through peer advocates. Peers offer clients 1:1 support and accompany clients to appointments, plus TB Peer Education project to support homeless and vulnerable people to get screened for TB.

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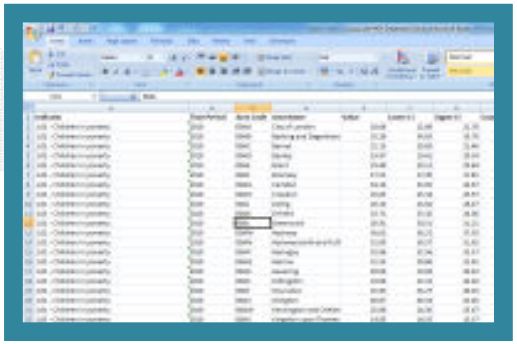
Recommendations

Immediate service improvements:

- Produce guidance of the proof of residents needed for GP registration
- Local needs assessment HRS providers to gather health needs data
- Improve coding of homeless status in patient records to more accurately assess prevalence and health needs



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