Health needs assessment of homeless in Haringey

Key findings from a report by Dr Ruth Watt

Haringey 2013

Haringey Council

“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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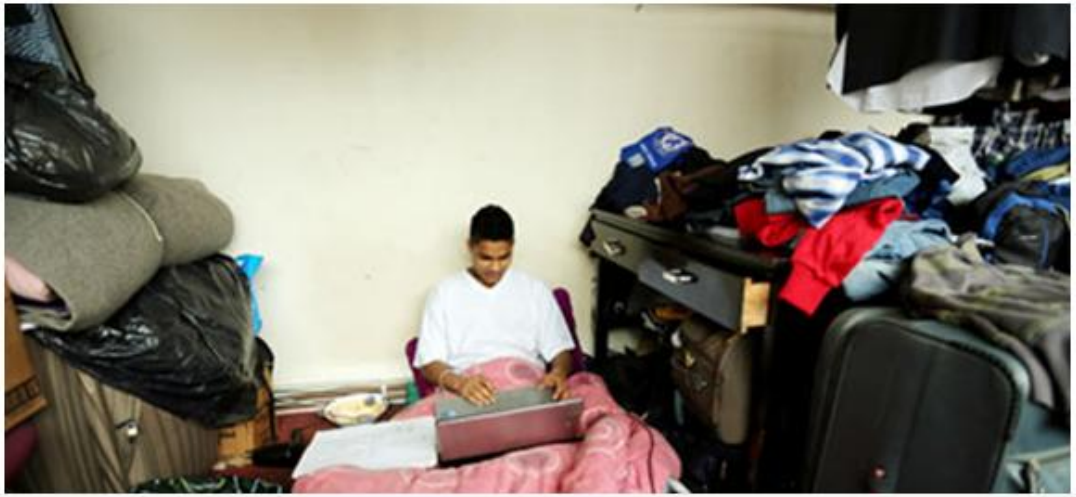
Why 50 homeless men are sleeping in a Tottenham church

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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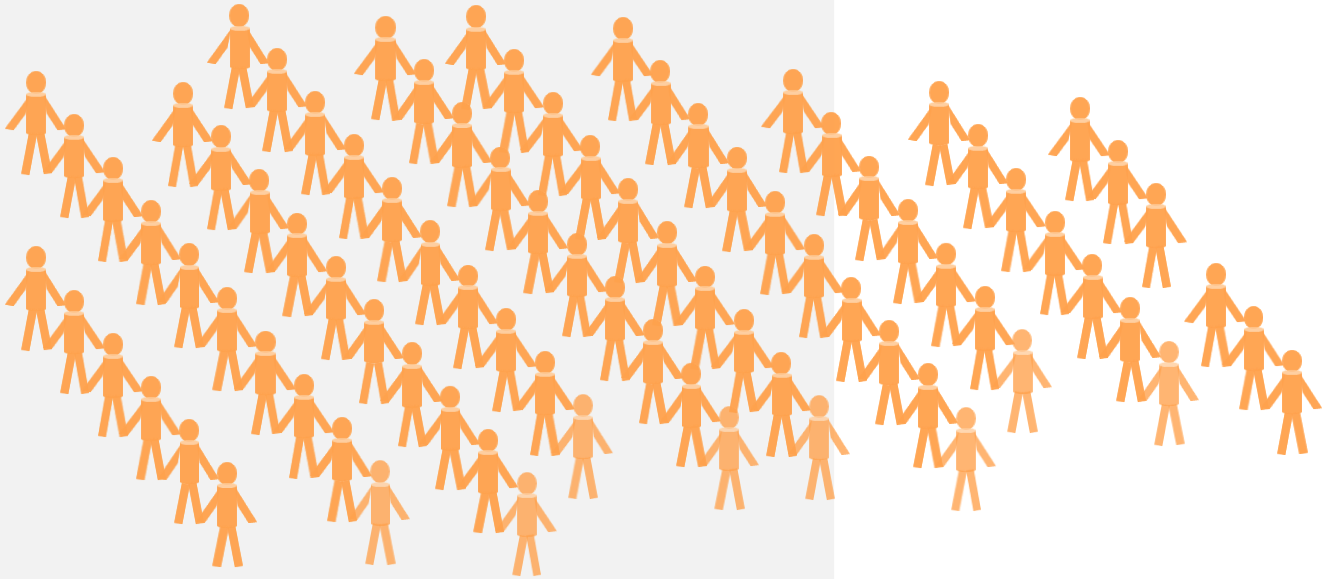
Rough sleepers in Haringey

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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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

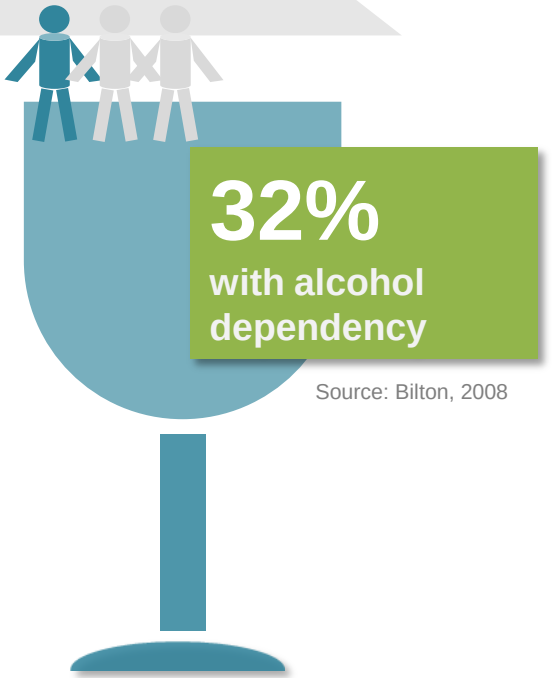
Source: Homeless Link, 2010

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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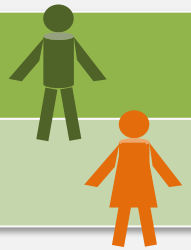
Impact on health

LIFE EXPECTANCY

Many die of treatable medical conditions

Rough sleepers	41
General population men	79
General population women	83



Source: Brodie, 2013; ONS, 2013

MENTAL HEALTH

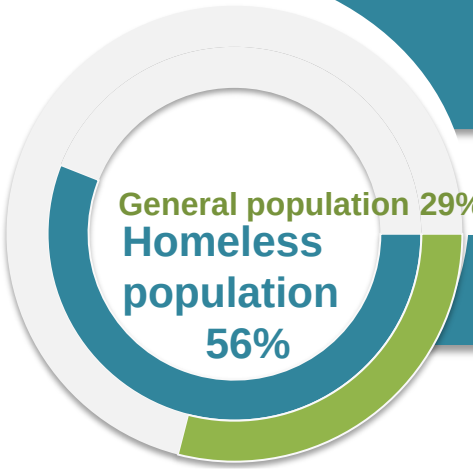
7 out of 10 clients of homeless have a mental health need. Twice the rate compared to general population

General population

Source: Homeless Link, 2010

PHYSICAL HEALTH

80%
with physical health needs



long term conditions

Source: Homeless Link, 2010

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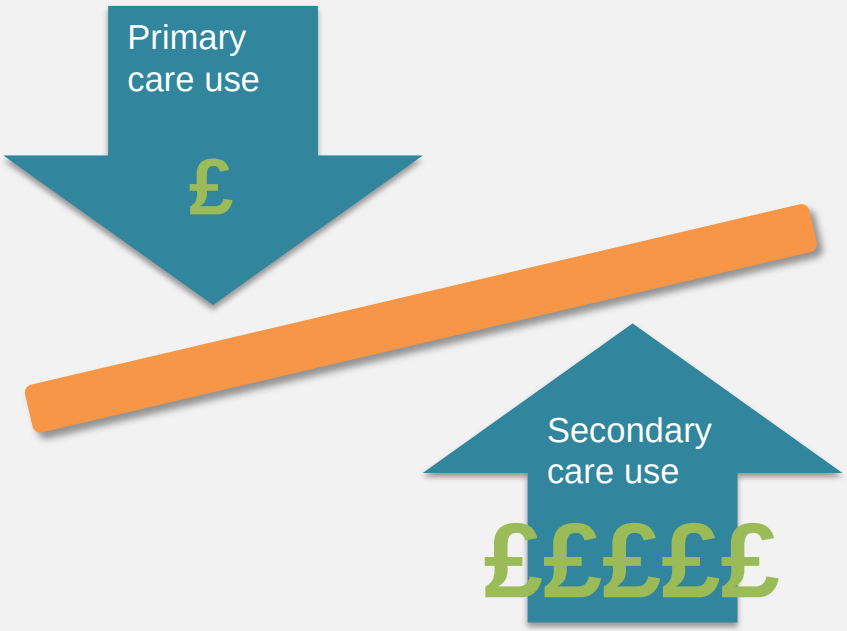
Cost to the NHS



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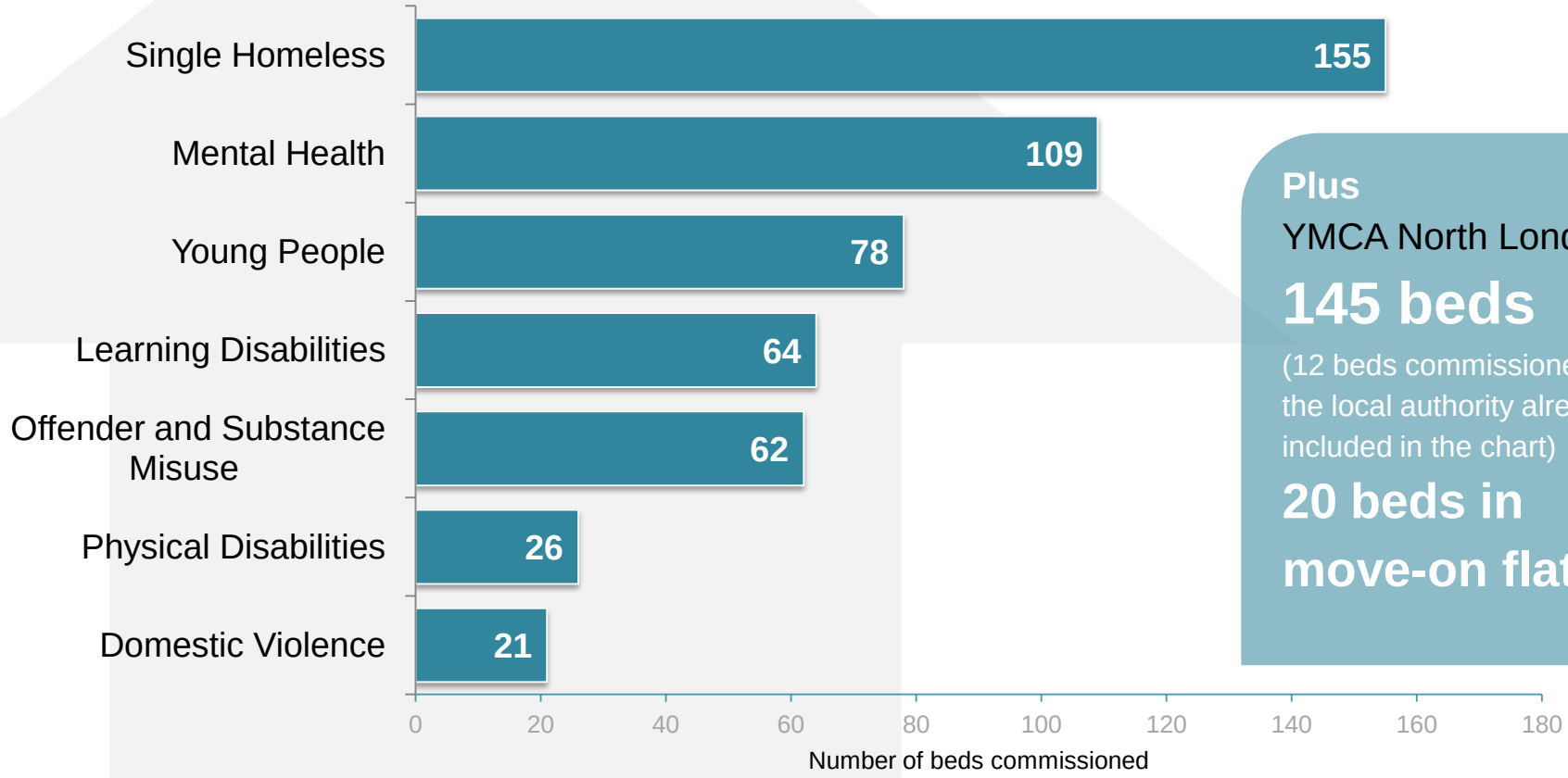
Hostel dwellers and rough sleepers in Haringey: commissioned bed spaces 2012/13



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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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 guidance for health practitioners.
- **Getting homeless people to attend appointments**, local homeless report poor experience of medical care and unreceptive environments
- **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** - Local housing strategy reports a lack of provision of complex single homeless people, discharges from acute and mental trusts problematic when patients have nowhere to go
- **Access for homeless people** – homeless providers barriers getting clients though housing advice to the Vulnerable Adults team
- **Pathways** – poor continuity of care between specialist health and homeless services
- **Services** – Inadequate services regarding cannabis, counselling and IAPT services
- Queenswood Medical Centre has a psychotherapist at the practise but report difficulties when referring clients to external mental health services (check)
- **Role of faith organisations** - Faith groups are offering shelter in churches to homeless people independently and these have no input from health

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Local services

- Single homeless projects with specialism's including substance misuse and mental health problems
- Substance misuse service in 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 every 6 months
- Queenswood Medical Centre – close to YMCA hostel and deals with high rate of homeless patients
- Mental health first aid training

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Future projects for 2013

- St Mungo's. a major provider of supported accommodation, has won a tender to provide a substance misuse recovery service and will open the college part to all service users
- 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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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

But what is the best local model?

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Recommendations

- **Develop a local model** for delivery of health and wellbeing for rough sleepers and hostel dwellers with key stakeholders, include community providers in the planning of services.
- **Joint commissioning** across the Council and CCGs to meet the health needs of homeless population – including joined up bids for external funding, explore providing similar level of support regardless of substance misuse status or history of offending.

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Recommendations

- **Exploit existing resources** - for example, 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 –** as an example 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. Other health related services include the TB Peer Education project to support homeless and vulnerable people to get screened for TB.

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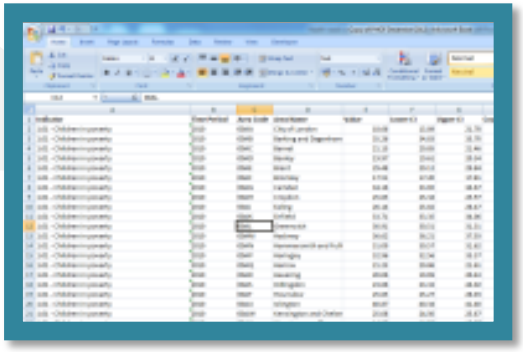
Recommendations

Immediate service improvements:

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



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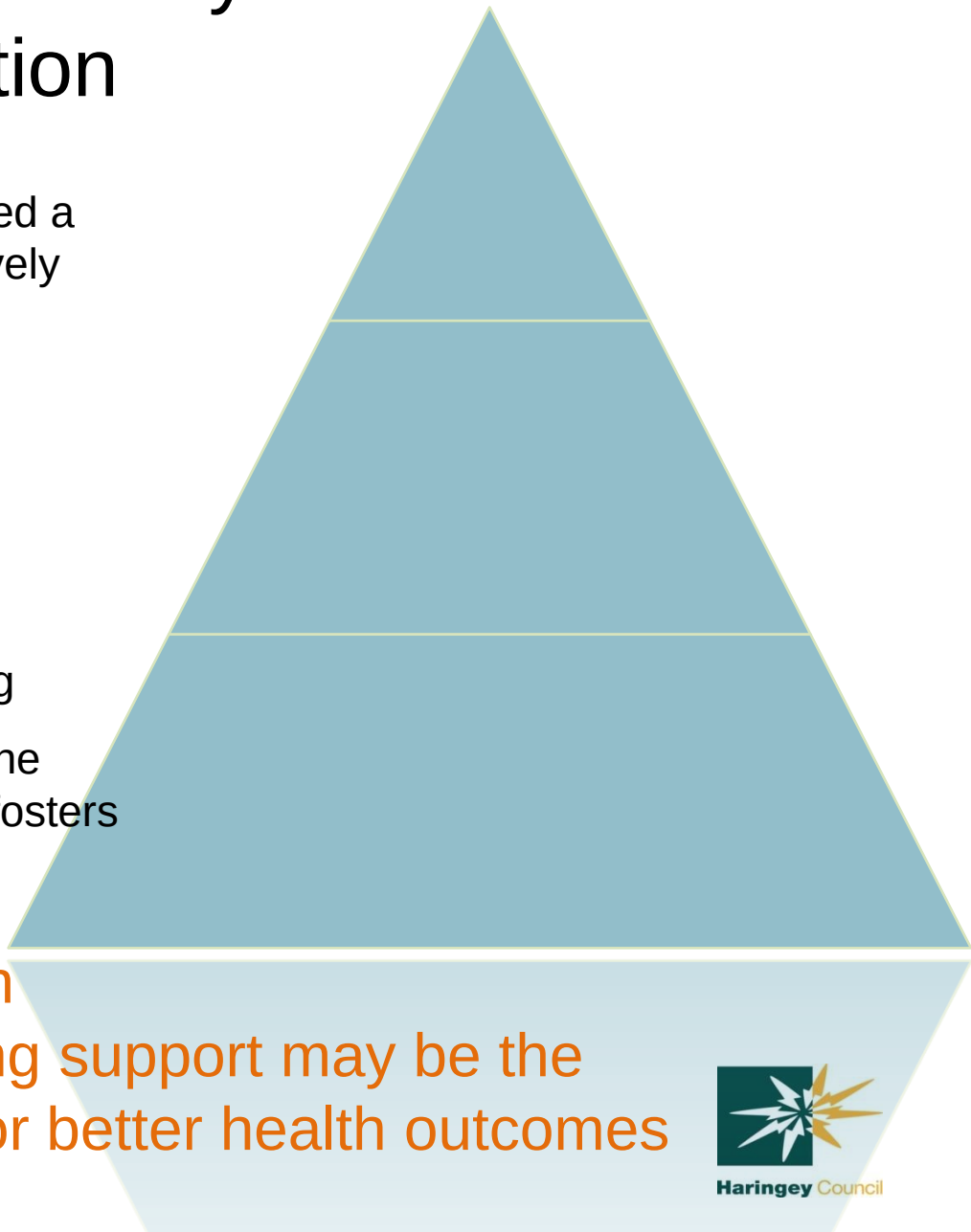
...but consider the hierarchy of needs and prevention

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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Next steps

- **Bring together key stakeholders** to develop a local strategy and explore the feasibility of different models locally
- **Gather further information on best practise** and different local models in London

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