Single homeless people’s access
to health-care services in South Yorkshire

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Final Report

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EXECUTIVE SUMMARY

This report describes findings from a study of health-care provision for single homeless people in South Yorkshire. It was commissioned and funded by the NIHR Collaboration for Leadership in Applied Health Research and Care, South Yorkshire (CLAHRC SY). The study had three objectives:

- To identify current arrangements for delivering primary-care, mental health and substance misuse services to single homeless people in South Yorkshire.
- To assess which arrangements are working well and which not so well, and the reasons for the variations.
- To identify gaps in health-care service-provision for single homeless people.

Inventory of services

- An inventory of temporary accommodation projects and day / drop-in centres for single homeless people in South Yorkshire was compiled. Overall, 36 projects were identified: 29 accommodation projects and seven day centres. 55% of the projects are in Sheffield. Altogether the 29 residential projects provide 793 beds for single homeless people (476 in Sheffield, 141 in Doncaster, 94 in Rotherham and 82 in Barnsley).

- None of the services are located outside the inner areas of the four principal towns of the former metropolitan county.

Survey of homelessness-sector service-providers

- A survey of homelessness-sector service providers in South Yorkshire was conducted. Questionnaires were sent to all projects in the inventory, and 81% responded. Most (74%) project managers believed that the current arrangements for accessing medical care for their clients were working well, while 26% said ‘yes and no’. Two-fifths of projects had a special arrangement with a local GP service or were visited by a Homeless Health Care Team. Others encouraged their clients to use walk-in health centres.

- A common problem (reported by 21% of staff) was the difficulty of accessing dentists, and that often their clients had to travel a long way to get dental treatment.

- Only 26 per cent of staff believed that the current arrangements for accessing mental health services worked well; 48% said ‘yes and no’, and 26% ‘no’. Common problems were long waiting times and delays in accessing advice and treatment. The staff believed that there was a need for a dedicated mental health worker to visit projects to assess clients, a ‘fast track’ into mental health services, better access to crisis intervention support, and more intensive help for clients with mental health issues.

- 56% of staff said that the current arrangements for accessing substance misuse services worked well, 37% were ambivalent, and 7% said ‘no’. A few mentioned the problem of long waiting times, but more referred to the poor compliance of clients and the difficulties
of persuading them to engage with services. The staff believed there was a need for substance misuse workers, particularly alcohol workers, to visit their project regularly to work with clients.

- Most projects have staff that carry out health promotion work with clients, such as giving advice and practical sessions on healthy eating, giving up smoking, and taking exercise. Several staff believed that health professionals should be more involved in undertaking health promotion work with homeless people.

- Two-fifths of staff identified gaps in their training. They believed they would benefit from more training on mental health and substance misuse issues, on motivating people with complex needs, on specific health issues such as tuberculosis and blood-borne viruses, health promotion, and on basic awareness of different medications.

Survey of single homeless people

- Sixty-one homeless people (50 men and 11 women) in Doncaster, Rotherham and Sheffield were interviewed. Using the 2008 General Lifestyle Survey (GLS) categories, 46% rated their health as ‘very good’ or ‘good’, while 23 per cent described it as ‘bad’ or ‘very bad’. In contrast, the equivalent figures for GLS respondents were 79% and 5%.

- Physical health problems were common among the respondents – 77% reported illnesses, including many with serious and long-standing conditions. Several associated health problems with their lifestyle, e.g. sleeping on the streets, alcohol and drug misuse, heavy smoking, and poor diet. The high prevalence of health problems is broadly consistent with national figures for single homeless people.

- 36 (59%) respondents were permanently registered with a GP, but only 23 (38%) locally. During the last six months, 80% had had contact with primary health-care services, 39% had attended a hospital A&E Department, and 23% had been admitted into hospital.

- When asked about health screening, the respondents who had been in prison or were in contact with a Homeless Health Care Team were more likely to have had vaccinations or testing for specified diseases. Overall, only 31% had been tested for TB during the last 10 years. A high rate (33%) of Hepatitis C was established among those screened.

- Only 34% of respondents had seen a dentist during the preceding six months. Nearly one-half reported untreated dental problems including toothache and loose and corroding teeth. More than one-half (57%) had no dentist.

- 79% of the respondents described mental health problems, including 57% who had been diagnosed with a mental illness. Only 37% who reported mental health problems were receiving treatment. Several who were not having help believed that medication or counselling would help them.

- Nearly one-half (46%) reported alcohol problems, most of whom consumed super-strength beers and lagers or strong cider. Among those with alcohol problems, 29% had
help from an alcohol worker. 54% reported drug problems, including several who were poly-drug users. Among those with drug problems, 48% were under the care of a specialist drugs team.

- The respondents in contact with a Homeless Health Care Team were more likely to be linked into specialist mental health and substance misuse services if suffering from the named problems.

**Recommendations**

- To improve single homeless people’s health and their access to health services, we recommend increased collaboration in South Yorkshire between NHS agencies and staff and the specialist homelessness services.

- Health monitoring and preventive interventions for single homeless people need to be improved. This requires systematic screening and vaccination programmes that take into account the movement of some homeless people between hostels and the streets and between towns, and should target those most at risk, *i.e.* those with histories of chronic or repeated homelessness and substance misuse problems. Pro-active approaches in collaboration with homelessness-sector staff are needed to encourage participation among those who are ‘hard-to-engage’.

- We recommend that health professionals work collaboratively with hostel and day centre staff in the delivery of health promotion advice and activities to homeless people. At present, most of the work is carried out by homelessness-sector staff, but they lack specialist knowledge and would welcome training and input from health professionals.

- There should be an increase in the number of specialist or dedicated primary health-care professionals that link with and support homeless people’s projects. Many study respondents were not registered with a local GP. Moreover, the advantages to homeless people of being in contact with a Homeless Health Care Team are well-demonstrated. Ways of improving homeless people’s access to local dental services should also be considered by NHS managers.

- Strategies need to be developed with community mental health teams to address the high rate of unmet mental health problems among homeless people, and to support homelessness-sector staff that are working with clients with mental health issues. Mental health workers could usefully visit hostels and day centres to assess clients, provide crisis intervention support, and to offer advice and training for staff.

- Strategies also need to be developed with substance misuse teams to address the high rate of unmet needs among homeless people, particularly with alcohol problems, and to support homelessness-sector staff that work with such clients. The challenge is not only to improve their access to services, but also for specialist workers and homelessness-sector staff collaboratively to find ways of encouraging heavy drinkers to accept help.
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I INTRODUCTION

The structured exclusion of single homeless people

‘Single’ homeless people are treated differently in UK law and by the welfare system from those who become homeless but have dependants, most often children. Under the Housing Act 1977 and amending legislation, local authorities have a duty to secure housing for those who become homeless unintentionally, have a local connection and have dependants or who are in a number of priority groups, e.g. those fleeing domestic violence. This duty does not extend to most of those without dependants. The consequence is that the majority of those accepted by local authorities as ‘officially’ homeless and who are allocated housing are family households, characteristically women with young children, and the single homeless population is predominantly male.

The structured exclusion of single homeless people also results in their relationship with the state welfare system, and in limited respects with health services, being different from that of the general population. Most support services for single homeless people are provided by ‘third sector’ organisations. These range from community-based and faith-based drop-in centres and soup runs, to incorporated charities that provide a wider range of services including hostels and ‘supported housing’ that help the residents both to deal with their problems and to gain the skills and training required to live independently. Primary care, mental health and substance abuse services have different relationships with the residents of homeless people’s hostels and temporary accommodation than they do with conventional households. In some places special arrangements are made by NHS providers to serve the residents of homeless people’s projects, but all too often this is not the case and, indeed, the population is neglected.1

The health and unmet health care needs of single homeless people

When standardised for age, single homeless people are among the least healthy members of the population and have high rates of physical health, mental health, alcohol and drug problems (Pleace and Quilgars 1996; Wright 2002). A thorough and authoritative study of the health of single homeless people by Bines (1994) estimated standardised morbidity rates for self-diagnosed conditions for two groups of homeless people (those sleeping rough and those resident in hostels and B&B) and made comparisons with the general UK population (Figure 1). ‘Chronic chest and breathing problems were twice as high among homeless people in hostels and B&B than among the general population, and three times higher among people sleeping rough’. A similar pattern emerged for skin complaints and ulcers, musculoskeletal problems, and frequent headaches. Mental health problems, defined as ‘depression, anxiety or nerves’, were 11 times more prevalent.

1. For a detailed review with examples of special services, see Warnes et al. 2003, Chapter 10, ‘Access to health care and substance misuse services’, pp. 127-32.
among people sleeping rough than in the general population, and eight times more prevalent for those in hostels and B&B (Pleace and Quilgars 1996: 42).

A study of single homeless people in the mid-1990s in Sheffield found that single homeless people had significantly worse health than a standard London population in ‘all dimensions’ (Westlake and George 1994). Anxiety and depression were at raised levels among all the groups of single homeless people who took part in this study. Other studies, many of them based on information about the patients at clinics dedicated to homeless people, have filled out this picture and established high rates of smoking, alcohol consumption, drug dependency, dental hygiene, trauma, skin problems such as scabies, lice and leg ulcers among rough sleepers and, to a lesser extent, hostel residents.

There has been rising concern about the prevalence of tuberculosis among single homeless people. ‘The concern in relation to those sleeping rough … is that they lead chaotic lifestyles or have to move between areas, and will not be able to complete a course of drugs to cure their TB. Resistant strains then emerge because drug courses are not completed’ (Please and Quilgars 1996: 45). Crisis screened 611 single homeless people for TB at shelters, hostels and day centres in the mid-1990s and found ‘a prevalence of tuberculosis of 2 per cent … 24 times the level found in the last screening of the general population in London in 1983 (Citron, Southern and Dixon 1995).
Single homeless people are relatively excluded from primary and specialist health-care services. They are less likely than the general population to be registered with a GP, and there are numerous difficulties in meeting their health-care needs. Many neglect their health, which they regard as low priority, and many display chaotic behaviour and follow an unsettled lifestyle that reduces their compliance with treatment programmes. At the same time, many face barriers in accessing health-care services, including the inflexibility of services, staff attitudes, and the difficulties that services have in treating people with complex and multiple needs (Crane and Warnes 2001b).

The arrangements for providing health and substance misuse services to homeless people vary greatly. Some homelessness organisations have agreements with a primary care practice to provide GP or primary-care nurse sessions in hostels, while some encourage registration with nominated practices. Treatment for substance misuse problems very often involves more than one NHS provider and not-for-profit specialist organisation. There are widely noted deficiencies in the provision of services for those with both mental health and substance misuse problems, as both services find the group problematic to treat.

For many years, a few general practitioners have taken a particular interest in homeless people and provided clinics and sessions for their treatment. A pioneer in this regard in South Yorkshire was the Devonshire Green and Hanover Medical Practice, Sheffield (Usherwood, Jones and Hanover Project Team 1993). For more than a decade, the NHS has encouraged and funded initiatives to improve primary health care for ‘special needs’ and disadvantaged groups, in part to reduce their high utilisation of emergency services. The raised interest prompted the Royal College of General Practitioners (2002) to review the role of primary care in treating homeless people and to publish recommendations. They included:

- Primary care practitioners should provide a welcoming and sensitive service to homeless people and enable them to access the full range of health and social services required to meet their needs.
- Homeless people should be registered permanently [with the NHS and a specific practice] wherever possible and integrated into all health prevention and promotion activity in a practice.
- In view of the impact of homelessness on health, homelessness issues should be recognised as part of the core Primary Care Trust (PCT) agenda.
- PCTs should acquire a good understanding of the number of homeless people in their area and the problems they face, as well as the range of local agencies equipped to meet their needs.
- The new GP contract negotiations should address structural barriers that may affect the permanent registration of homeless people, including the removal of perverse incentives such as deprivation and target payment anomalies.

In South Yorkshire, as across the UK, although single homeless people are a small element of the total population, their high rates of ‘unhealthy behaviours’ and exceptional quotient of unmet
health-care needs result in the population making a disproportionate contribution to the region’s health inequalities. If the single homeless population was reduced, or if their state of health was improved, this would make a substantial contribution to health equality (Wright 2002). It was in this context that the study reported here was proposed to the NIHR-funded Collaboration for Leadership in Health and Social Care in South Yorkshire and supported by the Health Inequalities Management Group.

Aims and objectives

The overall aim of the study was to develop a body of evidence about health-care provision for single homeless people in South Yorkshire. Such evidence will give local NHS trusts, the successor commissioning bodies, and their collaborating agencies more information about unmet treatment needs and about the strengths and weaknesses of current service provision. The objectives of the study are:

- To identify current arrangements for delivering primary-care, mental health and substance misuse services to single homeless people in South Yorkshire.
- To assemble evidence about which of the above arrangements are working well and which not so well, and the reasons for the variations.
- To identify gaps in health-care service-provision for single homeless people in the region.

Study design

There have been three elements to the study:

- An inventory of services for single homeless people in South Yorkshire
- A survey of homelessness-sector service-providers in South Yorkshire to establish their links with health-care services
- A survey of single homeless people to determine their health problems, utilisation of health-care services, and the extent to which their health care needs are being met.

Ethics approval for the study was given by the Trent NHS Research Ethics Committee.

II INVENTORY OF SERVICES

A starting point for the project was to compile an inventory or directory of all temporary accommodation projects and day centres or drop-in centres in South Yorkshire that target single homeless people (exclusively or along with other vulnerable groups). Single, specialised purpose facilities to which patients or service users are referred from elsewhere (such as detoxification units) were not included if they did not provide drop-in facilities and basic services for homeless people such as food. For similar reasons, some single-purpose and some generic advice points (such as local authority housing offices and the Citizens Advice Bureau) have not been included.
Churches that provide sandwiches before or after a religious service have not been included unless they open as a drop-in centre at least one day a week.

The foundation for the inventory was the projects listed on its website by the national coordinating organisation Homeless Link (www.homelessuk.org). Other projects were identified with the help of the CLAHRC Health Inequalities Management Group, through local contacts, and through internet searches and contacts with homelessness-sector organisations.

Overall, 36 projects were identified: 29 accommodation projects and seven day centres or drop-in centres (Table 1). Most of the services are in Sheffield (20), while Doncaster and Rotherham each have six, and Barnsley has four. None are located outside the inner areas of the four principal towns of the former metropolitan county. Altogether the 29 residential projects provide 793 beds for single homeless people (476 in Sheffield, 141 in Doncaster, 94 in Rotherham and 82 in Barnsley). Seven are small with fewer than 15 beds, and four have 50 or more beds. Thirteen residential projects are exclusively for young people (aged 25 years or less), two accommodate people up to the age of 35 years, and 14 are for homeless adults. Several staff working with homeless people and several of our homeless informants commented on the serious lack of temporary accommodation in Rotherham for homeless men and women aged over 25 years.

Table 1. Inventory of temporary accommodation and drop-in centres for single homeless people in South Yorkshire

<table>
<thead>
<tr>
<th>Name of project</th>
<th>Provider organisation</th>
<th>Service</th>
<th>Beds</th>
<th>Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BARNSLEY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barnsley Young People’s Accommodation Service</td>
<td>Stonham</td>
<td>Acc2</td>
<td>5</td>
<td>Young M/W</td>
</tr>
<tr>
<td>The Forge</td>
<td>South Yorkshire HA</td>
<td>Acc1</td>
<td>17</td>
<td>Young M/W</td>
</tr>
<tr>
<td>Holden House</td>
<td>Riverside English Churches Housing Group</td>
<td>Acc1, Acc2</td>
<td>60</td>
<td>MW 16-65</td>
</tr>
<tr>
<td>Barnsley Churches Drugs Project</td>
<td>Barnsley Churches Drugs Project</td>
<td>D-IC 3 days</td>
<td>n/a</td>
<td>MW 18+</td>
</tr>
<tr>
<td><strong>DONCASTER</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open House Plus</td>
<td>M25 Housing and Support Group</td>
<td>Acc1</td>
<td>26</td>
<td>MW 16+</td>
</tr>
<tr>
<td>Wharf House</td>
<td>M25 Housing and Support Group</td>
<td>Acc1, Acc2</td>
<td>30</td>
<td>MW 16+</td>
</tr>
<tr>
<td>Doncaster Foyer</td>
<td>Salvation Army HA</td>
<td>Acc2</td>
<td>40</td>
<td>Young M/W</td>
</tr>
<tr>
<td>Goodall House</td>
<td>Doncaster YMCA</td>
<td>Acc2</td>
<td>26</td>
<td>MW 18-35</td>
</tr>
<tr>
<td>Doncaster Move-On</td>
<td>South Yorkshire HA</td>
<td>Acc2</td>
<td>19</td>
<td>MW 16-65</td>
</tr>
<tr>
<td>Hope Centre</td>
<td>Restoring Broken Walls Trust</td>
<td>D-IC 3 pm</td>
<td>n/a</td>
<td>M/W</td>
</tr>
<tr>
<td><strong>Total beds</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total beds</td>
<td></td>
<td>82</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total beds</td>
<td></td>
<td>141</td>
<td></td>
</tr>
<tr>
<td>ROTHERHAM</td>
<td>SHEFFIELD</td>
<td>SOUTH YORKSHIRE</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>The Lighthouse</td>
<td>Lighthouse Homes</td>
<td>Acc1, Acc2</td>
<td>15</td>
<td>Men 18+</td>
</tr>
<tr>
<td>Interim Accommodation Project</td>
<td>Action Housing and Support</td>
<td>Acc2</td>
<td>15</td>
<td>M/W 18+</td>
</tr>
<tr>
<td>Rush House Supported Housing Scheme</td>
<td>Rush House Ltd</td>
<td>Acc2</td>
<td>32</td>
<td>Young M/W</td>
</tr>
<tr>
<td>Rotherham Young Person’s Project</td>
<td>Action Housing and Support</td>
<td>Acc1, Acc2</td>
<td>32</td>
<td>Young M/W</td>
</tr>
<tr>
<td>Shiloh</td>
<td>Shiloh</td>
<td>D-IC 3 am</td>
<td>n/a</td>
<td>M/W</td>
</tr>
<tr>
<td>The Hub Christian Community</td>
<td>The Hub Christian Community</td>
<td>D-IC 2 am</td>
<td>n/a</td>
<td>M/W</td>
</tr>
<tr>
<td><strong>Total beds</strong></td>
<td></td>
<td></td>
<td></td>
<td>94</td>
</tr>
</tbody>
</table>

| SHEFFIELD | | |
|-----------| | |
| Bevin Court | St Anne’s Community Services | Acc1, Acc2 | 66 | Men 18+ |
| Mickey Lane / Granville Road | Cherry Tree Support Services | Acc1, Acc2 | 28 | Young M/W |
| Emmaus Sheffield | Emmaus Sheffield | Acc2 | 8 | M/W 18+ |
| Grace Tebbutt House | Grace Tebbutt House Trust | Acc1, Acc2 | 9 | Women 16-60 |
| Pitsmoor Youth Housing Trust | Pitsmoor Youth Housing Trust | Acc1, Acc2 | 29 | Young M/W |
| Young Person’s Housing Project | Places for People | Acc2 | 26 | Young M/W |
| Station Foyer (Refugee Project) | Refugee Support / MST | Acc1, Acc2 | 20 | Refugees 18-35 |
| Roundabout | Roundabout | Acc1, Acc2 | 36 | Young M/W |
| Charter Row | Salvation Army Lifehouse | Acc1, Acc2 | 56 | M/W 18+ |
| Sheffield Foyer | Guinness Care and Support | Acc2 | 60 | Young M/W |
| Sheffield Women’s Service | Stonham | Acc1 | 12 | Women 16-65 |
| Peile House | Sheffield YWCA | Acc1, Acc2 | 14 | Young women |
| Infirmary Road | South Yorkshire HA | Acc1, Acc2 | 15 | M/W 16+ |
| Burngreave Young People’s Project | Turning Point | Acc2 | 30 | Young M/W |
| Victoria Court | Places for People | Acc1, Acc2 | 43 | M/W 16+ |
| Young Women’s Housing Project | Young Women’s Housing Project | Acc2 | 13 | Young women |
| Norman House | Norman House Trust | Acc1, Acc2 | 11 | Men 18+ |
| Ben’s Centre for Vulnerable People | Ben’s Centre for Vulnerable People | DayC 4 days | n/a | Street drinkers 18+ |
| The Cathedral Archer Project | The Cathedral Archer Project | DayC 5 days | n/a | M/W 18+ |
| St Wilfrid’s Centre | St Wilfrid’s Centre | DayC 5 days | n/a | M/W 18-65 |
| **Total beds** | | | | 476 |

**Notes:** Acc1: first-stage accommodation, i.e. emergency or direct-access accommodation which accepts people when they first become homeless or straight from the streets. These services concentrate on meeting basic needs such as nutrition, and access to health-care and welfare benefits. Acc2: second-stage accommodation, i.e. transitional accommodation with a focus on rehabilitation, life skills training, and engagement in education or work-training programmes to prepare residents for resettlement and independent-living. In some organisations, residents move from first-stage to second-stage accommodation as they progress, but many organisations now provide accommodation which has both emergency and rehabilitation features. D-IC: drop-in centre. DayC: day centre. For both the latter, the frequency of sessions per week is indicated, and whether they are morning, afternoon or day-long sessions. HA: Housing Association. M/W: men and women.

**Sources:** Information was gathered about the projects during the survey of service-providers. For those who did not respond, details were gathered from the Internet and from Homeless Link’s inventory of services (www.homelessuk.org).
III SURVEY OF SERVICE PROVIDERS

A survey was carried out of the arrangements in place at homeless people’s projects in South Yorkshire for the service-users’ access to primary health care and specialist mental health and substance abuse services. The aim was to include all the projects covered in the directory. A questionnaire was designed for both self-completion and interviewer administration. It was developed from questionnaires that the authors had used in previous studies of services for homeless people, and our knowledge of the questions and instruments used by other researchers of access to health care. The principal topics were:

- Type of project, facilities, and client groups served.
- The arrangements for accessing primary health-care services, mental health services, alcohol and drug misuse services, dental services, and complementary services. This included gp registration, and contracted and de facto collaborations and inter-agency referral pathways.
- The effectiveness of the above arrangements and reasons why they are working well / not so well. This included the uptake of the above services by clients.
- Gaps in health-care service provision generally for all clients and for particular client groups.
- Continuities / discontinuities of health and substance misuse service provision when the clients move on, and arrangements for linking them into alternative services.
- The training and involvement of project staff in dealing with basic health concerns, making initial health assessments, and in health-care delivery and health promotion work.

The manager of each project was contacted, the study explained to him/her, and his/her willingness to participate established. Those who consented were sent an Information Sheet and questionnaire. As all projects are busy and some have slender managerial and administrative resources, the initial response was low. At the time of the survey, some managers were also tied up with or anxious about the prospects for the continued funding of their organisation given the then pending Comprehensive Spending Review, and some faith-based organisations were much engaged with harvest festival arrangements. Through follow-up telephone calls, several managers agreed to participate but asked for more time. The deadline for the return of questionnaires was extended twice. To raise the response rate, appointments were also arranged to conduct face-to-face interviews at three projects. Eventually a high response rate was achieved. Questionnaires were completed by 29 projects (81% of all identified projects): 15 in Sheffield, five in both Doncaster and Rotherham, and four in Barnsley.

To supplement the questionnaire response information, interviews were also conducted with: (i) the manager and nurse at the Gate Surgery in Rotherham, a nurse-led Personal Medical Services project that offers primary health care to asylum seekers and socially-excluded vulnerable people, including those who are homeless; and (ii) the Community Outreach Street Drinkers’ Worker at Lifeline Alcohol Service in Rotherham.

2. For example, Crane and Warnes 2005; Crane et al. 2005; Warnes and Crane 2003; Warnes et al. 2005.
The projects

Responses were received from 23 of the 29 accommodation projects, and six of the seven day and drop-in centres surveyed. The great majority of the projects accept clients with all the backgrounds and problems common among homeless people. Only two excluded those with alcohol problems, three those with drug problems, one those with challenging behaviour, six refugees and asylum seekers, and one ex-offenders. Approximately one-half of the residential projects (12) have a maximum duration of residence of 24 months, but at three the limit is 12 months, and at seven there is no maximum duration.

Access to primary health-care services

Seventeen of the 29 projects have no particular arrangements with local practices for access to GP services, but six have a formal arrangement with a single practice, and six others have arrangements with more than one practice. Six projects are regularly visited by a primary care professional – all but one being the larger hostels. Two receive visits from a general practitioner at least weekly, and six are visited by a primary care nurse this frequently (one is very close to the GP surgery, and the GP visits the hostel and sees residents at the surgery). At one of the day centres in Sheffield, a Specialist Primary Care Outreach Nurse from the Homeless Assessment and Support Team attends three days a week. The nurse not only assesses health needs and provides nursing care, but also carries out sexual health screening, blood-borne virus screening and vaccinations.

Some of the projects without specific GP links encourage their clients to use local health centres which offer flexible services and are thus more fitting for the needs of homeless people. In Sheffield, the project staff signpost clients to the Sheffield City GP Health Centre at Rockingham House, which opens seven days a week from 8 am to 8 pm, sees unregistered people, and where no appointment is necessary.

In Doncaster, project staff refer clients who are not registered with a GP to the Regent Square Group Practice which is open five days a week from 8 am to 6 pm. One staff member said that it used to be extremely difficult getting medical care for homeless people in Doncaster, but since the opening of this new surgery, things have improved immensely.

In Barnsley, clients without a GP are referred to the NHS Barnsley Health Centre which opens seven days a week from 8 am to 8 pm.

In Rotherham, clients are signposted to the Gate Surgery which is open five days a week. The Gate Surgery offers exceptional services to address the needs of homeless people. Besides providing health screening, vaccinations and health-care treatment, it gives out clothing and food, allows people to use the surgery as an address to receive their post, and does outreach work on the streets and at the local drop-in centre to engage with homeless people not accessing health services.
Most of the 29 projects clearly prioritised their clients’ health and ensured that they had access to health care. This emerged strongly from the responses to an open-ended question that requested more detail about the arrangements for accessing general practice services. The following extracts are representative and illustrate the range of advice given to service users.

All clients are supported to access a GP close to their home. We also contact NHS Direct to ensure all clients are registered with a dentist.

Clients are encouraged to register with a local GP practice – to get temporary registration. Other medical care tends to be via A&E due to the high level of clients who require emergency treatment as a result of their issues, e.g. self-harm and alcohol misuse.

Three local GPs are aware of the project and the clients’ issues – and offer temporary registration. Generally it is a good service as they have drop-ins which suit people from the project.

We refer clients to the new city GP Health Centre (Rockingham House) if they aren’t registered with a GP – we give them a map and phone to make an appointment.

All clients are supported to access a GP close to their home. We also contact NHS Direct to ensure all clients are registered with a dentist.

When asked whether the current arrangements for accessing medical care for clients are working well, three-quarters of staff replied ‘yes’ and the rest said ‘yes and no’ (Table 2). At 13 projects, staff identified specific but very diverse problems. Some mentioned limitations or failings of the clients, e.g. their lack of awareness about their health needs, or their lack of motivation to seek help and register with a GP. A few believed that it would be helpful for nurses or doctors to hold clinics at the homeless projects so as to engage with those who were reluctant to address their health issues. Three emphasised that the service-users were impeded from getting medical attention by travel costs and because the shortage of staff meant that they could rarely escort a client to an appointments – one pointed out that many clients have no family member who could accompany them. One informant said, ‘the medical centre is seven miles away – the transport costs are a disincentive’. Some mentioned that health-care staff are unreceptive and occasionally hostile to the client group, as with ‘unhelpful receptionists’ and ‘lack of GP and practice staff knowledge about our vulnerable client group and the needs they have’.

<table>
<thead>
<tr>
<th>Service</th>
<th>Access to service is working well?</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>Yes and no</td>
</tr>
<tr>
<td>Medical care</td>
<td>74</td>
<td>26</td>
</tr>
<tr>
<td>Mental health services</td>
<td>26</td>
<td>48</td>
</tr>
<tr>
<td>Substance misuse services</td>
<td>56</td>
<td>37</td>
</tr>
</tbody>
</table>
The most common problem (reported by 21 per cent of staff) is the difficulty of accessing dentists, and that often their clients had to travel a long way to secure dental treatment. Once again, transport costs are implicated. Some mentioned problems encountered with all mobile patients, as with ‘at times it is hard to get previous notes from previous GPs’. Other responses clearly pointed to the constructed exclusion of homeless people. For example:

In several cases of residents with alcohol/drugs issues, [among the hospital staff] there was an assumption that if the resident did not drink / take drugs then they would be okay and could be discharged from hospital as they can look after themselves.

All agencies expect the hostel staff to sort out issues. Homeless people do not get care packages on leaving hospital. Tenants are deemed as adequately housed and sent back to the hostel, and where domiciliary care and support is needed, this is not put in place. Sometimes we are lucky and through staff persistence this is obtained but this is the exception.

There are general problems for the client group we deal with to access medical care through procedures as especially with addiction. Their lifestyle is dominated by the need to get their next fix. A&E queues plus prejudice towards them often cause problems. Although now in Doncaster there is a centre for registering with a GP if you don’t have one.

Access to mental health services

One project has a mental health worker on-site, and at two others mental health workers visit regularly or run clinics. When asked about how their service-users accessed mental health services, some said that they would directly refer to the Community Mental Health Team (CMHT), and others said that this would be done through the client’s GP. In an emergency, they would contact the local Crisis Intervention Team. A few mentioned that they had a good relationship with the CMHT (particularly some in Sheffield with the Homeless Assessment and Support Team), and that mental health workers would visit the project and attend care planning meetings for particular clients. Most of the projects found it difficult to report the average wait for a new client to be seen by a mental health worker, but among the 13 that estimated the interval, the range was from 0 to 36 weeks (mean 3, median 3).

Compared to accessing medical care, the staff were much less positive about the arrangements for accessing mental health services. Only 26 per cent believed that current arrangements worked well, 48 per cent said ‘yes and no’, and 26 per cent ‘no’ (Table 2). Seventy-two per cent of staff identified one or more problems. Again many different points were made. Twelve projects (41%) mentioned long waiting times and various delays in accessing advice and treatment. Illustrative comments included, ‘Some young clients are apprehensive about accessing services due to stigma … sometimes lengthy waiting periods until person is assessed and then again until treatment starts’ and ‘the waiting time to be seen initially is too long’. A disappointing number of projects also referred to both a lack of understanding about the client group and simplistic and incorrect assumptions about the nature of their health problems and contact with care:
GPs are reluctant to refer clients due to their belief that because the client has been homeless they must only be experiencing depression.

Long waiting list when some clients need immediate help. There is a lack of clarity and willingness to take responsibility by mental health services if a client has a dual diagnosis. No one seems willing to take the lead in these circumstances, i.e. when a client has an alcohol problem and mental health problems, they are pushed to and from services with no clarity on who is co-ordinating care.

If a client is assessed as being outside CMHT remit, e.g. borderline personality disorder, there appears to be no support readily available. If a client moves to Sheffield from another area, there can be problems in transferring their care from one CMHT team to another leaving the client unsupported. Sometimes we need support with a client who is presenting severe symptoms of mental illness, however it is often difficult to get mental health services to respond. An example of this was a client with acute psychosis who was a risk to herself and others but disputes over whose responsibility she was left her, other clients and staff at risk for some time before she was finally sectioned.

Sometimes all the outside workers involved think that other workers are working with the client, so no-one is. If someone has a drugs problem it can lead to mental health services washing their hands of them. Generally mental health workers won’t see a client who is drunk.

If clients don’t meet the criteria to be taken on by the mental health team, they don’t get a service even if they are quite vulnerable. Also it seems that services only kick in once a crisis is in full flow, whereas we try to get people to access help before things get really bad. This is very frustrating for us, can be seriously detrimental to the client and also means that more resources are required (i.e. admission and subsequent care) than if services had reacted quicker.

It is near impossible to get any mental health support for our clients due to the nature of their alcohol dependency and reluctance of current mental health teams to engage with these clients.

Several staff said that better mental health services were needed for their clients. In particular, they mentioned it would be useful to have a dedicated mental health worker who visited projects to assess clients, a ‘fast track’ into mental health services and better access to crisis intervention support, and more intensive help for clients with mental health issues. As one manager described, ‘we work through mental health issues with the residents and try to calm things down but they need more in-depth mental health services and counselling. They are just on medication for years and are walking around like zombies. Many have significant abuse problems that they have not dealt with. They need specialist abuse-related counselling and support’.

**Access to substance misuse services**

One project has had an alcohol worker on-site, two have drugs workers, and one has a joint substance misuse worker. Just two others reported regular visits (at least weekly or fortnightly) from an external drugs worker; one reported such visits from an alcohol worker, and two from substance abuse workers. Many said, however, that they refer clients to various local drugs and
alcohol agencies. Several in Sheffield mentioned the Fitzwilliam Centre; in Rotherham many refer to Milton House; and in Doncaster to The Garage. One Sheffield project manager summarised the accessible services as: ‘a joint substance misuse worker comes to the project three or four times a week. We have also developed good links with the Fitzwilliam Centre, Guernsey House, Phoenix Community Team, Turning Point and Breakthrough’.

Sixteen projects estimated the average wait for an assessment by an alcohol worker. The range was from ‘available on same day’ to 8 weeks (mean 2.3 weeks, median 2.0). Similarly, 16 projects estimated the interval before an assessment by a drugs service could be obtained. The range was from ‘available on same day’ to 6 weeks (mean 1.8 weeks, median 1.5).

In response to the question about whether the arrangements for accessing substance misuse services are working well, 56 per cent of projects stated ‘yes’, 37 per cent replied ‘yes and no’, and only seven per cent stated ‘no’. Seventeen projects described problems with accessing substance misuse services for clients. The comments were particularly diverse, and some contradictory. For example, one project wrote that the ‘drug services are brilliant’ but another that ‘the detox service and drugs service arrangements are unsatisfactory (although the alcohol outreach service works well)’. A few mentioned the problem of long waiting times, but more referred to the poor commitment to treatment among service users, as with ‘getting residents to continue seeing their workers is a problem’ and ‘the problem is not getting services but getting people to engage with services and having people with these issues together which is a temptation’.

There is clearly much variability in accessing substance misuse services across South Yorkshire, both by location and over time. The organisation that praised the drug services added, ‘we find we use this service for alcohol too as the waiting time for alcohol services is so slow due to their resources – this impacts on the drugs team’. Another organisation noted that ‘it is difficult to get an alcohol worker. Having the one phone number (Help is at Hand) should help in knowing where to turn as before there was confusion – it was a big problem. It’s a lot of work to keep in touch with who has the tender, which agency to contact and so on.’

Three projects made explicit reference to the need for a fast response, as with ‘the problems are mainly due to the capacity of local agencies/NHS to process referrals and allocate places on detox programmes. If a client is motivated at that time to go through a programme it should happen as soon as possible given the potential for the service user to lose motivation’. Some staff also mentioned the need for substance misuse workers, particularly alcohol workers, to visit their project on a regular basis and work with clients.

The staff’s involvement in health-care delivery and health promotion

Homelessness-sector staff clearly have an important role in helping clients access GPs, dentists, and specialist mental health and substance misuse services. Two-thirds of those surveyed said
that they sometimes also escort service-users to hospital and other health appointments, and a few supervise the taking of prescribed medication. These are generally roles carried out by family members for people who are vulnerable.

Almost all (28) the projects also said that they carry out health promotion work with service-users. Numerous activities were mentioned. The most frequent were ‘healthy eating’ advice and practical sessions, encouragement and onward referrals about giving up smoking, and arranging exercise or sports activities. One hostel, for example, had arrangements with the local council whereby residents were given free access to the gym and swimming pool. Several working with young people also give advice on sexual health. One project had a specific ‘Healthy Lifestyles Worker’. The diversity of activities is represented by their comments:

- Advice about healthy eating plans. Advise on healthy, cheap menus once in own accommodation. Arrange sessions on how to cook nutritional and value-for-money dishes (in collaboration with Connexions and other agencies).
- Encourage attendance at Boxercise, Fit Park and gym sessions at NACRO. Arrange walking, climbing and biking trips. Provide activities e.g. football, netball, ice skating.
- Discuss effects of smoking and put residents in touch with relevant agencies. Arrange appointments with the ‘stop smoking’ nurse at the Medical Centre.
- Provide advice around sexual health issues, and provide condoms, pregnancy testing and Chlamydia testing.
- Arrange for external services to come and give talks to clients. We provide sexual health advice (contraception / Chlamydia testing packs), smoking cessation advice, and healthy eating.
- Physical activity, diet, mental well-being, visit to leisure facilities and outward bound activities, advising on no smoking.
- Women’s group looks at different aspects of staying healthy, we have a relaxation group where we talk about strategies for managing anxiety and stress. Shipshape have been to do stop-smoking sessions.
- Promote monthly topics including healthy eating, five-a-day, diabetes, alcohol awareness, and arrange activities around these e.g. cookery sessions, healthy walking on arranged trips once a month.

Several staff believed that health professionals should be more involved in undertaking health promotion work with their clients by, for example, running sessions on general health, hygiene, nutrition, drugs and alcohol awareness, and sexual health. Three projects also mentioned that it would be beneficial if their clients had free passes to access local leisure and sports facilities.

**Training for homelessness-sector staff**

Various training programmes are available for homelessness-sector staff. Some large homelessness organisations run their own training courses for staff on various aspects of the work, such as effective key-working and mental health, alcohol and drug awareness. National
organisations such as Homeless Link and SITRA also run many short courses. More substantial courses are available through, for example, the NVQ in Health and Social Care (which some homelessness-sector staff have completed).

During the staff survey, information was obtained about whether project staff received any training around health-care and working with people who have health problems. As shown in Table 3, most staff received training in working with people with substance misuse problems and with challenging behaviour and complex needs, but many fewer had been trained in either recognising physical health problems or health promotion work. They are at the front-line of working with single homeless people, as on the streets and in hostels, often the first point of contact, and so have an important role in detecting physical health needs and in advising people to seek medical help.

Table 3 Training received by homelessness-sector staff

<table>
<thead>
<tr>
<th>Training</th>
<th>Most staff</th>
<th>A few staff</th>
<th>No staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognising physical health problems</td>
<td>42</td>
<td>27</td>
<td>31</td>
</tr>
<tr>
<td>Health promotion work</td>
<td>35</td>
<td>50</td>
<td>15</td>
</tr>
<tr>
<td>Recognising mental health problems</td>
<td>50</td>
<td>32</td>
<td>18</td>
</tr>
<tr>
<td>Working with people with mental health problems</td>
<td>44</td>
<td>37</td>
<td>19</td>
</tr>
<tr>
<td>Working with people with substance misuse problems</td>
<td>64</td>
<td>25</td>
<td>11</td>
</tr>
<tr>
<td>Working with people with complex needs / challenging behaviour</td>
<td>61</td>
<td>25</td>
<td>14</td>
</tr>
</tbody>
</table>

When asked about the training that would be useful for staff but is unavailable, two-fifths identified gaps. The most frequently mentioned were around mental health issues and motivating people with complex needs. Other suggestions referred to health promotion, substance misuse issues and regular updates on drugs trends and drug usage, accessing health-care services for clients, specific health issues such as tuberculosis, blood-borne viruses, health and safety at the work-place in relation to needles and injuries, and basic awareness of different medications and why they are prescribed. Some said that elementary courses are available but they would appreciate more in-depth awareness. Some mentioned the difficulty of accessing training courses because of transport and registration costs, a shortage of staff, and because many courses are run by Homeless Link and held in London. As one person described, ‘sending staff on training has logistical problems because we are only a small project with a few staff’.

Overview

Homelessness-sector staff are at the forefront in the delivery of health-care for homeless people. Few health care or specialist services are available in the projects. During the last few years, the
availability of primary medical care for homeless people seems to have improved greatly with the opening of GP surgeries and NHS Walk-In Centres that are open long hours, accept people who are not registered, and operate flexible appointment systems and ‘drop-in’ sessions. In great contrast, there remains a significant problem in accessing dental services and mental health services for the client group, and to some extent alcohol services.

Homelessness-sector staff encourage and assist their clients to access health-care services, escort them to appointments, and advise them about healthy living. For vulnerable people in the general population, these tasks are often carried out by family and relatives. It follows that homeless people’s project staff become ‘quasi informal supporters’. Yet they are not trained health experts, and receive little support from health professionals apart from the few projects in which GPs, nurses and substance misuse workers hold sessions. The benefits of having health professionals more engaged with homeless projects are demonstrated in the next section, which examines the health and health-care needs of homeless people.

**IV INTERVIEWS WITH SINGLE HOMELESS PEOPLE**

To complement the information from homelessness service-providers about access to health-care services, details were collected through semi-structured interviews from 61 single homeless people in Doncaster, Rotherham and Sheffield about their health problems, health-related behaviour, and use of health services.

Homeless Link has been funded by the DH Third Sector Investment Programme to pilot a Homeless Health Needs Audit Tool in nine PCT areas (none in South Yorkshire) during 2009-10, and to specify homeless people’s unmet health needs. An online survey tool was designed in collaboration with the DH to help Primary Care Trusts, local authorities and third-sector organisations gather data about the health needs of homeless people in their area. It collects information about: GP registration; use of primary care and dentistry services during the last six months; physical and mental health problems; alcohol and drug use; smoking and eating habits; vaccinations and screening for TB, Hepatitis C and HIV; and clients’ perceptions of whether their health needs are being met.

For our survey, we used or developed many of the questions from the Homeless Health Needs Audit Tool, and collected additional information about: (i) the actual services from which they received treatment for health and substance misuse problems, e.g. their GP or a specialist team; (ii) whether they had been referred to specialist services, by whom, and the outcomes; (iii) their opinions of the health-care arrangements provided for them, reasons for non-use of services, and unmet health needs; and (iv) their attitudes to health and engagement in healthy / unhealthy behaviours such as smoking, exercise and diet.
Interviewees were recruited through four projects: hostels in Doncaster, Rotherham and Sheffield, and a day centre in Sheffield. These four projects were selected because they work with homeless people of all ages, all except one work with both men and women, and all showed an interest in the study from the outset. Information Sheets about the study and a copy of the client questionnaire was sent to the managers, who discussed the study with his/her clients, and then passed on the names of those who were willing to participate. Six respondents to our FOR-HOME study of the resettlement of single homeless people who had recently been rehoused in Sheffield were also interviewed. The study was explained to each person at the start of the interview, the contents of the Information Sheet were discussed, and they were asked to sign a consent form (the documents were approved by the Trent NHS Research Ethics Committee). Each interview lasted about 40 minutes, and each interviewee was given £10 in appreciation of their time and help.

Profile of the respondents

Thirty respondents were interviewed in Sheffield, 18 in Doncaster, and 13 in Rotherham. Fifty were men and 11 women. Twenty-six per cent were aged 16-24 years, 51 per cent 25-39 years, and 23 per cent were aged 40 or more years. Most (85%) were White British. At the time of interview, 45 were staying in hostels, 10 were sleeping rough on the streets or in other makeshift arrangements, and six had recently resettled from hostels into their own tenancies. Only 26 per cent of those interviewed were involved in any education or training programme or were employed. Forty-four per cent had been in prison at some time, and 13 per cent were currently under probation or offending services.

Some of the hostel dwellers had been resident for more than six months, but many had been admitted just a few weeks earlier. Some had moved into hostels having slept rough for months, and some had moved from town to town. For example, one person had been in a hostel in Rotherham for just three weeks, but previously had slept rough for one month in Rotherham and for many months in Doncaster. Another person moved to Barnsley and then Rotherham having slept rough in north London for a few years.

General health and lifestyle

The respondents were asked to rate their overall health using the 2008 General Lifestyle Survey (GLS) categories. Forty-six per cent regarded their health as ‘very good’ or ‘good’, while 23 per cent described it as ‘bad’ or ‘very bad’. There was little difference by age, with young people as likely as those in the older age groups to describe poor health (25% aged 16-24 years said that their health was ‘bad’). When these findings are compared with the general population aged 16 and over in the GLS 2008, the CLAHRC sample were much more likely to perceive their health as ‘poor’ (Figure 2). It must also be remembered that the CLAHRC sample was relatively young compared to the GLS sample, which included people of pension age who are more likely to have health problems.
Forty-four per cent of respondents regarded themselves as having a disability. Ten per cent associated this with a long-term physical illness, 12 per cent with a mobility problem, 18 per cent with mental ill-health, 10 per cent with substance misuse, and eight per cent with a literacy problem such as dyslexia. Forty-six per cent said that health or substance misuse problems prevented them from engaging in training or employment.

**Smoking habits**

Ninety-two per cent of the respondents were smokers, including one-third who said that they smoked 20 or more each day. Five people claimed to smoke more than 40 a day. These figures are likely to be under-estimates – Kozlowski (1986) suggested that when asked how many cigarettes smoked each day, people tend to round down to the nearest multiple of ten. If this rule was applied to the CLAHRC respondents, 72 per cent could be smoking 20 or more cigarettes a day. The findings are also in great contrast to the general adult population, in which just 21 per cent are smokers (Robinson and Bugler 2010).

When asked if they wanted to stop, 45 per cent of the smokers said ‘yes’, 49 per cent ‘no’ and the rest were unsure. The most common reason for not wanting to stop was that the persons was trying to overcome drugs or alcohol problems, and were not ready to give up. Some also said that it was the only pleasure they had. Some had tried to stop smoking in the past but had found it too stressful and started again. Several believed that smoking was affecting their health. Eighteen per cent said that they had been offered help to stop smoking, such as patches, and had tried but without success. Thirty-six per cent had been offered help but had refused it, while 45 per cent said that they had not been offered help. Several acknowledged that they were aware of posters and information displays in hostels and day centres about smoking cessation services.
Eating habits

The respondents’ diets varied greatly. Two-thirds had a cooked meal most days, but 15 per cent had a meal only once a week or less (Figure 3). Those in hostels were more likely to be having regular meals than both those sleeping on the streets and those in their own tenancies. Seventy-six per cent in hostels, compared to just 31 per cent of others, had a cooked meal at least six days a week. Almost one-third on the streets and in their own tenancy had a meal once a week or less. Similarly, 56 per cent in hostels but only 31 per cent of others ate at least one piece of fruit or a serving of vegetables regularly (6+ days). Twenty per cent of the sample (11% in hostels and 44% of others) said that they never had fruit or vegetables.

The main reasons for the higher consumption of cooked meals in hostels are that they are available in canteens at subsidised prices and the staff encourage the residents to eat well. Low morale and depression associated with poor eating and nutrition. Although there were no differences between eating habits by whether a person had an alcohol or drug problem, there was a strong association with mental health problems. The respondents who reported long-standing depression (12+ months) were much less likely to be eating regularly – 45 per cent had a daily meal compared to 91 per cent of the rest of the sample.

![Figure 3: Number of days per week has a cooked meal by current housing](image)

Contact with medical services

GP registration

Fifty-nine per cent of the respondents were permanently registered with a GP, but only 38 per cent one no more than 20 minutes walk away from where they were living. For some, it took 20-60 minutes by public transport to get to their GP, including one person whose GP was 10 miles away, and two who were interviewed in Sheffield but their GPs were in Barnsley and Rotherham. Some who claimed to be registered had moved from another town or city but had not changed their GP. The observed registration rate of 59 per cent is significantly ($p<0.02$) lower than the
64.7 per cent found 20 years ago from a census of 340 single homeless people in Sheffield, a disappointing regression (George, Shanks and Westlake 1991: 1388).

Twenty-four people interviewed in Sheffield were in a hostel or at a day centre at which a Homeless Health Care Team visited, i.e. a GP and primary health care nurse held sessions at the project and had a surgery nearby. Most of this group (87%) used the Homeless Health Care Team, including some who were registered with a GP far away. Many were unclear, however, whether they were registered with the GP, and some who said they were registered did not know if the registration was permanent or temporary. Overall, 20 per cent of the respondents were not registered with a GP and did not access a Homeless Health Care Team. Only four people in the overall sample had tried to register with a GP during the last 12 months but been refused registration. In all cases, the reason for refusal was that they were homeless and had no permanent address.

**Use of medical facilities**

Eighty per cent of respondents had had contact with primary health-care services during the six months before being interviewed, mainly with GPs or the Homeless Health Care Team or both (Table 4). Thirty-four per cent had used these services at least five times. During the previous six months, 39 per cent had attended the Accident & Emergency Department at the local hospital. Most of the presentations followed accidents, assaults, blackouts, fits or overdoses. Some but not all of these episodes were related to alcohol and drug misuse. Twenty-three per cent were admitted into hospital at least once during the preceding six months. In comparison, according to the 2008 General Lifestyle Survey, just six per cent of the general population aged 16-44 years had inpatient hospital stays during the last 12 months (GLS 2008).

**Table 4. Number of times used health-care services during the previous six months**

<table>
<thead>
<tr>
<th>Services used</th>
<th>Number of presentations</th>
<th>Average frequency¹</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1-2</td>
</tr>
<tr>
<td><strong>Primary health-care services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP at surgery</td>
<td>34</td>
<td>26</td>
</tr>
<tr>
<td>Nurse at GP surgery</td>
<td>69</td>
<td>21</td>
</tr>
<tr>
<td>NHS Walk-In Centre</td>
<td>92</td>
<td>7</td>
</tr>
<tr>
<td>Homeless Health Care Team²</td>
<td>29</td>
<td>25</td>
</tr>
<tr>
<td><strong>Other health-care services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital A&amp;E</td>
<td>61</td>
<td>34</td>
</tr>
<tr>
<td>Hospital inpatient facility</td>
<td>77</td>
<td>20</td>
</tr>
<tr>
<td>Ambulance</td>
<td>70</td>
<td>25</td>
</tr>
</tbody>
</table>

Notes: Sample size 61. 1. Assuming average frequencies are 1.5 for 1-2 visits, 3.5 for 3-4 visits, and 6 for 5 or more visits. 2. GPs and primary care nurses who held sessions at hostels and day centres. Includes only the respondents using a project that had the dedicated service.
Information was collected from the respondents about specified vaccinations and health screening and when they were last vaccinated or tested. Twenty-eight per cent had had the influenza vaccination during the previous 12 months. Having been vaccinated was strongly related to whether or not they accessed a specialist Homeless Health Care Service. Fifty-nine per cent who used such a service had had a flu’ vaccination, compared to just 15 per cent of others. Forty-one per cent who reported respiratory problems such as asthma or bronchitis, and 22 per cent of others, had been vaccinated.

When asked about TB screening, two-thirds (68%) said that they had been screened for TB and had had the BCG (bacille Calmette-Guérin) vaccination. For many, however, this had been years earlier when they were at school. Only 31 per cent could confirm that they had been tested during the last ten years, including just 21 per cent within the last five years. There was little difference in screening according to whether or not they were in contact with a Homeless Health Care Team. These findings are of concern – there has been a gradual rise in the number of TB cases in the UK over the last 20 years, and Yorkshire and the Humber Region has the third highest rate of reported cases (after London and the West Midlands). According to the latest figures, the rate in Sheffield increased from 2001 to 2009, but the rates in Barnsley and Doncaster slightly reduced and in Rotherham fell substantially (from 14 cases per 100,000 in 2001-03 to 8 in 2007-09). People with histories of homelessness, drug and alcohol misuse and imprisonment are known to be at risk; nonetheless, although many of the CLAHRC respondents had more than one of these risk factors they had not been screened in recent years.

Fifty per cent of those interviewed said that they had been vaccinated for Hepatitis A and 54 per cent for Hepatitis B. Most had had three vaccinations, while a few had not completed the course. Some said that they had received the vaccinations while in prison. Those in contact with Homeless Health Care Services were more likely to have been vaccinated for Hepatitis A than others (72% vs 40%). Fifty-seven were able to say whether they had been tested for Hepatitis C, and 56 per cent had been screened. For most this had occurred within the previous three years. Of the 30 people who were tested and knew the result, for 33 per cent it was positive. This is in great contrast to the prevalence rate generally across Northern Europe of around one per cent.

Thirty-eight people had been screened for HIV, most within the last 24 months; only one result was positive. Those in contact with a Homeless Health Care Service were more likely to have been tested (81% vs 52%). The users of the Homeless Health Care Teams were also more likely to have had a sexual health check within the last 12 months (50% vs. 23%).
Physical health problems

Forty-seven respondents (77%) reported physical health problems (not including dental problems or disturbed sleep patterns). Many described multiple and long-standing conditions, and some had serious illnesses, including deep vein thrombosis, multiple sclerosis, Hepatitis C, and a leg amputation. Those aged 25-39 years were most likely to report physical illnesses (87%). Several associated health problems with their lifestyle, i.e. sleeping on the streets and alcohol and/or drug misuse. The respondents who were interviewed at projects visited by Homeless Health Care Teams were more likely to be aware of physical health problems (96% compared to 67% of others). This may be because they were more likely to have had a health assessment and unrecognised problems identified.

The most commonly-reported group of problems were musculoskeletal, including old injuries to lower limbs and the back, arthritis, and pains and numbness in legs through excessive alcohol consumption (Table 5). More than one-quarter (28%) reported respiratory problems, including 20 per cent who had suffered from asthma since childhood, and a few who had chronic bronchitis. Twenty-three per cent described heart or circulatory problems, most commonly deep vein thrombosis, and several linked these problems to injecting drugs over the years. One-fifth reported problems with their liver, including 10 who were known to have Hepatitis C and a few with cirrhosis of the liver; all in this group had alcohol and/or drug problems. Twenty-two per cent of the entire sample suffered from blackouts or fits, and once again this was mostly among those who were heavy drinkers or illegal drug users.

Table 5. Commonly-reported health problems and duration of problems

<table>
<thead>
<tr>
<th>Commonly-reported problems</th>
<th>Duration of problems</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;12 months</td>
<td>12+ months</td>
<td>All</td>
</tr>
<tr>
<td><strong>Percentages with problem</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal problems</td>
<td>23</td>
<td>25</td>
<td>48</td>
</tr>
<tr>
<td>Respiratory problems, <em>e.g.</em> bronchitis, asthma</td>
<td>5</td>
<td>23</td>
<td>28</td>
</tr>
<tr>
<td>Heart or circulatory problems</td>
<td>3</td>
<td>20</td>
<td>23</td>
</tr>
<tr>
<td>Skin or wound problems, <em>e.g.</em> psoriasis, abscesses</td>
<td>8</td>
<td>15</td>
<td>23</td>
</tr>
<tr>
<td>Fainting / blackouts / fits</td>
<td>7</td>
<td>15</td>
<td>22</td>
</tr>
<tr>
<td>Problems with liver, <em>e.g.</em> cirrhosis, hepatitis C</td>
<td>5</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>Gastric problems</td>
<td>3</td>
<td>17</td>
<td>20</td>
</tr>
<tr>
<td>Problems with eyes</td>
<td>10</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Foot problems, <em>e.g.</em> sores, calluses</td>
<td>8</td>
<td>7</td>
<td>15</td>
</tr>
</tbody>
</table>
When the health of those aged 16-44 years in the CLAHRC study sample is compared to those of a similar age in the 2008 General Lifestyle Survey, the higher prevalence of physical illnesses is striking. For example, 49 per cent of the homeless sample reported musculoskeletal problems compared to just five per cent of the GLS sample. The figures for respiratory problems were 28 and 5 per cent respectively, and for heart and circulatory problems 23 and 1 per cent respectively (cited in Homeless Link 2010: 3).

Addressing physical health problems

Among the 47 people with physical health problems, 79 per cent were receiving treatment for their problems, mainly from a GP or the Homeless Health Care Team. Eight people were also under the care of a hospital consultant. Fifty-three per cent said that the treatment they were receiving addressed their physical health needs, while 47 per cent believed that they needed (additional) help. A few believed that their doctor could be doing more to tackle their health problems. In many cases, however, the respondents had not sought help for their problems: some because they were scared, some because they did not trust doctors, and some because they did not consider their health a high priority. One man, for example, had pain in his right testicle. He had seen a doctor two years ago and was supposed to have had a biopsy but he failed to keep the appointment and never sought further medical help. Another person said, ‘If I had a better relationship with my doctor and she listened I would go to her with my health problems’.

Some people said that they were not ready to accept treatment. Among the 10 respondents with Hepatitis C, four were in receipt of treatment, two were due to start treatment, but four had refused it. The latter explained that the treatment makes people feel ill and that they did not feel able to cope with the side effects while in hostels or on the streets. In the FOR-HOME study of the resettlement of homeless people, a few respondents with Hepatitis C accepted treatment only after they had been rehoused and were settled (Crane, Warnes and Coward 2010).

Use of dentists and dental problems

Twenty-eight per cent of the respondents were registered with a dentist, 15 per cent used a dentist who visited a day centre for homeless people, and 57 per cent had no dentist. Among the 17 who were registered, however, seven had dentists in other towns. They all said that they found this difficult because of bus and train fares. Thirteen people (21%) had approached one or more dental practices in the preceding 12 months but had been refused registration. The most common reason for refusal was that the practice was full. Several believed that there should be easier access to local dentists:

I couldn’t get a dentist anywhere in Rotherham so I had to get one in Sheffield and it was really hard to get this one. I struggled and was years before I could get one. In that time my teeth deteriorated. It’s costly going to Sheffield to see a dentist. If I live in Rotherham, I should be able to have a dentist locally.
There needs to be more dentists. I have been trying to get one for ages. My teeth are bad and I had dental abscesses and had to go to the emergency dentist at Mexborough. Before I came to this hostel, I had not seen a dentist for 6-7 years. The hostel staff helped me get one but they could not get one locally – I am now registered with one in Conisbrough.

Only 34 per cent of respondents had seen a dentist during the preceding six months, including a few who had accessed emergency dental services at the Montague Hospital in Mexborough. When interviewed, 46 per cent reported untreated dental problems, including toothache, and loose and ‘corroding’ teeth. Although a few of this group admitted that they had not sought treatment as they feared dentists, most were not even registered with a dentist.

**Mental health problems**

Seventy-nine per cent of respondents reported mental health problems, including 57 per cent who had been diagnosed with a mental illness, and 24 per cent who reported being depressed, anxious and panicky, paranoid or hearing voices but with no clinical diagnosis. The most common problem was depression, reported by 72 per cent, and for most it had been a problem for 12 months or more (Table 6). Fifty-four per cent of the respondents had been diagnosed as suffering from depression, three per cent with bipolar disorder, and three per cent with schizophrenia. Twenty-two per cent had been diagnosed during the last two years, while 23 per cent had first been diagnosed more than 10 years ago. The prevalence of the named conditions contrast greatly with those in the general population – according to the 2000 *Survey of Psychiatric Morbidity*, among those aged 16+ years living in private households, 16 per cent suffered from anxiety, depression or other neurotic disorders (17% in the Northern and Yorkshire region).5

<table>
<thead>
<tr>
<th>Table 6. Self-reports of mental health problems and their duration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-reported problems</strong></td>
</tr>
<tr>
<td>-----------------------------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Often feels anxious</td>
</tr>
<tr>
<td>Panic attacks</td>
</tr>
<tr>
<td>Feels depressed</td>
</tr>
<tr>
<td>Suicidal thoughts</td>
</tr>
<tr>
<td>Attempts at self-harm</td>
</tr>
<tr>
<td>Hears voices</td>
</tr>
</tbody>
</table>

5. See www.lho.org.uk Tables 1 and 3.
Fifty-nine per cent of respondents had both a mental health and a substance misuse problem. Some used alcohol or drugs to cope with depression, while some said that their use of substances contributed to their mental difficulties. One person, for example, who sniffed aerosols said that this brought on bad hallucinations. Another claimed, ‘I have had a nervous breakdown – it was alcohol-induced’.

Among the 48 respondents who reported mental health problems, only 37 per cent were receiving treatment from a mental health team or from their GP (Table 7). Most had medication from their GP; just six people (12%) were under the care of mental health services. Another person had been under the care of a mental health crisis team but had recently moved to another town and lost contact. Among those not receiving help from mental health services, 11 had been referred to the Community Mental Health Team by either hostel or day centre staff or substance misuse workers. Six were waiting to be seen, two had been assessed but not offered help, and three had refused treatment or did not keep their appointment. Several said that their hostel or day centre key-worker or their substance misuse worker provided help and support around mental health issues. Among the respondents with mental health problems, those in contact with a Homeless Health Care Team were much more likely than the others to have been referred to mental health services (60% vs 22%).

### Table 7. Help received and needed for health and substance misuse problems:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Has the problem % of sample</th>
<th>Treatment by health professional</th>
<th>Treatment by specialist service</th>
<th>Needs more help % of sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical ill-health</td>
<td>77</td>
<td>79</td>
<td>n/a</td>
<td>47</td>
</tr>
<tr>
<td>Mental ill-health</td>
<td>79</td>
<td>37</td>
<td>12</td>
<td>42</td>
</tr>
<tr>
<td>Alcohol</td>
<td>46</td>
<td>43</td>
<td>29</td>
<td>25</td>
</tr>
<tr>
<td>Drugs</td>
<td>54</td>
<td>48</td>
<td>48</td>
<td>30</td>
</tr>
</tbody>
</table>

*Notes:* Based on interviewed homeless people’s reports. 1. Treatment from GP, practice nurse or specialist mental health or substance misuse service. 2. Patient of mental health or substance misuse service. 3. Respondents’ reports of (additional) help needed for the problem.

When asked if there was help they needed for their mental health problems that they were not receiving, 20 of the 48 respondents (42%) said ‘yes’. The main forms of help they stipulated were medication (eight said that they used to take tablets for depression but either they or their doctor had stopped them), and the opportunity to talk about their problems through counselling.

**Alcohol problems**

Twenty-eight respondents (46%) reported alcohol problems, including some who were drinking very heavily. Ten people were drinking daily. According to their self-reports, 24 people (39%)
were having 25+ units a week, including 15 (25%) who consumed 60+ units weekly. Most of the heavy drinkers consumed super-strength beers and lagers or strong, cheap cider. Only a few could afford to drink spirits.

Among the 28 respondents with alcohol problems, just eight (29%) were receiving help from a specialist alcohol or substance misuse service (Table 7). Another four were having treatment from their GP. A few had been through a detoxification programme and were receiving medication, such as *Antabuse*, to curtail drinking. Another 10 had been referred to alcohol services by hostel or day centre staff, probation services or GPs: three were waiting for an assessment, three were assessed but not offered help, and two had refused help. Two were not offered help because they were assessed as being ‘binge drinkers’, although both believed that they needed help. Those with alcohol problems who were in contact with a Homeless Health Care Team were much more likely to be under the care of specialist alcohol services (45% vs. 17%).

Most respondents with alcohol problems said that they did not need help, but one-quarter identified (more) help or support that would be useful, most often the need for a more gradual approach to overcoming alcohol misuse. Some found it hard to comply with the strict rules in some hostels which require rapid withdrawal from alcohol and do not allow residents on the premises if they have been drinking. One person was admitted to a non-NHS rehabilitation unit which requires people to go ‘cold turkey’ but s/he could not cope and left after a few days.

**Drug problems**

Thirty-three respondents (54%) reported drug problems, and most were still using drugs (47%). Several were poly-drug users. During the last month, 15 per cent had taken heroin, 16 per cent crack-cocaine, 41 per cent cannabis, seven per cent amphetamines, and a few had taken ecstasy or non-prescribed sleeping tablets and diazepam. One person regularly sniffed aerosols. Seven people admitted to injecting drugs – only two said that they ‘sometimes’ shared injecting equipment. Thirty-one per cent admitted to both alcohol and drug problems.

Among the 33 people with drug problems, almost one-half (48%) were under the care of a specialist drugs team (Table 7). Another five (15%) had been referred to the service – two had refused help, the other three were waiting to be assessed (one person had not received an appointment letter as he was on the streets and had no address). Most saw their drugs worker at least once a week, and some attended group therapy in their hostel run by external drugs workers. Thirteen people were prescribed a methadone or *Subutex* (buprenorphine hydrochloride) programme, and for some the script was gradually being reduced. One person, for example, had had his methadone reduced over several months from 70 ml to 28 ml daily. Several described how they benefited a great deal from the help and support they received from drugs workers:
I referred myself to the service. I was injecting four bags of heroin a day. I’m now on methadone and I stopped heroin two months ago. I see my drugs worker twice a week. S/he helps me look at the mental aspects of drug use and what I need to do to change.

I see my drugs worker once a week. I am able to talk about anything with my worker. S/he listens and gives me advice, and helps me with my mental health issues.

The respondents with drug problems who were in contact with a Homeless Health Care Team were much more likely to be under the care of specialist drugs services (89% vs. 33%). Ten of the 33 people with drug problems (30%) identified (more) help or support that would be useful. A few believed that help is available for people who misuse ‘hard’ drugs but there is a need for specialist workers to help with cannabis use. A few others said that they required more specialist support to cope with the mental trauma of coming off drugs. As one informant said:

I get into strange mental states; it’s a dark place to be in. I don’t know where to get help for it so I battle through alone. Drugs have been my best friend for years – since the age of 11, I’ve taken drugs and drink and I don’t know anything different. There needs to be better after-care for the mental side when people are coming off drugs.

Overview

Many surveys and studies of the health of single homeless people find high rates of physical health, mental health and substance misuse problems. Indeed, Homeless Link’s continuing national audit of the health-care needs of more than 700 homeless people across England has found that 56 per cent have a long-term physical health-care need, 72 per cent a mental health-care need, and that 52 per cent used illegal drugs and 20 per cent drank alcohol more than four times a week (Homeless Link 2010). The findings from the South Yorkshire sample of single homeless people are broadly consistent with the national figures.

The respondents in contact with Homeless Health Care Teams were more likely to be aware of physical illnesses, to have had health screening and vaccinations, and to be linked into specialist mental health and substance misuse services if suffering from the respective problems. It is likely that these teams are more aware than general GPs of the health problems and treatment needs of single homeless people, have established links with specialist agencies, and have the skills, motivation and time to pro-actively engage with clients who are wary of health professionals or reluctant to comply with treatment.

Recommendations

There needs to be increased between NHS agencies and staff collaboration in South Yorkshire and the specialist homelessness services to improve single homeless people’s health and their access to health services. Our particular recommendations are as follows.
Increase contact with primary health care services

Many of the study respondents were not registered with local GPs. Some were in hostels or at day centres at which a Homeless Health Care Team visited, and the advantages of being in contact with such a service are well-demonstrated. Others relied on walk-in clinics or surgeries that accept unregistered people. Although at least one was available in the central areas of each of the four principal towns (Barnsley, Doncaster, Rotherham and Sheffield) during the study, the one in Barnsley no longer accepts new patients. There were also access problems for those in projects outside the city centre, and some evidence of a pervasive disinclination by practice staff to welcome ‘difficult’ patients – those who are or have been homeless, or have mental health and substance abuse problems.

If the rate of registration of homeless people and their willingness to present to primary care staff are to be raised, the most effective course would be to increase the number of specialist or dedicated health-care professionals that proactively engage with homeless people’s projects.

Improve health screening

Health screening programmes for single homeless people need to be improved. The Department of Health have established ‘Find and Treat’ to support the detection, diagnosis and management of TB in hard-to-reach groups across London. Yet only a minority of the study respondents had been tested for TB in recent years. Those who were in contact with a Homeless Health Care Team or had been in prison were more likely to have been screened for TB, HIV and Hepatitis. Moreover, when screened, a high rate of Hepatitis C was established.

There needs to be more systematic health screening services for single homeless people in South Yorkshire, that take into account the movement of some people between hostels and the streets and between towns. The screening programmes should target those most at risk, e.g. with histories of chronic or repeated homelessness and substance misuse problems. The programmes need to work closely with homeless sector staff to encourage participation among homeless people who are ‘hard-to-engage’.

Engagement in health promotion work to tackle unhealthy behaviour

Exceptionally high rates of smoking, drinking, drug-taking and poor nutrition were evident among the study respondents. At most hostels and day centres, health promotion work was undertaken, but mainly by homeless sector staff who lack specialist health knowledge. Most recognised their limitations, and several said they would welcome training and input from health professionals. Health professionals should work collaboratively with hostel and day centre staff in the delivery of health promotion advice and activities to homeless people.
Increase access to mental health services

Only a minority of the sample with mental health problems were under the care of specialist services, and a high rate of unmet mental health needs was identified. Both homelessness sector staff and homeless people experienced difficulties in accessing mental health services, and acknowledged that more help was needed.

Strategies need to be developed with community mental health teams to address the high rate of unmet mental health problems among homeless people, and to support homelessness sector staff that are working with clients with mental health issues. Mental health workers need to visit hostels and day centres to assess clients, provide crisis intervention support, and offer training and advice to staff.

Increase specialist help for homeless people with alcohol problems

Strategies also need to be developed with substance misuse teams to address the high rate of unmet needs among homeless people, particularly with alcohol problems, and to support homelessness sector staff that are working with such clients. The challenge is not only to improve their access to services, but also for specialist workers and homelessness sector staff collaboratively to find ways of encouraging heavy drinkers to accept help. Only a small number of study respondents with alcohol problems were under the care of alcohol services, and many in this group felt that they did not need help.

Improve access to dental services

Difficulties in accessing dental services were reported both by the study respondents and by the homelessness sector staff who tried to help them. Dental problems were common among the respondents, and many experienced great difficulty in finding a dentist that would treat them. Several were required to travel to other towns if they wanted dental treatment. This in itself had cost implications as most were on low incomes. Arrangements should be in place so that homeless people have access to local dental services.

Limitations of the study

We are aware of a number of limitations of this relatively small study. While the sample of 61 is heterogeneous and, as far as we can judge, broadly representative in terms of age, gender, ethnicity and personal problems of single homeless people in the region (and in similar low socio-economic status ex-industrial regions of England), strictly it is a ‘convenience sample’ of volunteer respondents. This may have introduced some bias – in health status or, more likely, in attitudes to one’s own health. We cannot determine whether those who volunteered have more or fewer health problems than those who declined. A related limitation is that the reports of health conditions by homeless people have predominantly been self-diagnoses and assessments.
The study has examined the health status and health-care utilisation of single homeless people who access homeless people’s projects (all of which are in the principal urban centres of South Yorkshire), and has gathered only occasional information about the problems of homelessness in other areas – but there have been indications that the problems of access to services are more severe in the smaller settlements, whether the more remote former coal mining villages or the Pennine towns such as Penistone.

During the course of the study, we were informed about a major drinking problem in Dinnington (to the north of Anston) where there are no drug or alcohol services, and of a similar problem in nearby Maltby. Sofa surfing is reported to be a massive problem in Rotherham because of a lack of temporary accommodation. ‘Young women are moving from men to men so as to get a roof over their head’. Sometimes people are sent to Sheffield or Doncaster because of a lack of hostels in Rotherham. If they are already engaged with alcohol service in Rotherham, this leads to discontinuity of service and support as they do not have the fare to travel back to Rotherham.

There are also deep problems in some of the more deprived areas of Rotherham. On the east Herringthorpe estate, south of Rotherham town centre, people are allegedly drinking on the streets outside their houses (and have taken settees onto the streets). In Ferham, west of the town centre, there are many East Europeans and Asians and problems of racial tension, fighting, overcrowding – it was alleged to us that more than 40 people are living in one terraced house, and some stand outside a shop drinking heavily. In Canklow, south of the town centre, many residents are reported to have alcohol and / or drug problems. Similar issues occur on several of Sheffield’s larger public housing estates. There are no sharp boundaries between the problems of severe deprivation, restricted life chances, unhealthy behaviours, self-harm, and homelessness.

Acknowledgements

We warmly thank all the homeless people and staff of the service provider organisations that co-operated with the study. Thanks to Homeless Link for providing copies of the ‘Health Needs Audit Tool’ and in particular to the project co-ordinator, Helen Mathie, for her keen interest in the CLAHRC study. Thanks also to Helen and Dene Naylor (NHS Doncaster) for travelling to Sheffield to advise us about the project and instruments. Thanks also to Sarah Coward for carrying out a number of the interviews with homeless people.

References


