LNNM HOMELESSNESS AND HEALTH BRIEFING – Jan 2016

Increased homelessness

The number of individuals seen rough sleeping by street outreach teams in London has increased 90% between 2010-2011 (3975) and 2014-2015 (7581).[1] Note that this represents the number of individuals seen over the year, and not the street count for one night. In 2014 the street count revealed 742 rough sleepers in one night. This accounted for 27% of rough sleepers in the count nationally, and was up 37% on the previous year.[2]

During the same period hostel bed spaces in London have decreased 27% between 2011 (13,263) and 2014 (9,647).[3] It is thought these statistics may be related, although the increase in rough sleeping may also be related to welfare reform and migration.

There are many forms of 'hidden' homelessness including squatting, 'sofa surfing' with friends, family or acquaintances, and sleeping on buses or in transport hubs. Women and migrants are often hidden from view, with women sometimes exchanging sex for accommodation, and migrants frequently living in multiple occupancy accommodation. Some people sleep in safe places during the day, and wander at night.

Homeless Health

A large scale study of the death certificates of homeless people by Crisis in 2011 calculated the average age of death of homeless men to be 47, and homeless women to be 43. This study suggested that a third of deaths in this group are caused by drug and alcohol, and that homeless people are 9 times more likely to commit suicide.[4]

Homeless people are 2.5 times more likely to have asthma, 5 times more likely to have a stroke, 6 times more likely to have heart disease, and 12 times more likely to have epilepsy than the general population. They are also more likely to have more than one condition.[5] Traumatic and/or acquired brain injury is common, and in one recent study 45% of homeless people had a traumatic brain injury.[6]

Homeless people present health management challenges that mainly relate to tri-morbidity – the co-concurrence of physical health care, mental health care and addictions problems. As a result they often need specialist services, and high levels of support. Homeless people are often very transient across the capital, which can add to this challenge.

Literacy and learning difficulties

A St Mungos study showed that 51% of homeless people lacked the basic English skills needed for everyday life, compared to 15% of the general population in England.[7] A prior Thamesreach study identified that dyslexia and other mild learning difficulties were common, with 10% of clients being totally illiterate.[8] Undiagnosed learning difficulties are common in this population – they have often gone unidentified as sufferers have been out of school, and they have then begun to suffer from mental health difficulties and substance misuse conditions at an early age (which have then complicated the picture).

Public health risks associated with homelessness

In the UK, the prevalence of TB is reported to be 34 times greater in homeless people than in the general population, and the prevalence of hepatitis C viral infection is reported to be approximately 50 times greater. HIV prevalence has been found to be 1-20 times higher in homeless populations in the US than in the general population, but there are no UK studies.[9]

However for a variety of reasons homeless people access treatment less. For example it is estimated that only 3% of homeless people with Hepatitis C receive treatment. Story A.[5] Not providing adequate screening and management services for these clients presents a real public health risk.

Costs of homelessness to the NHS

A Department of Health Study in 2010 showed that homeless people attend A&E 5 times as much, are admitted 3 times as often, and stay 3 times as long as the general population. Overall they cost 8 times as much.[10]

Repeat attendance is often an indication that a client's needs are not being met, and many inpatient homeless teams have recently been set up in order to try to address this issue. However it is important to note that the increased costs are also a direct result of the fact that these clients have more complex health needs.

Concerns about GP registration

Although many homeless people **are** registered with GPs (most commonly with specialist or with GPs holding 'Locally Enhanced Service' contracts), a recent survey of 2,500 people by Homeless Link revealed that 7% of the homeless people surveyed had been refused access to a GP within the past 12 months, because they did not have identification or proof of address, or had missed a previous appointment or because of their behaviour.[10]

This rate can be much higher in some areas. For example, in a survey of 112 clients attending a specialist GP clinic in Brixton, 54% had been turned away from another GO, some several times.[11] Worryingly a Project London report recorded that 83% of the 1,454 clients they saw were not registered with a GP, and they have lived in the country an average of 6.5 years. 52% had not tried to register before because of perceived barriers. 12% reported having been refused access. Project London recorded 109 instances of refusals by GP practices when they called on a service users behalf. 73% of these clients had been involved in an asylum application at some point.[12]

Although the CQC is aware of these issues, the LNNM feels more needs to be done to ensure compliance with NHS England guidance on this topic.
https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/11/pat-reg-sop-pmc-gp.pdf

Lack of adequate data sharing

The widely acknowledged, and extremely expensive (?£12 billion) failure of Connecting for Health, is felt particularly strongly in our sector. Data not joined up between hospitals, GP practices and community nursing services results in a) duplication b) significant safeguarding failures in our extremely transient population c) lack of clinical effectiveness d) potential risks to health care professionals. The LNNM feels this issues should have the highest priority.

Services for people with personality disorder

It is estimated that 70% of single homeless people suffer from personality disorder (more recently called complex trauma), versus about 4% in the general population.[13] However services for homeless people with personality disorder are lacking. There are examples of good services in London e.g. a pilot of a 'Psychologically Informed Environment' hostel in Lambeth, and the walk-in counselling service provided by the Westminster Homeless Health Team, but these services are not sufficient to meet the need. These clients need good quality long term psychotherapeutic intervention in order to turn their lives around, and as a consequence use less public money. Personality disorder is also said to be present in 73% of prison populations.[14]

Services for people suffering from mental illness and addictions concurrently

Similarly there are a lack of mental health services for clients with suffer with mental health and addictions concurrently. For example many IAPT and primary care counselling services will not see clients with addictions. This is obviously unhelpful as mental health problems are often the root cause of the addictions. This problem is also experienced in the general population.

Local authority gatekeeping for single homeless people

A recent mystery shopper exercise by Crisis illustrated the problems homeless people have accessing accommodation. Actors were asked to present at local authorities with one of 4 typical homeless stories, to try to make a homelessness application. In 50 out of 87 cases the person received little or no help. This included a domestic violence victim directed to a phone that did not work, and a person with learning disabilities and mental health problems being told to fill in form even though he told them he couldn't read and write. They also told him they couldn't see him without ID and medical documents.[15]

Our clients are transient, and often have difficulty proving their local connection and organising documentation to prove they are priority need. This keeps many homeless clients on the streets for much longer than is necessary, and allows them to deteriorate. The LNNM feels the need to provide 'proof' needs to be appropriate and proportionate to the person's situation.

Homeless Families

The number of homeless families placed outside the capital by London boroughs has increased almost 80% in a year. 1,388 households were placed outside the capital by London councils between July 2013 and June 2014. This obviously has a major impact on children, potentially disrupting education, social networks, but also importantly their health provision.[16]

Lack of affordable housing

The above issues are obviously in part due to the critical lack of affordable housing in London. London's average house price has gone up 1/3 since 2007, and now sits at £498,000.[17] Most homeless health care professionals find this a major challenge – let alone the populations they serve.

Immigration Policy

It is has been estimated that if you give all undocumented migrants in the UK an amnesty you gain 1.5 billion in tax revenue, however it is estimated you would then lose 2.5 billion in education, health and welfare costs. Unfortunately the estimated cost of rounding them all up, putting them in detention, and deporting them is 5 billion. Hence the cheapest, short term position for governments is to do nothing. This obviously does not take any account of the long term financial and societal costs of children born into poverty, and appears to be very short-sighted.

Practitioners in homelessness are currently aware of many single homeless EEA nationals who are too unwell too work and 'not exercising their treaty rights', but who are literally deteriorating from a health point of view on the streets, and the authorities do not seem interested in taking responsibility for many of them. Similarly there are failed asylum seekers and visa overstayers who have serious health problems on the streets. We view this as an immediate concerning human rights issue that needs attention. The Home Office and health need to have a coherent strategy regarding what to do with these sections of the population when they become unwell.

For example, for those EEA nationals who refuse to accept reconnection serious thought needs to be given to offering these clients substance misuse treatment in the UK (perhaps in another part of the UK), because otherwise many progress on a death to early death secondary to alcohol whilst homeless – which was definitely not their dream when they came here.

Rising Threshold of Social Care

Adult social care departments made budget savings of 26 per cent between 2010 and 2014, amounting to £3.53 billion. As a result most councils have stopped providing support to people with low and moderate needs, and currently more than three-quarters of local authorities allow access to help only when a person's needs are deemed substantial or critical.[18]

Even when our clients have clear substantial or critical needs getting a borough to take responsibility (because of the client's prior transience) can be difficult. After that appropriate care provision is limited, because our clients' are often 'young olds' with

behavioural problems, mental health problems or cognitive deficits and appropriate care facilities for this client group are currently limited. Individual care packages often break down very quickly as care providers don't often have the skills to engage with this client group. This leaves many health care professionals struggling to manage clients with care needs with limited resources.

A pan London approach to meeting the care needs of homeless people probably needs to be taken with an assessment of what needs to be done to make current provision fit for purpose and easier to access.

Prison health and prison discharge

Homelessness and criminal justice also need to be linked up, and it is felt that there should be more attempts to get people housed on release from prison. 15% of newly sentenced prisoners report being homeless before custody. 9% report having slept rough. In one study prisoners who reported being homeless before custody were more likely to be reconvicted upon release than prisoners who didn't report being homeless (79% compared to 47% in the first year and 84% compared to 60% in the second year after release). 12% of prisoners released from custody in 2012/13 had no settled accommodation, and this has probably now got worse.[19]

From a health perspective 8% of prisoners interviewed in a recent survey were considered to have a physical disability, and 25% of women and 15% of men in prison reported symptoms indicative of psychosis. 46% of women prisoners and 21% of male prisoners reported ever having attempted suicide.[19] As previously stated personality disorder is also said to be present in 73% of prison populations.[14] This is a very vulnerable population. Consideration needs to be given to providing homeless prison discharge teams, similar to the homeless hospital discharge teams that have recently been set up in many hospitals across the UK.

Briefing prepared for the London Network of Nurses and Midwives Homelessness Group by Samantha Dorney-Smith

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Briefings will be issued 6 monthly. Upcoming briefings will cover young people, homelessness prevention, mental health, Medical Respite and End of Life Care.

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