

Homelessness Health Needs Assessment

1. Foreword

Homelessness and, in particular, rough sleeping is often viewed as a problem which only exists in large cities. This report shows that there is a significant number of people homeless and rough sleeping in Devon, not just in the larger urban areas such as Exeter, but also in the more rural and remote parts of the county.

The health needs assessment demonstrates the impact that homelessness can have on an individual's health and wellbeing and highlights good practice in the county where support is delivered to those who are vulnerable and in greatest need. It also identifies that homelessness is everyone's problem and can only be resolved through an integrated, multi-agency approach to the various issues presented.

A Health and Homelessness Strategy and accompanying implementation plan will be produced by the end of 2011 setting out key areas where Public Health can work in partnership with a range of agencies to improve the health outcomes of this population.

I strongly encourage all partners to consider this needs assessment and then commit to the recommendations.

Dr Virginia Pearson
Joint Director of Public Health
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2. Executive summary

Introduction

- 2.1 The aim of this health needs assessment is to scope the level of homelessness in Devon, identify the health needs of the homeless population, assess whether their identified needs are currently being met and make recommendations as to how their health needs could be better addressed.
- 2.2 The definition of homeless as used in this report will encompass those who are rough sleeping, living in hostel style accommodation, or receiving support to assist them maintain their own tenancy; those at risk of losing their accommodation; those staying with friends or relatives without express permission from the landlord and those living in squats, tents or vehicles due to lack of any alternative accommodation. This population are considered to be non priority for assistance by the Local Authority
- 2.3 Historically homelessness has either been viewed as the fault of the individual or due to a lack of resources; it has often been the responsibility of housing departments within central and local government. More recently though, it has been argued that homelessness is a complex issue that crosses departmental boundaries and is everyone's responsibility including health, social care, housing, criminal justice systems and welfare services.

Demography

- 2.4 Rough sleeping can be seen as the tip of the iceberg; it is the most visible form of homelessness, it is sometimes also referred to as chronic homelessness. Since the 1990's there has been a drive from central government to resolve the problem in England.
- 2.5 The Labour Government's 'Rough Sleeper Initiative' (1999- 2002) aimed to reduce rough sleeping by two thirds. This was achieved at the turn of the century when the focus then shifted towards sustaining low numbers and prevention services.
- 2.6 The past 2 years has seen an increase in rough sleeping nationally. The evaluation method has been changed by the incoming administration; arguably this combined with the economic downturn has seen numbers of rough sleepers rise. The current official government number is 1,768, of these 270 are in the South West and 72 in Devon (including Plymouth and Torbay). This means that the South West along with London has the highest incidence of rough sleeping per 1,000 households. (Communities and Local Government 2011)
- 2.7 Data from outreach services based in Exeter and North Devon and Supporting People show that there were approximately 336 people who slept rough in Devon (April 2009 – March 2010). This indicates a high level of turnover in numbers over a year (Bennett 2010).
- 2.8 Last year 1697 people accessed Supporting People services (April 2009 – March 2010). This includes accommodation based services with support and Floating Support to help an individual maintain a tenancy in the private rented

sector or in social housing. The Supporting People budget for Devon has been reduced from £6.8 million in 2010 – 2011 to £3.5 million for 2011 – 2012. This will lead to a reduction in current provision, both in terms of units of specialist accommodation and levels of housing related support (Bennett 2010).

- 2.9 There are a group of people living in insecure or overcrowded accommodation, staying with friends and family without permission from the landlord etc. This part of the homeless population is often described as 'Hidden Homeless' and therefore it is difficult to calculate how large this group is. The charity Crisis estimates that there are around 400,000 hidden homeless nationally (Crisis 2010).
- 2.10 Data from Devon Home choice (Hancock 2011) shows there are 6,488 people registered who are sharing facilities with people who they do not wish to be re-accommodated with, these figures give some indication of the levels of 'hidden homelessness' in the county.

Evidence of health need among the homeless population

- 2.11 National data and research highlight that the homeless population are not a homogenous group. The reasons for becoming homeless are complex and varied and there are usually a number of interlinked personal and social factors that contribute towards people being at risk of, or losing their accommodation.
- 2.12 Those individuals who experience 'chronic homelessness' (rough sleeping) tend to be predominately male, predominately white and predominately substance misusers (both drugs and alcohol) (Griffiths 2003).
- 2.13 The homeless population often have a range of complex needs which makes engagement with health, social and welfare agencies difficult. These needs in isolation often do not solicit a response from statutory services as they do not meet the threshold for an intervention, however combined with other issues including lack of accommodation, poor budgeting skills, trauma, a lack of social skills and 'anti social behaviour' some individuals are caught in a cycle of chronic exclusion, unable to get the support needed to cope with basic functions of every day life.
- 2.14 People with mental health problems are more likely to be homeless, vulnerably housed. Conversely there are a disproportionate amount of people with mental health problems among the homeless population (Mental Health Development Unit 2010).
- 2.15 It has been identified that there are a number of institutional barriers that prevent people who are homeless from accessing both primary and secondary health and social care (Department of Health 2010).

Evidencing local need

- 2.16 In order to get a spread of data for the Health Needs Audit and to include the service user in the process it was decided to carry out a Health Audit. The Toolkit used was devised by Homeless Link and the Department of Health. It was decided to concentrate on three areas of Devon; Exeter, Northern Devon and South Devon.

- 2.17 In total there were 259 respondents to the Health Audit: 133 from Exeter, 87 from North Devon and 39 from South Devon.
- 178 of the respondents were male and 75 female
 - 216 of respondents described themselves as white British (83%)
- 2.18 Additional information was also gathered from the Clock Tower Surgery, Devon County Council (via the Supporting People programme) The Royal Devon and Exeter Hospital and the voluntary sector.

Key issues

Reducing health inequalities

- 2.19 National data shows that homeless people are 40 times less likely to be registered with a GP than the general population (Department of Health 2010). In Devon GP registration among this population is fairly high. 82% of respondent to the health audit said that they were registered with a GP as a permanent patient; however this high prevalence is possibly due to there being a specialist service in Exeter (The Clock Tower Surgery) and to support workers motivating their clients to access primary healthcare as part of the 'support planning' process.
- 2.20 Despite high registration levels for primary care, there is still a heavy reliance upon acute services such as Ambulance and Accident and Emergency (A&E). Data from the Clock Tower Surgery and The Royal Devon and Exeter shows a rise in attendances to A&E by people identifying themselves as 'no fixed abode'. This could be because recording mechanisms have improved, or that people choose not to give an address due to the nature of the condition for which they are presenting with.
- 2.21 Data from the Clock Tower Surgery and the health audit suggests that there is a heavy use of A&E by a small number of the homeless population. On average 50 patients registered at the Clock Tower Surgery have more than 3 A&E admissions in a year and one respondent of the Health audit claimed to have accessed A&E 80 times in the previous 6 months.
- 2.22 Smoking is identified by the World Health Organisation as the biggest health inequality and local data shows that the prevalence among the homeless population is high 82% compared with the Devon average of 19% of the general population. Only 40% of respondents had been offered any help or support to stop smoking.
- 2.23 The homeless population do not have 'healthy lifestyles', according to the health audit, uptake of regular exercise is low among the population with 45% percent stating that they did not exercise. Only 4% of respondents stated that they ate 5 pieces of fruit or vegetables a day compared to 32% of the general population in Devon. 42% said that they didn't eat any fruit and vegetables at all.
- 2.24 National data shows that there are significantly higher levels of premature mortality among the homeless population with the average age of death being 42 (Griffiths 2003, Department of Health, 2010). Data of patients registered

with the Clock Tower Surgery shows that there are high levels of 'avoidable deaths' among the patient population and that the average age of death is 43.

Epidemiology

- 2.25 Reporting of physical ailments was relatively low, joint or muscular pain and respiratory problems had the highest prevalence as did dental problems and difficulty seeing. Low reporting could be interpreted as the low importance that physical health problems might have to the individual or a sense that poor physical health is the norm.
- 2.26 Data from the Clock Tower Surgery shows that mental health and depression have a higher than average prevalence among the patient population. High levels of mental health problems were also recorded as part of the health audit, both expressed and normative.
- 2.27 Of the 259 respondents to the health audit 118 stated that they had a mental health need or condition that has been diagnosed by a doctor or other health professional, this accounted for 45% of all respondents to the survey. The majority; 91 had a diagnosis of depression with 71 of them experiencing symptoms for over 12 months.
- 2.28 23 respondents had a diagnosis of Schizophrenia 20 of those long term; over 12 months and 10 respondents had a diagnosis of Bipolar disorder, with nine stating they had experienced the condition for over 12 months.
- 2.29 21 respondents had been diagnosed with a personality disorder. Nationally the prevalence is high among the homeless population; it is estimated that 60% of adults living in hostels have a Personality Disorder.
- 2.30 Recent research (Maguire 2010) among the homeless population has shown that some of the population are suffering from a condition termed as Complex Trauma. This condition can be understood as the behaviour observed in people with personality disorder that can be described as reactions to and ways of coping with the traumatic experience of difficult childhoods. It may, therefore be more useful to describe Personality Disorders as 'Complex Trauma'; a reaction to an ongoing and sustained traumatic experience (Maguire 2010).
- 2.31 Forty eight respondents stated that they suffered from a dual diagnosis again most of these (42) stated that it was a long term condition. Forty three percent of respondents claimed that they used drugs or alcohol as a way of coping with their mental health problems.
- 2.32 A pilot project using individualised budgets with entrenched/ long – term rough sleepers found that seven of the sample group of 14 were experiencing symptoms that align to those along the adult autistic spectrum, some had a diagnosis of Aspergers, none were getting any formal support.
- 2.33 Levels of substance misuse are disproportionately high among the homeless population, 43% of respondents to the health audit stated that they either took drugs or were recovering from a drug problem. Only 24 respondents stated that they were prescribed methadone which could indicate a low take up of drug treatment among this client group. 10% of respondents stated they were currently injecting drugs which appears low compared to data from Gabriel

House (a high support hostel) which showed a high prevalence of injecting drug use among the residents which was about 40%.

- 2.34 Recorded levels of alcohol consumption were also high with just over a quarter of respondents to the health audit stating that they drank more than 10 units of alcohol on a typical day when they were drinking, 18% of respondents stated that they drank every day. 35% stated that they have or are recovering from a drink problem.
- 2.35 Take up of screening and vaccinations was low among this population, this is concerning as nationally it is recorded that there is a high prevalence of Blood Borne Viruses such as Hepatitis C and Tuberculosis among the homeless population.

Recommendations for commissioning

- 2.36 Identify an existing forum, or convene a new group, to oversee the implementation of the Homelessness Health Needs Assessment and the Homelessness Joint Strategic Needs Assessment. (This group should be comprised of key stakeholders; health, social care, housing, criminal justice and welfare services).
- 2.37 Ensure an appropriate database is developed for use among a range of agencies for the effective collection of data about this population and their health and social needs.
- 2.38 Maintain the commissioning of preventative and early intervention services.
- 2.39 Ensure all staff working with in this sector are supported through appropriate training to deliver effective proactive models of good practice in the following areas:
 - a) Brief interventions and onward referral for health and social care related issues, including lifestyle advice
 - b) Infectious diseases and conditions prevalent in this population or where there is a high risk of infection such as Tuberculosis, Wernicke's Encephalopathy and Hepatitis
 - c) Dual diagnosis; awareness of mental health conditions and substance misuse
- 2.40 Ensure that effective levels of staffing are available for this client group, to provide support and treatment services for Dual Diagnosis and complex needs through community mental health services, a range of psychological therapies and substance misuse treatment services.
- 2.41 Further develop services provided by key health and social care agencies through a range of settings appropriate for the population i. day centres, hostels, specialist health care settings and the mobile harm reduction units.
- 2.42 Provide access to clinical supervision and support for all staff working with this complex client group.

- 2.43 Offer screening for Blood Borne Viruses and Tuberculosis, within in a range of settings, to those members of the homeless population designated at high risk of infection.
- 2.44 Maintain the existing level of services provided through the Clock Tower Surgery for this client group. Both temporary and permanent registration should be offered to meet the needs of the more transient members of the homeless population. The possibility of extending outreach services and retaining more services within primary healthcare should be explored.

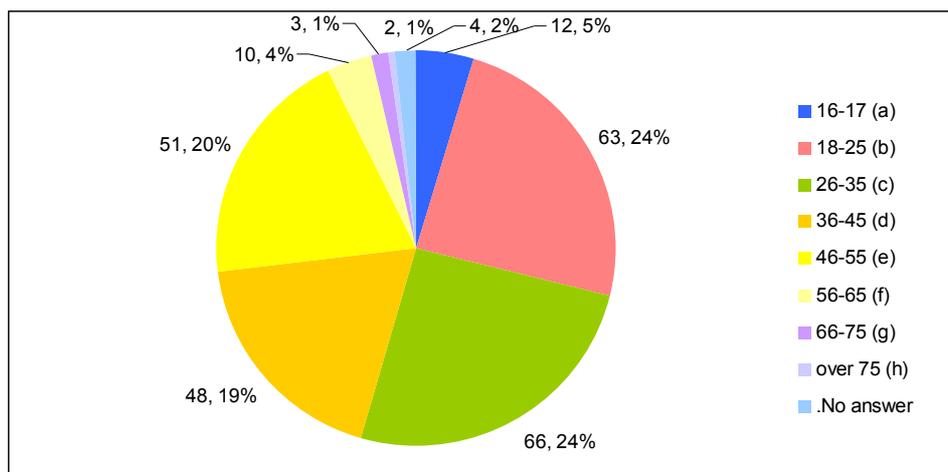
3. Introduction

- 3.1 A Health Needs Assessment is a tool that is used to identify the health needs of a particular population or a population in a particular geographical area. It is a vital tool in reducing inequalities in health as it targets populations most in need of improved support and services. The purpose of this Health Needs Assessment is to identify the health needs of people who are currently homeless or living in temporary, supported accommodation.
- 3.2 The Health Needs Assessment recognises that a number of Joint Strategic Needs Assessments have also been undertaken that have identified the accommodation needs of the homeless population. These include the Homelessness Joint Strategic Needs Assessment commissioned by the Devon Strategic Housing Group and the Accommodation and Support Joint Strategic Needs Assessment for Mental Health. These strategies look at the current and projected accommodation needs, maps existing services, identifies where gaps exist and make recommendations for the commissioning of future services that both prevent homelessness from occurring and aiding a quick resolution when someone finds themselves with nowhere to live. The intention is to compliment these strategies by focussing more upon the health needs of this population, however it cannot be overstated that suitable accommodation will improve health outcomes, so the two are inextricably linked.
- 3.3 The report has been developed by reviewing a range of national reports focussing on the physical, mental and emotional health needs of the homeless population. At a local level, the report has used data from providers in the homelessness sector including Outreach Services, Day Centres and Supported Accommodation Providers as well as data from Local Authorities and Supporting People, who currently commission a wide range of services in the county. There is a specialist health care service in Exeter called the Clock Tower Surgery that offers a range of primary healthcare services to people who are homeless or vulnerably housed and data was requested from them. Unfortunately not all the requested data was available. There was also a Health Audit carried out where service users were invited to complete a questionnaire about how they access healthcare as well as questions about their particular health needs.
- 3.4 The Health Audit Tool kit was devised by Homeless Link and funded by the Department of Health. It has been piloted in 9 PCT areas in England and is due to be officially launched in the spring of 2011. Homeless Link allowed the Health Audit Tool to be used for this Health Needs Assessment prior to its

official launch. Devon is the largest geographical area to use the Health Audit Tool so far.

- 3.5 Three areas were identified to carry out the Health Audit; Exeter, North Devon and South Devon, this is because each area has identified that they have a rough sleeping population and have some services to support them. All of these areas also have some supported accommodation projects in the areas and a floating support team. The areas were also chosen as they represented the different demographics of the county; urban, rural and market towns.
- 3.6 The Health Audit is a questionnaire designed to be completed by a service user with help from a support worker. Voluntary agencies were approached and invited to take part in the audit. The district authorities assisted by uploading completed questionnaires on to a database. The answers given by the service user are not corroborated and denote expressed need unless otherwise stated. (see Appendix one for breakdown)
- 3.7 The Audit took place between 15th November and the 10th December 2010. In total 259 service users took part; 133 from Exeter, 87 from North Devon and 39 from South Devon. 178 men and 75 women took part.
- 3.8 Currently in Devon the way that support is funded and delivered to a range of vulnerable groups is undergoing a fundamental change; the ring-fence that protected funding for housing related support has been removed and Local Authorities are facing the challenge of a reduction of their overall annual income by up to 30%. Devon County Council aim to move to a new commissioning framework by April 2011, currently services for the population identified are not included in this framework, which could see a dramatic reduction in provision. Therefore it is important to note that this Health Needs Assessment, took place at a time when there were a range of services available that help people find suitable accommodation and then support them to address their other health, economic and social needs.

Figure 1: Breakdown of respondents by age



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

4. Background and context

Purpose of a Health Needs Assessment

- 4.1 The National Institute for Clinical Excellence (2005) states that '*Health Needs Assessment (HNA) is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities*'

Definition

- 4.2 It can be argued that there has always been homelessness, but that the issue became more polarised with industrialisation and the migration of people to urban areas in the 18th and 19th century. Then it was thought that poverty and homelessness were caused by a failing in the individual and therefore the solutions were punitive;

'... every penny that helps make the position of the pauper more eligible than that of the workman will encourage laziness' (Poor Law 1834).

In terms of provision, there was the workhouse which was seen as the 'place of last resort'. Each Workhouse had casual wards or 'Spikes' where homeless people could stay for a night before being moved on. Spikes remained in existence well into the 20th century (Seal 2005).

- 4.3 In the post war period, homelessness was starting to be viewed as more of a structural problem; a lack of available and affordable housing and there was a statutory recognition of the need to house homeless people.

The aim ...was to relate homelessness to housing scarcity and not to welfare (in its administrative sense) and to get full recognition of the scale of the problem' (Wilson 1970).

- 4.4 It can be argued that by the 1990's a series legislative failure had led to an increase in the levels of homelessness; 'Right to Buy' and 'Care in the Community' and changes to benefits for the under 25's. Other societal factors such as unemployment and drug use also have an effect on homeless numbers (Seal 2005).

- 4.5 At this time homeless services were piecemeal, run by church and voluntary groups. Accommodation was often hostel based with shared rooms and dormitories and very little support was available to help individuals resolve the issues that caused their homelessness.

- 4.6 By the late 1990's government launched 'The Rough Sleeper Initiative' with the aim to reduce rough sleeping by two thirds, initially in London and then the scheme was rolled out throughout England. By this time homelessness was becoming viewed as a mixture of structural and societal issues and that solutions involved 'more than a roof'. Research carried out found that a disproportionate amount of rough sleepers had been in local authority care, suffered from a range of mental health problems and used drugs and alcohol:

'People on the street drink to cope with the cold weather, depression, isolation and physical and emotional pain. Because it dulls pain, induces

euphoria and fills idle time, alcohol is accepted as the drug of choice and as a means of fostering sociability amongst homeless men and some homeless women'. (Daly 1996)

National policies and legislative paperwork

- 4.7 Under the 1970 Housing Act all Local Authorities have a statutory duty towards people who are homeless. These duties have been extended by subsequent Housing Acts (1996, 2002) to include 16 – 17 year olds, people fleeing violence (not just women fleeing domestic violence) and where possible to prevent homelessness and reduce the number of homelessness acceptances made by helping people to maintain their current accommodation or to assist in finding an alternative within the private rented sector. These 'Housing Options' may also include rent guarantee or bond schemes. Some Local Authorities have their own private letting services. Local Authorities have also had to meet targets to reduce the number of households in Bed & Breakfast style temporary accommodation. Local Authorities also have a general duty to ensure that advice and information about homelessness and the prevention of homelessness is available free of charge to everyone in their district.
- 4.8 In England, under Part 7 of the Housing Act 1996, local housing authorities must secure suitable accommodation for applicants who are eligible for assistance, homeless through no fault of their own, and who fall within a priority need group ("the main homelessness duty"). The priority need groups are set out in legislation and include, among others:
- a pregnant woman or a person with whom she resides or might reasonably be expected to reside
 - a person with whom dependent children reside or might reasonably be expected to reside
 - a person who is vulnerable* as a result of old age, mental illness, mental disability, physical disability or other special reason (or a person with whom such a vulnerable person resides)
 - a person aged 16 or 17 who is not owed a duty under the Children Act 1989
 - a person aged 18-20 who has previously been looked after, accommodated or fostered
 - a person aged 21 or over who is vulnerable as a result of having been looked after, accommodated or fostered
 - a person who is homeless, or threatened with homelessness, as a result of an emergency such as flood, fire or other disaster

*Case law has established that, when determining whether an applicant is vulnerable, the local authority must consider whether, when homeless, the applicant would be less able to fend for themselves than an ordinary homeless person. The Local Authority then needs to determine whether the applicant is homeless and whether they have a right to reside and seek

assistance in the UK. Next the Local Authority needs to ascertain whether the applicant has made them self intentionally homeless e.g. through non payment of rent or anti social behaviour and finally it needs to be determined whether the applicant has a local connection to the area where they are seeking to be accommodated.

- 4.9 The 2002 Housing Act stated that every Local Authority needed to write a Homelessness Strategy for both priority and non priority cases including proposals to reduce rough sleeping within their area. Some LA's have a single Rough Sleeping Strategy whilst others cover this group within their core Homelessness Strategy. <http://www.legislation.gov.uk/ukpga/2002/7/contents>
- 4.10 Most of the population identified for the purpose of this Health Needs Assessment are not eligible for assistance by the Local Authority. Even if they are seen as priority due to their vulnerability, they are often deemed to be intentionally homeless. Locally routes into social housing have been developed for those people who have gone through supported housing as a longer term move on option.
- 4.11 The population covered by this Health Needs Assessment often experience a range of complex needs which both serve to cause and exacerbate their homelessness and social exclusion; poor mental health, learning difficulties, substance misuse and psychological problems that in turn can lead to anti social behaviour, however often they do not meet the required threshold for statutory support or are denied help because of their substance misuse or chaotic behaviour. The challenge for those commissioning health and social services will be to ensure that this difficult to reach and vulnerable group are not further pushed to the margins of society unable to access services that they need to improve their health outcomes.

5. Demography and population projections

Identified population for the Health Needs Assessment

- 5.1 The term 'homeless' covers a wide range of experiences from being literally roofless to living in insecure, temporary accommodation. For the purpose of this Health Needs Assessment the population has been defined as people who are rough sleeping, living in supported accommodation, such as a Hostel or Night Shelter or receiving floating support to help sustain an independent accommodation option. It will also include people who are vulnerably housed; living in squats or staying with family and friends without permission of the landlord, people at risk of homelessness, fleeing domestic violence and those who have a history of episodic homelessness. The group is comprised of single males, single women and couples. The Health Needs Assessment will not include the health needs of homeless families with children living in temporary accommodation provided by the Local Authority under Homelessness legislation. This is because it can be argued that although their situation may lead to increased health problems, they are not considered to have substantially different health needs to that of the general population, neither do they experience the same difficulties in accessing healthcare as the population identified for this Health Needs Assessment (Department of Health 2010). This definition also aligns itself with the population identified by

the Department of Health (2010) in their report 'Single Homelessness and Health Care:

'this paper focuses on people sleeping rough or living the hostel system rather than those who otherwise resolve their homelessness..... because it is generally agreed that these people are vulnerable, have particularly high health needs and are hard to reach through mainstream services....'

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh114369.pdf

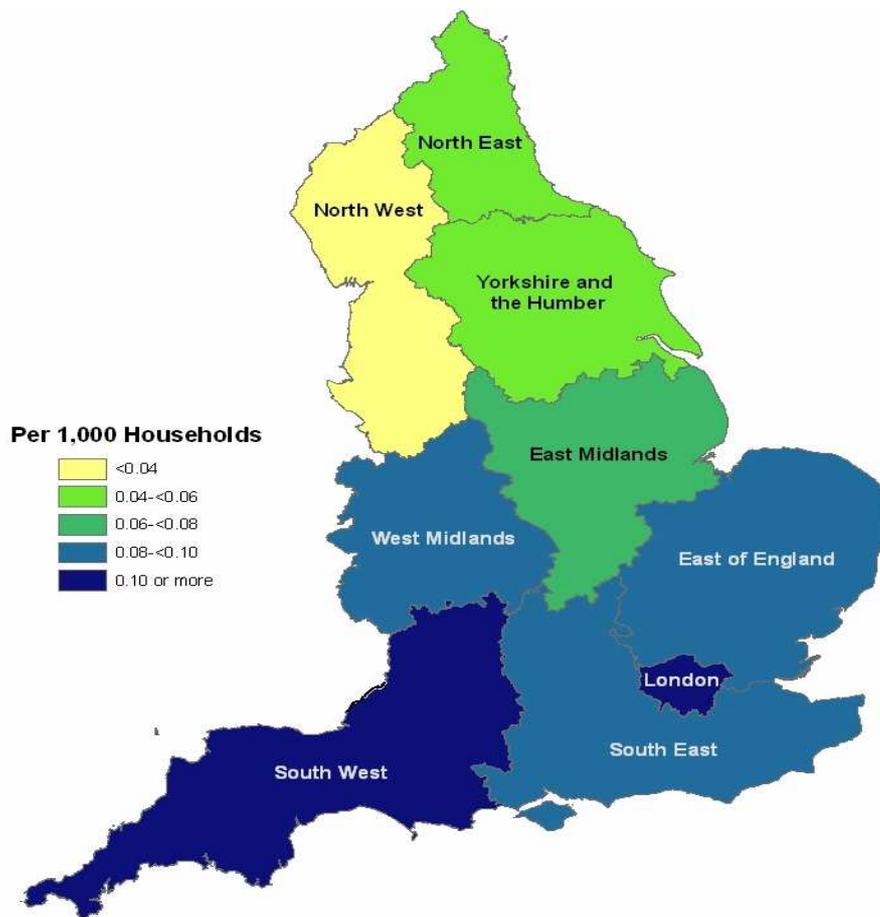
Estimate of hostel population

- 5.2 Due to the transient nature of a lot of individuals it is difficult to estimate how many people are living in Hostels, shelters or supported accommodation in England. The Charity Crisis estimates the figure to be 43,000 adults living in hostels, night shelters or refuges on a temporary basis at any point in time. This group meets the legal definition of homelessness, as they are known to be unsettled, with no security of tenure, and presumably have nowhere else to live (Crisis 2010).
- 5.3 The Charity Homeless link estimate the figure to be 40,500 based upon an analysis of a database which calculated the number of hostel beds available in England. In the 2007/8 Supporting People data, around 65,000 client records relate to the single homeless and rough sleepers. Since these records relate to new clients (or a switch in the service received by an existing client), they will not include the estimated 40,500 living in hostels at the start of the year. This yields 105,500 people per year.

Estimated rough sleeper numbers

- 5.4 In 1998 the government set a target to reduce rough sleeping by two thirds by 2002. Using the methodology of street counts throughout the country, numbers have fallen from 1,850 in 1998 to 585 in 2002 and 483 in 2008. The count methodology is controversial and it is accepted that it gives only a snapshot on one given night.
- <http://www.communities.gov.uk/documents/housing/pdf/1713784.pdf>
<http://www.communities.gov.uk/documents/housing/xls/1713802.xls>
- 5.5 The methodology for evaluating the numbers of rough sleepers has been amended, with all Local Authority areas asked to either carry out a street count or give an estimate of the numbers of people rough sleeping. In June 2010 the number of people rough sleeping was estimated at 1,247. The number in Autumn 2010 is 1,768. 270 rough sleepers were recorded in the South West. This means that the region along with London has the highest incidence of rough sleeping per 1,000 households. In Devon (including Plymouth and Torbay) 72 rough sleepers were recorded. This would indicate that over a quarter of people rough sleeping in the South West are located in Devon.

Figure 2: Incidence of rough sleepers per 1,000 households



Source: Communities and Local Government February 2011

- 5.6 It is difficult to gain an accurate number of people who are rough sleeping. This is due to the often transient nature of their lifestyle. Rough Sleepers are often broken down in to 3 separate sub groups; New Rough Sleepers, Episodic Rough Sleepers and Entrenched Rough Sleepers in an attempt to better describe the experience. For some rough sleeping may be a very brief episode due to a relationship breakdown or loss of accommodation, they may then get assistance to find accommodation quickly either through their social capital or voluntary agencies. Others may have a lifestyle where they move from accommodation to the streets frequently this may be due to offending behaviour which leads to a short prison term and loss of accommodation or unresolved issues that mean they are frequently evicted. The last group are those who habitually rough sleep and often state that this is through choice. Research in to rough sleepers shows that this group of individuals have a range of complex needs and a distrust of services which makes them incredibly difficult to reach and support. Often there multiple vulnerabilities and lack of specialist involvement limits any accommodation option. It can be further argued that the range of responses to these different types of rough sleepers is needed. Current rough sleeper strategies also highlight the importance of prevention services to stem the flow of new rough sleepers on to the street, whilst more specialist multi - agency approaches are needed to work with the longer term entrenched individuals.

Rough sleeping population demographics

5.7 The rough sleeper population has been generally characterised as:

- 90% male
- 75% aged over 25
- between 25%-33% have been in local authority care
- having a life expectancy of 42 years, in comparison to a national average of 74 for men, and 79 for women*
- 35 times more likely to kill themselves than the general population
- four times more likely to die from unnatural causes, such as accidents, assaults, murder, drugs or alcohol poisoning
- 50% alcohol reliant
- around 70% misusing drugs
- 30-50% with mental health problems
- 5% from black and minority ethnic groups. (Griffiths 2003)

*It is necessary to point out that although there is a lot of evidence that people who are homeless have significantly higher levels of premature mortality with an average age of death between 40-44 years, this should not be misinterpreted as life expectancy figures as has happened in the past. The figures give the average age at death of a sample of homeless people who die whilst they are homeless and do not take into account those people who become settled in a home. (Department of Health 2010)

Hidden homeless

5.8 It is acknowledged that there are a group of people who fit the definition of being homeless but do not rough sleep or who are not supported through the Supporting People programme. They may be living in bed and breakfasts, squats, in unsatisfactory or overcrowded accommodation, or who are staying with friends or families sleeping on floors or settees, without an explicit right to do so. By its very nature it is extremely difficult to accurately estimate the levels of 'Hidden Homelessness'. The national charity Crisis has estimated that there are around 400,000 hidden homeless people Great Britain.

http://www.crisis.org.uk/policywatch/pages/homelessness_statistics.html

5.9 As part of Devon Home Choice, the register of all applications for social housing, data has been collected on single households that share facilities with other people that they wouldn't want to be re-accommodated with. This data may cover people currently living in Houses of Multiple Occupation as well as those staying with a friend or relative because they have no where else to go, but potentially they are all 'one argument' away from being asked to leave and becoming homeless, therefore this data can give an indication of the levels of 'Hidden Homelessness' in Devon.

Table 1: Single Households sharing facilities on Devon Home Choice March 2011

	Under 18	Under 25	Under 35	Under 55	Over 55	Total
East	1	85	145	240	47	518
Exeter	47	602	1080	1597	114	3'440
Mid	3	75	124	179	23	404
North	4	86	169	272	50	581
South Hams	2	47	101	158	34	342
Teignbride	9	117	193	285	47	651
Torridge	1	25	39	70	18	153
West Devon	4	83	120	174	18	399
Total	71	1'120	1,971	2'975	351	6'488

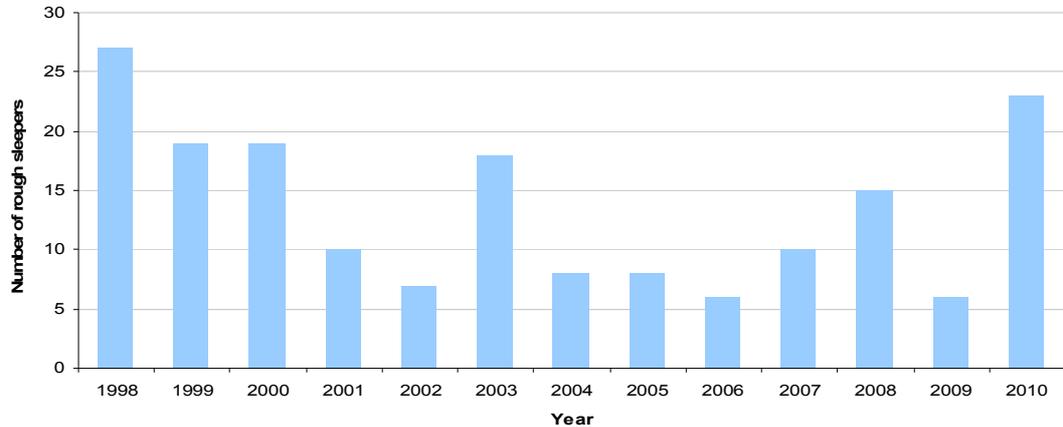
Source: Exeter City Council (Hancock) March 2011

Non priority single homeless population in Devon

- 5.10 The data collected from outreach services and Supporting People shows that last year there were approximately 336 people who slept rough in Devon.
- 5.11 Exeter has a long established homelessness problem. The geographic situation of the city; at the end of the M5 motorway has always attracted transient people travelling to and from casual agricultural labour in Devon and Cornwall. Homelessness was first acknowledged as a problem in the late 60's when a homeless man was found dead on Cathedral Green, The Shilhay Community opened the first hostel in Exeter in 1969 at Gabriel's Wharf.
- 5.12 In 1998 Exeter was included in the government's Rough Sleeper Strategy. A count was carried out in the city and 27 people were found to be rough sleeping. The aim was to reduce this number by two thirds by 2002.
- 5.13 There were barriers for a lot of the rough sleeping population to accessing services these included no accommodation in the city for couples, accommodation providers not allowing dogs and accommodation providers not taking active drug users. Those with substance misuse issues also found it difficult to access drug treatment as they did not have an address, were not registered with a GP and often failed to adhere to the regimen required to demonstrate a willingness to address their drug use.
- 5.14 By 2002 the rough sleeper numbers had reduced to 9 and the focus changed to ensuring that low numbers were sustained by effective multi agency working to ensure that once accommodated the client was able to thrive by learning life skills such as cooking and budgeting. Move on options were also created so that the direct access hostels did not 'silt up' and by ensuring that there were opportunities for education, training and employment (Meaningful Occupation) that would facilitate a permanent move away from a street homeless lifestyle.
- 5.15 Exeter City Council funds an Outreach Service to contact and assess all new rough sleepers. There is also a section on rough sleeping in the 2008 – 2011 Homelessness Strategy (Chapter 10). The Outreach Service; the Street

Homeless Outreach Team (SHOT) was hosted initially by Exeter Primary Care Trust and then subsequently by Devon Primary Care Trust until March 2010. The service was then re-tendered and the contract awarded to Shilhay Community. The service continues to be co located with the Clock Tower Surgery. <http://www.exeter.gov.uk/CHttpHandler.ashx?id=10173&p=0>

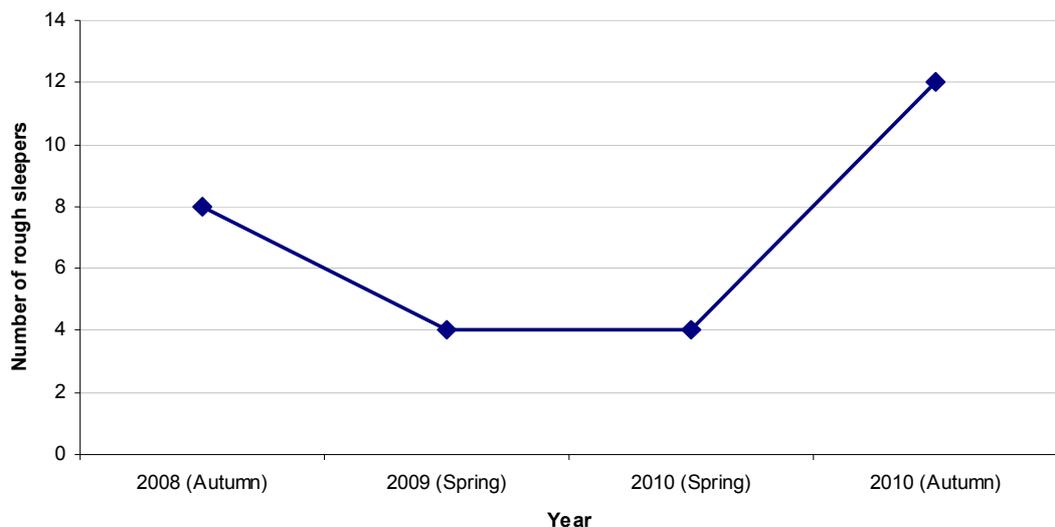
Figure 3: Numbers of rough sleepers found on official street counts in Exeter



Source: Exeter City Council (Hancock) 2011

- 5.16 The SHOT has contacted and assessed 227 rough sleepers; 167 males and 60 females from April 2010 – Dec 2010.
- 5.17 North Devon District Council identified that they had a growing and significant Rough Sleeper problem in both urban and rural areas of the district. In 2008 the district council appointed an outreach worker. In 2008/09 the service made contact with and assessed 81 individual rough sleepers. http://www.northdevon.gov.uk/ndc_rough_sleeper_strategy.pdf

Figure 4: Numbers of rough sleepers found on official street counts North Devon 2008 – 2010

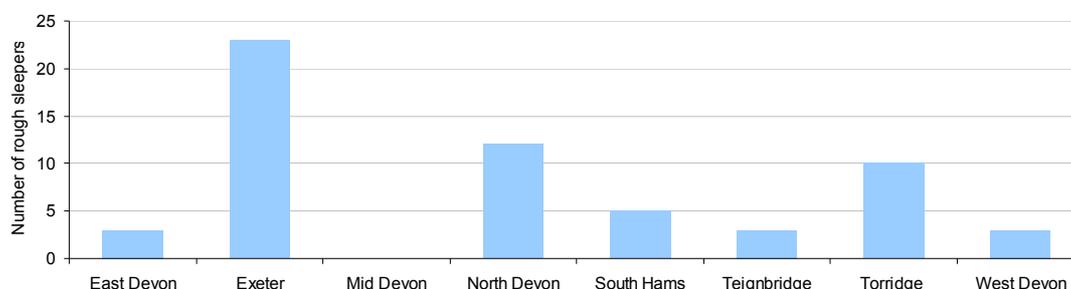


Source: North Devon District Council (Copp) 2011

5.18 South Hams District Council has experienced an increase in anti social behaviour in Totnes. In April 2010 a Street Needs Audit was carried out to establish the accommodation status of those people believed to be the perpetrators. 29 people were interviewed and 5 of them were currently rough sleeping. South Hams have no dedicated services for people who are non priority homeless.
http://www.southhams.gov.uk/20100507_totnes_street_needs_audit_-_report.pdf

5.19 Using the new guidance for evaluating the extent of rough sleeping issued by the Coalition government, all Local Authorities were required to either carry out a street count give an estimate of how many people they believed to be rough sleeping in their district. The guidance stated that the estimated figure should be agreed by other agencies in the area, including the police, any specialist services and voluntary agencies and church groups.

Figure 5: Numbers of rough sleepers in Devon by local authority area (Autumn 2010)



Source: NHS Devon Public Health Intelligence Team 2011

5.20 Exeter City Council was the only Local Authority to conduct a street count; all other district authorities gave estimates. It should also be noted that Exeter's numbers have been recalculated to 21 by the Department of Communities and Local Government. This was because 2 tents were found and counted as people without verification that they were occupied.

Numbers of people in supported accommodation

5.21 The Supporting People programme began on 1 April 2003, bringing together seven housing-related funding streams from across central government. It was a decentralised programme administered through 152 top-tier authorities (via Area Based Grant) who had complete discretion over where to direct their funds to best meet local needs. Services were largely delivered by the voluntary and community sector, and housing associations. Devon County Council has grouped a number of Supporting People client groups together to define the homelessness sector (now renamed the Social Inclusion and Recovery sector). The data table below shows the number of people from this sector that accessed Supporting People services during the past three years. The data does involve some double counting where individuals move between services.

Table 2: Breakdown of people accessing Supporting People Homeless services by client group

Primary client group	2007/08	2008/09	2009/10
Single homeless	541	486	525
Rough sleepers	14	60	70
Homeless families	154	131	98
Domestic violence	226	202	182
Alcohol problems	65	78	60
Drug problems	97	122	119
Offenders	87	145	201
Young people at risk	202	202	206
Young people leaving care	21	20	17
Teenage parents	29	20	38
Generic or complex needs	102	209	180
Other groups	3	2	1
Total	1451	1677	1697

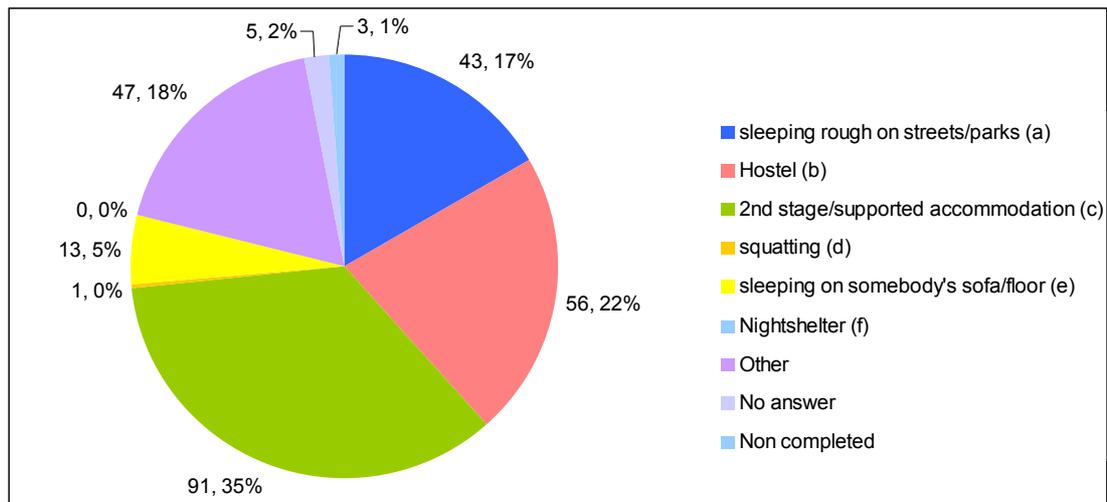
Source: Homelessness Joint Strategic Needs Assessment. Bennett (2010)

- 5.22 Any of those who fall into these client group categories have secondary needs, eg some rough sleepers may have drug and alcohol problems and/or mental health problems. Those whose primary need is mental health are not shown in the above list as they will generally access Supporting People Mental Health services and most are known to statutory agencies.
- 5.23 The Homelessness grant for Devon is £700,000 and the Supporting People budget for 2010 – 11 was approximately £6.8 million.

Accommodation status of Health Audit sample

- 259 service users took part in the Health Audit to gather data for the Health Needs Assessment. When asked to describe where they were currently sleeping
- 43 stated that they were rough sleeping
- 56 were living in a hostel
- 91 were in second stage supported accommodation
- 1 was squatting
- 13 were sleeping on somebody's sofa/floor

Figure 6: How would you describe where you are currently sleeping?



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

Projected growth in the homeless population

5.24 Indications from the autumn street counts is that the population of non priority single Homeless is rising, especially in the urban areas. Exeter has seen an increase from six rough sleepers in November 2009 to 23 in November 2010. Despite a commitment at ministerial level to reduce rough sleeping, by minimising the cuts to monies allocated to achieve this, there is no ring fence. Each Local Authority will decide its own priorities and allocate funding accordingly. Devon County Council have made it clear that they will be prioritising services for client groups that they have a statutory responsibility towards. A prioritisation process was carried out in September 2010 which reduced the current provision by 50%, further cuts are expected with the aim to create a 'safety net' of services from April 2011. There is a real risk that homelessness will increase; those currently receiving floating support to maintain their tenancies could face eviction once the support is withdrawn, some accommodation providers will have to close their services, reducing the number of available beds and those already in supported accommodation may struggle to find a move on option, thus silting up the beds that will still be available.

5.25 Redundancies in the Public Sector may also mean that people default on their mortgages or rent which could potentially mean that there would be new people facing homelessness and potentially ending up sleeping on the streets, this would put an additional strain on services.

Conclusion

5.26 The population identified for this Health Needs Assessment are not a homogeneous group, indeed, it is more useful to look at homelessness as a symptom rather than a label that is used to describe a type of person. Within the homeless population there are individuals with varying needs; some experience homelessness briefly due to their economic situation or a relationship breakdown, but their homelessness is quickly resolved. Others have more complex psychosocial problems that can both trigger a homeless episode or exacerbate and extend it. If the right support is not available, a small group of people will become entrenched, long term rough sleepers.

The common theme for all these individuals is that they are not considered to be a priority for assistance from the Local Authority and often don't meet the threshold for assistance from Adult Social care or mental health services, so are effectively no one's responsibility.

'It's not that homeless people are difficult to reach – they are just easy to ignore.' (Dr Reid, House of Commons 2008)

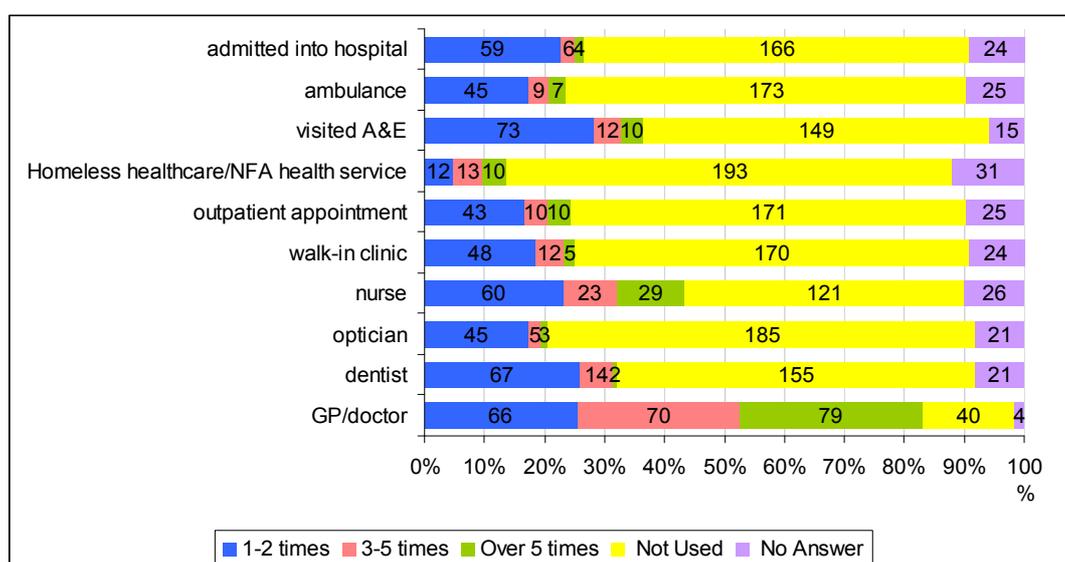
6. Health inequalities

Introduction

- 6.1 There is evidence to suggest that the homelessness population are 40 times more likely to not be registered with a GP than the rest of the population (Crisis 2002). Arguably this is because they face many barriers to accessing primary health care including mainstream GP surgeries often require proof of address for registration. Some of the homeless population have poor engagement skills and chaotic lifestyles which make it difficult for them to book and keep appointments.
- 6.2 Some of the homeless population do not value their health and wellbeing, or address their health needs until the situation becomes critical. Some GP practices are reluctant to register people who they consider to be transient as they may bear the cost of any future treatment administered elsewhere in the country.
- 6.3 Many homeless people demonstrate a tri-morbidity of physical illness, mental health problems and substance misuse. Research by the charity St Mungo's found that approximately half of their residents have mental health problems including depression and schizophrenia, emotional and psychological disorders and 'lower level' mental health illnesses. The research also found that 32% had an alcohol dependency and that 63% had a drugs problem (St Mungo's 2009). The report 'Reaching Out: An Action Plan on Social Exclusion' states: *"Among the homeless population there are a group with complex needs who are not benefiting from services because their lives and engagement with services are too chaotic. These adults continue to face poor outcomes in the form of offending, long-term mental and physical health problems, poor family relationships, continuing substance misuse, worklessness and deprivation."* HM Government (September 2006).
- 6.4 Specialist services for the homeless have been effective in being able to remove some of the barriers and meet the needs of those with more complex needs. Out of 150 primary care trusts in England, 48 have no specialist provision for homelessness, 43 have a GP surgery offering permanent registration, 31 provide an 'Outreach team' (Department of Health 2010).
- 6.5 The Health Audit found that there was a high level of registration with a GP practice with 82.24% of respondents stating that they were permanently registered. Interestingly respondents saw the Clock Tower Surgery as a mainstream practice rather than a homeless health care or NFA health service as only 32 respondents stated that they were registered with a specialist service.

- 6.6 30.50% of respondents had seen a GP over five times in the past six months and 27.03% had seen their GP between three to five times in the past six months, which could indicate persistent health needs for a significant number of the cohort.
- 6.7 Over half of the respondents had not used a walk in centre. This may be because there is not a walk in service in their area, or that people do not feel the need to access the service if they are registered with a GP.
- 6.8 Just under half of respondents; 41.70% stated that they were registered with a dentist, however, 59.85% had not used the service in the past six months. An even higher percentage had not seen an optician; 71.43%.

Figure 7: Which of these health services have you used in the past six months?



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

Access to secondary healthcare

- 6.9 A report by the Department of Health (2010) which focuses upon Single Homelessness and Healthcare uses a 'No Fixed Abode' indicator, as a proxy to identify hospital admission data for part of the Homeless Population. The NFA data shows that the most common reasons for admission include; toxicity (alcohol and drugs) and mental health problems. The data also found that this group compared with the 'fixed abode' population aged between 16 – 64 were high users of secondary care with high rates of emergency admissions and up three times the length of stay. The report also uses a method to calculate the cost of these admissions to the NHS. Making the assumption that homeless people attend A&E five times as frequently as the non-homeless, the report calculates that there would be approximately 53,000 visits to A&E made annually by the homeless population, costing £5 million a year.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_114369.pdf
- 6.10 It is acknowledged that the NFA indicator is not perfect; the information is given by the individual, who may not choose to give an address due to the nature of their admission, also patients may give an address of the hostel or

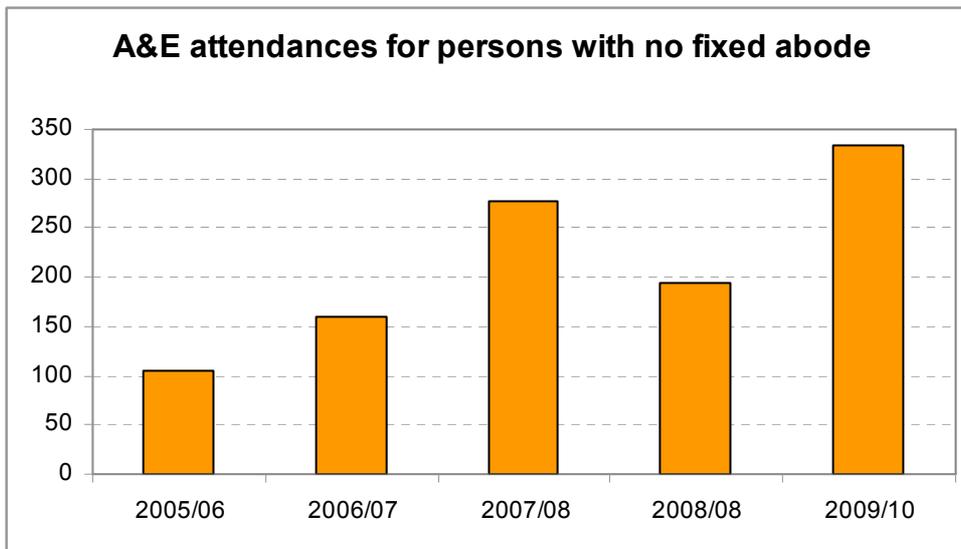
shelter that they are staying at, so it is only capturing some of the admissions for the homeless population that we have identified for the purpose of this HNA.

6.11 In 2007/8 there were approximately 17,400 inpatient episodes coded as NFA (15,800 different patients) nationally.

Levels of A&E attendances in NHS Devon

6.12 Figure 10 below shows the number of A&E attendances using data from NHS Devon.

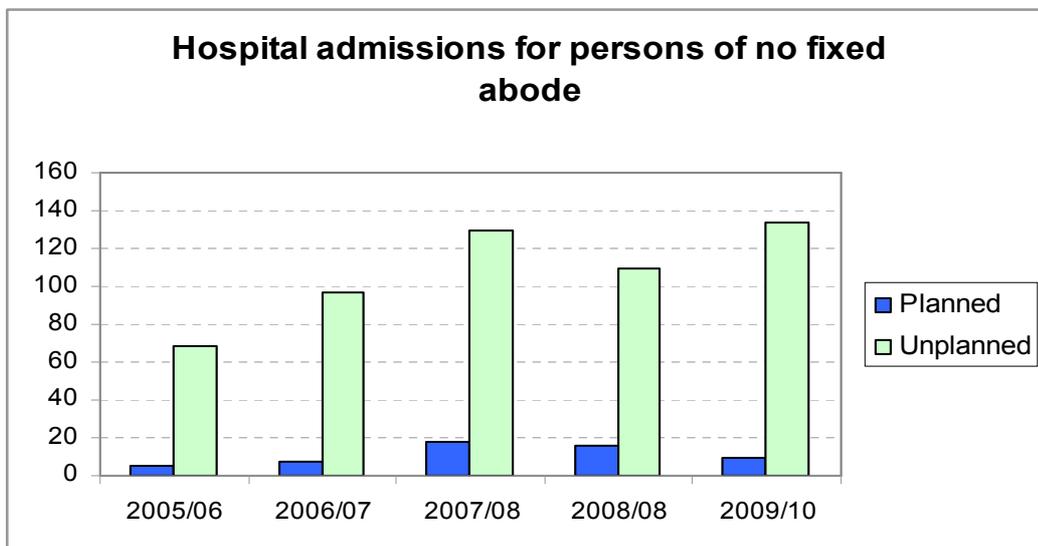
Figure 8: The number of A&E attendances for persons of no fixed abode



Source: NHS Devon Public Health Intelligence Team 2010

6.13 The data suggests that the numbers of A&E attendances among this client group is rising. This may however be due to better recording of those who are NFA. Further research would be needed to fully understand the figures.

Figure 9: The number of hospital admissions for persons of no fixed abode

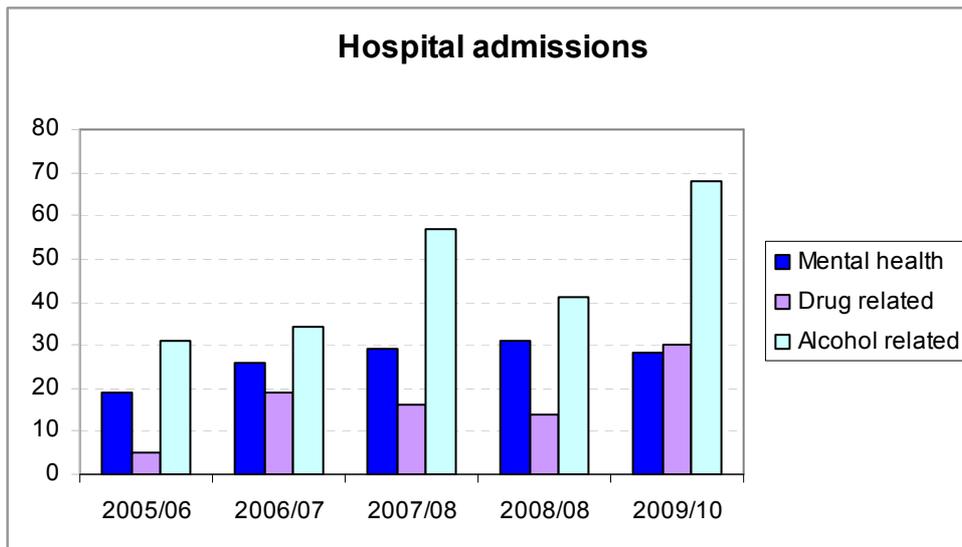


Source: NHS Devon Public Health Intelligence Team 2010

6.14 The data on hospital admissions shows that there is a high proportion unplanned hospital admissions for homeless people. Unplanned admission is more costly to the NHS.

6.15 The hospital admissions for homeless people shown in Figure 11 can be broken down as follows for admissions related to mental health, drugs and alcohol.

Figure 10: Hospital admissions related to substance misuse and mental health



Source: NHS Devon Public Health Intelligence Team 2010

6.16 As with the national data, these figures do not include people living in insecure accommodation or hostel accommodation who are admitted to hospital because of mental health, drugs or alcohol. Nor do the figures include people who are homeless, living in insecure accommodation or at risk of homelessness and are in receipt of treatment services, however there may be some misreporting given the nature of the admission. The data also identifies episodes and not individuals so we cannot see if there are people who are using A&E frequently. The table below shows the frequency of A&E admissions among patients from the Clock Tower Surgery and the subsequent costs. Results from the Health Audit indicated heavy use of A&E by a small number of respondents, with one claiming to have accessed A&E 80 times in the previous six months.

Table 3: Number of A&E admissions made by patients registered at the Clock Tower Surgery in Exeter

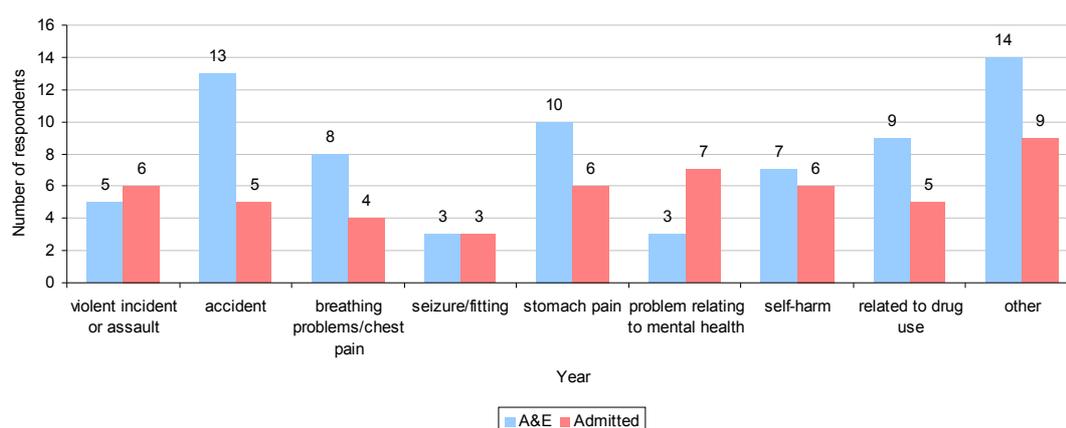
	2007/08	2008/09	2009/10	2010/11 YTD (up to/including September)
Number of patients with 3 or more A&E admissions	53	53	59	23
Total attendances of above patients	289	263	349	120
Total cost of patients with 3 or more A&E admissions	£26,759	£22,218	£29,751	£9,891
Total number of patients attended A&E	289	313	275	163
Total attendances of A&E	573	588	608	281
Total cost of A&E attendance	£52,854	£48,898	£51,247	£23,622
Number of A&E attendances with postcode 'ZZ99 3VZ'	91	47	67	16
Cost of A&E attendances with postcode 'ZZ99 3VZ'	£8,451	£4,035	£5,333	£1,404

Source: NHS Devon Public Health Intelligence Team 2010

6.17 The data shows that a small number of patients from the surgery have had more than three attendances in a year with each attending A&E on average 5.5 times. The table also shows numbers of admissions of patients with a ZZ99 postcode which indicates that they have not been given an address. This data indicates that even those people registered with specialist health services such as the Clock Tower Surgery can be heavy users of acute hospital services. This could be due to the very complex nature of some of the homeless population, especially as the Devon PCT data indicates around their substance misuse and mental health.

6.18 As part of the Health Audit respondents were asked the reasons why they accessed A&E the answers are illustrated in the figure below.

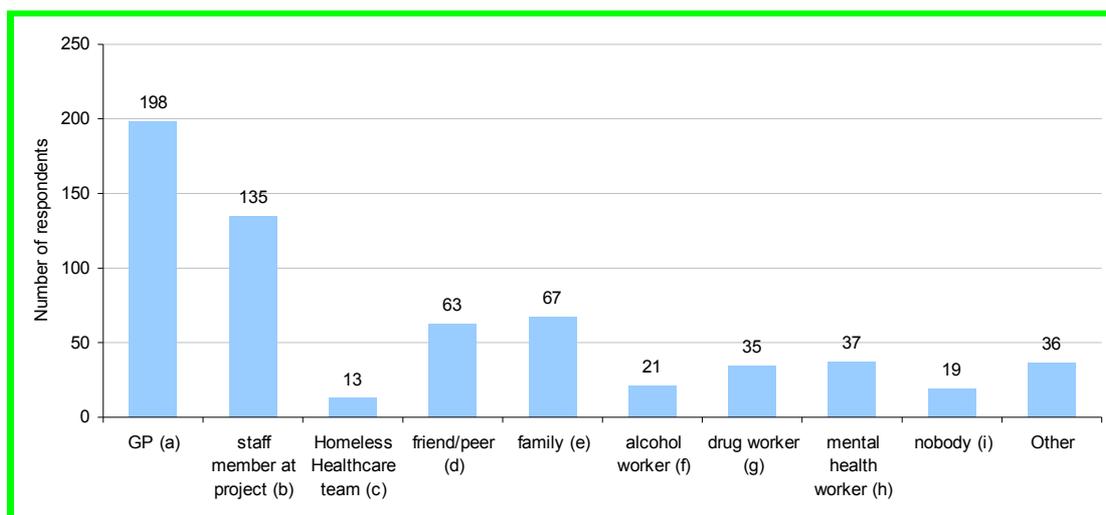
Figure 11: Reasons for A&E visits and admissions



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

6.19 As part of the health audit, respondents were asked who they felt looked after their health. The majority cited their GP, but a significant amount also stated that a staff member at a project did. This demonstrates that workers in homeless projects often perform a generic function, as they may be the only professional who the client engages with.

Figure 12: Who looks after your health?



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

Smoking

6.20 Smoking has been identified by the World Health Organisation as a major cause of health inequalities. 106,000 deaths are attributed to smoking each year in the UK. Reports (NICE 2001) show that smoking disproportionately affects the least well off; 31% of manual workers smoke compared to 20% of non manual workers. Devon has one of the lowest levels of smoking at 19% of the population compared to the national average of 21%.

6.21 There is a high prevalence of smoking amongst the homeless population. Of the Health Audit respondents 82.63% stated that they smoked which is almost three times the national average. Only 20.85% of this sample said that they wanted to give up smoking with 61% stating that they did not want to stop smoking, however only 40.77% had been offered advice or help to stop smoking.

Table 4: Clock Tower Surgery – Number of current smokers broken down by age group (May 2010)

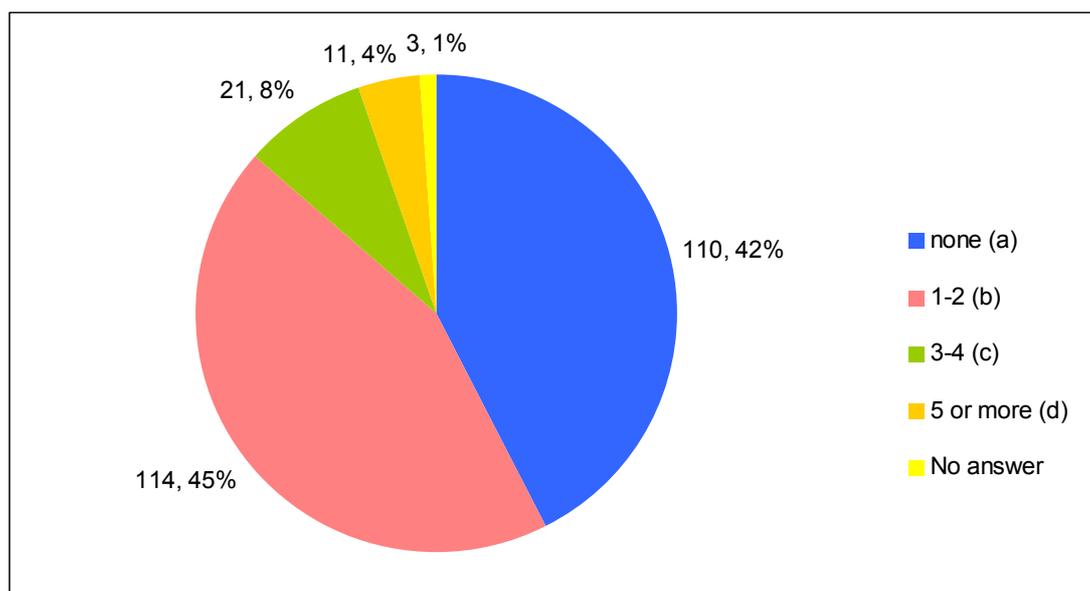
Age Group	Males		Females	
	No	%	No	%
0-4	0	0%	0	0%
5-16	0	0%	0	0%
17-24	39	70%	23	92%
25-34	97	81%	27	77%
35-44	137	88%	21	66%
45-54	90	83%	14	100%
55-64	25	76%	1	33%
65-74	3	60%	1	100%
75-84	1	100%	0	0%
85-89	0	0%	0	0%
90+	0	0%	0	0%

Source: NHS Devon Public Health Intelligence Team 2011

Healthy lifestyles and health inequalities

- 6.22 The findings of the Health Audit indicate that a high percentage of the homeless population are leading unhealthy lifestyles which could affect health outcomes in the long – term. 39% of respondents stated that they did not, on average eat 2 meals a day, with 42.47% stating that they did not eat any fruit and vegetables. Only 11 respondents (4.25%) said that they eat five or more pieces of fruit and vegetables a day, which is the recommended amount, this compares with 32% of Devon’s general population who claim to eat ‘5 a day’.

Figure 13: How many pieces of fruit and vegetables do you eat a day?



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

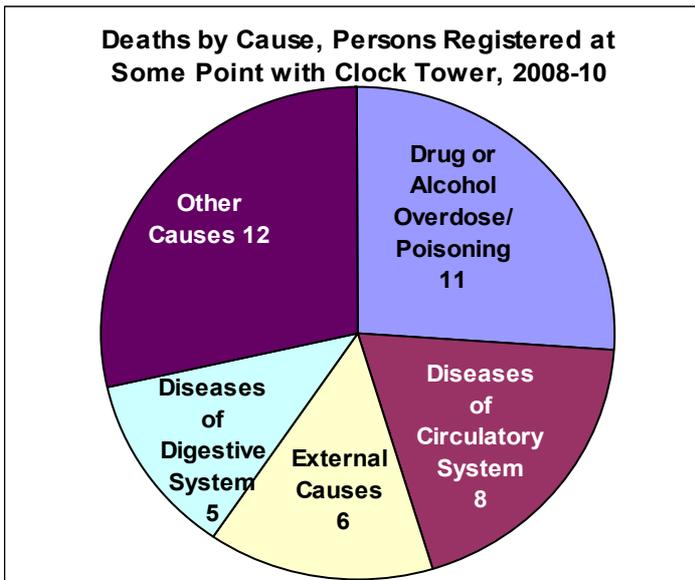
- 6.23 Just over half of the respondents state that they exercised at least twice a week (55.21%) but they were not asked about what form of exercise they took or for how long. 16.22% did state that they would like to exercise more.

Morbidity

- 6.24 There is evidence that people who are sleeping, or have slept, rough and/or are living in hostels and night shelters have significantly higher levels of premature mortality and mental and physical ill health than the general population. Several sources show that of deaths that occur in hostels or while registered with homelessness services, the average age at death is low, about 40-44 years (Department of Health 2010).
- 6.25 Data has been collected on deaths among the patient population at the Clock Tower Surgery from 2008 - 2010. Data has been split to identify deaths of persons registered at some point with the Clock Tower Surgery between these dates and those who were registered with the surgery at the time of death:
- 42 deaths were recorded of persons registered at some point between 2008 and 2010 (of those 29 deaths were avoidable)
 - there were 26 recorded deaths among patients who were registered at the Clock Tower Surgery at time of death. Of these 23 or 88% were avoidable

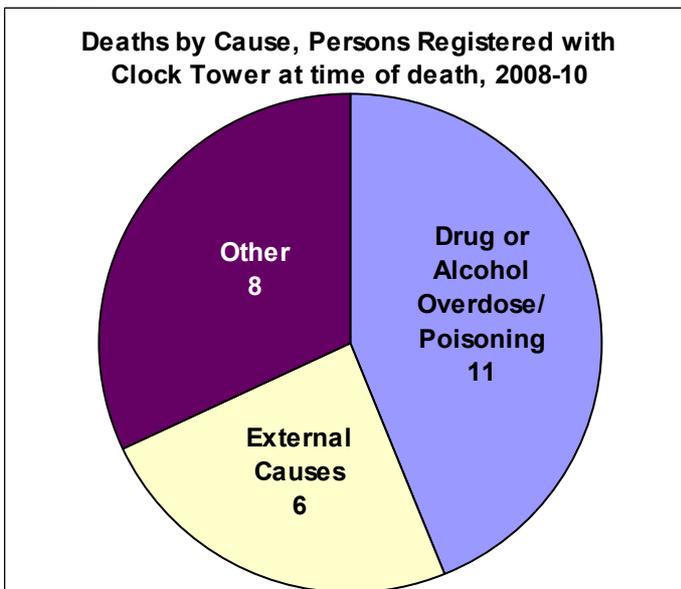
- of the 42 deaths recorded of persons registered at some point with the Clock Tower Surgery 30 were male and 12 were female. Of those 26 registered with the surgery at time of death 21 were men and 5 were women
- avoidable deaths include all deaths under 75 from conditions which are either preventable or amenable to health care interventions

Figure 14: Deaths by cause, persons registered at some point with Clock Tower Surgery 2008 – 2010



Source: NHS Devon Public Health Intelligence Team 2011

Figure 15: Deaths by cause, persons registered with Clock Tower Surgery, at time of death (2008)



Source: NHS Devon Public Health Intelligence Team 2011

6.26 The data shows that the average age of those who died (both mean and median) is roughly 43 years of age. Average life expectancy for the practice population is 62 years, which is almost 20 years lower than average life expectancy across Devon and over 25 years lower than the communities in Devon with the longest life expectancy.

- 6.27 The data shows a high level of avoidable deaths among this population. Contributory factors could be late diagnosis, poor retention in treatment due to the transitory and unsettled nature of some homeless people's lifestyles. In terms of causes of death, drug overdoses feature prominently as do external causes such as accidents, self harm and assaults, this again reflects the national data recorded by Griffiths (2003) that members of the homeless population are 4 times more likely to die from unnatural causes such as accidents, assaults, drug and alcohol poisoning etc and 35 times more likely to kill themselves than the general population.

Conclusion

- 6.28 Currently it would seem that an individual's accommodation status does not affect the access to primary care services. The Health Audit showed that most respondents were registered with a GP as a permanent patient. This may be because the majority are currently in some form of accommodation and receiving support from a service that encourages an individual to register with a GP.
- 6.29 There is also the Clock Tower Surgery in Exeter which provides permanent registration and easy access to both nurses and GP's.
- 6.30 There is also some indication that a smaller percentage of the population are heavy users of primary health care services; indicating a high level of health needs that require on going treatment.
- 6.31 The results from the health audit show that a high percentage of clients state that their support worker looks after their health and that on the whole they are living unhealthy lifestyles; high prevalence of smoking, poor nutrition and lack of exercise. Therefore services designed to promote healthy lifestyles could target this population by training support workers to deliver brief interventions and to offer advice on smoking cessation etc.

7. Epidemiology

- 7.1 **Disease prevalence amongst the homeless**
- 7.2 In the paper 'Single Homeless and Healthcare' (Department of Health 2010), they identify the most prevalent health problems among the population. These are listed in the table below.

Table 5: Disease prevalence among the homeless population

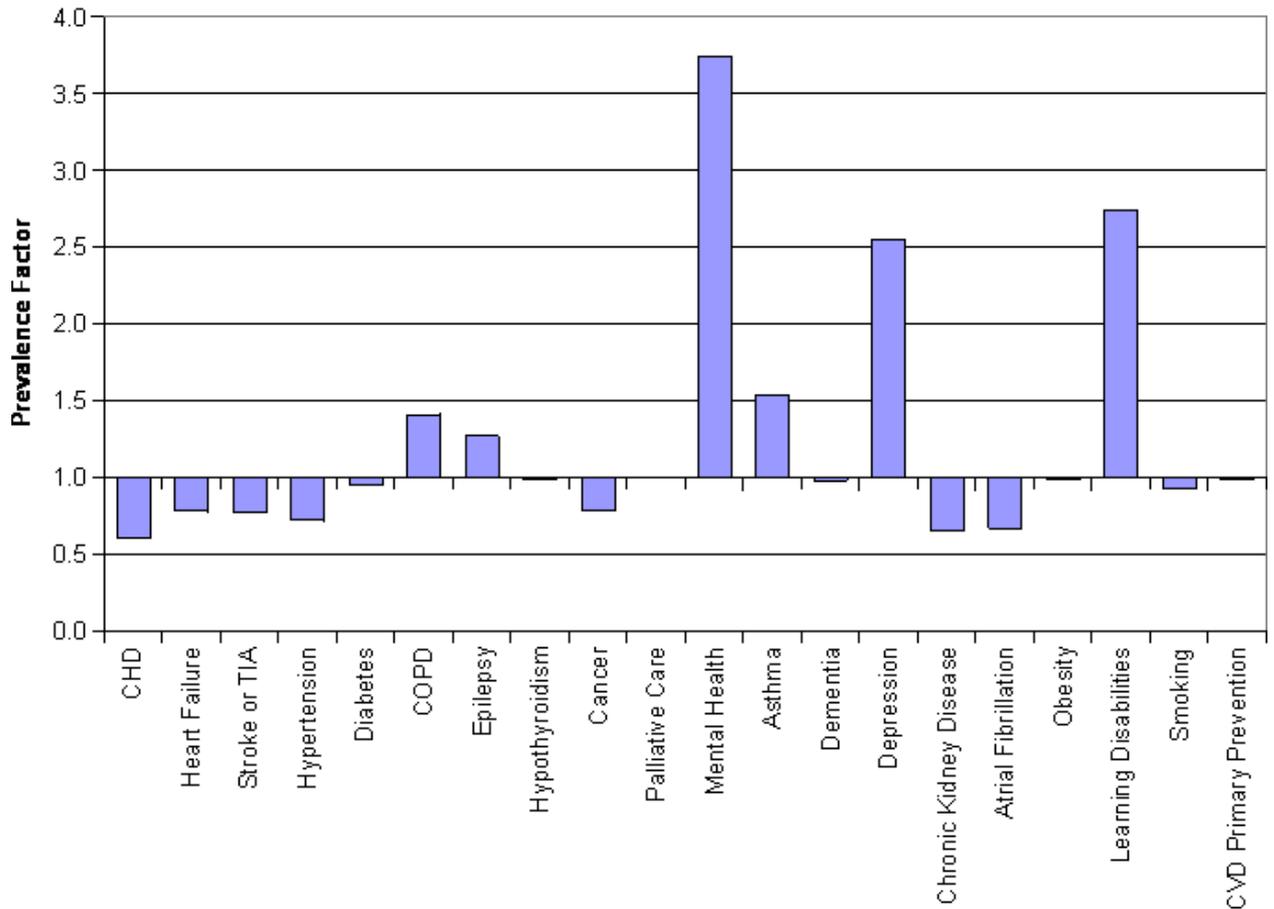
Condition	Details
Drug dependence syndrome	<ul style="list-style-type: none"> • most commonly heroin or cocaine
Alcohol dependence syndrome	
Mental ill-health:	<ul style="list-style-type: none"> • schizophrenia • depression and other affective disorders • psychosis • anxiety states • personality disorder • earlier onset of drug misuse • increased severity of alcohol use
Physical Trauma	<ul style="list-style-type: none"> • Injury • Foot trauma — due to walking for long times in inappropriate shoes, standing or sitting for long periods leading to venous stasis, oedema and infection, frost bite, skin anaesthesia due to alcoholic peripheral neuropathy, lack of hygiene due to over wearing of unwashed clothing, or overgrown toe nails • Dental caries due to self neglect
Adverse effects of illicit drugs	<ul style="list-style-type: none"> • Heroin-related death secondary to respiratory coma. Cocaine — case reports of toxic inhalation leading to pulmonary inflammation and oedema ('crack lung') agitation and paranoia due to acute toxicity and thromboembolic events. Adverse effects of alcohol overuse • Cardiological — cardiomyopathy • Neurological — peripheral neuropathy, erectile dysfunction, Wernicke's encephalopathy, Korsakoff's psychosis, amnesic syndrome, cerebellar degeneration, alcohol withdrawal seizures • Gastrointestinal and hepatobiliary — hepatitis, liver cirrhosis, pancreatitis, gastritis, peptic ulceration, oesophageal varices, carcinoma of the oesophagus and oropharynx, cardiomyopathy • Metabolic — vitamin deficiency (particularly thiamine), obesity • Psychosocial ill-health — including depression and suicide, sexual dysfunction, alcoholic hallucinosis, marital, family or employment breakdown
Complications of injecting illicit drugs	<ul style="list-style-type: none"> • Blood-borne virus infections (see below) • Skin commensals or pathogens causing septicaemia, encephalitis, endocarditis, cellulitis and abscesses or deep vein thrombosis (a combination of poor hygiene and repeated skin puncture) • Tetanus — possibly secondary to injecting contaminated drugs
Infections	<ul style="list-style-type: none"> • Blood-borne virus — hepatitis B,C or HIV • Hepatitis A • Skin infections — cutaneous diphtheria impetigo, viral warts • Secondary to louse infestations — typhus (caused by Rickettsia prowazekii), trench fever (caused by Bartonella Quintana) or relapsing fever (caused by Borrelia recurrentis) • Fungal — most commonly tinea
Inflammatory skin conditions	<ul style="list-style-type: none"> • Erythromelalgia • Pediculosis • Seborrhoeic dermatitis • Acne rosacea • Eczematoid eruptions • Xerosis • Pruritus
Skin infestations	<ul style="list-style-type: none"> • Body louse • Scabies
Respiratory illness	<ul style="list-style-type: none"> • Pneumonia — common pathogens Streptococcus pneumoniae, Haemophilus influenza b, aspiration of anaerobes or Pneumocystis carinii (the latter occurring almost exclusively in immunocompromised patients). • Influenza • Minor upper respiratory infections • Tuberculosis (often latent)

Source: Department of Health 2010

Figure 16: Clock Tower Surgery disease prevalence

Disease Prevalence Factors, Clock Tower Surgery, 2009/10

1 = average, lower scores are below average, higher scores are above average



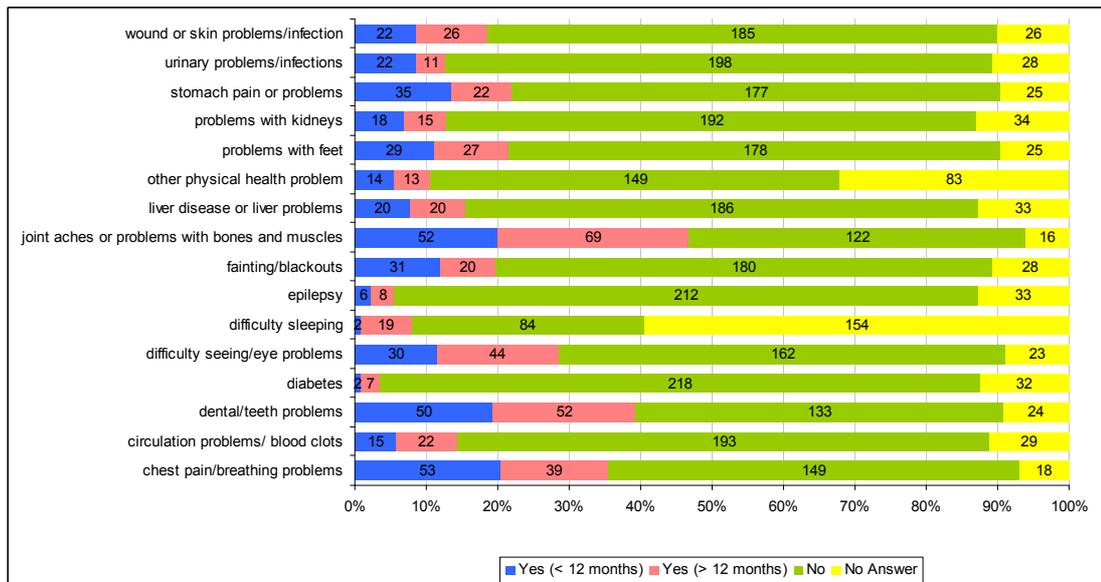
Source: NHS Devon Public Health Intelligence Team 2011

- 7.3 The data from the Clock Tower Surgery shows a high prevalence of mental health problems among the patient population, however data was not available around the type of problem, (apart from depression which is recorded separately) or whether the patient receives specialist support.
- 7.4 The data also records a higher than average level of Learning Disability. Historically it has been very difficult to get Adult Social Care to work with a homeless person with learning difficulties. This data is useful as it shows that there is a need for Adult Social Services to provide support to the homeless population.
- 7.5 The data here may show some inaccuracies with recording; smoking prevalence is shown as below average, whilst other data from the surgery shows smoking prevalence to be almost 3 times the average for Devon. High rates of Asthma and COPD (especially in such a young population) may also indicate a high smoking prevalence. Other factors leading to respiratory problems such as excess cold and damp, (from rough sleeping or living in sub standard accommodation), or drug use also have to be considered.

Expressed health needs

- 7.6 For the purpose of the Health Audit health needs were broken up into physical health, mental health, drug and alcohol use. Below are the responses around physical health problems. Note that no specific disease or conditions were mentioned, rather conditions, this was to make it easier for the respondent to answer.

Figure 17: Reported physical health needs of respondents



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

- 7.7 The responses were quite low to this question. This could be that physical health needs are not viewed as important by the client population, or that certain health conditions are 'a way of life' such as a cough. Or aches and pains.
- 7.8 Ninety two respondents did report respiratory problems, this could be due to a combination of environmental factors and smoking, or possibly even an indication of more serious health problems such as tuberculosis which has a higher prevalence among this population.
- 7.9 One hundred and twenty one respondents reported muscular or skeletal problems, again their lifestyle could contribute towards this; sleeping on hard surfaces, carrying heavy bags, lack of exercise.

Mental Health

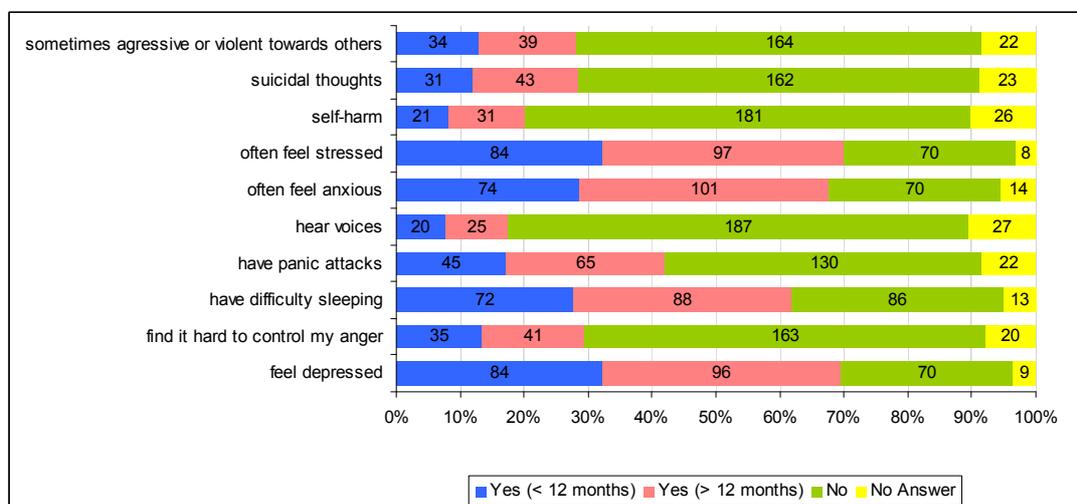
- 7.10 There is a high level of expressed need amongst the homeless population around Mental Health and Wellbeing which arguably can be both a cause and consequence of homelessness. In a study of homeless people (North 1998) it was found that the signs of mental illness antedated their first loss of accommodation in 98% of the sample.
- 7.11 The last comprehensive study in the UK (Gill et al 1996) included the following key findings:
- psychosis in 8% of hostel residents, compared with 0.4% of the general population

- neurotic disorders in 38% of hostel residents compared with 16% of the general population
- 7.12 Psychiatric disorders often go un diagnosed or untreated due to the chaotic and transient lifestyle of the population and because often poor mental health is just one problem amongst a range of other complex issues such as substance misuse or more psychological disorders that can act as a barrier to treatment.
- 7.13 The homelessness charity St Mungo’s carried out peer research (Happiness Matters 2008) and found that 76% of interviewees who lived on the streets had some form of Mental Health problem, either diagnosed by a doctor (65%) or self identified (11%). A Client Needs Survey of their hostel clients found that 69% had a mental health problem and 61% had both a mental health and substance misuse problem.
- 7.14 The London CHAIN (a database recording all people found rough sleeping in London) recorded that of a third of those assessed had mental health problems, however this figure is felt to be an underestimate.
- 7.15 Homeless Links SNAP survey (2009) found that 43% of clients in an ‘average’ homeless project have mental health needs and 59% have multiple needs.

‘Arguably everyone who is homeless has a mental health problem by virtue of his or her homelessness.’ (David Houghton Specialist Nurse – Down and Out St Mungo’s 2008)

- 7.16 The Bradley Review (2009) noted that a high proportion of those in custody have mental health problems; 72% of male and 70% of female prisoners have two or more mental health problems. As many of 66% of them have a personality disorder compared to 5.3% in the general population. Of those with mental health problems 43% have no fixed abode upon the day of their release; 8% of men and 10% of women are homeless when they enter custody, so there is a suggestion that these prisoners are part of the homeless population. (Bradley 2009)

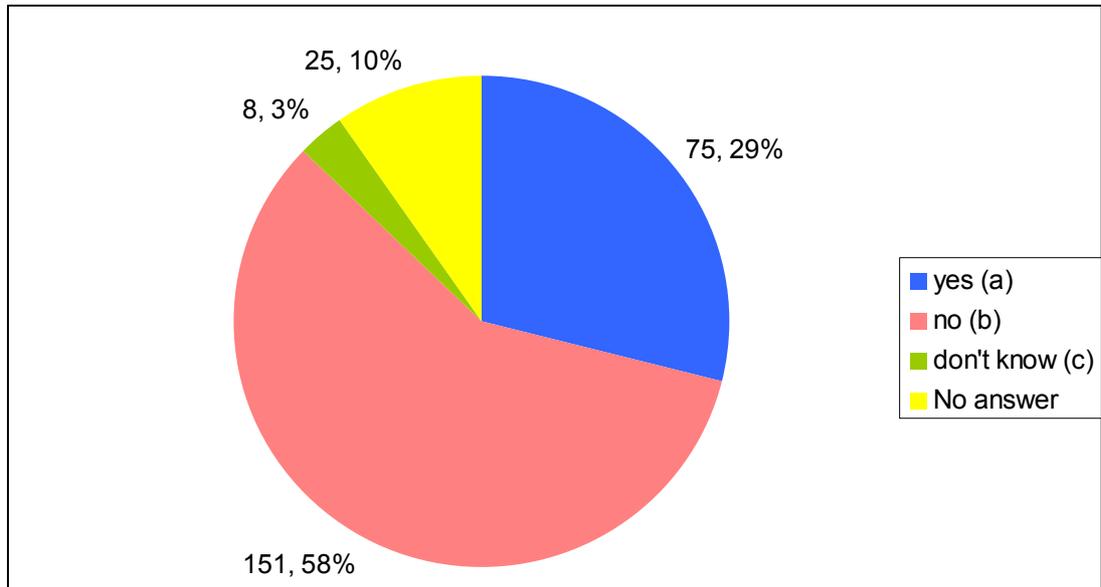
Figure 18: Expressed mental health need



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

7.17 The results demonstrate a high level of anxiety and depression among those surveyed. This could be seen to support the assertion made that all homeless people suffer from mental health problems due to their rooflessness; lack of decent housing can cause as well as exacerbate conditions such as anxiety, depression and stress.

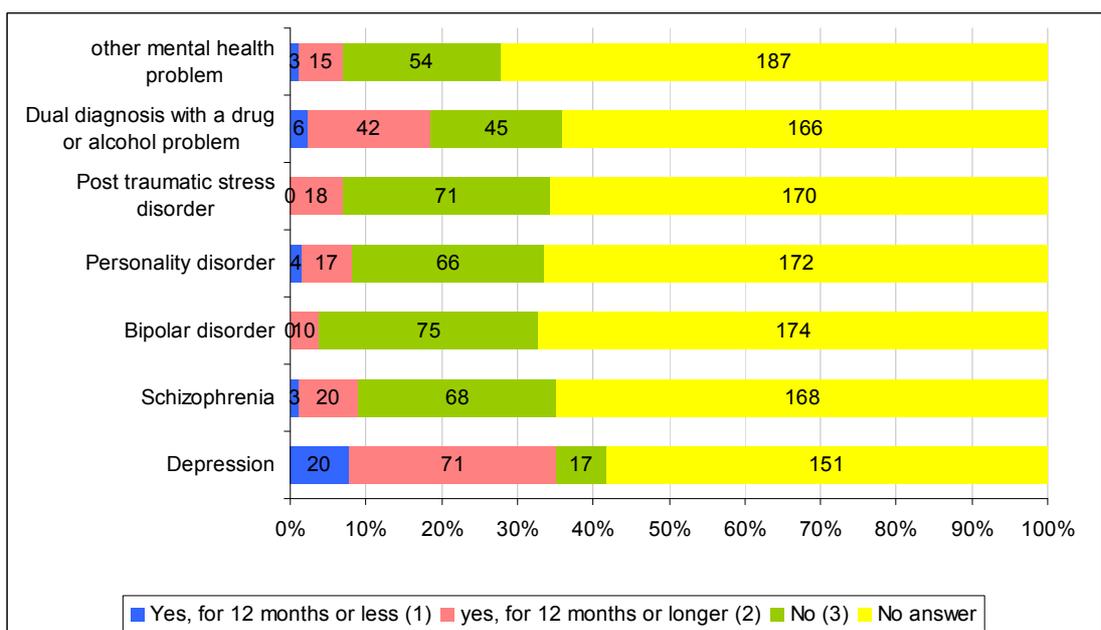
Figure 19: Do you have a mental health condition that has been diagnosed by a doctor or other health professional



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

7.18 One hundred and eighteen respondents had been diagnosed by a doctor or other health professional. Figure 25 shows the diagnosis and how long the person has had the condition.

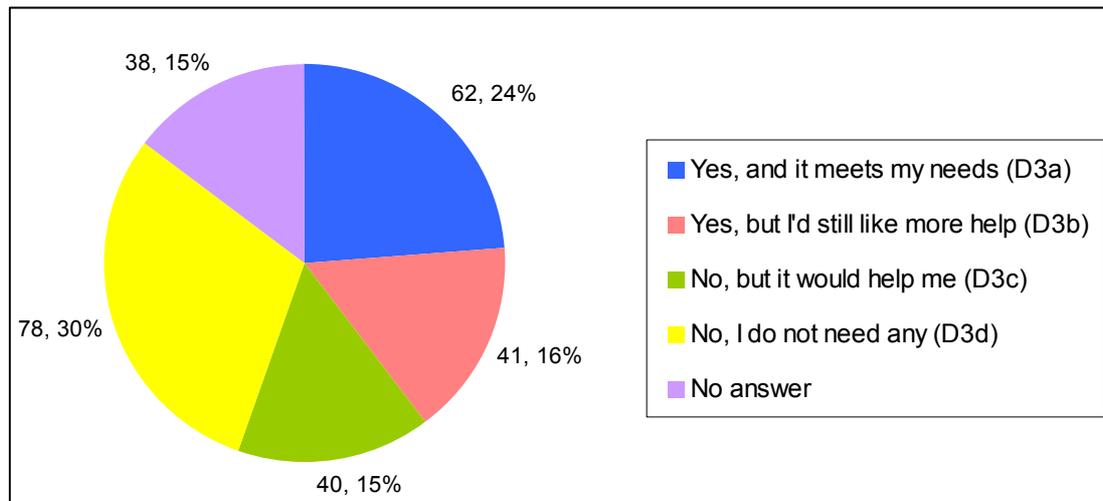
Figure 20: Diagnosis by a doctor or other health professional



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

- 7.19 The responses show that most of the respondents had their condition for over 12 months.
- 7.20 The range of responses show that there are significant numbers of the survey who suffer from a severe and enduring mental health problem.
- 7.21 Anecdotally both homeless individuals and services will state that it is difficult for people to access support for their mental health problems. The health audit asked whether people got support and if it met their needs. There were further questions asking about the type of support they receive and what type of support they would like to receive.

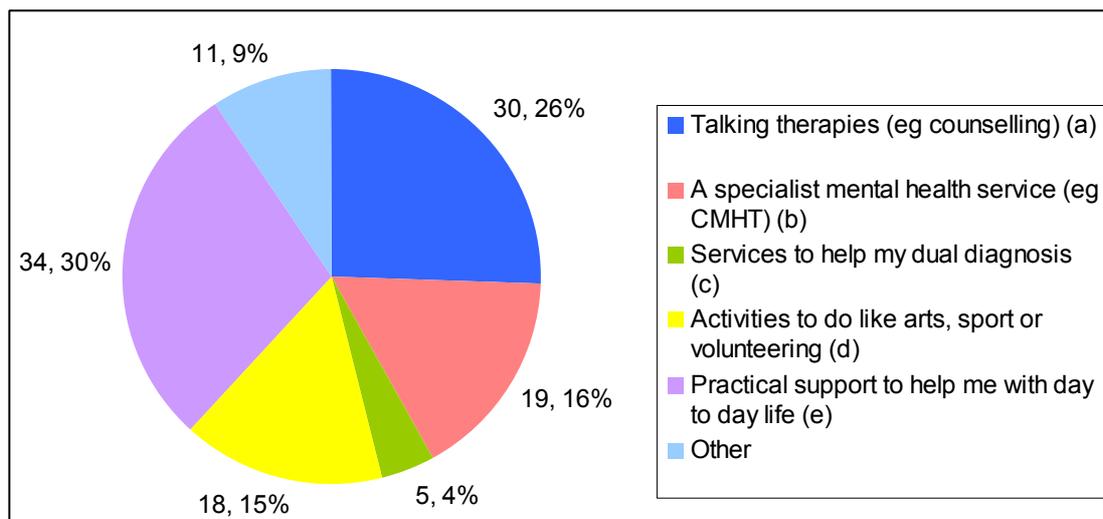
Figure 21: Do you get any support for your mental health problem?



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

- 7.22 The survey shows that only a small percentage of those surveyed felt that the support they got actually met their needs.

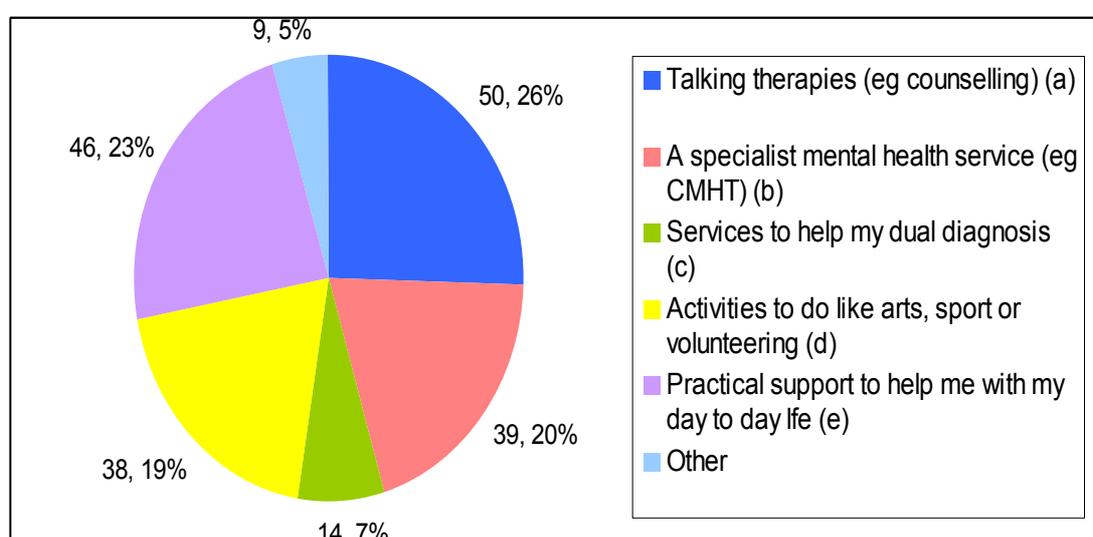
Figure 22: What kind of support helps you?



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

- 7.23 A lot of respondents felt that practical help was useful. This would be provided by a non health professional possibly a housing support worker. Again this shows that housing support plays a vital role in the recovery process, but workers need the support of health professionals to do their job effectively and prevent burn out.
- 7.24 Despite the high levels of expressed and diagnosed mental health problems highlighted in the Health Audit, only 39.77% were getting any support for their mental health condition. Of those 15.83% stated that they got some support but needed more help. 15.44% stated that they received no support for their condition, but felt that it would help them. Talking therapies were viewed as being the most helpful intervention, with practical support to assist with day to day life as second.

Figure 23: Which kind of support would help you?



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

- 7.25 Practical help and activities rated highly among the respondents demonstrating the need for more holistic services for this client group.

The numbers of people with mental health problems accessing ‘Supporting People’ services

- 7.26 Supporting People had until 2010 separate clients groups; Mental Health and Homelessness. Crudely clients with mental health as their primary need would get a service that was under the Mental Health grouping and those who were actually homeless but had mental health as a secondary need were recorded under homelessness.
- 7.27 The Accommodation and Support JSNA for Mental Health (Bennett 2010) shows that in 2007/8 there were 16,080 people in contact with mental health services in Devon. Adult Community Services data shows that during the same period 3,047 people with mental health problems were helped to live at home.

‘It is important to point out that there is an overlap between homelessness and mental health, as a significant proportion of people who are homeless also have mental health problems. This JSNA includes some data on those who are homeless with mental health problems, but there is a larger group

who are living in temporary accommodation, and have mental problems, on which only a limited amount of data is available.’ (Bennett 2010).

- 7.28 During 2008/09, 370 people with mental health problems accessed supporting people services, prior to receiving support services most clients were living independently; 32% in social housing, 32% in private rented accommodation and 6% were owner occupiers. 12% were in temporary or supported accommodation and 9% were leaving hospital or residential care. This data would suggest that although there was arguably prevention of homelessness very few were actually homeless at the time of referral. The Homelessness JSNA identifies that 1,697 people accessed services from what is now called ‘Social Inclusion and Recovery Services’. Of those 227 people had mental health as their secondary issue (homelessness being the first). There were also a further 71 clients who were homeless but their primary need was defined as mental health.

Conclusion

- 7.29 The local data is broadly in line with the findings from national research, which shows a disproportionate level of mental health problems among the homeless population. Evidence from the Health Audit shows that people do not feel that they get enough support to help them, but the help they would like does not necessarily need to be provided by a health professional. A lot of support provided by non health professionals such as housing support workers needs to be recognised and Mental Health services potentially have a role in supporting generic workers by offering clinical supervision and training.

Recommendations

- more support from mental health services to front line workers including training and supervision
- more holistic support packages for the individual which assists them with the practicalities of day to day life
- better access to a range of therapies including talking therapies
- mental health services to look at the possibility of providing a range of interventions in non medicalised institutionalised settings, such as homeless day centres and hostels

Dual diagnosis

- 7.30 It is well documented that there is a strong co-morbidity between mental health and substance misuse amongst this population. The London Chain (2009) found 41% of people rough sleeping had a drug problem, 49% had an alcohol problem, 35% had a mental health problem and 25% had all three. Research shows that often substance misuse is largely secondary to mental health and often used as a form of self-medication to cope with their mental health problems and life on the streets. (Klee 1999, St. Mungo’s 2008, Fountain and Howes 2003). There still remains a barrier to services for clients with a dual diagnosis.

“Dual diagnosis” can suggest that there are only two problems. In fact many people have multiple needs. These might include one or more medical problems and a range of social issues such as housing, income, employment

and social isolation. In practice, people are usually only given a formal diagnosis of “dual diagnosis” if they have severe mental health problems (generally psychotic disorders) and severe substance misuse problems eg that meet the criteria for specialist services. The issue then arises of how to access appropriate care for people whose problems, whilst distressing, are not considered “serious” enough to meet the threshold for specialist care and support’. (Devon and Torbay Dual Diagnosis Strategy 200?)

- 7.31 Even those with a psychiatric diagnosis can be refused treatment or an assessment because of their substance misuse. Often mental health services will require a person to have been detoxified before they will assess their mental health, whilst the treatment agencies will often be reluctant to offer treatment until the individual’s mental health has been addressed, especially if they exhibit high risk behaviours.
- 7.32 Treatment services often like to see a degree of commitment or motivation by the client, this may include cutting down on their substance and attending appointments. Arguably these requirements can provide a barrier to support as the rigours to living on the street make either difficult to achieve.
- 7.33 Only 48 respondents in the Health Audit stated that they had a dual diagnosis (18.54%) although this is nearly a fifth of the total survey and 16.22% stated that they had experienced the condition for over 12 months. However 42.86% of those surveyed stated that they used drugs or alcohol to help them cope with their mental health.

Psychological problems/complex trauma

- 7.34 A survey in 2008 by a clinical psychologist (St Mungo’s 2009) found that 85% of St Mungos clients had a personality disorder; around 40% with an anxiety disorder; around 25% with a depressive disorder and or Post Traumatic Stress Disorder (PTSD), He noted that all had some form of substance misuse problems and were characterised by 'avoidant' engagement patterns.
- 7.35 The term complex trauma can be understood as the behaviour observed in people with personality disorder that can be described as reactions to and ways of coping with the traumatic experience of difficult childhoods. It may, therefore be more useful to describe personality disorders as ‘Complex Trauma’; a reaction to an ongoing and sustained traumatic experience (Maguire 2010).
- 7.36 The prevalence of personality disorders in the general population varies according to the way it is measured, but it is generally acknowledged that around 10 percent may reach diagnostic levels. However, it is estimated that this rate rises to 60 per cent of adults living in hostels in England. Rough sleepers and young people who have experienced homelessness generally experience higher rates of mental health problems than the general population.
- 7.37 These are people who, with a few exceptions, will not be accessing mainstream mental health services and they can present challenges to which conventional mental health services have not on the whole responded well.

- 7.38 In some cases, primary health care may be engaged, though good practice here is far from universal. The term 'complex trauma' does not seek to convey a medical diagnosis, but rather a set of experiences which may underpin emotional, cognitive and behavioural patterns seen in adulthood.
<http://www.nmhd.org.uk/silo/files/meeting-the-psychological-and-emotional-needs-of-people-who-are-homeless.pdf>

Adult autistic spectrum disorders

- 7.39 In 2009 Exeter City Council and North Devon District Council were awarded £35,000 from central government to pilot individualised budgets with long – term rough sleepers. In North Devon it was decided to work with 4 individuals who had been found in the Spring street count. In Exeter 10 clients were selected that had been known to services for a number of years and who had either not engaged with services or those for whom there had not been a solution found to assist them off the streets. The pilot ran for 9 months and was then evaluated by a psychiatrist. He interviewed 12 of the 14 participants, interviewed workers and had access to case notes. He then ascertained that 7 of the individuals were displaying behaviours along the Adult Autistic Spectrum, 3 of whom had a diagnosis of Aspergers and none of whom were receiving any support to manage this condition.
- 7.40 These conditions are difficult to diagnose in adults and often people are misdiagnosed. It could be argued that a lack of diagnosis and awareness of these 'disorders' could lead to and exacerbate an individuals homelessness; clients labelled hard to engage may simply find any social interaction challenging.
- 7.41 Some research has been done into the links between Aspergers in adults and alcohol misuse (Sarah Hendrickx 2008), but very little research has been done into the levels of Aspergers amongst the homeless population.

Learning difficulties

- 7.42 A common factor amongst the homelessness population is a range of learning difficulties, including dyslexia, poor literacy and numeracy skills and low IQ. As with most other conditions, often their IQ is just above 70 which is the threshold for support from adult social services. A client with Learning Difficulties is extremely vulnerable to exploitation and robbery by other homeless people.

Conclusion – complex needs

- 7.43 It is clear from national and local data that the homeless population experience a wide range of mental health problems. These problems are often undiagnosed, behaviour is misinterpreted and vulnerable people are left to cope in the harsh environments of the streets, night shelters and hostels, which can often exacerbate their mental ill health. It is frequently too easy to exclude this population from services set up to support those with a mental health problem. These services including psychological therapies are often over subscribed, so thresholds are raised. Despite recognition of Dual Diagnosis, people using substances, including alcohol are often denied support for their mental health. Referral pathways can prove prohibitive for rough sleepers with chaotic lifestyles who struggle to keep appointments or are unwilling to attend appointments based in a large institution. Too often those in the homeless population's needs are too easily dismissed as they are

viewed to have made the choices that have led to their situation and display little motivation to change.

'Homelessness is understood to be a symptom of people suffering from complex needs that at first sight might appear 'self-harming'. Nonetheless, based upon these in-depth interviews, for some it appears to be their method of coping with the inner psychological turbulence, as those along the autistic – mentally ill spectrum find it easier to be on the streets than dealing with day-to-day life. Many explained that they had become accustomed to homelessness and, in a sense, can exercise a degree of control because it is what they know. This becomes a form of defensive 'Institutionalisation without Walls'. The effect is a form of social exclusion, not really 'chosen' as such, but an alternative to dealing with life and which results in a degree of 'social ostracism'. Thus it is easy to view the circumstances of the rough sleeper as "their choice - their fault" resulting in a public perception of 'undeserving' as opposed to 'deserving' (poor) people. This is especially so in the case of those with chronic alcohol difficulties, who appear so unprepossessing to the general public and, perhaps, professionals? Yet it appears that the majority of them, even if we exclude those with alcohol dependence, are mainly people with mental health problems who have fallen outside the care of the community.' (Pritchard 2010)

Recommendations

- 7.44 Assertive and proactive outreach can be an effective way of starting to engage people who have a range of complex mental health problems. The initial stage can take a while to enable the workers to begin establishing a trusting relationship with the client that has clear boundaries and objectives. Other pilots working with rough sleepers have also demonstrated the effectiveness of using more person centred approaches and Multi Agency panels that the client attends. It is also important for the client to be supported to enable them to be part of any support plan or care plan that is drawn up for them, that they are instrumental in their recovery, rather than having things done for them.

Substance misuse including alcohol

- 7.45 There are strong links between substance misuse and homelessness. Drug users are seven times more likely to be homeless than the general population and research suggests that two-thirds of individuals report increasing problem substance misuse after becoming homeless. Homeless people using drugs may face a range of problems in accessing appropriate support to address their problems with drugs. A report (Health Protection Agency 2008) into injecting behaviours amongst drug users reported these key findings listed below:

- 75% of Injecting Drug users (IDU's) have experienced homelessness
- 50% of IDU's reported an episode of homelessness in the past 12 months
- one in four of those who had been homeless in the last 12 months reported direct sharing of needles and syringes in the past 12 months compared with one in six of those who had not been homeless
- there is a higher rate of Hepatitis C infection amongst homeless IDU's

- homeless IDU's are more likely to report an abscess/open sore/wound at injecting site
- during periods of homelessness injectors are likely to find it harder to maintain hygienic injection practices as a result of having to inject in public places, or have difficulty in storing injecting equipment somewhere clean
- hostels and other services for the homeless have an important role to play in reducing the increased harms for homeless, injecting drug users

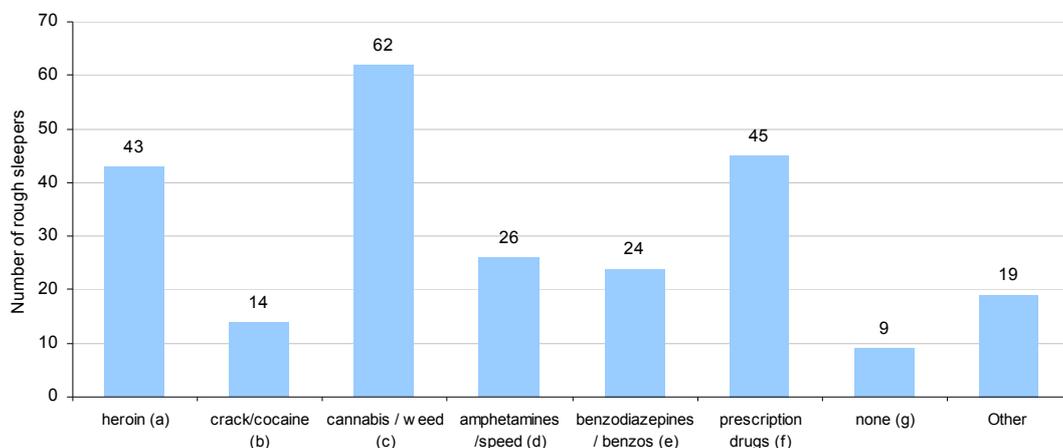
7.46 There is a comparatively small but persistent group of alcohol using rough sleepers who maintain high levels of alcohol use and have endured long and sustained periods of rough sleeping. Evidence also shows that drinkers who live in supported accommodated or are vulnerably housed often drink on the street with other drinkers forming 'drinking schools'. They can spend the majority of the day intoxicated, which can cause concerns to the general public. They are also more likely to suffer from falls or incontinence and be frequent visitors to A&E departments. This group are also likely to have other issues such as untreated mental health problems for which they are using alcohol to self medicate.

7.47 A report into homelessness and substance misuse in London interviewed 389 all of whom had been rough sleeping for a minimum of 6 nights in the previous 6 months. Respondents were 81% male, 83% white and 73% under 35. 54% had become homeless before the age of 18 and almost half the sample had been continually homeless since then. Two thirds of the sample cited drug and alcohol use as the reason for first becoming homeless; 63% drug and/ or alcohol use, 36% alcohol use and 50% drug use.

7.48 When asked about the types of drugs used the picture was one of poly drug use including alcohol. 47% of respondents had used both heroin and crack cocaine in the past month and 73% had used cannabis in the past 12 months. Only 4% of respondents reported using no drugs or alcohol in the previous month (see Appendix 2 for breakdown)

7.49 The Health Audit asked a series of questions around drug use.

Figure 24: What drugs have you used in the past month?



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

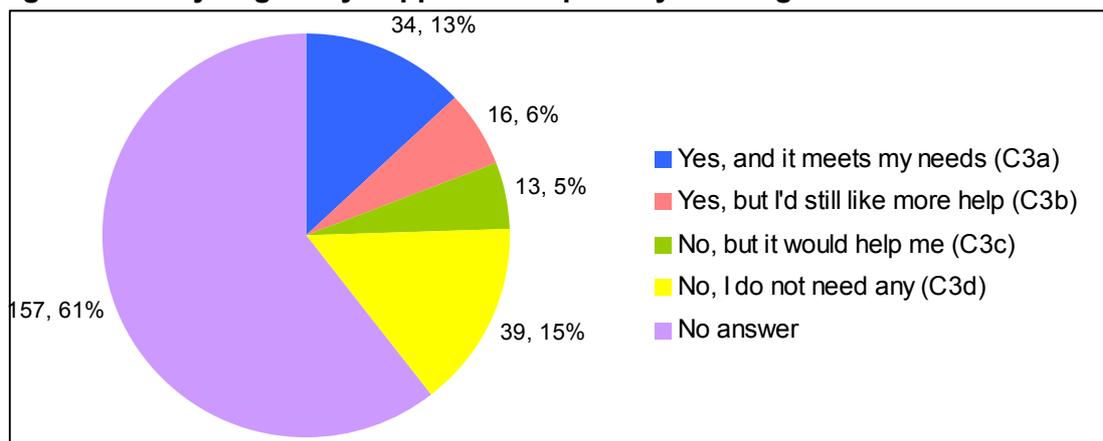
7.50 The Health Audit data shows that 112 people either take drugs or are recovering from a drug problem this is 43.24% of the total respondents. Like the national data, the survey indicates a picture of poly drug use.

7.51 Only 31 respondents stated that they were taking Methadone, three stated that they were using it illicitly. There was also a low recording of injecting drug users with only 27 respondents stating that they currently injected drugs, of those five admitted to sharing injecting equipment with others; three sometimes and two usually, most of them were aware of a needle exchange service that they could use but two were not aware, 20 of the injecting drug users also stated that they knew where to access advice or training on safer injecting.

7.52 Fifty respondents stated that they received support to help them address their drug use, but they were not asked to specify what sort of support they were receiving. Of those receiving support 16 (6.18%) said that they would like more help. 13 respondents (5.02%) stated that they were not getting any help but would like some.

Access to support for drug use

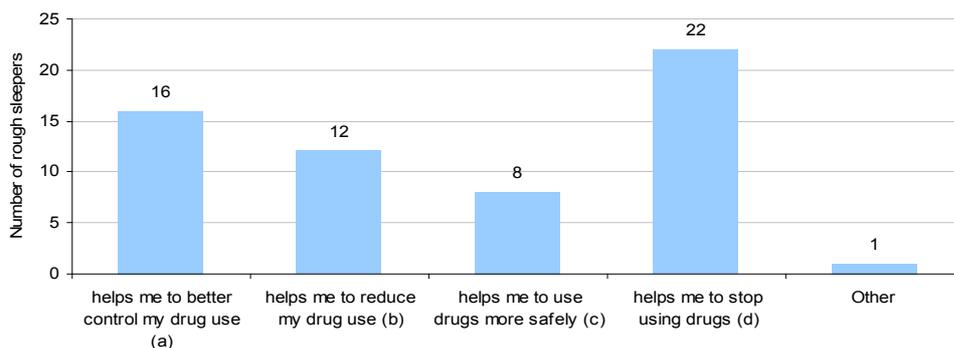
Figure 25: Do you get any support to help with your drug use?



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

7.53 Data shows that there is a poor take up of drug treatment among this population. This could be because their drug use is not considered problematic enough. The audit did not look at retention rates in treatment or ask how many times the person had tried to stop using drugs. These areas would need a separate piece of research to be carried out.

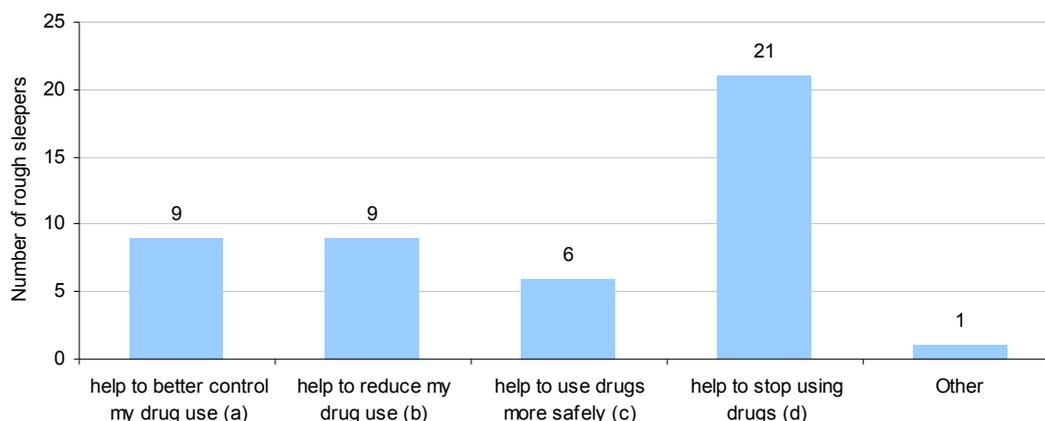
Figure 26: How does this support help you?



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

7.54 There is a link between being in settled accommodation and a successful treatment outcome therefore accommodation services have an important role to play in assisting an individual to address their drug problems. Meaningful occupation and access to training, volunteering or employment are also useful services and many of these are either provided by housing support providers or workers are able to signpost their clients to them.

Figure 27: What sort of help would you like?



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

7.55 Data from the Health Audit shows that those people currently not getting any support around their drug use wanted either interventions to reduce the harm around their use or to stop using drugs altogether

Snap shot from high support hostels

Gabriel House

7.56 The hostel accommodates 45 individuals; mainly males but also women as part of a couple. The snap shot, carried out in October 2008, showed that 22 residents were actively using heroin, of those 18 were injecting drug users and three were also using alcohol. Seven clients reported using amphetamine, all of them injecting. Five residents reported alcohol related health problems and 5 reported drug related health problems. It is also worth noting that only six residents were engaged in formal treatment (Tier 3).

Bridge Project

7.57 The Bridge project accommodates 14 male and females who have high support needs. There was a snap shot of need done in November 2008 which showed that 10 residents reported using drugs and one resident reported using alcohol. Six of the residents were receiving formal drug treatment which is 42% of residents compared with only 13% of residents at Gabriel House.

Esther Community

7.58 This hostel accommodates 15 women. In May 2009 as part of a rapid appraisal a snap shot of needs was done among the women resident at the time. This showed that:

- 10 of the 15 women reported using drugs

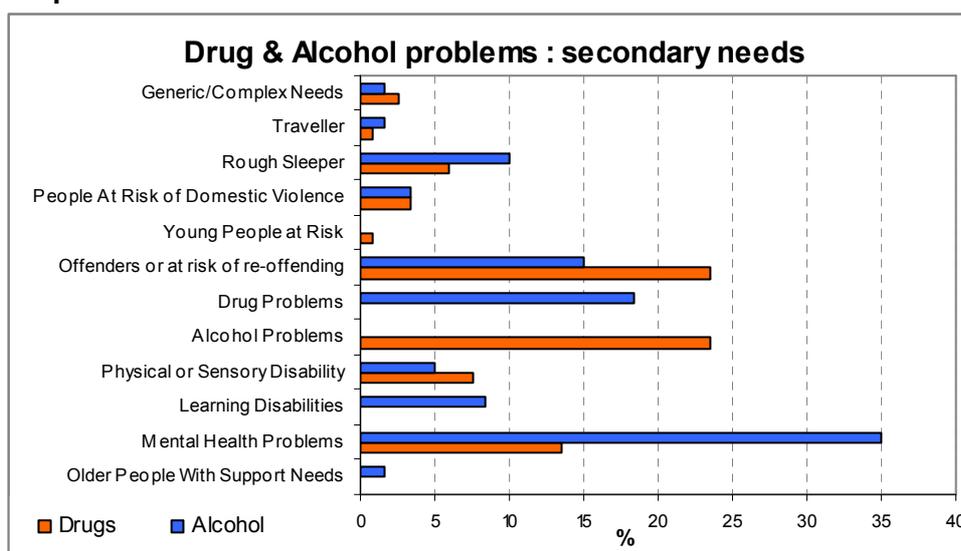
- eight women reported using alcohol
- 6 women reported using drugs and alcohol

7.59 The type of drugs used and routes of transmission were not recorded but the data shows that drug and alcohol use is high amongst the hostel population and considerably higher than among the general population. (See Appendix 2 for further breakdown of drug use in high support hostels).

Supporting People data

7.60 During 2009/10 a total of 315 people with drug problems and 257 people with alcohol problems accessed Supporting People services. Of these 119 people were identified as having a primary need related to drug problems and 60 people as having a primary need related to alcohol problems. The vast majority (91%) were host referrals with a local connection to Devon. The chart below provides an analysis of the needs of people with drug and alcohol problems.

Figure 28: Drug and alcohol use among people accessing Supporting People homeless services



Source: Bennett 2010

7.61 The data shows that many of those with drug problems also had alcohol and mental health problems and conversely those with alcohol problems also had drug and mental health problems. Of those whose primary need was identified as drug use 22% were part of a Drug Intervention Programme, while only 5% participated in such a programme whose primary need was alcohol use. Only one person was in receipt of Secondary Mental Health services, although 37 were identified as having mental health problems.

7.62 The data from HALO provides information on known drug cases who are either at risk of homelessness or who are of no fixed abode. For the year 2008/09 the data shows that of the 2,006 drug cases across Devon about 17% (342) experienced housing problems and about 9% (172) were of no fixed abode. Therefore there is large number of people with known drug problems who are at risk of homelessness and a significant number that are homeless.

7.63 Outside of these numbers there are those who do not engage with drug services, many of whom have complex needs and are homeless. The evidence from the recent rapid appraisal report shows that most homeless drug users, who are active, are not engaging in treatment. There is evidence of some engagement of drug treatment once people access housing and support services as a result of assertive and proactive 2 tier work. The Supporting People outcomes data shows that 62% of those with drug problems were able to manage their substance misuse issues as a result of the support provided.

Table 6: Drug dependence - broken down by age group

Age Group	No	%	No	%
0-4	0	0%	0	0%
5-16	0	0%	0	0%
17-24	12	22%	11	42%
25-34	84	49%	18	56%
35-44	104	53%	15	43%
45-54	36	31%	1	6%
55-64	2	6%	0	0%
65-74	0	0%	0	0%
75-84	0	0%	0	0%
85-89	0	0%	0	0%
90+	0	0%	0	0%

Source: Clock Tower Surgery (Feb 2009)

Total males	40%
Total females	37%
Both sexes	39%

7.64 There are high levels of drug dependence amongst the practice population. This would reinforce the national data about high levels of drug use amongst the rough sleeping/street homeless population. Most drug dependency is occurring amongst the 25 – 44 age group for both sexes although this data suggests that women are experiencing drug dependency earlier as 42% of the 17- 24 age group are dependent compared to 22% of the males in the same age group. Men appear to have more problems later in life, the data shows that 31% of males aged 45 – 54 are drug dependent compared to 6% of females in the same age group. Current data shows that of the Clock Tower population, 107 are currently receiving drug treatment (breakdown).

Alcohol dependence - broken down by age

Table 7: Alcohol dependence broken down by age:

Age Group	Males		Females	
	No	%	No	%
0-4	0	0%	0	0%
5-16	0	0%	0	0%
17-24	6	11%	2	8%
25-34	30	17%	7	22%
35-44	46	23%	8	23%
45-54	36	31%	9	50%
55-64	18	51%	1	33%
65-74	1	33%	0	0%
75-84	0	0%	0	0%
85-89	0	0%	0	0%
90+	0	0%	0	0%

Source: Clock Tower Surgery Feb 2009

Total males	23%
Total females	22%
Both sexes	23%

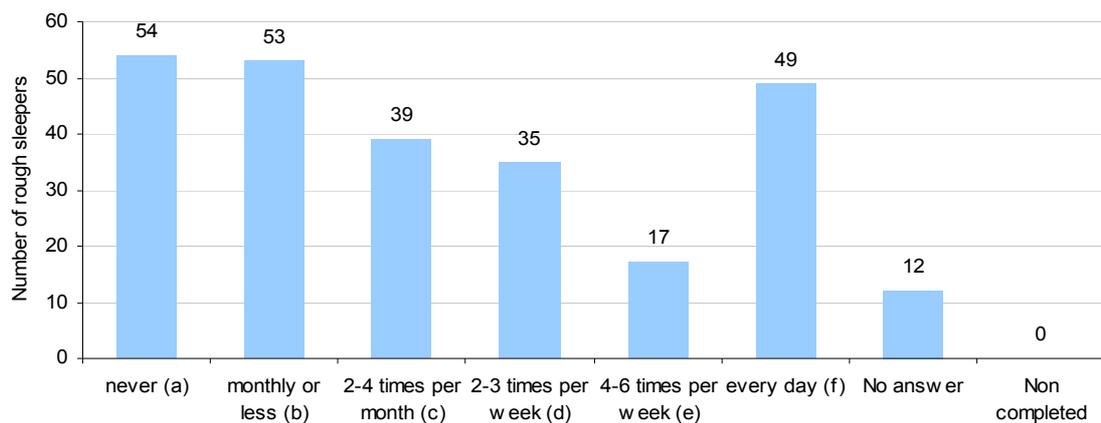
- 7.65 Figures show that just under a quarter of the practice population are alcohol dependent. There is not much disparity between men and women except 50% of women aged 45 – 55 were alcohol dependent compared to 31% of men in the same age group, these percentages then practically reverse in the 55- 64 age group. This may suggest that women address their alcohol dependency at a younger age.
- 7.66 A report by St Petrock's 'Shelter From The Storm: Identifying the needs of rough sleepers' (Taylor, Maguire 2010) focussed upon 11 males aged between 23 – 74 all of whom had been homeless for a time and identified as being well immersed in the rough sleeping/ drinking subculture. Traditionally this group are the most disenfranchised; their intoxication means that they are more likely to be excluded from services such as a day centre where they would receive basic support and an initial assessment. The report aimed to gain a better understanding of the characteristics of this group, to establish the links between hazardous/ dependent drinking and rough sleeping and to examine whether there had been 'critical' events in peoples lives that had led to their current situation. The report also set out to establish whether different types of intervention had been effective with this group and understanding what motivates change. The report is based upon in depth open- ended interviews with 11 respondents and a focus group of relevant professionals. The main findings of the report were:
- within the sample group a significant alcohol problem had mainly predated the transition to homelessness, but another crisis; significant relationship breakdown had been the trigger to a pattern of rough sleeping and drinking
 - alcohol use and the need to maintain this throughout the day was the 'central organising principle' for this sample, this can give us some understanding as to why addressing physical ailments may have a lower priority
 - alcohol was used as a holding mechanism; allowing feelings to be blocked, as a form of self – medication and blocking physical discomfort such as the cold
 - some of the respondents expressed a strong sense of ennui; a complete lack of capacity to envisage change, or they felt that they had been on the streets so long that they could not move into accommodation. Others ambivalence changed according to the time of year; there was a greater motivation to 'come indoors' during the winter months
- 7.67 The sample showed an ageing population, with just under half the sample aged between 42 – 52. In many cases chronological age and physical age were about 25 years adrift; a man of 40 having health problems consistent with a man in his 60's. Risks identified could be broadly characterised into:
- personal risk – being assaulted due to their rough sleeper status, especially at night or weekends in the city centre a number of the sample reported being kicked whilst sleeping, being beaten up, urinated on and had objects thrown at them
 - physical risks – including hypothermia, bronchitis, pneumonia, alcoholic withdrawals, seizures, constant colds and chest infections. There is also

the risk of liver damage associated with heavy drinking and poor nutrition due to poor eating habits

- mental wellbeing - one respondent reported having made at least 6 previous suicide attempts, linked to feelings of low self esteem and a lack of control exacerbated by an increase in alcohol use. Another respondent described being overcome with hopelessness

7.68 As part of the Health Audit, respondents were asked a range of questions about the use of alcohol.

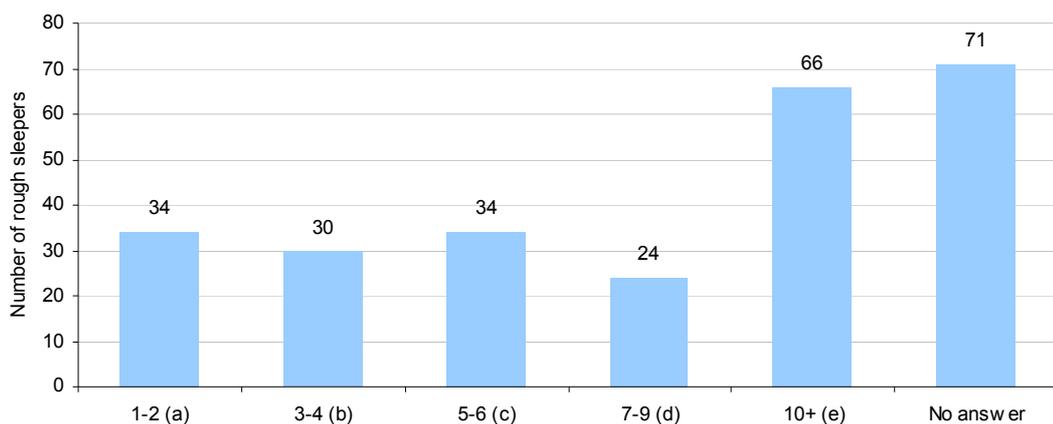
Figure 29: How many times do you drink alcohol?



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

Figure 30: How many units do you drink?

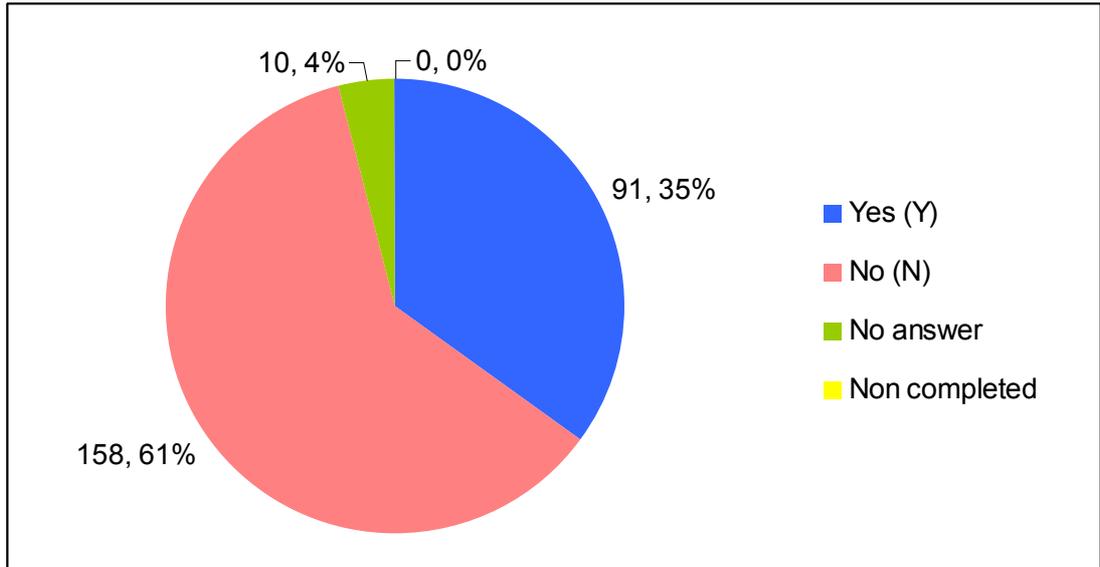
7.69 Forty nine respondents stated that they had a drink everyday which represents just under 20% of people surveyed.



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

7.70 The results for the data show high levels of drinking. Although the responses are not broken into male and female the data shows that most respondents are drinking over the recommended daily units.

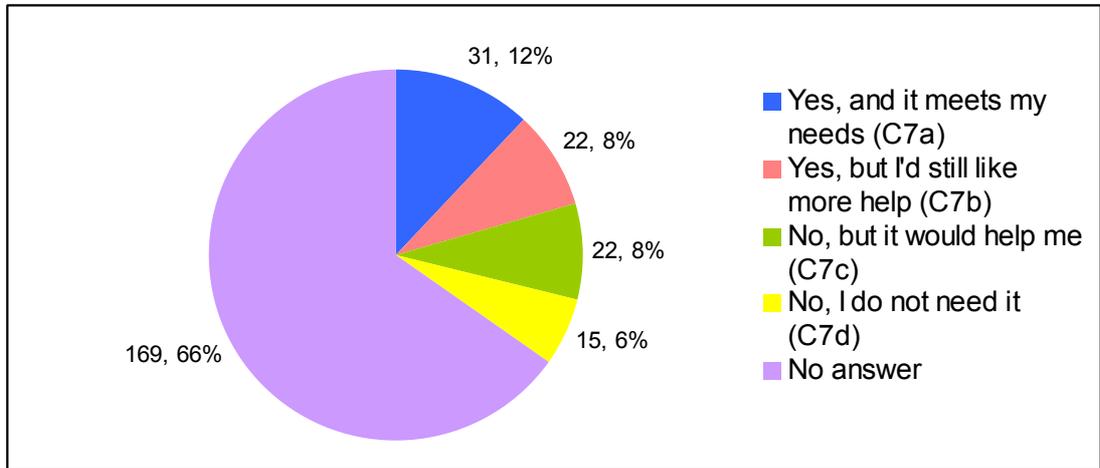
Figure 31: Do you have or are you recovering from an alcohol problem?



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

7.71 35.14% stated that they had or were recovering from an alcohol problem. Only a third of these respondents (11.97%) were getting support for their alcohol problem which met their needs; 8.49% felt that they needed more support and 8.49% stated that they were currently receiving no support but would like some.

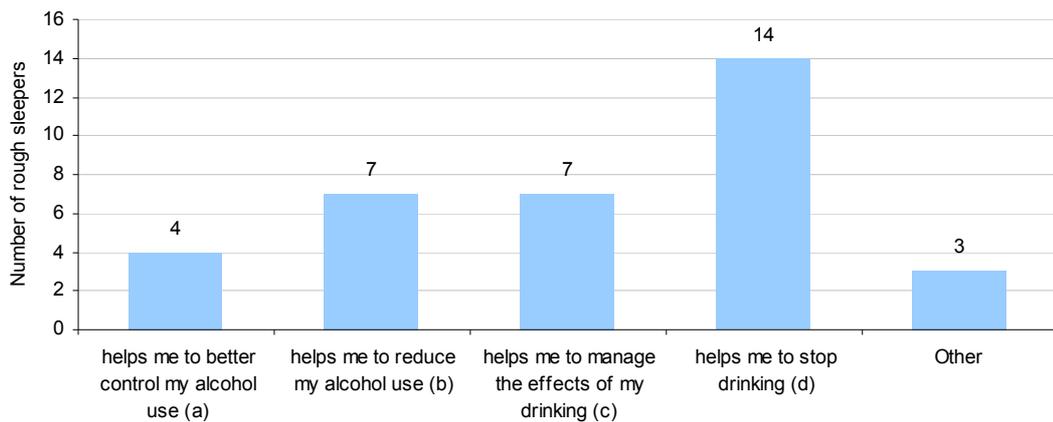
Figure 32: Do you get support to help with your drinking?



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

7.72 The data shows only a small percentage of those surveyed stating that they get support for their drinking which meets their needs. This may be a result of the low levels of funding which have gone into support services or that the services are not geared up to meeting the needs of this client group.

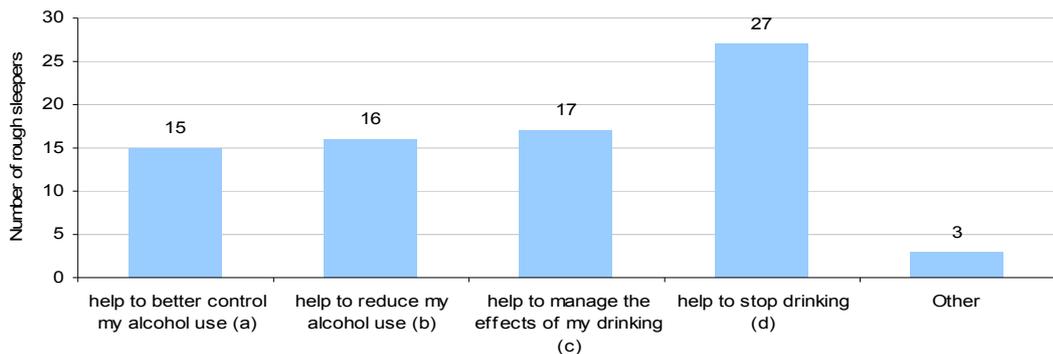
Figure 33: How does this support help you?



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

7.73 The Health Audit did not ask the respondents to specify the type of support that they receive but the results may indicate that some receive their support via Alcoholics Anonymous who run an abstinence based recovery programme.

Figure 34: What would you like help with?



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

7.74 The data shows that 27 clients who do not currently get support would like help to stop drinking whilst 48 would like advice on controlling and reducing their intake.

Conclusion

7.75 Access to alcohol services does need to be improved. This could simply be by educating support staff as to what services are available including Alcoholics Anonymous. Addaction do hold surgeries at the day centres in Barnstaple and Exeter but often the service is over prescribed and there is a waiting list.

Recommendations

7.76 There is a need for more proactive / opportunistic work in engaging street drinkers. There could be a variety of support offered from harm reduction to abstinence advice. More holistic support around diet is needed as indications are that heavy drinkers are more likely to suffer malnutrition and housing support staff could receive training around basic interventions.

Alcohol related harm

- 7.77 The levels of alcohol use amongst the homeless population would seem to suggest a high prevalence of alcohol related harm; from injuries caused by falls or accidents, violent attack and longer term harms such as liver damage or coronary heart disease.
- 7.78 There has been very little research carried out that examines the prevalence of alcohol related brain damage among the homeless population. One study that took place in Glasgow in 2003 found that from a sample of 266 hostel dwellers, 82% had cognitive impairment and 78% were drinking hazardously. The prevalence of alcohol related brain damage was 21%.
<http://eurpub.oxfordjournals.org/content/15/6/587.full>
- 7.79 Other specialist health care services in the country have done more research into alcohol detoxification and alcohol related harm. In particular the Luther Street Medical Practice in Oxford has looked at the prevalence of Wernicke's Encephalopathy, a condition caused by thiamine deficiency, that if left untreated can lead to Korsakoff's Syndrome.
http://www.addictionsearch.com/treatment_articles/article/alcoholism-and-vitamin-deficiency-treatment-and-recovery_62.html
- 7.80 There is evidence on post mortem of Wernicke's Encephalopathy in about 2% of the population and 12.5% of dependent drinkers. It can be fatal in 17 – 20% of all cases and 85% of survivors go on to develop Korsakoff psychosis, a quarter of which will require long term residential care.
- 7.81 Thiamine is a co-enzyme that aids with metabolism, in particular, breaking down sugars. It is only possible to absorb 4.5mg a day. Malnutrition reduces absorption by 70%, alcohol reduces absorption by 50%. Therefore there could be a high prevalence of Wernicke's Encephalopathy amongst the homeless population, especially if the information collected around diet is valid.

Recommendation

- 7.82 Wernicke's Encephalopathy is relatively easy to spot in an individual, symptoms include reduced or abnormal eye movement, confusion or agitation and a 'staggering' gait'. Workers in the homelessness field working with clients who drink, could receive training to identify the signs and then assist their clients in going to see their GP. Luther Street surgery have prescribed high doses of Thiamine as a preventative measure (50mg, 3 – 4 times daily) and also check for Wernicke's as part of the home detox service that they offer. Investment in prevention and early diagnosis could reduce the numbers of people needing specialist residential care.
- 7.83 More research needs to be done as to the prevalence of Wernicke's Encephalopathy amongst the homeless population and more awareness of the condition amongst the population, support workers and health workers

Communicable diseases

Hepatitis C

- 7.84 The virus was first identified in 1989 and since then has rapidly emerged as a significant Public Health problem. It is often described as a hidden epidemic as often symptoms do not occur at the time of infection and may not appear for some time. It has been described as a 'timebomb'.

- 7.85 Estimates suggest that the disease will cost the NHS up to £8 billion over the next 30 years, due to people suffering liver failure, cirrhosis and liver cancer. Hepatitis C accounts for 40% of cases of end-stage cirrhosis, 60% of hepatocellular carcinoma and 30% of liver transplants in the industrialised world.
- 7.86 World Health Organisation has declared HCV a global public health problem with an estimated 170 million people infected worldwide.
- 7.87 Major routes of transmission are transfusion of unscreened blood and blood products, use of inadequately sterilised or contaminated instruments and needle sharing, Some reports state that 90% of Hepatitis C infections are related to Intravenous Drug Use.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4059510.pdf
- 7.88 The UK is classed as a low prevalence country although Injecting drug users have been identified as a high risk group as they are at main risk of exposure and the main source of transmission. (Koye Balogun2008)
http://www.thetruthabouthepc.co.uk/index.html?ret_return
- 7.89 Some research estimates that between 50 – 80% of injecting drug users are infected with the virus and Homeless people and drug users have been identified as being at greater risk of infection with Blood borne viruses than the rest of the population J Britton (2002).
- 7.90 It is difficult to get an accurate picture as to the levels of Hepatitis C amongst the Homeless population in Devon. Data from Devon DAAT indicates a 33% prevalence; a third of Injecting drug users (IDU's) are likely to be infected. TheHealth Audit showed that 84 respondents stated that they had been tested for hepatitis C with 22 of those stating that they had tested positive, however only eight respondents stated that they had received treatment for the condition; 11 were not offered any treatment and three were offered treatment but did not take it up.

Hepatitis B

- 7.91 Less prevalent among intravenous drug users and there is a vaccine available.
- 7.92 Below is a table showing details of vaccinations from Devon Drug Services; this cannot be broken down by accommodation status but 107 Clock Tower Surgery patients are in treatment so they may account for some of these.

Table 7: Number of individuals who have received a Hepatitis B vaccine – new to treatment

Number of individuals who have had a Hepatitis B vaccination (new treatment journey YTD)			
Vaccination status	Of 'offered and accepted'		All
Individuals who have started a course of Hepatitis B vaccination	40	22%	51
Individuals who have finished a course of Hepatitis B vaccination	19	11%	169
Total individuals who have had a Hepatitis B vaccination	59	33%	220

Source: NDTMS Q4 2009-10

- 7.93 Sixty six respondents from the Health Audit stated that they had been vaccinated against Hepatitis B (25.48%) with a further 19.69% uncertain as to whether they had or not.

HIV

- 7.94 Nationally the HIV infection rate is rising. The population groups most at risk are black Africans and men who have sex with other men. The infection rate amongst drug users is low, arguably because of the level of Harm Reduction services.

Table 8: HIV infection rates by local authority 2009

Local Authority	Residents accessing HIV related care (aged 15-59)	Diagnosed HIV prevalence per 1,000 (aged 15-59)
East Devon	40	0.61
Exeter	74	0.96
Mid Devon	21	0.5
North Devon	20	0.41
South Hams	16	0.35
Teignbridge	29	0.43
Torridge	21	0.61
West Devon	13	0.46
Devon PCT	234	0.57

Source: NHS Devon Public Health Intelligence Team 2011

- 7.95 Infection rates amongst homeless population, anecdotally very low. There may be a problem with the late detection of the virus as homeless people are less likely to have access to screening. Given that it has been shown that this population are less likely to access a GP or prioritise their health needs, so it could be argued if people are infected they are less likely to receive treatment and therefore more likely to develop AIDS.
- 7.96 Data from the Health Audit shows that 30.12% had been screened for HIV. Of those, five had tested positive (1.93%), although 18 people chose not to disclose their HIV status. Two people stated that they have received treatment but five people stated that they were not offered any.

Tuberculosis (TB)

- 7.97 Tuberculosis is an infection caused by a germ called mycobacterium tuberculosis. Most commonly it affects the lungs but can affect other parts of the body such as the lymph glands, bones or the brain. TB usually begins as a small inflamed area in one lung. This inflamed area then becomes a hole. If it is not stopped in time the bacteria then spreads to the other lung and the holes become bigger. If left untreated TB can sometimes be fatal. However, TB treatment is very effective and few now die of the disease. Improper medication regimes or failing to complete a full course of treatment can lead to drug resistant TB. Multi-Drug Resistant TB (MDR-TB) is a form of the disease that is especially hard to treat. The germ has in this case become resistant to at least two of the most powerful TB drugs. People with MDR-TB are more likely to be infectious for long periods and more likely to die from TB. TB sometimes causes no immediate problem but remains dormant in the body. Illness may then develop years after the original infection with the germ, particularly if the body's immune system is weakened by other factors.

7.98 Tuberculosis rates have doubled in the UK in the last ten years and the homeless population is particularly vulnerable to the disease, as they are likely to experience difficulties and delays in getting diagnosed and therefore more likely to present with advanced and infectious forms of the illness. Research suggests that 10% of TB patients had a history of homelessness and 4% were currently sleeping rough. It also shows that the homeless population are more likely to be diagnosed late, take treatment intermittently and be lost to treatment follow up. These factors increase the risk of TB outbreaks and the emergence of drug resistant TB. The risk factors are:

- the increased number of undetected cases among homeless people
- delayed diagnosis caused by problems accessing healthcare and reluctance of some homeless people to consult health services
- generally poor nutrition and weakened immunity, which increases the risk of initial infection and progression to active disease
- high alcohol intake has a direct effect on immunity and can be linked to poor nutrition
- hard drug use; smoking crack cocaine can mask TB as it produces similar symptoms (Crack Lung)
- overcrowding; crowded or poorly ventilated accommodation with little natural light makes the spread of infection more likely
- taking TB treatment for a minimum of 12 months is often very difficult for a homeless person due to other priorities, low self esteem, lack of knowledge about TB, alcohol misuse, mental illness and insecure accommodation
- the prevalence of MDR –TB among homeless people. This form of the disease is much harder to treat and is likely to be infectious for longer periods of time

7.99 The charity Crisis estimates that nearly one in fifty homeless people have TB which is 25 times the national average. The HPA report (2010) notes that of the 9,040 reported cases during 2009, one in 10 had at least one social risk factor (homelessness, drug or alcohol misuse or imprisonment), with a quarter of these reporting more than one risk factor.

<http://www.bradfordvts.co.uk/ONLINERESOURCES/05.%20PROMOTING%20HEALTH%20AND%20PREVENTING%20DISEASE%20incl%20poverty%20and%20social%20medicine/homelessness%20statistics.pdf>

Local data

7.100 The Clock Tower Surgery reports no cases of TB within their current patient population.

7.101 There have been outbreaks of TB in South Devon in 2000 and 2009 respectively none of these cases were identified as homeless.

7.102 The health Audit showed that only 44 respondents had been screened for TB (16.99%). This is alarming considering that this cohort is in a high risk group

for contracting the disease. Of those screened, only 2.32% tested positive which is six people which matches estimates made by Crisis. Twenty people chose not to disclose their TB status. Only four people received treatment for the condition and another five respondents state that they were not offered any.

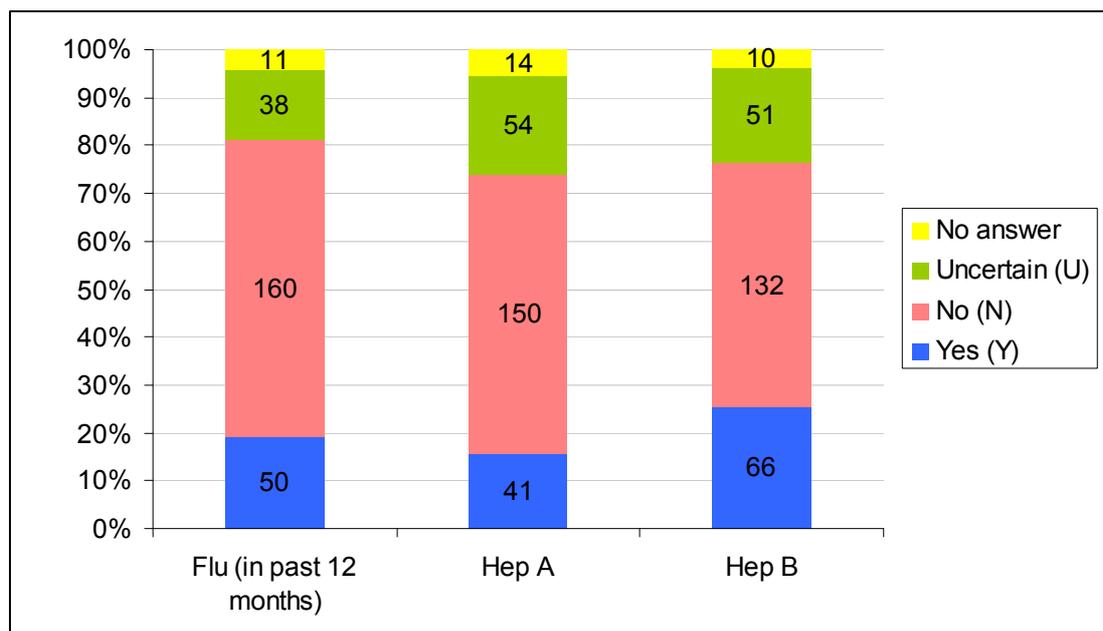
Health promotion: access to screening and disease prevention

7.103 Most specialist healthcare services in England offer a wide range of primary health care services including screening and vaccinations, but there is very little data available on the up take of these services by the homeless population. As we have already established that this population have difficulty accessing primary health care and don't necessarily prioritise their health then it is likely that prevention services will have a very poor uptake.

7.104 The practice nurses at the Clock Tower Surgery report that screenings and vaccinations are often done in an opportunistic way; when a patient comes to the surgery for another reason, or as part of the registration process and initial health check.

7.105 Those surveyed for the health audit were asked about vaccinations

Figure 35: Vaccinations for Hepatitis A, B and influenza

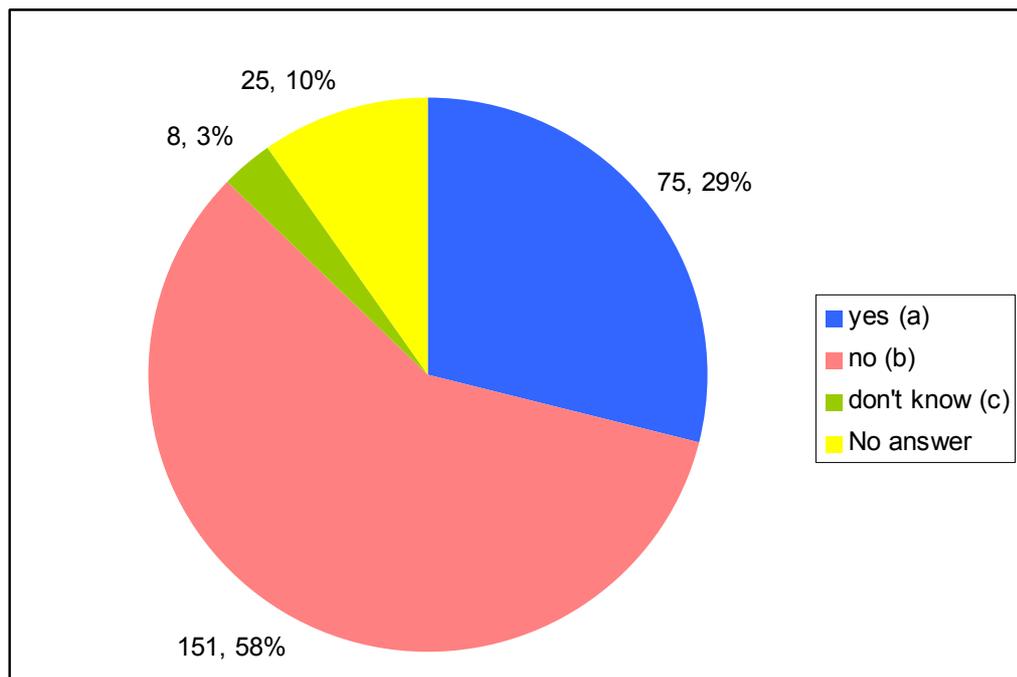


Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

Sexual health

7.106 Traditionally the sexual health of the homeless population has not been prioritised and often overlooked. Some of their behaviours would suggest that they would be in high risk groups for sexually transmitted infections.

Figure 36: Sexual health check in the past 12 months



Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011

7.107 There is a very low take up of sexual health checks among the population, however 84.56% of respondents stated that they knew where to access contraception and support around their sexual health. The respondents were asked who they approach for information and support;

- 55% said a GP or nurse
- 34% said a GUM/ sexual health clinic
- 11% said a housing or homelessness worker

Women's health services

7.108 Seventy five women took part in the Health Audit. Of those, 22 stated that they had a cervical smear test in the past three years; 41 had not and four were not sure. Only 11 women stated that they had a breast examination in the past three years. 53 had not and two were unsure.

Conclusion

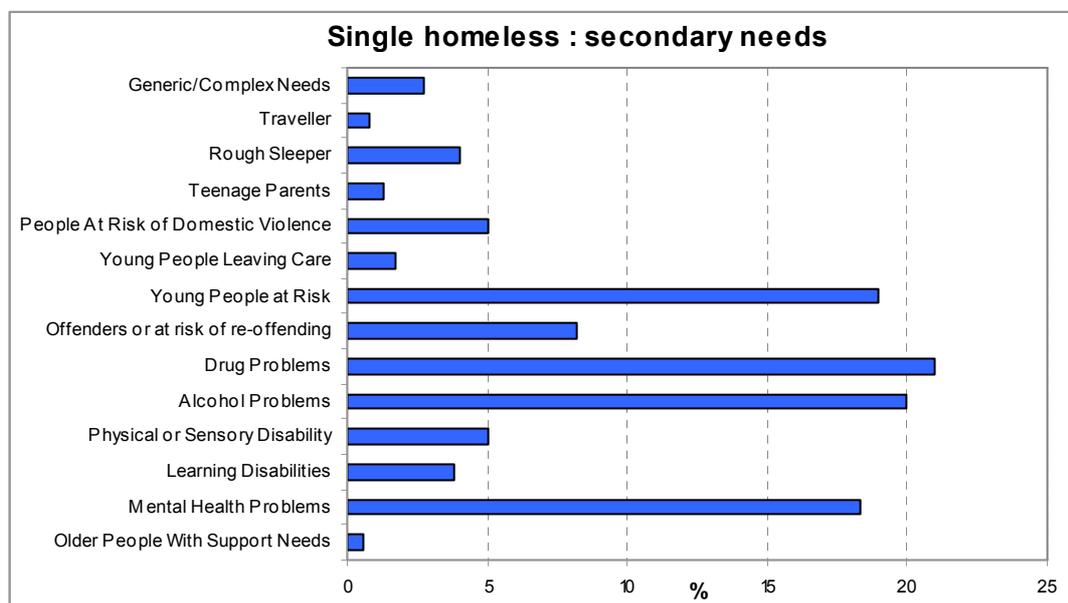
7.109 Health prevention interventions are not on the whole well used by this client group. This could be for all the reasons previously discussed; low self esteem, not prioritising health etc. National data does suggest that the homeless population do have a higher risk of contracting blood borne viruses, Tuberculosis and flu which would suggest that they should be targeted for screening. It also appears that they are not taking up the opportunity to be screened for cancers and therefore, given their other characteristics would be more likely to be diagnosed when the cancer is at a more advanced stage and therefore more difficult to treat. Other high risk populations have been identified and targeted for screening, this population should also be targeted, where possible enabling screening to happen in homelessness environments such as hostels and day centres.

8. Evidence of effectiveness

The role of supported housing in achieving positive health outcomes - Introduction

- 8.1 For most rough sleepers the recovery process usually starts with some form of accommodation. In the first wave of the 'Rough Sleepers Initiative' the focus was upon assisting rough sleepers in to accommodation. In London however, outreach teams noticed that some people were abandoning their tenancies and returning to live on the street. This was often because accommodation was found on housing estates, far away from the areas where they used to sleep rough. They felt isolated from the people that they used to have contact with on the streets, or felt too vulnerable in large hostels. The 2002 paper 'More Than a Roof' outlined the need for a range of housing options, for single homeless and couples with support to help individuals sustain that accommodation. This support ranged from help with budgeting, support to maintain a tenancy and help to find something to occupy their time, to help them form new social networks and encourage them towards training, volunteering or employment (Meaningful Occupation).
- 8.2 It has to be noted that under 'Models of Care' drug services were looking to develop 'structured day-care' which had broadly similar objectives to that of the Meaningful Occupation programme, however these 2 programmes ran in parallel, despite it largely targeting a similar client group, it is an example of how there has historically been a disconnect between different agencies, which if jointly commissioned could deliver effective streamlined services.
- 8.3 The statistics from the Supporting People client record system shows that 525 single homeless people accessed Supporting People services during 2009/10. The vast majority (94%) were host referrals and had a connection with Devon. The chart below provides an analysis of the needs of single homeless who accessed these services, using the St Andrews Supporting People Client Record System, each individual may have up to a maximum of three secondary needs.

Figure 38: Secondary needs of people accessing Supporting People homeless services



Source: Homelessness Joint Strategic Needs Assessment (Bennett 2010)

- 8.4 A significant proportion of single homeless people had drug, alcohol and/or mental health problems. These types of needs tend to fall below the thresholds required to receive statutory services, with only about 5% under ACS care management, 2% under Secondary Mental Health Services and 4% part of a Drug Intervention Programme.
- 8.5 The data therefore shows that there is large group of vulnerable people who are not accessing statutory services, for a variety of reasons that have been previously highlighted in this report. Substance misuse can act as a barrier to a client from being able to access Mental Health or Adult Community Services despite them meeting the threshold for assistance, therefore this group are only in receipt of community based support services. It can also be argued that Community based support provides a safety net of services that can prevent a persons situation becoming more critical, leading them to require more acute and costly interventions.
- 8.6 In the early part of the century, a high proportion of people rough sleeping were drug users who had been evicted from hostel's and night shelters due to their behaviours around their drug use. After the Winter Comfort case in 1999 many providers became wary of accommodating active drug users, therefore drug users were caught, in many cases in a double bind; they could not access drug treatment without an address, but couldn't access accommodation whilst still using. Another consequence was individuals not disclosing their drug use in order to get a bed. This then led to undetected drug overdoses or collapsed people being left in corridors.

'The positive role that housing and services plays in providing drug users with a stable base from which to engage with treatment services and effect change in their lives as well as prevent homelessness is well recognised. Those with accommodation are reported to be nearly twice more likely to have positive outcomes than those who have no fixed abode. The provision of accommodation can be particularly important for those who are hard to reach and engaged in harm minimisation services. This will include those who are rough sleeping for some or all of the time (Homeless Link 2007)'
<http://www.homelesspages.org.uk/node/22617>

- 8.7 In 2003 the Exeter DIG commissioned a report 'Housing and Support Needs of Substance Misusers in Devon. (Yeoman 2003) The report highlighted that accommodation is a significant factor influencing the treatment outcomes, and that there was a lack of appropriate, affordable housing available to this group. It also noted that the client group faced a large amount of prejudice and hostility. Very few providers had policies regarding the management of drug use and often used it as a barrier for their service. The report recommended that all accommodation providers should have policies in place. Work has subsequently been carried out to ensure that drug users have fair access to accommodation. This has involved working with accommodation providers; assisting with the writing of drugs policies and offering training around the legal implication of accommodating active drug users storage of medication etc, as well as offering training that helped housing providers and support workers to better understand the psychosocial reasons behind drug use (which interestingly are similar to the causes of homelessness).
- 8.8 In 2001 Exeter received £65,000 of central government funding to work directly with rough sleepers helping them to access residential treatment and accommodation. This was a multi agency approach with homelessness and drug services working together; identifying the most entrenched clients, drugs workers performing street based outreach work and the local authority

assisting with housing. In the short term the scheme had some successes in working with some very entrenched long – term rough sleepers who had already experienced a range of treatment interventions, however it was felt to be more useful in the long term to work with the drug treatment services to create better pathways in to a range of treatments for these clients. Due to their chaotic nature some clients struggled with the routine of residential treatment.

- 8.9 There are now fewer barriers for drug users to access accommodation with some projects moving towards a more open policy. The Wallich Clifford Community allows drug use in all of its single room hostel accommodation and has noted that since doing this there have not been any drug – related deaths. This approach needs to be backed up with education for the residents and harm reduction training. The SHOT Team and the Devon DAAT have devised a harm reduction course for both residents and hostel staff.

Innovations in accommodation

- 8.10 The Bridge Project is a 'Housing First' project that enabled rough sleepers to be accommodated in self contained accommodation. This was aimed at couples rough sleeping and those who refused hostel accommodation, either because they had previous bad experiences of living in a hostel, their psychological problems made it difficult for them to live in close proximity to others, or their mental health and behaviours made them very vulnerable. Often it has provided an opportunity for drug users and drinkers to stabilise their use and access treatment. The project offers high levels of floating support which is flexible to meet the client's needs. Once the client has shown that they are able to sustain the tenancy they can access the move on panel where they would be offered social housing or access to the private rented sector.
- 8.11 The STAR project uses Exeter City Council owned accommodation to offer short term accommodation options to rough sleepers, the accommodation is self contained and there is floating support attached but less intense than is offered by Bridge. The project aims to offer quick solutions to rough sleeping, thus preventing an individual from becoming entrenched in to a street lifestyle. It can also provide an opportunity for a client to demonstrate their ability to maintain a tenancy, if successful they can then be referred to a rent deposit scheme, if not assessments and referrals can be made to a more suitable accommodation option. The project was originally funded by Supporting People under- spend money but now uses enhanced Housing Benefit so effectively has a zero cost. The project has been running since 2008 and has successfully assisted 25 clients into more permanent accommodation.
- 8.12 Exeter Move On Panel offers an exit route out of supported housing for those who have successfully managed to sustain their accommodation, but remain vulnerable and in need of social housing. Floating Support is required to help the client move and settle in to their new accommodation. In the past 3 years 150 clients have been allocated social housing or secure private rented accommodation via the panel. Of these 104 were single people. There is an 88% success rate.

Limitations of Supporting People

- 8.13 The Supporting People programme helped to bring focus to the needs of people at risk of, or experiencing homelessness for which there was no statutory duty to accommodate or offer support or treatment. There are however a number of limitations to the programme. The assumption of the programme was that an individual's support needs would taper off until they were fully independent; there was an expectation that this 'transformation' would take 2 years. As this report demonstrates the needs of this population are varied and complex and change for a lot of people is not a linear process. Some clients, particularly long term rough sleepers, those suffering from complex trauma, or complex needs may never attain full independence and may continue to require some form of on going support for an indeterminate period.
- 8.14 The nature of the programme had the potential for providers to cherry pick potential clients who had a better chance of achieving the desired outcomes. The self reporting of outcomes by agencies only gave a limited understanding of why outcomes were not achieved or why tenancies broke down.

Risks

- 8.15 The Supporting People monies have sat in executive councils and until 2009 the funding was ring-fenced. For the year 2010/11 there was an agreement that the money would continue to be used for supported housing. In Devon, The Supporting People programme has now become part of Adult Community Services and been renamed Community Based Support. Adult Community Services are currently devising a framework with which to commission its services. The framework will incorporate personal care, domiciliary services and community based support, however these services will only be available to those clients who Adult Community Services have a statutory duty towards. All the services that used to be under the homelessness 'badge' (now called Social Inclusion and Recovery) will sit outside of the Framework Agreement. At the time of writing it is unsure how these services will continue to be funded, although ACS are looking at a 'safety net' of services to be funded in 2011 – 12.
- 8.16 Arguably the biggest impact of these cuts will be upon those individuals with high levels of complex need who are outside of Adult Community Services provision. With cuts to funding providers may feel the need to increase their thresholds, effectively excluding clients with higher support needs. It will also be more difficult to help clients access accommodation in the private rented sector without the additional Floating Support service that offers landlords some reassurance.
- 8.17 Even if a decision to focus what little service there is left upon rough sleepers, there will be a real risk of more people becoming homeless as the services that helped to prevent homelessness are removed. With a lack of resources to re-accommodate these people, they will be at risk of becoming entrenched and prone to the multiple health risks that are a consequence of living on the streets.
- 8.18 Those people currently benefitting from supported housing are likely, without it, to relapse to an extent where they will meet the threshold for a statutory intervention or require residential care.

9. Commissioning

Introduction

- 9.1 Homelessness, as this Health Needs Assessment has demonstrated, is a complex health and social issue; indeed it can be argued that Homelessness is a symptom of underlying economic/social and psychological issues.
- 9.2 Historically, in terms of government strategy, homelessness has always been seen as a housing issue and has sat with Housing in the relevant government department, currently the Department of Communities and Local Government (DCLG).
- 9.3 The argument has been made for homelessness to be viewed more holistically, and for there to be recognition that the issues cross different government departments including Health.
- 9.4 The paper 'Inclusion Health' (DOH Cabinet office 2010) acknowledges that the health needs of socially excluded groups are often complex and require a sophisticated response from a range of services. The costs of failing to address these health needs are great, not only for the socially excluded individual but also to the taxpayer, services and communities who are left to pick up the pieces.

Challenges for people who are homeless

- their complex needs and chaotic lifestyles can make it difficult to navigate systems
- many homeless clients lack self esteem and therefore do not value 'good health' or prioritise their health needs
- some clients may have a history of poor engagement with mainstream services or exclusion. They may distrust services or avoid services as they feel stigmatised

Challenges for health practitioners

- many practitioners, especially those in mainstream services do not have the necessary skills to work with people who are socially excluded
- in most mainstream health care settings the focus is upon treating the presenting problem, rather than looking at the patient holistically
- specialist practitioners often work in isolation, feel isolated and don't receive the support necessary to deal effectively with high need clients

Challenges for providers

- as this Health Needs Assessment has shown, there is a limited evidence as to what works, this is partly because the homeless population is heterogenic and almost require bespoke solutions and because small specialist services do not always have the resources to evaluate the effectiveness of their interventions

- mainstream services often lack the flexibility to manage very complex clients; appointment regimes, opening hours, expected behaviour and impact of behaviour on the rest of the patient population
- there are few incentives to promote partnership working around clients with complex needs, as there is often no statutory obligation to do so as once separated out each need often does not meet the threshold for an intervention
- it is too easy for clients to fall between the gaps in services, these can lead to unplanned and expensive care and a prolonged time spent 'revolving' around a small number of services
- there continue to be barriers to Mental Health services for those with a substance misuse issues or behavioural disorder
- there is an artificial divide between clinical and social models of care

9.5 As health and social care are to be come more aligned, the challenge will be around working with clients who have a range of complex needs who are currently excluded from services.

Challenges for commissioners

- there is considerable variation in the provision of specialist services between different areas of the country. In Devon current specialist health provision is available in only one location. The challenge will be to meet the health needs of the homeless population in rural areas and where the population is more dispersed e.g. North Devon
- the homeless population do not necessarily show up on Health Needs Assessments as relatively the population is quite small, however this Health Needs Assessment has demonstrated that despite the size of the population the health needs are disproportionate to the general population
- the homeless population is not a homogenous group; indeed it is arguably better to view this population as people with a range of social, psychological or economic problems who are also experiencing homelessness
- in many areas there is limited join-up between primary care trusts, local authorities and the Third Sector in sharing knowledge about the most excluded clients. In Devon there are some good examples of multi agency panels, however it can prove difficult to get some statutory agencies to commit to this way of working
- there is a limited focus on health promotion prevention and recovery with the hardest to reach

Conclusion

- 9.6 As has been stated in this Health Needs Assessment, the greatest challenge with this client group is that despite having a multifarious mix of needs, quite often each need in isolation does not meet the criteria for anyone service, therefore there is no statutory duty upon district councils or executive authorities to help them. The risk in the current economic climate with cuts to public spending is that services for homeless people will be viewed as superfluous; 'not core business' and some of the most vulnerable people in society risk being further marginalised, their needs ignored until their health needs or behaviour requires emergency/acute/costly interventions.

Recommendations

- 9.7 Inclusion Health recommends a greater focus upon members of the population that are socially excluded. Arguably the homeless population contains within it some of the most excluded individuals in society, therefore they are chronically excluded.
- 9.8 The Department of Health / Cabinet office paper Inclusion Health uses a framework to highlight key areas where changes can be made or services enhanced to ensure a greater equity of access to health services, a better understanding of the needs of this groups and better treatment outcomes. This framework will be used to will explore what can be done in Devon to help meet the needs of the homeless population.

Focus

- 9.9 By carrying out this Health Needs Assessment and as part of it carrying out a Health Audit, NHS Devon has started a process of gathering evidence about this group. During this process it has become more evident where the gaps in data are, especially with cross referencing complex needs; numbers of homeless people accessing mental health services, the numbers of homeless people accessing A&E and the prevalence of BBV infection amongst this group.
- 9.10 There does need to be better recording structures put in place especially to track individuals through a number of statutory and voluntary services. Data bases like the London Chain are an effective way of tracking and holding information on clients, this enables the service at which the client presents to know the extent of their needs, any associated risks and any treatment services that the client is registered with, this means that the client gets a consistent response and duplication of costly interventions is avoided. Such databases can be expensive to create and there is a maintenance cost, however this cost could be shared amongst a range of interested parties; local authorities, health, social care and the voluntary sector.
- 9.11 There has been a focus in building services that prevent people from becoming homeless in the first place; debt advice and support, schemes that provide a deposit or rent in advance, mediation services and a range of early interventions to prevent tenancy breakdowns. These kinds of services are delivered by the voluntary sector and more increasingly by Local Authorities housing departments as part of their Enhanced Housing Options scheme. Early Intervention and prevention services are key to reducing the health impacts of being homeless and in reducing health costs, therefore it is important that these services continue to be commissioned.

Voice

- 9.12 Nationally the Government have set up a The Homelessness Interministerial working group which has representation from Communities and Local Government, Department of Health, Ministry of Justice, Ministry of Defence, Department of Work and Pensions, Department of Children and families and the Border Agency. There has also been an inclusion health board set up, which will be chaired by Professor Steve Field, who says: *'The board will champion the cause of people who are vulnerable and socially excluded such as the homeless'*. (Health Service Journal 30/11/10)
- 9.13 With a strong steer nationally, Devon should be able to get sign up from the key agencies: Local Authorities, Adult Community Services, Health, Voluntary Agencies and faith-based groups to have a champion for homeless/socially excluded groups within their organisations.

Personalisation

- 9.14 In 2009/10 the CLG hosted four pilots which worked with long-term entrenched rough sleepers using individual budgets and a person centred approach. All pilots were very successful in engaging with clients who had either avoided or been excluded from services.
- 9.15 One of the pilot areas was Devon and the pilot was carried out by Exeter City and North Devon Districts Councils. The pilot proved very effective at engaging entrenched rough sleepers and, by using a person centred approach, the lead professional was able to identify the right type of accommodation for the client and begin to link them in with the relevant services. This way of working with those most excluded is effective but as the evaluator commented:

'In a major sense, the Devon Individualised Budget Pilot does not or cannot stand alone, but rather is based effective outreach work and the sustenance of, a day centre charity for homeless people. The Individualised Budget workers main 'home' base is the Street Homeless Outreach team, but they have links with other services and resources'.

- 9.16 It would therefore be recommended that an Individualised Budget approach should and could become an integral part of social care agencies specialising with people with long-term psychosocial problems. This would empower agencies to reach out in a preventative way to people at risk of rough sleeping before they become entrenched-rough-sleepers, which is costly to both individuals and services trying to help them. As Entrenched Rough Sleepers become "adapted" to coping on the streets – and where this coping process in itself helps them manage more profound psycho social trauma, the entrenched nature of their rough sleeping hinders the helping services providing the necessary assistance and motivation to move indoors. With the recent emphasis upon joined-up thinking and practice, focusing upon the individual rather than their category so that "Every One Counts", which led to consideration of "Healthcare for the Single Homeless" (Department of Health 2010c) so that "No one is left out" (DCLG, 2009b). This review indicates that the timely involvement of mental health services will support the goal of ending rough sleeping and is key to both preventing some entrenched rough sleeping as well as the sustainability of arrangements delivered through the Individualised Budget pilot'. (Professor Colin Pritchard, 2010)

- 9.17 'People with multiple needs and chaotic lifestyles are frequently those who have the most difficulty in engaging with services. This leads to those individuals, including those with problematic drug or alcohol use, missing out on provision which could halt the downward spiral into deeper exclusion. Consultation events with socially excluded individuals, groups and stakeholders confirm that a holistic response which puts the individual at the centre and may include housing related and life skills support is consistently cited as being of priority importance'. (Devon Drug and Alcohol Action Team 2008)
- 9.18 As cuts to public services occur, there is a risk that a range of services will only be available to those currently viewed as being the most vulnerable; those individuals assessed as being FACS (Fair Access to Care Services) eligible. As this HNA has highlighted, the homeless population consists of individuals with a wide range of complex need, but are either not meeting the criteria for a single service or are excluded from these services due to their challenging behaviour. Homeless services will need to be better at negotiating with statutory services to be able to advocate for clients that they consider require more specialist support. Homeless services could consider employing qualified social workers specifically to assist with referrals into statutory services.

Quality and innovation

- 9.19 The Clock Tower Surgery service is currently under review the following recommendations are likely to be made:
- better recording systems to be able to evaluate the outcomes and cost benefits of the service
 - an option of temporary and permanent registration so that the PCT can help meet the needs of the transient homeless population without having to pick up the cost of treatment once the individual has moved out of area
 - to explore the possibility of extending the outreach capacity to target difficult to reach individuals
 - explore the possibility of retaining more services within Primary healthcare for this population like the HEP C protocol
 - to explore the possibility of extending the service to other hard to reach/ socially excluded groups: prisoners, gypsy and travellers
 - explore ways of monitoring access to Primary health care in the areas of Devon with a significant homeless population but no specialist health care services (North Devon)
- 9.20 Explore the possibility of working in Partnership with Devon Drug Services to explore the feasibility of developing an enhanced mobile harm reduction service that could encompass mental health outreach, health promotion; screening, advice and information and vaccinations, housing support workers etc, especially in rural areas of Devon.

- 9.21 The Department of Communities and Local Government run a Hostel as Places of Change initiative. Money was provided to improve the physical environment of many 'homeless hostels; in the country. The aim was also to improve the quality of the services provided within the hostels. One way to further enhance services is for hostel workers to be take up the RSPH Health Trainer training, so they can deliver effective health prevention and smoking cessation advice to their residents. Other initiatives with hostels and daycentres could also be looked at that would push staying healthy higher up the agenda.
- 9.22 The Torbay and Devon Dual Diagnosis strategy focused on people with severe mental health and serious substance abuse, establishing responsibility and ownership within specialist mental health services. It also recognised the importance of developing and delivering integrated care pathways for people with less serious mental health problems alongside substance misuse problems such as the North Devon Custody Diversion Pilot.

Recovery

- 9.23 *'Recovery is the process of regaining a positive sense of self, and purpose, and meaning in life. Everyone who experiences mental health related problems should be supported to retain, develop or rebuild a valued and satisfying life. The recurrence or continuation of symptoms and the presence of disabilities do not preclude the recovery of a life which includes those things that give all of us meaning and shape to our existenceStable housing is the linchpin for increased mental stability, health and well-being. Lives without housing are characterised by vulnerability and higher levels of mental illness. Housing is a vital aspect of most recovery planning'. (Lozier, 2006.)*
- 9.24 Most Adult Community Services are adopting the recovery model as are Probation and Devon Drug Services. This is a useful model for all homeless services to adopt, in order to align more closely with health and social care. Training in WRAP (Wellness and Recovery Action Planning) has already been offered to the homelessness sector to enable them to work better with their clients who are recovering from mental illness.

Professional development

- 9.25 There is a wealth of experience in the homelessness sector around working with a challenging client group, but there is often lack the clinical knowledge around a clients health needs. Inter agency training would be a cost effective way of sharing skills and expertise in a locality.
- 9.26 Homelessness workers often have to deal with highly stressful situations, or have to help a client to stabilise their very chaotic behaviour, but lack access to more clinical supervision, this could be something offered through either mental health or psychological services with the benefit being that housing staff would feel more supported and therefore more able to successfully work with clients, meaning that they would be able to sustain their accommodation diverting them away from more costly and acute services.
- 9.27 The use of peers has also been shown to be effective in this field. People who have experienced homelessness themselves are often best placed to work with those who are less willing to engage with officials and can provide advocacy as well as motivational support. Peer led overdose training for example has been seen to be very effective in getting key harm reduction messages across to injecting drug users. To be really effective these 'peer

mentors' require good quality supervision and access to a range of training. All health and social care agencies could consider investing in 'peer mentors' to work with those clients that they have traditionally considered to be 'difficult to engage'.

10. Service Provision in Devon

Accommodation and floating support funded by Supporting People in 2008

10.1 The table below summarises the type of services, typically accommodation based or floating support services, and their capacity in terms of the number of units by district area. Some services have slightly different service type definitions, for example 'outreach' services have been included under the floating support service type. Some services cover more than one district area but the capacity is shown for services that are specific to each district.

Table 9: The type of service, accommodation based and floating support by number of units by district area (2008)

Area	Accommodation	Based Services	Floating Support	Services
	Services	Units	Services	Units
East Devon	3	37	1	30
Exeter	23	366	7	93
Mid Devon	2	32	3	36
North Devon	10	68	3	16
Torrige	3	20	1	1
South Hams	2	14	3	33
Teignbridge	4	25	1	25
West Devon	2	9	0	0
Cross District	0	0	15	428
All Devon	49	571	34	662

Source: Supporting People Commissioning Framework p. 12 (2008)

10.2 The accommodation provided ranges from high support, staffed 24 hours a day, to low support where staff may only visit a project or have a minimal presence. Likewise 'Floating Support' to people living in their own accommodation (usually private rented or social housing) can vary from daily to weekly or monthly depending on need.

10.3 Some accommodation is configured specifically to provide accommodation for those currently rough sleeping, whilst other accommodation is designated as 'move on' accommodation. Criteria for these projects tends to vary but on the whole the assumption is made that a client is ready for move on once behaviours have been stabilised and they need less intense support.

- 10.4 Exeter has the most accommodation units currently funded through Supporting People. This reflects the higher level of need in the city than in some of the more rural areas of the county. However it can be argued that the concentration of services in Exeter causes an inward migration from the neighboring districts. This should not be assumed when commissioning further services as some rough sleepers choose to stay in the rural areas, despite the lack of services as they wish to avoid the larger rural areas to stay away from the 'drug scene' and to avoid violent confrontation with homeless people. (Totnes Street Needs Audit 2010)

Support services

Clock Tower Surgery

- 10.5 The Clock Tower Surgery, based in Exeter (area Cluster 1&2), started as a 'Personal Medical Service' (PMS) pilot in 1999, set up as a surgery based service run by a GP/nurse team. A number of outreach clinics have also been set up in the city in hostels and the day centre. The surgery offers a wide range of services including screening and vaccinations for Chlamydia and Hepatitis C for which the surgery has devised its own protocol. There are also two CPN's located at the surgery and a counsellor offering a range of psychological therapies.

Performance and activity:

- 10.6 *GP:* am – drop in clinics x five mornings a week
pm – seven slots each afternoon = 35 each week
- Nurse:* am – drop in clinics x five mornings a week
pm – four slots each afternoon = 20 each week

Outreach activity carried out by the grade 6 practice nurses:

- St Petrock's Day Centre - three mornings per week
- Gabriel House - one afternoon per week
- Esther Community - one afternoon per week
- Big Issue – one morning per week

Community Psychiatric Nursing and counselling - referrals are made direct to these and they send out their own appointments.

The surgery offers a wide range of primary healthcare interventions including: screening, vaccinations, sexual health checks and contraception advice, however, most of these are carried out opportunistically due to the nature of the client group.

Devon Drug Services - 107 Patients registered at the Clock Tower Surgery are receiving 'formal drug treatment':

- nine are prescribed directly by the Clock Tower Surgery
- 98 are in secondary care (Devon Drug Services), 20 of whom with a non medical prescriber

Harm reduction services provided by Devon Drug Services

- 10.6 EDP have a mobile harm reduction units; one that covers North Devon, One that covers Exeter, East and Mid Devon and one that covers South and West Devon. There is a lot of potential for these units to target more difficult to reach clients as well as being able to offer a service in more rural parts of the county.

Services in North Devon

- 10.7 The Harm Reduction Unit in North Devon does target homeless drug users:

- Mondays Freedom Centre Barnstaple 11.30 – 13.00
- Tuesdays, Salvation Army Soup kitchen, Ilfracombe 11.00 – 13.00
- Fridays, St Mary's Church Soup Kitchen, Bideford 11.30 – 14.30

Services in South and West Devon

- 10.8 Will meet service users in a wide variety of settings; GP surgeries, clients own accommodation (supported)

- The mobile is available to travel to rural areas
- Carr- Gomm hold a weekly surgery at Devon Drug Services premises in South Devon
- Drugs workers attend Multi Agency meetings and homelessness / housing forums

Services in Exeter, East and Mid Devon

- 10.9 There is a direct access services available every afternoon at the Exeter premises:

- a surgery is held at Gabriel House Hostel once a week offering advice, information and Needle Exchange
- the mobile goes out twice a week; on a Wednesday it goes to Cullompton (morning) and Tiverton (afternoon)
- on Thursday the mobile unit bases it self in Exeter City centre in the morning, but often staff will do outreach in Exeter on a Wednesday afternoon to contact people who are street homeless. In the afternoon the unit is available in Axminster
- a support worker attends the Clock Tower surgery once a fortnight to meet with service users and a care -coordinator visits the surgery approximately every 12 weeks

Addaction

- 10.10 Addaction are commissioned to provide a range of interventions around alcohol in Devon:

- they provide a weekly surgery at St Petrock's day centre in Exeter and Freedom Social projects in Barnstaple
- team leaders attend locality complex care meetings and housing forums

Sanctuary Carr Gomm

- 10.11 Sanctuary Carr-Gomm are a national organisation who are commissioned by Supporting People to provide floating support services through out Devon to a range of vulnerable groups. Primarily their role is to offer support and advice to people that helps them to access and sustain their accommodation, this is often achieved by working closely with other support and care providers for the individuals well as liaising with other organisations such as the local Authorities, Probation and 'recovery services'.
- 10.12 Due to the high demand for the service there is often a waiting list. One way of managing this is to hold a number of surgeries at a number of locations. The surgeries mean that those people awaiting support can still access a worker's for advice. Surgeries also provide a venue for those with lower level needs to seek assistance if they are experiencing difficulties, or for one off pieces of advice, which if not addressed could escalate in to much bigger problems requiring a more substantial intervention.

Surgeries in North Devon

Civic Centre, Barnstaple – weekly

Harbour Project, Bideford – weekly

Probation, Barnstaple – twice weekly

North Devon District Council. Ilfracombe – third Tuesday of every month

Community Venue. Torrington – third Thursday of every month.

Surgeries in South and West Devon

EDP Drug and Alcohol services (Teignbridge) – weekly

West Devon Borough Council (Okehampton) - weekly

Surgeries in Exeter, East and Mid Devon

EDP Drug and Alcohol services (Exeter offices) – fortnightly

Probation (Exeter office) – twice weekly.

Exeter City Council – weekly

Community venue, Axminster – weekly

Mid Devon District Council - weekly

Conclusion

- 10.13 This Health Needs Assessment has shown that there are high levels of drug and alcohol use among the homeless population in Devon.
- 10.14 There are also high levels of expressed mental health need, but seemingly few opportunities to access any support other than via a GP surgery. This may mean some of the homeless population are not able to access any support.
- 10.15 Data collected from documents like the Totnes Street Needs Audit suggests that when homeless or rough sleeping, some individuals choose to stay in rural areas, rather than move to urban areas where they could more easily access housing and other support services.
- 10.16 The evidence also suggests that a percentage of the population are difficult to engage.
- 10.17 Both national and local evidence shows that proactive and assertive outreach is an effective way of working with difficult to engage individuals.
- 10.18 There is an opportunity to use current resources more efficiently to deliver a range of services to those who are difficult to engage and/or choose to stay in more rural areas of the county.

Recommendations

- 10.19 To work with the Drug and Alcohol Action Team (DAAT), Addaction, Sanctuary Carr – Gomm and Devon Partnership Trust to explore the possibility of jointly delivering a range of services through the mobile units.

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13. Appendices

Appendix 1	Homeless health Needs Audit, background and sample questionnaire
Appendix 2	Levels of drug use among rough sleepers Additional Data
Appendix 3	Findings from the Devon Individualised Budget Pilot
Appendix 4	Rough Sleeper data Sept 2009 – May 2010. North Devon
Appendix 5	Case Studies

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HEALTH INEQUALITIES PROGRAMME MANAGER

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Health Audit Tool

1. What is the Homeless Health Needs Project?

- 1.1 Homeless Link, the national umbrella organisation for homelessness agencies in England, is delivering a new project on health and homelessness with funding from the Department of Health Third Sector Investment Programme.
- 1.2 The project, which runs from March 2009-March 2011, has developed an audit tool which enables homelessness agencies to gather data about the health needs of their clients. It is aimed at capturing the needs of rough sleepers, and homeless people living in emergency and temporary accommodation (e.g. hostels, supported accommodation).
- 1.3 It has been developed in collaboration with a national steering group and nine local partnerships who have piloted the audit tool in their local area. The nine participating areas are:
 - Ashton, Leigh & Wigan
 - Birmingham
 - Brent
 - Bristol
 - Leeds
 - Lincolnshire
 - Southampton
 - South East Essex
 - Sunderland

2. Why Health?

- 2.1 The health needs of homeless people have been well documented. Homeless people face barriers to accessing mainstream services and as a result experience poor health. Addressing health inequalities and improving the access of services for homeless people are key priorities outlined both nationally and locally. However, there is little existing data about what health problems homeless people have which makes it difficult to represent their needs at a strategic and commissioning level and make informed decisions about how services might be improved.

- 2.2 The introduction of the JSNA has provided very welcome opportunities to influence the local strategic environment. Additional support is required to ensure that the third sector provides evidence to support their advocacy and to help local commissioners see how working with homelessness services can assist them in improving the health of their local community.

3. What will the impact of the Project be?

- 3.1 The audit tool collects consistent data about homeless people' health needs and their usage of local services. This data can be used to inform policy and service development and ensure that the needs and voices of this excluded group are recognised through processes such as the JSNA. We believe it will facilitate partnerships across the sectors and increase the understanding of homeless people's health among local strategic commissioners. It will present an opportunity to make a real difference to the health of people who are often invisible to the communities they live in.
- 3.2 Already, we have powerful new evidence from over 700 homeless individuals who, to date, have contributed to the audit. Between March 2010-March 2011, Homeless Link is working with the nine pilot sites to explore ways to link up this evidence to relevant strategic opportunities and use it to inform local change. Following the pilot, the audit tool will be rolled out as a nationally replicable tool.

4. Homeless Health Needs Audit Survey

HOMELESS HEALTH NEEDS AUDIT

PAPER VERSION OF THE SURVEY

Welcome to the Health Needs Audit. This is the paper version of the audit questions. If you are using the paper version, please input the responses afterwards onto the online tool.

This survey asks clients questions about their health needs and access of health services. Please refer to **Information for Interviewers (R4) and Clients (R5)** to read more about completing the survey.

INTRODUCTION

a) Before you get started, we want to make sure you have read about this survey.

- This is the first time I (the client) am completing the survey
- I (the client) understand how this information will be used and am happy to go ahead

b) Please say which area you are in:

- North Devon
- Exeter
- South Devon

c) Please write the first part of your post code here.....

1: ACCESS OF HEALTH SERVICES

1

ARE YOU REGISTERED WITH THESE SERVICES IN YOUR LOCAL AREA?

	yes, permanent	yes, temporary	no
A homeless health care or NFA health service	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dentist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2

WHICH OF THESE SERVICES HAVE YOU USED IN THE PAST 6 MONTHS?

	Not used	1-2 times	3-5 times	over 5 times*
GP/doctor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dentist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Optician	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nurse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Walk-in clinic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Outpatient appointment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Homeless health / NFA service	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Visited A&E	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				number of times.....
Used an ambulance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				number of times.....
Admitted into hospital	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				number of times.....

2a)

If you have used ANY of A&E, hospital OR ambulance in the past 6 months please answer these questions:

What was the reason why you last used:

Please select the reason which best fits the primary cause of using the service, or use the other box if the reason is not listed.

	A&E	Ambulance	Admitted into hospital
Violent incident or assault	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Accident	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breathing problems/chest pains	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seizure/fitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stomach pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problem relating to mental health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Self harm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Relating to drug use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Relating to alcohol use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Other for A&E,			
<input type="radio"/> Other, for ambulance.....			
<input type="radio"/> Other, for hospital			

2b)	<p>If you were ADMITTED INTO HOSPITAL, please answer these questions about your <u>most recent</u> admission:</p> <p>How many nights did you stay in for? (Please estimate if you need to)</p> <p>Did staff in the hospital make sure you had somewhere suitable to go when you were discharged?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>												
3	<p>HAVE YOU BEEN REFUSED REGISTRATION TO A GP OR DENTIST IN THE PAST 12 MONTHS?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>IF YES, why was this?.....</p>												
4	<p>HAS YOUR HOUSING OR HOMELESSNESS PROJECT GIVEN YOU INFORMATION ABOUT LOCAL HEALTH SERVICES YOU CAN USE?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know</p> <p>IF YES, did you find it useful?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know</p>												
5	<p>OVERALL, WHICH PEOPLE HELP YOU LOOK AFTER YOUR HEALTH? Please choose all that apply:</p> <table border="0"> <tr> <td><input type="checkbox"/> GP</td> <td><input type="checkbox"/> friend/peer</td> <td><input type="checkbox"/> drug worker</td> </tr> <tr> <td><input type="checkbox"/> staff member at housing/homelessness project</td> <td><input type="checkbox"/> family</td> <td><input type="checkbox"/> mental health worker</td> </tr> <tr> <td><input type="checkbox"/> Homeless health care team</td> <td><input type="checkbox"/> alcohol worker</td> <td><input type="checkbox"/> nobody</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Other:.....</td> </tr> </table>	<input type="checkbox"/> GP	<input type="checkbox"/> friend/peer	<input type="checkbox"/> drug worker	<input type="checkbox"/> staff member at housing/homelessness project	<input type="checkbox"/> family	<input type="checkbox"/> mental health worker	<input type="checkbox"/> Homeless health care team	<input type="checkbox"/> alcohol worker	<input type="checkbox"/> nobody	<input type="checkbox"/> Other:.....		
<input type="checkbox"/> GP	<input type="checkbox"/> friend/peer	<input type="checkbox"/> drug worker											
<input type="checkbox"/> staff member at housing/homelessness project	<input type="checkbox"/> family	<input type="checkbox"/> mental health worker											
<input type="checkbox"/> Homeless health care team	<input type="checkbox"/> alcohol worker	<input type="checkbox"/> nobody											
<input type="checkbox"/> Other:.....													

2: YOUR PHYSICAL HEALTH

6	<p>DO YOU SMOKE?</p> <p><input type="radio"/> Yes <input type="radio"/> No If 'no' go to Q7.</p> <p>Do you want to stop smoking?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>
---	---

Have you been offered advice or help to stop smoking?

Yes, and took this up Yes, but did not take this up No

7 **ON AVERAGE, DO YOU EAT AT LEAST 2 MEALS A DAY?** If this is difficult, please think about the meals you ate yesterday.

Yes No

8 **HOW MANY PIECES OF FRUIT AND VEG DO YOU USUALLY EAT PER DAY?** If this is difficult to answer, please think about what you ate yesterday.

none 1-2 3-4 5+

9 **DO YOU EXERCISE AT LEAST TWICE A WEEK?** (play sport, swim, or cycle for at least 30 minutes each time?)

Yes No

IF NO, would you like to? Yes No Don't know

10 **DO YOU EXPERIENCE ANY OF THE FOLLOWING HEALTH PROBLEMS?** Please choose **all** that apply:

	Yes, less 12 mnths	Yes, 12 mnths +	No
chest pain/breathing problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
joint aches/problems with bones and muscles	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
difficulty seeing/eye problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
skin/wound infection or problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
problems with feet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
fainting/blackouts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
urinary problems/infections	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
circulation problems/ blood clots	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
liver problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
stomach problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
problems with kidneys	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
dental/teeth problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
epilepsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10b **IF YES TO ANY HEALTH NEED:**
Are you receiving support/treatment to help you with your physical health problem?

Yes, and it meets my needs
 Yes, but I'd still like more help
 No, but it would help me
 No, I do not need any

4: YOUR MENTAL HEALTH

11 **DO YOU EXPERIENCE ANY OF THE FOLLOWING MENTAL HEALTH DIFFICULTES?**

	Yes, less 12 mnths	Yes, 12 mnths +	No
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Often feel stressed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Often feel anxious	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Panic attacks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Feel depressed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Have difficulty sleeping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Suicidal thoughts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Self harm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Hear voices	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	I find it hard to control my anger	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	I can be aggressive or violent towards others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12	DO YOU HAVE A MENTAL HEALTH NEED OR CONDITION WHICH HAS BEEN DIAGNOSED BY A DOCTOR OR OTHER HEALTH PROFESSIONAL? <input type="radio"/> YES <input type="radio"/> DON'T KNOW/prefer not to say <input type="radio"/> NO (please go to Q13) IF YES, what was this, and how long have you experienced it for? Please select all that apply			
		Yes, less 12 mths	Yes, 12 mths +	No
	Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Schizophrenia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Bipolar disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Personality disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Post traumatic stress disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Dual diagnosis with a drug or alcohol problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Other mental health condition (please state).....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13	DO YOU GET SUPPORT WITH YOUR MENTAL HEALTH, eg from a worker, medic or support service? <input type="radio"/> Yes, and it meets my needs GO TO 13a <input type="radio"/> Yes, but I'd still like more help GO TO 13b <input type="radio"/> No, but it would help me GO TO 13b <input type="radio"/> No, I do not need any GO TO 14			
13a	What type of support helps you? Tick all that apply <input type="checkbox"/> Talking therapies (eg counselling, physiological therapies) <input type="checkbox"/> A specialist mental health worker – eg Community Mental Health team <input type="checkbox"/> Service to address my dual diagnosis <input type="checkbox"/> Activities to do like arts, volunteering or sport <input type="checkbox"/> Practical support to help me with my day to day life <input type="checkbox"/> Other			
13b	What sort of support would help you? Tick all that apply <input type="checkbox"/> Talking therapies (eg counselling, physiological therapies) <input type="checkbox"/> A specialist mental health worker – eg Community Mental Health team <input type="checkbox"/> Services to address my dual diagnosis <input type="checkbox"/> Activities to do like arts, volunteering or sport <input type="checkbox"/> Practical support to help me with my day to day life <input type="checkbox"/> Other			
14	DO YOU USE DRUGS OR ALCOHOL TO HELP YOU COPE WITH YOUR MENTAL HEALTH – this can be called 'self-medicating'? <input type="radio"/> Yes <input type="radio"/> No			

15 **DO YOU TAKE ANY DRUGS OR ARE YOU RECOVERING FROM A DRUG PROBLEM?** *(by drugs this does not include medication prescribed to you for a specific medical condition)*

YES, use drugs No **GO TO Q18**

IF YES, IN THE LAST MONTH, HAVE YOU USED ANY OF THE FOLLOWING? Please choose **all** that apply:

heroin
 crack/cocaine
 cannabis /weed
 amphetamines/ speed
 benzodiazepines/ benzos

prescription drugs

Other drugs, please say.....

None

Do you take methadone? YES No

IF YES: is this prescribed to you? YES No

16 **DO YOU CURRENTLY INJECT DRUGS?**

YES No (Go to Q17)

IF YES: Do you share injecting equipment with others?

yes, usually yes, sometimes no

Do you know about:

	yes	no
A needle exchange scheme you can use	<input type="radio"/>	<input type="radio"/>
Advice or training on safer injecting	<input type="radio"/>	<input type="radio"/>

17 **DO YOU GET SUPPORT TO HELP YOU ADDRESS YOUR DRUG USE?**

Yes, and it meets my needs GO TO 17a
 Yes, but I'd still like more help GO TO 17b
 No, but it would help me GO TO 17b
 No, I do not need any GO TO 18

17a **How does this support help you?** Tick all that apply

Helps me to better control my drug use
 Helps me to reduce my drug use
 Helps me to use drugs more safely
 Helps me to stop using drugs
 other.....

17b **What sort of help would you like?** Tick all that apply

	<input type="radio"/> Help to better control my drug use <input type="radio"/> Help to reduce my drug use <input type="radio"/> Help to use drugs more safely <input type="radio"/> Help to stop using drugs <input type="radio"/> other.....
18	<p>HOW OFTEN DO YOU HAVE AN ALCOHOLIC DRINK?</p> <input type="radio"/> never <i>go to Q 19</i> <input type="radio"/> monthly or less <input type="radio"/> 2-4 times per month <input type="radio"/> 2-3 times per week <input type="radio"/> 4 -6 times per week <input type="radio"/> every day
19	<p>How many units do you drink on a typical day when you are drinking? Please refer to flashcard to work this out</p> <input type="radio"/> 1-2 <input type="radio"/> 3-4 <input type="radio"/> 5-6 <input type="radio"/> 7-9 <input type="radio"/> 10+
19a	<p>DO YOU HAVE OR ARE YOU RECOVERING FROM AN ALCOHOL PROBLEM?</p> <input type="radio"/> YES <input type="radio"/> No (go to Q 20) <p>Do you get support to help with this?</p> <input type="radio"/> Yes, and it meets my needs GO TO 19a <input type="radio"/> Yes, but I'd still like more help GO TO 19b <input type="radio"/> No, but it would help me GO TO 19b <input type="radio"/> No, I do not need it GO TO 20 <p>How does this support help you? Tick all that apply</p> <input type="checkbox"/> helps me to better control my alcohol intake <input type="checkbox"/> helps me to reduce my alcohol intake <input type="checkbox"/> helps me to manage the impact drinking has on my health <input type="checkbox"/> helps me to stop drinking <input type="checkbox"/> other
19b	<p>What sort of support would help you? Tick all that apply</p> <input type="checkbox"/> help to better control my alcohol intake <input type="checkbox"/> help to reduce my alcohol intake <input type="checkbox"/> help to manage the impact drinking has on my health <input type="checkbox"/> help to stop drinking <input type="checkbox"/> other

4: VACCINATIONS AND SCREENING

20

HAVE YOU BEEN VACCINATED FOR THE FOLLOWING?

Please choose the appropriate response for each item:

	Yes	No	Don't know
Hep A	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hep B	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Flu (past 12 mnths)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

21

HAVE YOU BEEN TESTED FOR THE FOLLOWING HEALTH PROBLEMS?

	Not tested	Tested +ve	Tested -ve	Prefer not to say
Hep C	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
TB	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HIV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you tested positive for ANY of these, did you go on to receive any treatment?

	Yes	No, not offered any	No, offered but didn't take it up	N/A	Prefer not to say
Hep C	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
TB	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HIV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

IF TESTED FOR TB:

What type of TB screening was this? skin test x ray Don't know

22

HAVE YOU HAD A SEXUAL HEALTH CHECK IN THE PAST 12 MONTHS?

Yes No Don't know

23

DO YOU KNOW WHERE TO ACCESS ADVICE ABOUT SEXUAL HEALTH?

Yes No (go to Q25)

IF YES, Where would you go?

GP or nurse Homeless/housing staff GUU/sexual health clinic
 Other.....

24

FEMALE CLIENTS ONLY: Have you had access to specialist women's health services?

		Yes	No	Uncertain
	cervical smear in past 3 years	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	breast examination in past 3 years	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5: A FEW QUESTIONS ABOUT YOU

25 **HOW WOULD DESCRIBE WHERE YOU ARE CURRENTLY SLEEPING?** (if this frequently changes, please say where you slept last night)

sleeping rough on streets/parks
 hostel
 2nd stage or supported accommodation
 squatting
 sleeping on somebody's sofa/floor
 nightshelter
 Other

26 **AT THE MOMENT, ARE YOU:**

	Yes	No
In training or education	<input type="radio"/>	<input type="radio"/>
volunteering	<input type="radio"/>	<input type="radio"/>
In employment	<input type="radio"/>	<input type="radio"/>
Accessing guidance around work or training	<input type="radio"/>	<input type="radio"/>

Do you think your health stops you being able to undertake any training, volunteering or employment that you want to?

Yes No Don't know

27 **PLEASE TICK IF YOU ARE WORKING WITH ANY OFFENDING SERVICES:**

currently with probation
 current community order
 Youth Offending service/YOT
 Other

28 **DO YOU HAVE ANY OF THESE BACKGROUNDS?** (this helps us to understand how your past experience may have affected your health or services you've been able to access)

	<input type="radio"/> Left prison within last 12 months <input type="radio"/> Left prison more than 12 months ago <input type="radio"/> Left Care Services (for young people) within past 5 years <input type="radio"/> None of these backgrounds									
29	<p>DO YOU CONSIDER YOURSELF TO HAVE A DISABILITY?</p> <p><input type="radio"/> Yes <input type="radio"/> No (Go to Q 30)</p> <p>How would you describe this disability? Choose any that apply</p> <table border="0"> <tr> <td><input type="checkbox"/> mobility</td> <td><input type="checkbox"/> sensory impairment (eg hearing or sight problems)</td> </tr> <tr> <td><input type="checkbox"/> learning disability</td> <td><input type="checkbox"/> developmental disability</td> </tr> <tr> <td><input type="checkbox"/> mental health</td> <td><input type="checkbox"/> long term condition</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Other:.....</td> </tr> </table>	<input type="checkbox"/> mobility	<input type="checkbox"/> sensory impairment (eg hearing or sight problems)	<input type="checkbox"/> learning disability	<input type="checkbox"/> developmental disability	<input type="checkbox"/> mental health	<input type="checkbox"/> long term condition	<input type="checkbox"/> Other:.....		
<input type="checkbox"/> mobility	<input type="checkbox"/> sensory impairment (eg hearing or sight problems)									
<input type="checkbox"/> learning disability	<input type="checkbox"/> developmental disability									
<input type="checkbox"/> mental health	<input type="checkbox"/> long term condition									
<input type="checkbox"/> Other:.....										
30	<p>WHAT IS YOUR MIGRATION STATUS? <i>Please refer to Definitions guidance if necessary</i></p> <p><input type="radio"/> UK resident <input type="radio"/> A10 national <input type="radio"/> other EU national <input type="radio"/> asylum seeker <input type="radio"/> Indefinite leave to remain <input type="radio"/> Unknown <input type="radio"/> Other</p>									
31	<p>WHAT AGE RANGE DO YOU FALL INTO?</p> <table border="0"> <tr> <td><input type="radio"/> 16-17</td> <td><input type="radio"/> 36-45</td> <td><input type="radio"/> 66-75</td> </tr> <tr> <td><input type="radio"/> 18-25</td> <td><input type="radio"/> 46-55</td> <td><input type="radio"/> over 75</td> </tr> <tr> <td><input type="radio"/> 26-35</td> <td><input type="radio"/> 56-65</td> <td></td> </tr> </table>	<input type="radio"/> 16-17	<input type="radio"/> 36-45	<input type="radio"/> 66-75	<input type="radio"/> 18-25	<input type="radio"/> 46-55	<input type="radio"/> over 75	<input type="radio"/> 26-35	<input type="radio"/> 56-65	
<input type="radio"/> 16-17	<input type="radio"/> 36-45	<input type="radio"/> 66-75								
<input type="radio"/> 18-25	<input type="radio"/> 46-55	<input type="radio"/> over 75								
<input type="radio"/> 26-35	<input type="radio"/> 56-65									
32	<p>WHAT IS YOUR GENDER?</p> <p><input type="radio"/> male <input type="radio"/> female <input type="radio"/> transgendered</p>									
33	<p>WHAT IS YOUR SEXUALITY?</p> <table border="0"> <tr> <td><input type="radio"/> Heterosexual</td> <td><input type="radio"/> Bi-sexual</td> </tr> <tr> <td><input type="radio"/> Gay or lesbian</td> <td><input type="radio"/> Prefer not to say</td> </tr> </table>	<input type="radio"/> Heterosexual	<input type="radio"/> Bi-sexual	<input type="radio"/> Gay or lesbian	<input type="radio"/> Prefer not to say					
<input type="radio"/> Heterosexual	<input type="radio"/> Bi-sexual									
<input type="radio"/> Gay or lesbian	<input type="radio"/> Prefer not to say									
34	<p>HOW WOULD YOU DESCRIBE YOUR ETHNICITY?</p>									

White		Asian/Asian British		Black/Black British		Mixed			Other ethnic background					
White British	White Irish		Pakistani	Other Asian	African		Other black	White and Black	White and Black African	White and Asian	Other mixed	Chinese	Romany/traveler	Other ethnic background
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Please state:									

35	<p>IS THERE ANYTHING ELSE YOU WOULD LIKE TO TELL US ABOUT YOUR HEALTH OR THE HEALTH SERVICES YOU USE? (please include views about how health services could best be improved, or positive/negative experiences you have had in accessing local health services)</p>
36	<p>INTERVIEWER: please write down the service where this survey was completed – eg day centre name</p> <p>.....</p>

THANK YOU FOR COMPLETING THIS SURVEY

5. Health Audit Participating Agencies.

North Devon / Torrington

- Charris House: Alabare Christian Care and Support – Bideford
- Bethany Project - Barnstaple
- Wynstay : Beck care Ilfracombe
- Freedom Centre: Freedom Social Projects – Barnstaple
- Barnstaple Poverty Action Group – North Devon / Torrington
- Sanctuary Carr-Gomm - North Devon / Torrington
- Harbour – Bideford
- Young Devon
- North Devon District Council
- Torrington District Council

Exeter

- Street Homeless Outreach Team
- St Petrocks
- Gabriel House
- Esther Community
- Bridge Project
- Exeter YMCA
- Sanctuary Carr – Gomm
- Homemaker Southwest
- Exeter City Council

South Hams

- St Barnabas project – Dartmouth
- Revival Life Ministries – Totnes
- Sanctuary Carr-Gomm
- Young Devon.

- Shekinah Mission
- South Hams District Council

APPENDIX 2

Levels of Drug use among Rough Sleepers Additional Data

1. Drug use amongst homeless people in London

Table 1: Levels of drug use amongst homeless people in London 'Home and Dry: Substance misuse in London

Frequency of use	% of people who had used drugs or alcohol in the past month	% of people who had used drugs or alcohol in the past year	% of people who had used drugs or alcohol at some point in their life
No drugs or alcohol	4%	2%	1%
Any Substance including alcohol	96%	98%	99%
Any drug excluding alcohol	83%	88%	94%
Alcohol only	13%	10%	5%
Heroin	47%	55%	67%
Other opiates (1)	30%	41%	58%
Crack	47%	56%	66%
Other Stimulants (2)	25%	46%	74%
Benzodiazepines (3)	32%	47%	65%
Hallucinogens (4)	6%	12%	51%
Cannabis	65%	73%	86%
Solvents	3%	6%	27%
Alcohol	68%	78%	93%

Source: Fountain and Howes 2002

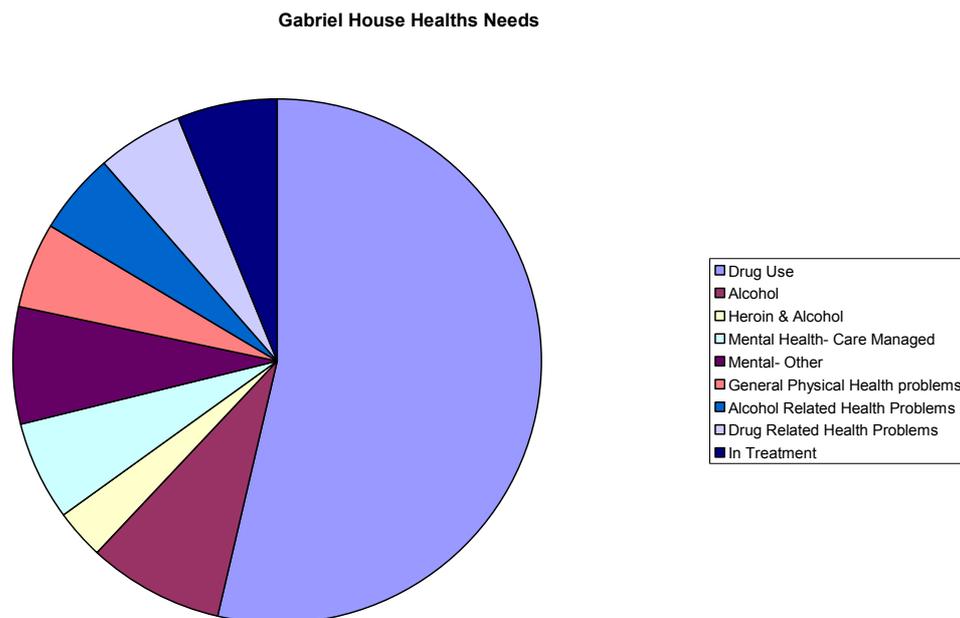
- (1) *methadone, morphine, DF118 (dihydrocodeine tartrate), Temgesic (buprenorphine), Diconal (dipipanone hydrochloride), Palfium (dextromoramide)*
 (2) *Cocaine powder, amphetamine, ecstasy*
 (3) *Diazepam, temazepam, Rohypnol, Mogodon, Librium, Ativan.*

(4) LSD, PCP, Magic Mushrooms, Ketamine.

2. Levels of Drug Use in High Support Accommodation Projects in Exeter (Glassbrook 2009a and b)

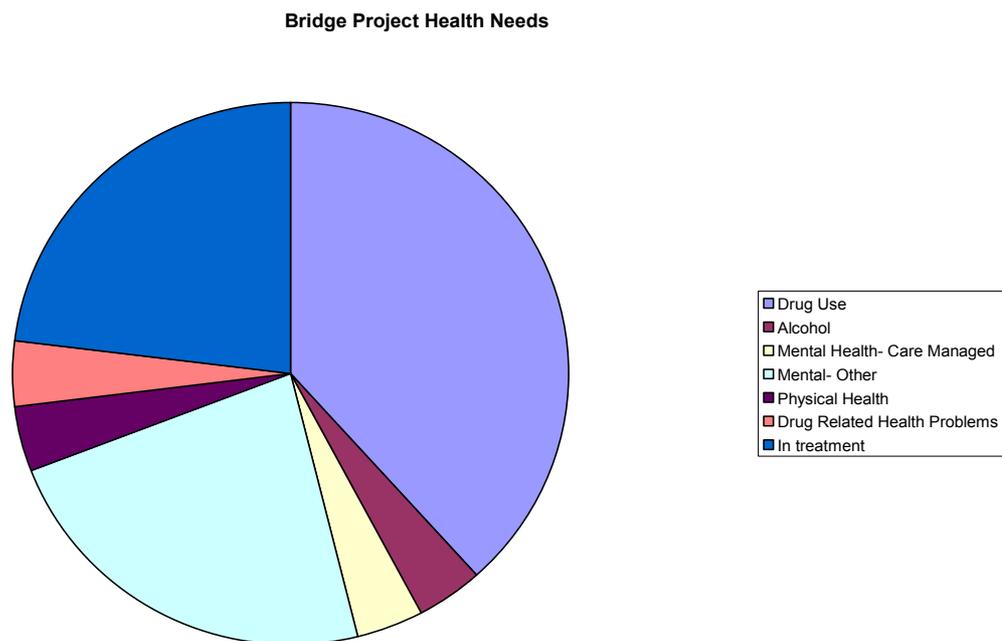
2.1 Gabriel House is a 40 bed hostel with 5 rooms for couples situated in Exeter. Shilhay Community have provided accommodation for homeless people in the city since the late 1960's; firstly at Gabriels Wharf, then at Palace Gate and now in a purpose built building in Smythen Street. The new hostel was built in 1999 but was soon considered to be not fit for purpose. Shilhay were awarded funding through the Places of Change initiative <http://www.cih.org/training/placesofchange/> and the building was redesigned in to smaller clusters of rooms (most ensuite) and a hotel style foyer with IT equipment. The hostel has always traditionally accommodated people with very high support needs including, mental health, substance misuse and antisocial behaviour. The hostel is staffed 24 hours a day.

2.2 Figure 1: Health Needs of Gabriel House Residents October 2008



Bridge Project

- 2.3 The bridge project is a high support dispersed hostel using the 'Housing First' Model
[http://england.shelter.org.uk/ data/assets/pdf file/0008/145853/GP Briefing Housing First.pdf](http://england.shelter.org.uk/data/assets/pdf_file/0008/145853/GP_Briefing_Housing_First.pdf)
- 2.4 Rough sleepers are able to access either a single or shared flat. There are 14 units of accommodation available throughout Exeter; 3x 2 bed flats and 8 x 1bed for singles or couples.
- 2.5 Figure 2: Health Needs of Bridge Project Residents



Esther Community

- 2.6 Esther Community is a 15 bed women's hostel managed by Keychange Charity and situated in Exeter. It has been open since 1999. Like Gabriel House, it provides high support accommodation. Women tend to deal with homelessness differently than men, often intentionally being less visible.
[http://www.crisis.org.uk/data/files/publications/Crisis Homeless Women 2006 full report.pdf](http://www.crisis.org.uk/data/files/publications/Crisis_Homeless_Women_2006_full_report.pdf) Therefore it could be argued that those women who end up in hostels have the most complex need.
A Snap shot of the health needs of the residents was taken in May 2009 as part of a Rapid Appraisal (see table 2 below)
- 2.7 Table 2 shows that each resident (represented numerically) has a range of complex needs. On average each resident has 4.7 needs and a median of 5 needs.
- 2.8 Both diagrams illustrate the high level of complex needs present within the homeless population, in particular those who live in high support accommodation.

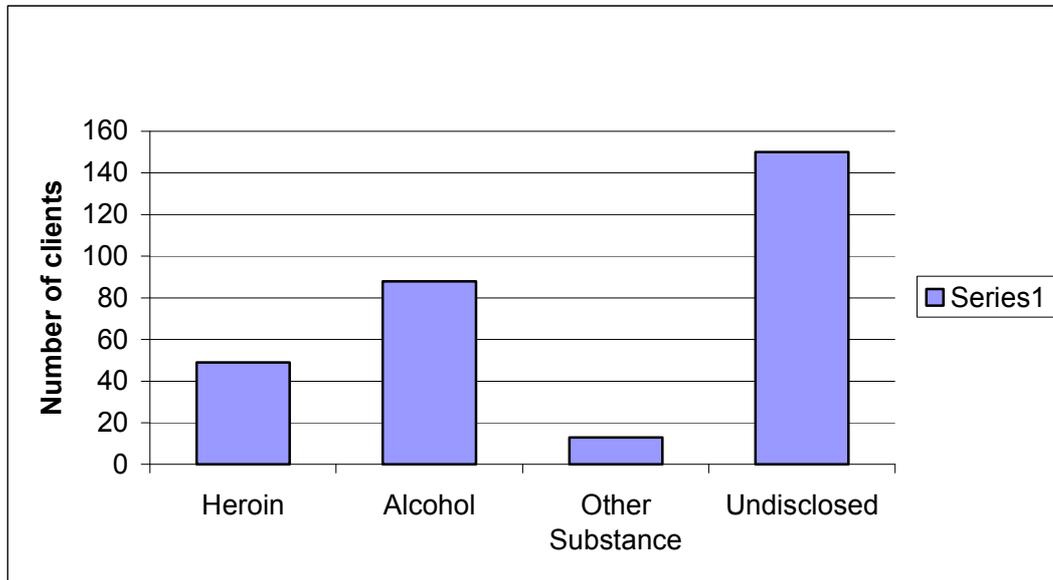
Table 2: Health Needs of residents at Esther Community May 2009

Esther Community Resident Health Needs - May 09																
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Substance misuse																
	Alcoholism	YES	YES	YES					YES		YES	YES	YES	YES	YES	YES
	Drug Misuse	YES		YES	YES		YES		YES	YES	YES		YES	YES		YES
Mental Health																
	Bipolar					YES										
	Learning Disabilities						YES		YES		YES		YES	YES		
	Depression				YES		YES	YES	YES			YES		YES	YES	
	Schizophrenia										YES					
	Anxiety		YES		YES			YES				YES	YES	YES		
	Self Harm													YES		YES
	Over Dose											YES			YES	YES
	Suicide											YES			YES	YES
	Aspergers				YES								YES			
Physical Health																
	Cancer		YES						YES							
	Pancreatitis								YES							YES

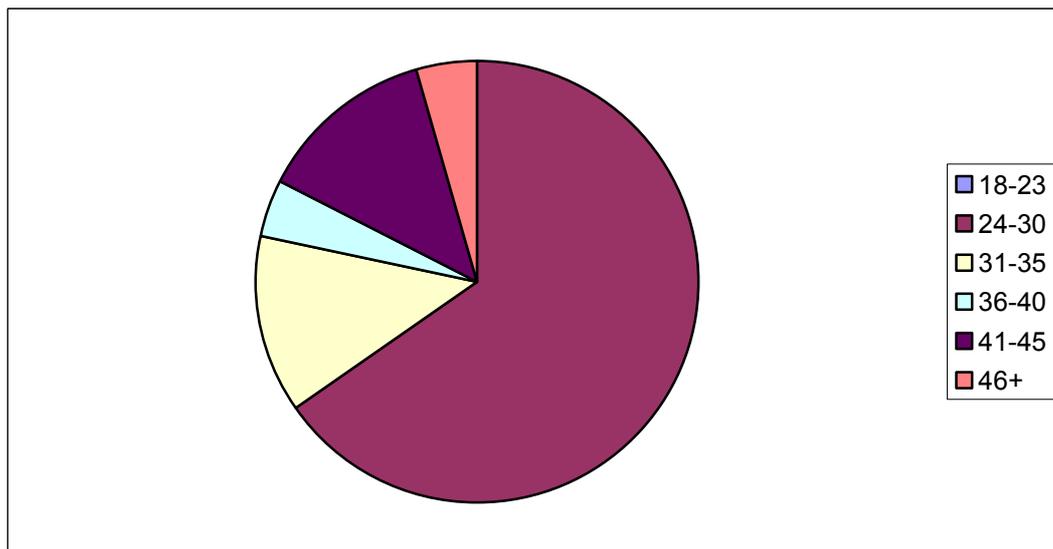
	Duplex Kidneys										YES					
	Asthma								YES	YES		YES				
	Tourettes														YES	
	Smoking	YES		YES												

3. Evidence of drug use amongst the Rough Sleeping population in Exeter: Data from the Street Homeless Team (Glassbrook 2009a)

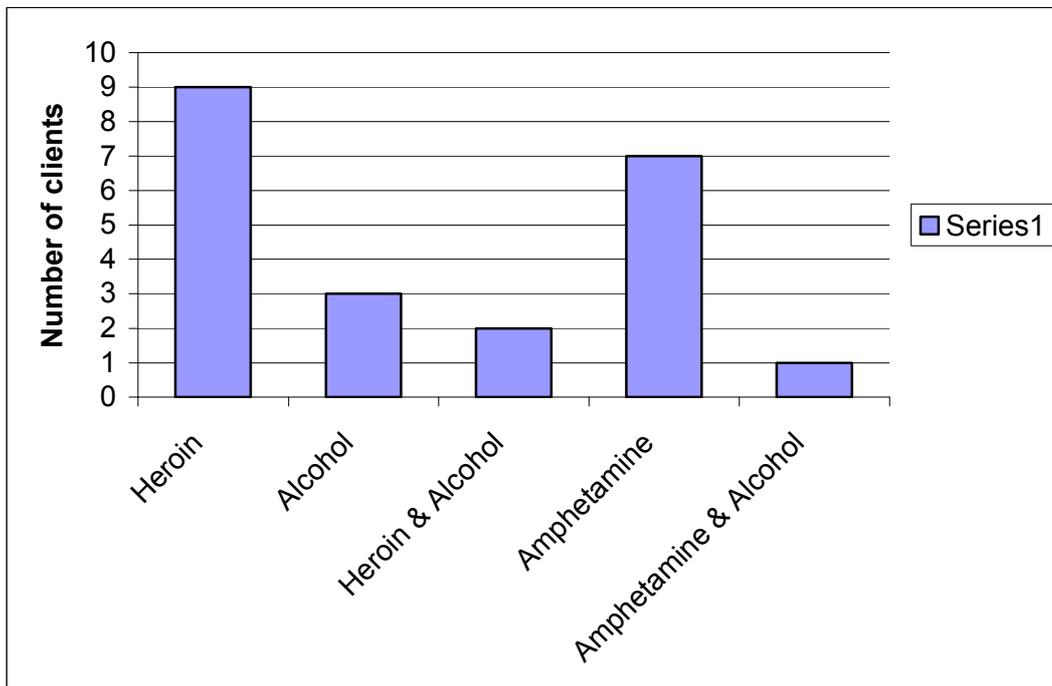
3.1 Figure 3: Substances used by SHOT Clients



3.2 Figure 4: Age Profile of Clients Accessing SHOT Drug Services tier 2 & 3 treatment in 2004/05.

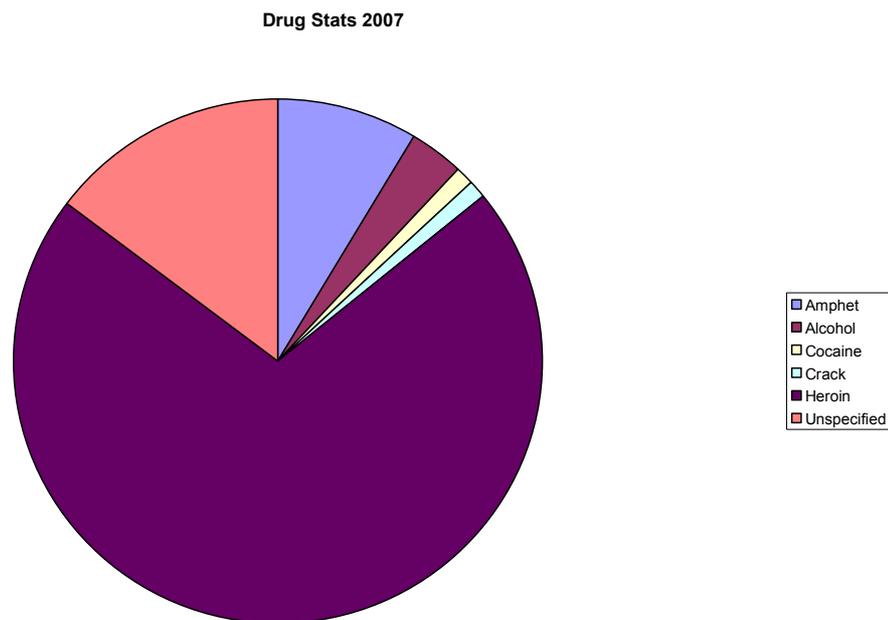


3.3 Figure 5: Primary dependant drug for clients accessing SHOT for enhanced Tier 2 & 3 treatment in 2004/05.

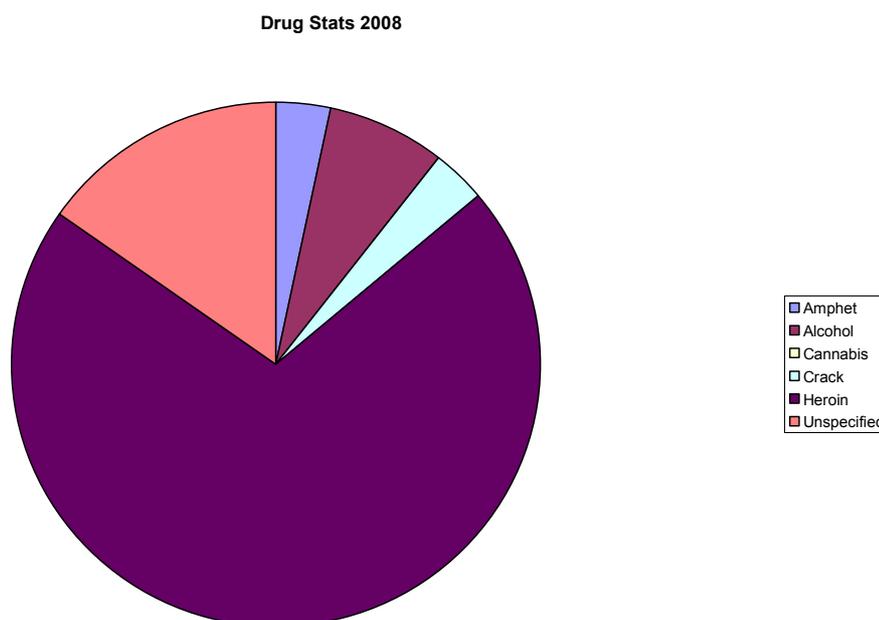


3.4 The SHOT Team hosted a tier 2 drugs worker to assertively engage with drug users who were street homeless. Their role was to engage with clients, deliver brief interventions such as Harm Reduction and to assist the client access drug treatment.

3.5 Figure 6: Number of interventions carried out by the SHOT tier 2 drugs worker in 2007



- 3.6 Figure 7: Number of interventions carried out by the SHOT tier 2 drugs worker in 2008



- 3.7 The charts illustrate that between 2007 -08 the majority of interventions were in association with heroin use. The next most significant substance is alcohol, often this is the secondary drug as the EDP service worked with drug users only.

Volume of SHOT service

- 3.6 Listed below are the recorded numbers of tier 2 and tier 3 contacts made by the drug workers on the SHOT Team

Tier 2 Client Contacts:

- 2006 – 2007 = 524
- Quarter 1 07-08 = 97

Clients in Tier 3 Treatment

- 2006 – 2007 = 57
- Quarter 1 07-08 = 18

4. References

Glassbrook, N. (2009 a) *A rapid appraisal of the health needs of the homeless population in Devon*. (Not published)

Glassbrook, N. (2009 b) *A rapid appraisal of the health needs of homeless women residing at the Esther Community in Exeter*. (Undertaken as part of HNA module for Plymouth University)

APPENDIX 3

Findings from The Devon Individualised Budget pilot which ran from August 2009 – July 2010

1. Pilot Findings

- 1.1 The pilot identified 4 rough sleepers in North Devon and 10 in Exeter.
- 1.2 There were 11 men and 3 women involved in the pilot.
- 1.3 In March 2010 the pilot was evaluated by Professor Colin Pritchard, Ph.D., M.A., A.A.P.S.W., F.R.S.A., Research Professor in Psychiatric Social Work, School of Health & Social Care, Bournemouth University, and, Visiting Professor, Dept of Psychiatry, School of Medicine, University of Southampton. He interviewed 12 of the clients involved in the pilot; the support workers and had access to case files.

Below are his findings:

Numbers of ERS who engaged with project:

- 13, from a target group of 14 – a 93 per cent initial “success” level

Numbers leaving the streets:

- to date, 11 people have left rough sleeping (at least for a period of time) and one whose current accommodation/ rough sleeping status is unknown
- in Exeter the ten clients who have engaged is more than the total number identified in the recent official street count, with a further 4 in North Devon. If these moves off the streets can be sustained, the pilot is likely to have made a significant contribution towards ending rough sleeping in the city

Type of subsequent accommodation:

- six people have been accommodated in a flat
- two in B&B
- one is intermittently staying in B&B

- one has moved into a Hostel
- one is in a special detoxification unit
- one is in B&B but awaiting court outcome
- two remain Rough Sleeping but engaged with the project.

Effectiveness of the IB approach:

- almost by definition the IB approach has been more effective in engaging ERS than the `standard approach`, with 13 out of 14 in active engagement with project workers

1.4 Clients' views of the approach are generally very positive though 3 clients are at early stages in their journeys away from the streets having professed ongoing doubts and uncertainties about `coming inside' (See detailed interviews with clients in Appendix A).

1.5 A review processes of project found very good to good responses from local agencies, based upon a very persistent and assertive client-focused outreach, backed by cooperative responses from agencies to which the clients were re-referred.

1.6 The review has identified both strengths and weaknesses. The personalised approach is effective in reaching clients and has improved accommodation uptake rates: see below `former rough sleeper client `Adrian's' comments. As yet, it is not clear how sustainable these early outcomes may be, and not all partners have fully engaged in the pilot.

1.7 An assessment of whether a `spend to save' business case can be presented by the new approach reducing rough sleeper costs to a multiplicity of agencies will be dependent upon the baseline costs incurred by other agencies. Initial evidence suggests there are `savings' by securing accommodation and moving people away from rough sleeping, although some `costs' remain, but when juxtaposed against estimates of the health costs of `Single Homeless People' at a national level, there seems little doubt, an IB approach would lead to `savings' as well as improved health care : see below.

Nature of the ERS Clients:

1.8 All 14 clients were rough sleeping at the start of the pilot and had a history of homelessness and entrenched rough sleeping (characterised by the duration of the time they had slept rough, and their refusal of/ an inability to make appropriate offers of support and accommodation).

- 1.9 Table 1: schematically outlines the 14 identified ERS, of whom 12 were successfully interviewed as part of the review. Their homelessness has spanned between 3 to 20 years, averaging 10.8 years, with 11 men and 3 women, aged between 21 to 58 years. Nine clients could be categorised along the adult autistic spectrum (D.o.H, 2010), five with either primary or severe secondary alcoholism, one client had a dual diagnosis and one person had learning difficulties - highlighting the homeless-psychiatric, or 'health and housing' interfaces. Two reported mental health contacts; five hospital contacts and ten of the 12 interviewed had links with GP-type services that included local psychiatric involvement.
- 1.10 At the commencement of the IBP, all 14 people were 'Entrenched Rough Sleepers' (ERS) and on the streets, many known to the police, with 8 clients having had some previous former conviction, at least three having spent time in prison, and two 'Ian' and 'Harry' having been arrested 6 and 5 times since July 2009.
- 1.11 One client is currently lost to the project, awaiting the disposal of the courts and his whereabouts are uncertain, three others, whilst engaged with the project, continue to be RS. Nine are in accommodation and one is awaiting discharge from a centre for alcohol-related brain-damaged. To successfully actively engage 12 out of 14 ERS is commendable.
- 1.12 Six are accommodated in flats, two in B&B, one in Hostel, and one awaiting discharge from a Specialist detoxification unit in another county. Their situation in 6 or 12 months would give a firmer indication of longer-term prospects for 'success' i.e. the sustainability of their progress.

Table 1: 100% Entrenched Rough Sleepers Clients Characteristics: Diagnostic Assessment & Current Outcome, all were 100% Entrenched Rough Sleepers

Client's characteristics and contacts with IB workers	Years Rough Sleeping #	Diagnostic Assessment: Previous Offence = #, Hospital contact = H. Mental health = MH
1. Adrian 47. 15 contacts	6	Autistic spectrum. Depression & OCD H & M.H to 3/12 Flat
2. Brian 47. 5 contacts	10	Autistic spectrum (paranoia) #. H. MH RS & no contact to start contact
3. David 25. 20 contacts	7/8	Autistic Spectrum (Asperser). #. MH RS to Flat 3/12
4. Eve 39. 12 contacts	4	Autistic Spectrum (paranoia) MH RS to Flat 2/12
5. Frances 44. 17 contacts	3/4	Autistic Spectrum (paranoia). MH RS to Flat 2/12

Client's characteristics and contacts with IB workers	Years Rough Sleeping #	Diagnostic Assessment: Previous Offence = #, Hospital contact = H. Mental health = MH
6. Jack 49. 35 contacts	13	`Autistic Spectrum (paranoia) & Alcoholism #. H & M.H. RS & part-time B&B acclimatising
7, Ian 48. 25 contacts	20	Schizophrenia (hallucinations) & Alcoholism. H. & MH. RS to Detox Unit, waiting discharge #
8.Ken 48. 29 contacts	14	Psychotic (delusional/hallucinatory) # MH. RS to Flat 3/12.
9. Lenny 21. 42 contacts	5yrs	Mixed diagnosis Aspergers & ADHD #. MH. RS & continues RS but with good contact
10. Charlie 58. 20 contacts	9	Dual diagnosis: Depression & Alcohol. H. MH RS to B & B
11. Harry 44. 12 contacts	15	Alcoholism. # . ? MH. RS, Post Detox to Hostel.
12. Mike 47. 36 contacts	20	Alcoholism & offender. # RS to lat 2/12 <i>Declined Interview</i>
13. Neil 47. 6 contacts	20	Alcoholism, offending, ASBO # RS to B&B before Courts, outcome unknown
14. <i>Georgie</i> 44. 20 contacts	4/5	Learning difficulties. H RS to B& B

Females Italics. Years RS * some years are virtually continual, others broken intermittently by entry into night shelters & the like.

2. The Psychiatric-Homelessness / Health and Housing Interface

- 2.1 The DH. 'Strategy for Adult Autistic people in England' (2010) is timely, as nine of the clients could be categorised along this spectrum; although the DoH stressed that 'diagnosis was not an end in itself' and the autistic spectrum, whilst is at last recognised, is far from exact.
- 2.2 It can be see in Table [3] that within a reduced NHS bed capacity, indicating the success of maximising care in the community, Mental Health beds fell from 67,122 to 26,430. Thus the ratio of Mental Health beds fell from 1 to 751 per person in England to 1 to 2,218 per person. If, amongst these clients one or more might well have occupied a mental health bed ten or twenty years ago, then in one sense 'savings' have already been made, as DCLG services cost less than D.H. Most of these clients fell outside the care of community services because of formal eligibility criteria, reliance upon formal "diagnoses" and FACS thresholds, illustrating the psychiatric-homelessness and Health-Housing interfaces.

- 2.3 The D.o.H (2009) identified a £5.892 billion 'Investment in Adult Mental Health Services', is on these figures 6.5% of total NHS budget in 2008/9. Taking the present numbers of Mental Health beds, 26,430, this would be the equivalent of £610 per day, the cost of a person admitted to a mental health bed. However, based upon 2008-09 schedules, the cost of a mental health bed alone was £452-647 averaging £572 per day (DoH,2009b). This might be considered to be a potential saving, to offset the cost of re-establishing an ERS person in appropriate supported accommodation.

Table 2: Mental Health Beds in England 1987-2009. Accessibility per rate of England & Wales population 1987/88 & 2006

Years & Pop	All Beds	Mental Illness	Ratio
1987/88 50.39m	297,364	67,122	1: 4.43
Beds per population	1: 169	1: 751	
1997/98	193625	37,640	1: 5.14
1987-97	-35%	-44%	
2008/09 # 57.73	159,386	26,430	1. 6.03
Beds per population	1: 362	1: 2184	
1998-2009 % change	-18%	-30%	
1987-2009 % Change	-46%	- 61%	1: 1.36

Source: Department of Health 2010.

3. Conclusions

Towards an integrated more effective intervention

- 3.1 There is a greater need to recognise the homelessness-psychiatric and health and housing interfaces. As the mental health bed capacity has been disproportionately reduced, it *may be* that many ERS or persistent RS might previously occupy a mental bed, but why they were 'lost to the service' is less important than the question of how to reduce and prevent such problems in the future?
- 3.2 First an integrated IB project such as this one to re-integrate current entrenched rough sleepers is likely to be needed until DCLG's ambition to end rough sleeping has been achieved...
- 3.3 Second, consideration is required to identify what might currently lead to people becoming homeless post-psychiatric discharge and to develop appropriate interventions?

Continued Exclusion a form of Punishment?

- 3.4 Following this 'exclusion/ excluded' theme it links up with the old concepts of 'deserving' - 'undeserving' people, with the resulting social exclusion and social ostracism, that is a form of punishment or, indeed, 'exile'. Entrenched Rough Sleeping might well be defined as a 'social exile' and 'exile' for the

ancients it was but one degree less than a death sentence. But this project taught this researcher, that it is not fundamentally the individual's 'choice' but rather the result of their being inadequately cared for earlier in the process, hence they end up 'institutionalised but without walls' as a self-defeating coping mechanism. Yet, whilst there is evidence that mental disorder leads to crime (Swanson, 1996; Bean 2008), being mentally ill is not in itself a crime. A European President was asked to determine the punishment for a Senator accused of a serious crime, which the defence claimed was committed during a serious delusional state. The President's response was "if he really was delusional, then ask not what punishment he deserves because *insanity is punishment enough*". The President was the Emperor Marcus Aurelius, and it might be argued that chronic mental health is '*punishment enough*' and a civilised society owes these people a support service as a compensation for their disability, which contributes so much to 'Years-living-with disability' (WHO, 2008). Such a perspective should be considered when reviewing 'spend to save' objectives.

- 3.5 There is good evidence that mental disorder can be at best resolved or at least well managed (Pritchard 2006; Wright et al, 2008; Mental Health Foundation, 2009; Turkington et al, 2009), in the words of the D.o.H. (2010) to enable people to lead reasonably independent fulfilling lives.

Thus the apparent continued 'punishment' of the rough sleepers reflects an inadequacy in our science or a failure of our statutory services to include them in a wider citizenship.

The Inconsistency: Clash of Objectives

- 3.6 At the core of many recent Governmental documents, which attracts cross-party support, is the notion of choice and 'empowering the user' (DCLG, D.o.H. 2009, 2010). This is reflected in the Personalisation initiative from which the present IB project emerges (D.o.H, 2010c). Clearly the two of the aims of the project are very 'client-focused' seek out and empower the individual to choose. Yet in the case of the DIBP, the third objective is to help people into accommodation, is essentially an agency objective. Currently two people do not want accommodation, Brian and Lenny. Brian, in effect because of his chronic mental condition, dominated by paranoid ideation; whilst Lenny has a degree of rationality about it, i.e. he wants to eventually work in the field of 'survival instruction' but again, his thinking is somewhat distorted by his familial and Aspergers situation.
- 3.7 In the case of Ian, currently in a placement outside Devon, there is a potential clash of objectives and some ambiguity about choice or what he wants or what is 'best for him'? This latter case is complex and is 'work in progress' whereas in the case of Brian and Lenny, for the foreseeable future, unless Brian was found a caravan, placed on an 'organic farm' – in his present state he is adamant that he is happy where he is, although welcomes a degree of engagement. Lenny on the other hand, also has grounds to ask the IB for modern outdoor equipment as it serves his aim of becoming an 'outdoor survivor instructor'. Moreover, in his particular case, it may be argued bringing him inside, inevitably nearer his mother, increases rather than lessens, the likelihood of him being more involved in criminal damage or indeed personal violent behaviour. Neither client is currently significantly adversely affected by their rough sleeping – both are in reasonable physical health, so even with

their mental fragility it would be hard to use the mental health acts to “section” them on grounds that they pose a risk to themselves (they do not to others). Can such a project or the agencies accept or tolerate a medium term apparent ‘abdication’ of their primary objectives, when it clashes with the client? This is a debatable point that may not happen often but needs some degree of resolution, even if it is at the case-specific level.

**Rough Sleeper data – Sept 09 – May 2010
(9 months) – North Devon**

1. Findings

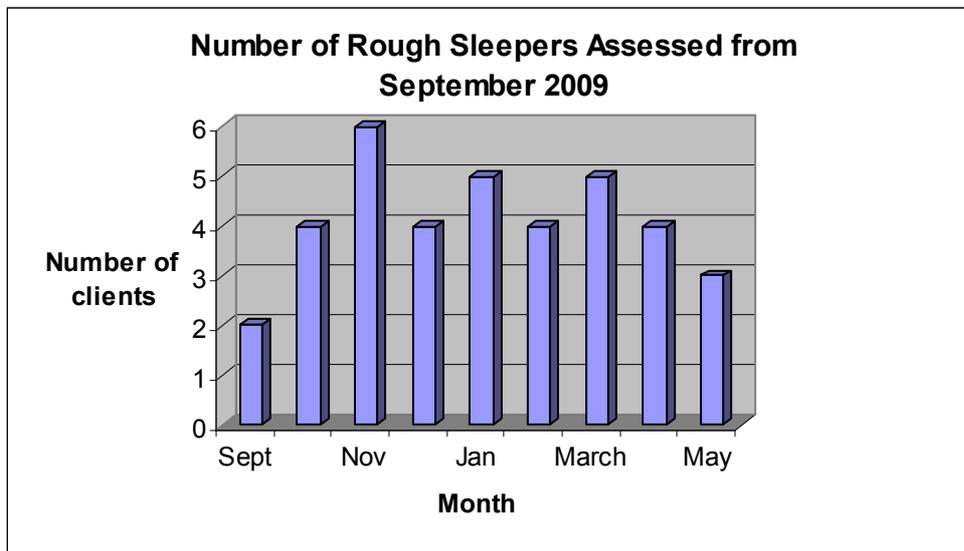
Total number of Rough Sleeper clients – 42

- 1.1 Please note that five of these individuals were entrenched rough sleepers with Complex needs and have not been included in the main body of statistics. This is because we have been working with an individual budget for 4/5 of these individuals and information will be presented separately.

Total number of individuals assessed as new cases/new approach – 37

- 1.2 Note that not all of those presenting as rough sleepers were rough sleeping every night or did they continue to remain a rough sleeper. Some of these individuals are now in independent or supported accommodation. Some find temporary accommodation with friends/family, albeit very unstable – The Rough Sleeper Outreach Worker aims to keep in touch with these people to advise and support move on.

Figure 1: Rough Sleepers assessed from September 2009



Source: NHS Devon Public Health Intelligence Team 2011

NB:

Total no. Of RS cases Sept 08-Aug09 = **81**

9 month total of new RS case Sept 09 –May 10 = **37**

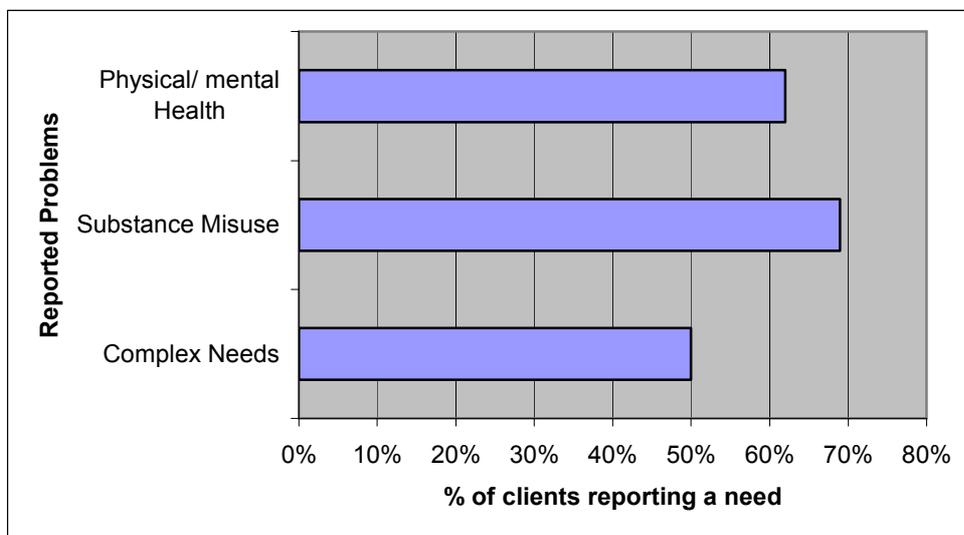
Male = 38

Female = 4

Complex Needs

- 21/42 individuals – 50% were deemed as having 3 or more presenting needs (Complex)
- 29/42 individuals – 69% presented with a substance misuse (drug or alcohol) problem
- 26/42 individuals - 62% presented with either/or a physical or mental health problem

Figure 2: Rough sleeper self reported needs



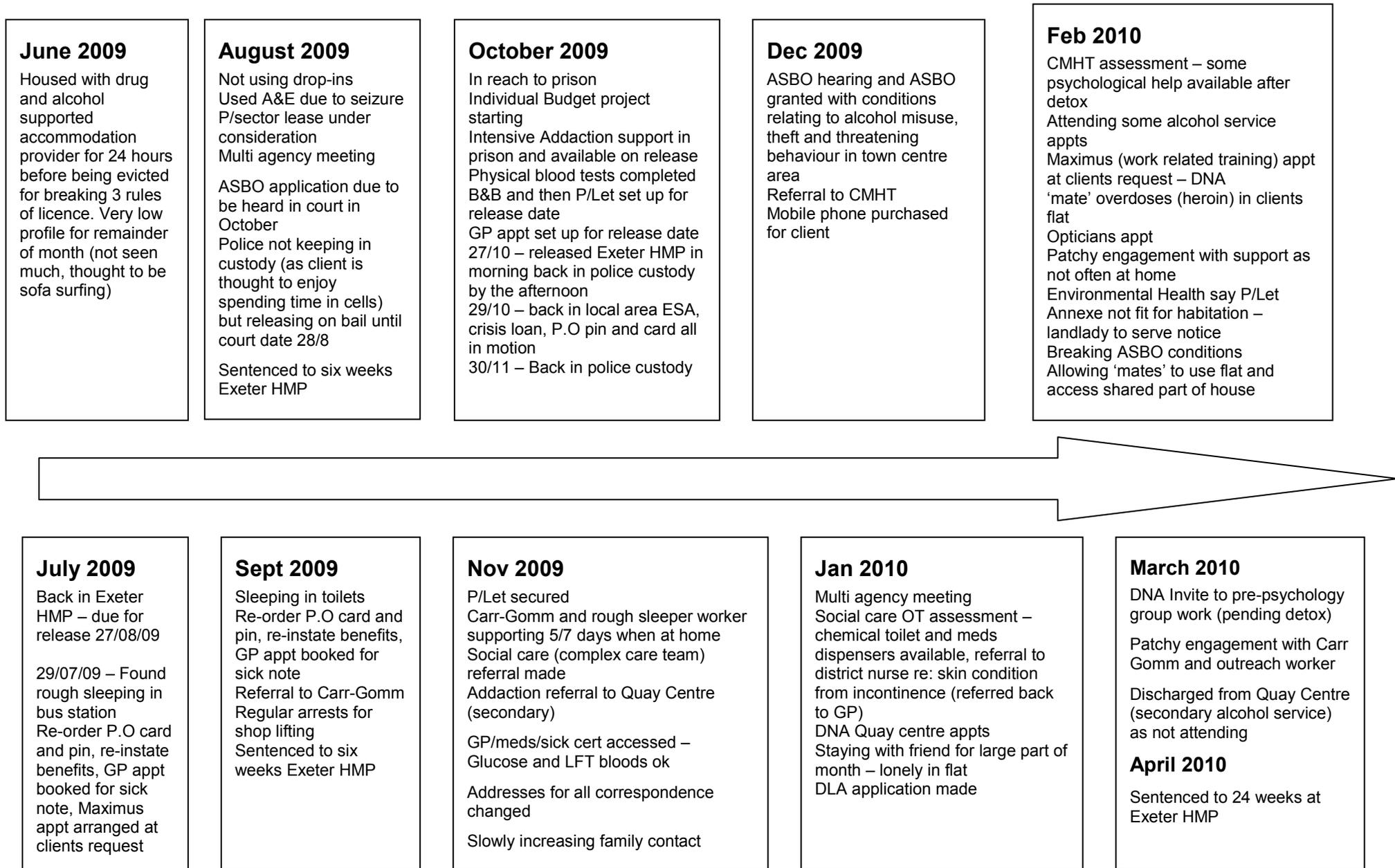
Source: NHS Devon Public Health Intelligence Team 2011

Case Studies

1. North Devon Case Study

- 1.1 As part of the Individualised Budget pilot, The North Devon outreach service worked with a male in his late 40's with a long history of offending, short prison sentences and homelessness. The client had been involved in a car crash in which his passenger was decapitated. This trauma had a deep impact on the client who began drinking heavily. His drinking led to the breakdown of his marriage and loss of employment.
- 1.2 The client then had an accident which resulted in brain damage; however he continued to drink heavily, which led to a cycle of street homelessness, broken up by short prison stays.
- 1.3 The client's offending was mainly petty crime (stealing alcohol) and breaches of the peace. At the time of the individualised budget pilot he had been served with an Anti Social behaviour Order (ASBO). This was published on the front page of the local paper, making the client very visible to the general public. He was unable to comply with the conditions of the ASBO, so was serving short prison sentences.
- 1.4 The client suffered from incontinence which made accommodation difficult, he also had mobility problems.
- 1.5 At the time of the pilot, the client was not linked in to any services except his engagement with the outreach workers and occasional use of the Freedom centre's day facilities.

Figure 1: Individual Budget Client timeline showing interventions and events from June 2009 – April 2010.



2. Exeter

Background

2.1 Tina has been known to the Outreach Team for about 5 years. She has a history of getting involved with men who are abusive towards her she has been badly beaten in the past and on occasions has been admitted to hospital. She is also often underweight and suffers from Asthma and Eczema.

Tina uses alcohol and can drink quite heavily, once accommodated and stable she does significantly reduce her drinking.

In the past she has been accommodated either at the women's hostel, or placed in a B&B by the Local Authority. This has broken down in the past because Tina abandons the accommodation often to return to the abusive partner.

It was highlighted by an outreach worker back in 2004 that Tina possibly had some learning difficulties and efforts were made to get her assessed by the Learning Difficulties team. This did not happen.

Individualised budget Pilot

2.2 It was agreed to include Tina in the pilot. She had come to the attention of homelessness agencies again due to being hospitalised by an abusive partner.

- Tina was assessed by a clinical psychologist on the 16th September 2009. She was assessed at the homeless day centre and it was assessed that her full IQ scale was between 59 – 66, it was noted that her ability to solve practical problems was slightly higher than her verbal ability whereas her understanding of language and ability to express herself produced the lowest scores. In summary the psychologist said ' I think it is highly likely that she would need a considerable amount of support to make decisions about issues to do with housing support and support needs; and indeed she may not have full capacity in these regards.'
- Tina was accommodated by the city council on 17th September 2009 in a Bed and Breakfast which is staffed and provides low level support. This accommodation did not meet her needs but was all that was available.
- A Needs Assessment Meeting was held on 6th October 2009 between Tina, an outreach worker and a member of the Learning Difficulties team. Initially the LD worker argued that Tina did not need support as she coped really well. The worker present felt that the LD worker was trying to prompt a response from Tina and advocated on her behalf. After some discussion about Tina's ability to support herself a referral to specialist accommodation was suggested.

- A referral to specialist accommodation was completed by the LD worker on 26.10.09 and signed by Tina on 04.11.09
- No further contact from the LD worker as they were on sick leave.
- A Multi Agency meeting was arranged for 3rd December 2009. All parties informed. The LD worker sent apologies at the last minute.
- Some discussions at the Multi Agency meeting about linking Tina in with an independent living service and a specialist day centre to get her away from homeless services, where it was felt that she was vulnerable to exploitation from other homeless clients due to her learning difficulties. Frustration was expressed that she is still in B&B because of a lack of input from LD. Tina often spends nights away from the B&B, workers then have to try and find her and persuade her to return. The council are being very flexible about her absences, but really they should terminate her tenancy.
- Tina was reunited with her mother and sister over Christmas which was very emotional. She then disappeared from the B&B rumoured to be staying with a man in the city. There were concerns about this 'relationship' given Tina's history of becoming involved in abusive relationships. Workers manage to speak to the man and tell him that Tina needed to return to the B&B or lose her tenancy. Initially he appeared supportive but workers become suspicious that he is abusing Tina.
- LD worker was contacted on 11.01.10. The LD worker stated that Tina had been referred to the independent living service, but the outreach team were not aware of this because there has been no communication from the LD team since the beginning of October. In the course of the conversation the LD worker disputed the outreach workers comments that Tina had a severe Learning Difficulty until the worker challenged this by arguing that this had been the assessment of the clinical psychologist who had assessed Tina back in September.
- The LD worker then called back to give the contact person at the independent living service. The LD worker said that an appointment had been made for Tina before Christmas and that she had not attended. The outreach service knew nothing of this. It clearly states in her Needs Assessment meeting that Tina finds it difficult to keep appointments, it could be argued that more effort could have been made; informing partner agencies so that Tina could attend.
- The LD worker asked the outreach service to arrange another Multi - Agency and to invite the independent living service
- When pressed about the specialist accommodation that Tina had been referred to, the LD worker suggested leaving Tina where she was until it became an issue; until it became likely that she would be evicted. Despite the staff at the B&B going the extra mile, Tina was not receiving the right level of support there and the local authority were being extremely flexible in allowing Tina to stay despite

her constantly breaching the terms of her tenancy. These issues had been pointed out to the LD worker.

- The outreach worker spoke to a worker from the independent living service. They said that the LD worker had agreed to arrange a Multi Agency for Tina as Case Coordinator this was their role.
- Tina was spending more time away from the B&B with the man in the city. Outreach staff were concerned that Tina was being abused by this man and felt that because of her learning difficulties Tina was unable to resolve the

Outcome

- 2.3 Learning Difficulties accepted that they had a duty to Tina. They worked closely with the outreach team who assisted the LD worker to engage with Tina. There were 3-way discussions (LD, SHOT and Tina) about the best accommodation and support.
- It was agreed that supported accommodation away from Exeter would be preferable, Tina wanted to live by the sea, so a supported lodgings placement was found for her in a coastal town
 - The Outreach workers assisted with the move liaising with the landlady and the LD team to ensure a smooth transition. It was anticipated that initially Tina may come back into the city and not stay at her accommodation and this was built in to the support plan
 - Tina did eventually settle into her new accommodation and has been there for 9 months