Achieving positive shared outcomes in health and homelessness

Contents

Introduction and summary

1. This guidance provides advice on positive shared outcomes that the Office of the Deputy Prime Minister's Homelessness and Housing Support Directorate would like to see local authorities, Primary Care Trusts and other partners achieve on health and homelessness. It does not represent statutory guidance.

2. This guidance has been produced by the Homelessness and Housing Support Directorate in conjunction with the Department of Health's Health Inequalities Unit. It is based on analysis of good practice, data and research. It sets out the health issues and health inequalities faced by homeless people and those vulnerable to homelessness, and relates these to existing statutory and non-statutory targets.

3. The recent Wanless Report recommends that local Primary Care Trusts and local authorities agree joint local objectives for tackling health inequalities and their local needs. By working together to achieve shared outcomes, local housing authorities and health providers can deliver:

- marked improvements in the health of homeless people;
- reductions in homelessness caused by poor health;
- reductions in poor health caused by homelessness;
- reduced public expenditure on health and housing;
- improved health support to enable vulnerable clients to maintain their tenancies and reduce health needs.

4. This guidance suggests five key positive outcomes which health and homelessness partnerships might work towards:

    1. improving health care for homeless families in temporary accommodation;
    2. improving access to primary health care for homeless people;
    3. improving substance misuse treatment for homeless people;
    4. improving mental health treatment for homeless people;
    5. preventing homelessness through appropriate, targeted health support.

5. This guidance sets out possible actions to achieve these outcomes, and includes examples of where these actions are already making a positive impact. It also suggests measures to assess performance. Agencies may choose additional or different positive outcomes and performance measures.

6. Local authorities, Primary Care Trusts, Drug Action Teams, Mental Health Teams and the voluntary sector need to agree local aims and objectives to deliver homelessness strategies, Supporting People strategies, local delivery plans and drug and alcohol treatment plans.

7. We welcome feedback on the suggestions in this guidance and are keen to hear about other objectives or targets that authorities set themselves and their partners.

    Comments or questions should be sent to the Homelessness and Housing Support Directorate, Office of the Deputy Prime Minister, Zone 1/H10, Eland House, Bressenden Place, London SW1E 5DU or email: hmd.comms@odpm.gov.uk

Background

Homelessness is a serious and growing problem. It is caused by a complex interaction of structural problems, including the supply and accessibility of housing, and personal problems, such as debt, relationship breakdown and poor health.

Every year, more than 200,000 households experience homelessness or the threat of homelessness. Their experience varies. A small but significant number end up sleeping rough (around 500 on a single night in 2003, compared with nearly 2,000 in 1998). A larger group of single homeless people live in hostels and other insecure accommodation, or stay in squats or with friends, and are dependent on support services to sustain independent living away from the streets. In 2003-04, the Government's Supporting People programme is providing housing related support for around 45,000 single homeless people.

An even larger group apply for help from local housing authorities under the homelessness legislation. In 2002-03, out of 280,000 households who applied for homelessness assistance, 130,000 were accepted as unintentionally homeless and in priority need (just over 70,000 were homeless but intentionally so, or not in priority need, while nearly 80,000 were found not to be homeless). Most of the households accepted as unintentionally homeless and in priority need are placed in temporary accommodation until settled housing becomes available. This group has been growing in recent years, with 95,060 households living in temporary accommodation at the end of December 2003[1]. More than half of these households contained dependent children (around 100,000 children in total) or a pregnant woman, the remainder being vulnerable in some way - for example due to age, or physical or mental health. The Supporting People programme is also providing housing related support for around 14,500 homeless families.

The Government is determined to tackle homelessness more effectively and is taking forward a number of new approaches, set out in the March 2002 report, *More than a roof*[2]. A stronger emphasis on identifying and tackling the under-lying causes of homelessness, and preventing people from becoming homeless in the first place, are key principles under-pinning these new approaches. The impact of health on homelessness, and vice versa, is one of the issues being addressed. This guidance is being issued alongside a policy briefing *Addressing the health needs of homeless people*[3] giving an overview of the health needs of different groups of homeless people, with signposts to further information, and setting out the action that is being taken currently and is under development.

Why do we need to look at shared Health and Homelessness outcomes?

For the first time, health inequalities were made a key priority for the NHS in the Priorities and Planning Framework (PPF) for 2003-06[4] (see **Annex A**). The framework stresses the importance of reducing inequalities in health outcomes across different groups and areas in the country and ensuring that the distribution of health benefits from service expansion and development consistently favours individuals and communities that have been traditionally under-served. The NHS' role in tackling the wider determinants of health is also recognised, for example by agreeing a single set of local priorities with local authorities and other partners, and contributing to regeneration and neighbourhood renewal programmes.

Homeless people are identified in the Cross Cutting Review on Tackling Health Inequalities[5] as one of the vulnerable groups for whom targeted interventions may be needed to address their specific needs and poor health outcomes. *Tackling Health Inequalities - A Programme for Action*[6] recognises the role that Primary Care Trusts (PCTs) have in working closely with local partners to improve health outcomes for homeless people.

The recent Wanless Report *Securing Good Health for the Whole Population*[7] recommends that the Government should set a clear national framework of objectives for all key risk factors to health, and that:

> " Primary Care Trusts, local authorities and other partners should determine shared local objectives based on these national objectives and their local needs."

Research evidence suggests that homeless households experience poorer physical and mental health than the general population, which can be exacerbated by their continuing homelessness and poor living conditions. A number of studies have also found a high prevalence of alcohol and drug dependency amongst homeless people.

For example:

- Homeless families living in temporary accommodation report a higher incidence of infections[8], and are more likely to be malnourished and have babies with a low birth weight[9].
- A small-scale study of homeless families who had been re-housed found that mothers and their children had a higher incidence of mental health problems than comparison groups and mental health problems amongst children actually increased from 29% to 39% one year later[10].
- Homeless households are less likely to be registered with a general practitioner and single homeless people in particular have been found to be high users of accident and emergency services as their main point of access for primary care[11]. This is likely to be related both to frequent moves before being re-housed as well as a higher incidence of health problems.
- A number of studies have found a high prevalence of alcohol dependency amongst single homeless people[12]. The research has also shown that the prevalence and severity of dependency is linked to housing problems and is highest amongst rough sleepers.
- Research has found that homeless people with drug problems tend to be younger than those with alcohol problems[13]. Some research has suggested that young homeless people use drugs to help them to cope with the trauma associated with homelessness[14].

Only 74 local authorities currently collect information on repeat homelessness on a regular basis. The information currently available suggests that around 10% of homeless household acceptances each year have been previously accepted as homeless[15]. From 1 April 2004, local authorities will be required to monitor and report repeat homelessness quarterly, and it is expected that the quality of information will improve as many more authorities introduce better monitoring systems for repeat homelessness.

Housing related support services for homeless households aim to prevent homelessness occurring or recurring. Supporting People, a strategic planning and funding programme which assists vulnerable people to sustain their tenancies, plays a significant preventative role in the reduction of homelessness and ill health. It brings together local health, drugs and housing teams to address the support needs of those vulnerable to homelessness.

Shared health and housing action will help towards achieving the PPF objective of reducing inequalities in health outcomes across different groups and geographic areas and achieving the PSA target of reducing by 2010 the gap in inequalities in health outcomes by 10 per cent as measured by infant mortality and life expectancy at birth. By working together to achieve shared outcomes, and taking a public health approach to addressing the health needs of homeless and vulnerable people, local housing authorities and health providers can deliver:

- marked improvements in the health of homeless people;
- reductions in homelessness caused by poor health;
- reductions in poor health caused by homelessness;
- reduced public expenditure on health and homelessness;
- reduced repeat homelessness and increased sustainability of tenure through relevant support.

Who needs to be involved?

The following are some of the agencies that would benefit from developing partnerships to achieve shared health and homelessness outcomes:

- Local Authorities, including the Housing Department, Social Services, and Supporting People team;
- Local Strategic Partnerships;
- Primary Care Trusts, including Directors of Public Health, GPs and Health Visitors;
- Drug Action Teams and Drug and Alcohol Action Teams;
- Mental Health Trusts; and,
- Voluntary and community organisations.

How can this be achieved?

In order to achieve some of the existing outcomes and targets for local authorities, the NHS and social services set out in Annex A, improved health and housing services will need to be provided for people who are homeless or at risk of losing their home.

Local authorities, Primary Care Trusts, and voluntary organisations are invited to develop shared local outcomes to improve health and reduce homelessness. In doing so you may wish to look at the suggested outcomes below.

The five key outcomes recommended to improve the health of homeless people in this guidance are:

- Improving health care for homeless families in temporary accommodation;
- Improving access to primary health care for homeless people;
- Improving substance misuse treatment for homeless people;
- Improving mental health treatment for homeless people; and
- Preventing homelessness through appropriate, targeted health support.

In order to measure whether shared outcomes are being achieved, local authorities and PCTs could agree a performance assessment measure for each outcome, such as the ones suggested in the following sections. Individual projects may collect data already, as outlined in the examples, or they may wish to in the future, following the introduction of new monitoring arrangements, for example the number of GPs in a PCT area providing enhanced services for homeless people. However, it is recognised that in many cases systems will need to be developed to collect such information to build a baseline in order to begin measuring success over time.

Suggested local shared outcomes

1. Improving health care for homeless families in temporary accommodation

There is growing awareness of the importance of providing timely, appropriate and ongoing health care for homeless families while they are in temporary accommodation and after they have moved to settled accommodation. There are also child protection risks if homeless families become disengaged from services. Studies have revealed high rates of contact with social services and increased incidence of being on the child protection register amongst homeless families than the national average for children, which is 0.28% (Department of Health, 2001). A study[16] found that 12% of the children interviewed were placed on the child protection register and 27% of parents reported having a social worker.

A headline indicator of the "Number of Homeless Families with Children in Temporary Accommodation" has been included as part of a set of national indicators to support the 2010 health inequalities target. This is also a key indicator for ODPM's Public Service Agreement target (PSA5) on housing supply and demand, and there is a related new Best Value Indicator proposed for 2004/05.

Examples of action to improve health care for homeless families in temporary accommodation include:

- putting in place a notification system for tracking homeless families in temporary accommodation and ensuring effective health checks, and referral between housing, social services and health services
- undertaking a health needs assessment for homeless families in temporary accommodation
- having a named social worker/health visitor with a dedicated homelessness prevention budget

2. Improving access to primary health care for homeless people

Many homeless people are unaware that they do not need a permanent address to register with a GP, or encounter difficulties in trying to do so. Other homeless people may have difficulty registering or keeping appointments because of their chaotic lifestyles or because health needs are not prioritised against other needs. Others will need to engage with primary care after a period in hospital. The Department of Health has issued guidance on hospital discharge for homeless people[17] referring to the need to ensure that they have access to primary care services following discharge.

Examples of action to improve access to primary health care for homeless people include:

- reshaping existing GP services, providing health outreach/using non-health premises for health sessions, or implementing a Personal Medical Services[18] scheme
- providing information packs to relevant agencies on how/where homeless people can register
- implementing a hospital discharge policy to ensure that a patient has accommodation upon discharge

3. Improving substance misuse treatment for homeless people

There is a large body of research which has identified widespread problematic drug use among homeless people, and the Advisory Council on the Misuse of Drugs identifies drug misuse as having a central role in homelessness[19]. Homelessness can make it difficult for drug users to access drug treatment services or to maintain a treatment programme. A good practice handbook *Drug services for homeless people*[20] has been produced by the Department of Health, the National Treatment Agency, Home Office, Office of the Deputy Prime Minister and DrugScope.

Examples of action to improve substance misuse treatment for homeless people include:

- developing screening and referral protocols for substance misuse
- providing outreach drugs services to day centres or temporary accommodation
- providing structured after-care/tenancy support to enable drug users to sustain their accommodation

4. Improving mental health treatment for homeless people

Many homeless people have mental health problems, such as personality disorders, which make it harder to engage with people and services. The latest homelessness statistics[21] show that 9% of households accepted as unintentionally homeless and in priority need by local authorities in England were vulnerable due to mental illness. A Mental Health Foundation report (2002)[22] found that mental health problems are eight times higher for people living in hostels and bed and breakfast accommodation, and eleven times higher for those who sleep rough compared to the general population.

Examples of possible action to improve mental health treatment for homeless people include:

- providing joint training for staff from homelessness and mental health fields in identifying and assessing mental health needs of homeless people
- developing effective support techniques that can be used in hostels and day centres to treat mental health problems such as depression, anxiety and personality disorders.

5. Preventing homelessness through appropriate, targeted health support

The Supporting People programme provides funding and facilitates strategic planning of housing related support for vulnerable people to sustain their tenancies. Homeless people, substance misusers and people with mental health problems are just three of the client groups provided for in the programme. Research has identified that a lack of, or ineffective, housing related support can result in repeat homelessness, particularly amongst substance misusers, ex offenders and those with mental health problems.

Supporting People Partnerships include senior representatives from health (PCTs), 1ocal authorities (including housing departments), probation whose role is to strategically plan and implement the delivery of housing related support across all Supporting People client groups. Local Authorities are due to submit their 5 -year Supporting People strategies to the ODPM in November 2004.

Examples of actions taken to prevent homelessness through appropriate, targeted health support include:

- undertaking a needs analysis to identify local housing support needs
- developing an effective multi-agency partnership to address housing related support needs through strategic planning and implementation of services
- implementing tenancy sustainment programmes to address specific groups of vulnerable people, for example former drug misusers

Conclusion

The Government is encouraging joint health and homeless action to improve health and reduce homelessness. Health objectives need to be an explicit part of local housing authorities' homelessness strategies and Supporting People strategies, and the health needs of homeless people need to be addressed by health services. Developing shared outcomes and monitoring them against agreed performance measures will be an important step in achieving these objectives.

Annex A

Existing targets and outcomes on health

The NHS *Planning and Priorities Framework* sets out the priorities until 2006 for the NHS and social services and describes what local organisations and communities need to do to plan for and implement these improvements. Every organisation needs to ensure that services are provided equitably to all who need them. Health and social care priorities and objectives fall under the following categories:

- Improving access to all services
- Focusing on improving service outcomes
- Improving the overall experience of patients
- Reducing health inequalities
- Contributing to the cross-government drive to reduce drug misuse

At the national level, the following Department of Health targets may impact upon homelessness:

- **Guaranteeing access to a primary care professional within 24 hours and to a primary care doctor within 48 hours from 2004**.

  Only a quarter of rough sleepers have a GP[23] and homeless people are 40 times more likely not to be registered with a GP than the general public[24].

- **Reduce to 4 hours the maximum wait in A&E from arrival to admission, transfer or discharge.**

  Homeless people are four times more likely than the general public to turn to A&E for primary care if they cannot access a GP.

- Improving life outcomes of adults and children with mental health problems through improvements in access to Mental Health Trust services and CAMHS (Child and Adolescent Mental Health Services), and reduce the mortality rate from suicide and undetermined injury by at least 20% by 2010.

  Suicide accounts for one in four deaths among homeless people and living in stressful, cramped and unsatisfactory conditions - such as in B&B accommodation - can create or exacerbate mental health problems. Reducing the stress and anxiety caused by losing one's home would also positively impact upon other types of health service, notably GPs, health visitors and community and secondary mental health services.

- Increase the participation of problem drug users in drug treatment programmes by 55% by 2004 and by 100% by 2008, and increase the proportion of users successfully sustaining or completing treatment.

  Around 80% of those in the hostel environment misuse drugs. "Problem" drug users and those with mental health issues cannot be overlooked when pulling together treatment programmes.

- By 2010, reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.

  The life expectancy for a rough sleeper is 42 years of age and homelessness increases the risk of a low birth weight for children. This is exacerbated by a poor diet, stress, and other health problems.

- Improve access for both emergency care and planned care.

Homeless people must be able to access: high quality primary care services that are responsive to their needs; integrated emergency care that links together primary care, social care, hospital care, ambulance services, voluntary services and NHS Direct; efficient appointment and admission systems that offer choice and fast access to planned care.

Existing targets and outcomes on homelessness

All local authorities are expected to meet the Government's targets of:

- Avoiding the use of B&B hotels for homeless families with children, except in emergencies, and even then for no longer than six weeks[25].
- Sustaining reductions in rough sleeping at two-thirds below the levels recorded in 1998, or lower.

Research[26] on families with children indicates that homelessness can have a negative physical and emotional impact on health, even where B&B is not used. So, while achieving the B&B target will provide real benefits for the children of homeless families, homelessness and the use of other forms of temporary accommodation will continue to have implications for health and social services, both while people are in temporary accommodation and after they have moved to settled accommodation.

Additionally, local authorities have been asked to set further outcomes, as set out in *Achieving Positive Outcomes on Homelessness*, from the examples set out below:

- **Reduced levels of repeat homelessness** (which can be one of the strongest indicators of families or vulnerable individuals suffering health and other non-housing problems);
- **Reduced levels of homelessness against main causes** (preventing homelessness by targeting specific and timely interventions before homelessness occurs);
- **Reduced inappropriate use of temporary accommodation** (tackling the most damaging experiences, for example where families are placed in cramped conditions, moved frequently, or placed away from existing support networks).

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[1] Statutory Homelessness: England Fourth Quarter 2003
http://www.odpm.gov.uk/stellent/groups/odpm_housing/documents/page/odpm_house_604177.hcsp

[2] More than a roof - A report into tackling homelessness
http://www.odpm.gov.uk/stellent/groups/odpm_homelessness/documents/page/odpm_home_601520.hcsp

[3] Addressing the health needs of homeless people, ODPM March 2004
http://www.odpm.gov.uk/stellent/groups/odpm_control/documents/contentservertemplate/odpm_index.hcst?n=855&l=1

[4] NHS Priorities and Planning Framework
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4008430&chk=lXp8vH

[5] Cross Cutting Review of Health Inequalities
http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthInequalities/HealthInequalitiesAssociatedPublications/fs/en?CONTENT_ID=4001790&chk=GmuwE%2B

[6] Tackling Health Inequalities: A Programme for Action, 2003
http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthInequalities/ProgramForAction/fs/en

[7] Securing Good Health for the Whole Population: Final Report, 25 February 2004
http://www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless03_index.cfm

[8] Hutchinson, K. (1999) Health Problems of Homeless Children in Vostanis, P. and Cumella, S. (ed) Homeless Children: problems and needs, London: Jessica Kingsley

[9] Quilgars, D. (2001) The Incidence and Impact of Homelessness in Bradshaw, J (ed) (2001) Poverty the Outcomes for children, London, Family Policy Studies Centre Occasional Paper 26

[10] Vostanis, P. and Cumella, S. (1999) Homeless Children: problems and needs, London: Jessica Kingsley

[11] see 7

[12] Gill et al, 1996, cited in Alexander, 1998; Randall and Brown, 1996

[13] see 10

[14] Klee and Reid 1998b, cited in Fitzpatrick et al, 2000

[15] Homelessness Statistics September 2003 and Repeat Homelessness Policy Brief
http://www.odpm.gov.uk/stellent/groups/odpm_homelessness/documents/page/odpm_home_026079.hcsp

[16] see 8

[17] Discharge from hospital: pathway, process and practice
www.doh.gov.uk/hospitaldischarge/ch5app5.htm

[18] HHS has issued a Health and Homeless information sheet on PMS schemes available on the homelessness pages of the ODPM website www.homelessness.odpm.gov.uk

[19] Advisory Council on the Misuse of Drugs *Drug Misuse and the Environment*, Home Office 1998

[20] Drug services for homeless people: a good practice handbook, 2002
http://www.odpm.gov.uk/stellent/groups/odpm_homelessness/documents/page/odpm_home_601516.pdf

[21] http://www.odpm.gov.uk/pns/DisplayPN.cgi?pn_id=2003_0266

[22] The Mental Health Needs of Homeless Young People, 2002
http://www.mentalhealth.org.uk/page.cfm?pagecode=PBBRCY

[23] Rough Sleeping Report by the Social Exclusion Unit, 1998
http://www.socialexclusionunit.gov.uk/publications/reports/html/rough/srhome.htm

[24] Crisis Media Brief, 2002 http://www.crisis.org.uk/pdf/gpmediabrief.pdf

[25] From April 2004 this target will be incorporated in legislation.

The Homelessness (Suitability of Accommodation) (England) Order 2003: guidance
http://www.odpm.gov.uk/stellent/groups/odpm_homelessness/documents/page/odpm_home_026585.hcsp

[26] see 7