Homelessness statistics: March 2004

Contents

Front cover

Homelessness statistics: March 2004 and addressing the health needs of homeless people

Summary

This briefing is seventh in a series produced by the Homelessness and Housing Support Directorate to accompany the Office of the Deputy Prime Minister's quarterly statistical release on homelessness. The briefings are intended to improve understanding of homelessness and to highlight issues that local authorities and other agencies should address through local homelessness strategies and services.

Numbers of homeless acceptances and the numbers of households in temporary accommodation continue to rise in line with the long-term trend. The work of the Homelessness & Housing Support Directorate is now focussing more on possible ways to address the number of households in temporary accommodation. Against these rises, many local authorities have already managed to end or avoid the use of Bed and Breakfast hotels to accommodate homeless families with children. Good progress towards meeting the B&B target continues to be made by the remaining authorities.

Following a general description of the key issues in the latest homelessness statistics, this issue concentrates on addressing the health needs of homeless people and those vulnerable to homelessness, under the following main headings:

- The reasons for addressing the health needs of homeless people
- Policy Context
- Shared outcomes for local authorities and health providers
- Addressing inequalities in accessing services
- Addressing the health needs of different groups of homeless people
- Addressing the health needs of homeless families with children
- Addressing the health needs of single homeless people
- Addressing the health needs of rough sleepers
- Addressing the health needs of other vulnerable people
- Joint working on health
- Future work

Fourth quarter 2003 statistics

The quarterly statistics published by ODPM represent the number of households who approached local authorities and were found to be homeless through no fault of their own and to have a priority need for accommodation under the provisions of the homelessness legislation. This briefing accompanies the release of the statistics for the fourth quarter of 2003 (covering the period 1 October to 31 December 2003).

During the quarter, 32,100 households were accepted for re-housing by local authorities. This figure is 3% higher than a year ago but 11% lower than the previous quarter. It is usual for the number of homeless acceptances to decrease between the third and fourth quarters but this is the highest such quarterly reduction since 1999.

Around half of the households accepted as homeless in the last quarter were placed in temporary accommodation. At the end of December 2003, there were 95,060 households living in temporary accommodation, an increase of 13% compared to the same time last year. These households were living in a range of different forms of temporary accommodation, with 40% in privately leased or rented housing, 11% in hostels or women's refuges, 9% in bed and breakfast hotels and 40% in other forms of housing (including local authority and housing association homes let on a temporary basis).

The number of households in temporary accommodation is still rising and we recognise that this is not acceptable and needs to be addressed. In the short term, having consulted on improving the standards of temporary accommodation for homeless households, the revised statutory Homelessness Code of Guidance for Local Authorities, will include guidance on new standards for B&B accommodation and bring together and restate existing fitness standards for all forms of temporary accommodation. The revised Code of Guidance is due to be published this year. The key work of the Homelessness and Housing Support Directorate is now focussing more on possible approaches to tackle the record numbers of homeless households placed in temporary accommodation. In recognition of this, from the 1 April a new BVPI will be introduced to measure the percentage yearly change in the average number of homeless families with children, or a pregnant woman, placed in temporary accommodation.

The total number of households in Bed and Breakfast accommodation fell for the fifth consecutive quarter to 8,350, a sustained trend not seen since the 1990s. This represents a reduction of 4,180 households or 33% over the last year. Bed & Breakfast accommodation now accounts for 9% of all temporary accommodation, which is the lowest ever recorded proportion.

Spending prolonged time in B&B hotels can be particularly damaging for families with children. That is why the Government set a target in March 2002, to end the use of B&B hotels for homeless families with children, except in emergencies, and even then for no more than six weeks. Since setting the target in March 2002, the number of families with children has been reduced by more than two-thirds from 6,700 to 1,680 at the end of December 2003. Families with children at the end of December 2003 represent 20% of all households in Bed and Breakfast accommodation, down from 40% the year before.

Of the 1,680 households with dependent children in B&B hotels at the end of December 2003, 930 or 55% of the total had been resident for more than six weeks. This is 660 families, or 44%, less than previous quarter and over 2,100 families, or 69%, less than December 2002. This fall reflects the excellent progress being made by many local authorities, with support from the Homelessness and Housing Support Directorate, towards the Government's B&B reduction target.

In addition to the good news on the reduction in the number of homeless families with children in B&B there has been a small reduction of 6% in the number of single households in B&B. This shows that local authorities are moving away from using B&B accommodation for all homeless households.

Following a public consultation on its proposals, the Government has announced its intention to make a new Order under the homelessness legislation. The Order will make it unlawful for a local authority

to discharge a statutory duty to provide temporary accommodation for any homeless household with family commitments (i.e. dependent children or a pregnant woman) by placing them in a B&B for more than six weeks from 1 April 2004.

Quite simply, this means that homeless families with children will be able to challenge their local authority through the courts if they have been placed in B&B for longer than six weeks.

A copy of the Order and related guidance has been sent to all local authorities and is also available at: www.odpm.gov.uk/stellent/groups/odpm_homelessness/documents/page/odpm_home_026585.hcsp

The statistics provided by local authorities also show that over the same period 16,470 households were found a settled solution to their homelessness. Of these, 93% were offered a tenancy in social housing with long term, or potentially long term, security of tenure, while just over 6% accepted a fixed-term assured shorthold tenancy in the private sector. Around 25% households provided with settled housing solution did not have to spend any time in temporary accommodation.

People from different black and minority ethnic groups continue to be over-represented among those accepted as homeless. Of the 32,100 households accepted as homeless between September and December 2003, 22% were from a black or minority ethnic background. 5% of households were recorded as ethnic origin unknown, which shows there is scope for better data collection on ethnicity. From 1 April 2004 local authorities will provide information in line with the Census 2001 classifications for black and minority ethnic groups.

Research commissioned by the Homelessness and Housing Support Directorate on homelessness amongst different black and ethnic minority groups is almost complete. A report will be published before the summer along with more information for local authorities about effective responses to tackling homelessness amongst black and ethnic minority groups.

Around a half of all households accepted as homeless during the fourth quarter of 2003 were in "priority need" for accommodation because they were families with dependent children and a further 11% of households included a pregnant woman. These figures are almost the same as the previous quarter.

The highest levels of homelessness continue to occur in London, but that level as a proportion of all homelessness acceptances nationally level has fallen slightly to 23%. The number of households accepted as homeless fell in all regions during the last quarter, most notably in London (-16%), the West Midlands (-15%) and Yorkshire & the Humber (-12%).

Nationally, the top three causes of homelessness (recorded reasons for loss of last settled home for households accepted as unintentionally homeless and in priority need in England) remained the same as in previous quarters:

- **Parents, relatives or friends not being able or willing to provide accommodation** resulted in **37%** of households being accepted as unintentionally homeless and in priority need, some 12,170 of all homeless acceptances - this proportion has varied little in recent years;
- **Relationship breakdown** resulted in **20%** of households being accepted as unintentionally homeless and in priority need, 6,480 of all homeless acceptances. Domestic violence was a cause in around two-thirds of cases - this proportion has varied little in recent years; and
- **End of assured shorthold tenancy** resulted in **11%** of households being accepted as unintentionally homeless and in priority need, 3,650 of all homeless acceptances - this level has been declining slowly but steadily since a high of 15% in mid 2002.

The Government's approach to tackling homelessness, as outlined in 'More than a roof' in March 2002, is beginning to change how housing authorities tackle homelessness. Every housing authority in England now has a homelessness strategy in place that sets out how they, along with local stakeholders, will seek to prevent homelessness in their area and ensure that accommodation and support will be available for people who are homeless or at risk of homelessness.

The Homelessness and Housing Support Directorate is continuing to provide funding, advice and practical assistance to local authorities as they implement their strategies. Funding allocations of £60 million were announced on 10 December 2003 in support of local authority and voluntary sector action to tackle homelessness more effectively in 2004-05. This is part of the Homelessness and Housing Support Directorate's homelessness funding of £260 million for 2003/04 - 2005/06.

The aim now is to ensure that success in tackling the most extreme problems of rough sleeping and use of B&B hotels for homeless families with children is sustained. We also want to make sure that the good practice on wider homelessness prevention that is emerging in some authorities is taken up more widely.

The achievement of the rough sleeping target has been sustained as a result of a targeted and partnership-based strategy. This is an excellent example of government, local authorities and the voluntary sector working together to tackle the problems faced by vulnerable individuals. It has resulted in the lowest number of rough sleepers across England, since the target was set in 1998, being recorded by local authorities in 2003.

The continuing reduction in the number of families with children in B&B accommodation, again the result of a targeted approach, means that over the year from December 2002 a reduction of over 3,300 families with children in B&B has been achieved. That's an estimated 5,700 less children at risk from disruption to their educational development, behavioural problems and health problems.

The reasons for addressing the health needs of homeless people

Homeless people are more likely to suffer from poor physical, mental and emotional health than the rest of the population, and ill health is often associated with poverty and homelessness.

Studies have shown consistently that the experience of homelessness and living in temporary accommodation can exacerbate existing problems and disadvantage households in a number of ways. These disadvantages can include the quality and type of accommodation which homeless households are placed in, the disruption to social and other support networks and the negative impact on the education, health, and well-being of homeless households and their children, including their development

Homeless households suffer health inequalities, compared to the general population, and many of them have complex needs, including:

- increased risk for children of a low birth weight and greater likelihood of illness, behavioural problems and delayed development;
- greater risk of infection, musculo-skeletal disorders, poor diet and nutrition, stress, and depression;
- substance misuse - over 75% of rough sleepers in London had used a drug and around a half of rough sleepers were dependent on a drug (excluding alcohol)[1];
- mental ill health - 9% of households accepted as unintentionally homeless by local authorities are in priority need due to mental illness[2];
- multiple needs - around 48% of single homeless people have multiple needs, e.g. they have a mental health problem plus one or more other issues, such as alcohol or drug misuse[3]; and,
- poor life expectancy - a report by Crisis suggested that the average life expectancy of a rough sleeper was 42 years of age[4].

This document gives an overview of the health needs of different groups of homeless people, with signposts to further information, and sets out the action that is being taken and under development to address them.

Policy context

In March 2002, the Government published *More than a roof*[5] which set out new approaches for preventing and tackling homelessness. It highlighted the importance of joining up health and homelessness solutions, both locally and nationally, in partnership with the voluntary sector. It also underlined the value of preventing negative health outcomes and addressing the health needs of homeless households, from ensuring children of homeless families placed in temporary accommodation have regular health and development checks, to ensuring a rough sleeper with problematic substance misuse issues can access effective treatment services.

The Homelessness Directorate was set up in April 2002 to develop and support new ways to prevent and tackle homelessness more effectively. In December 2003 the Supporting People programme was incorporated into the Directorate to form the Homelessness and Housing Support Directorate. Key to these new approaches is a stronger emphasis on tackling the under-lying causes of homelessness, and preventing people from becoming homeless in the first place.

The Homelessness Act 2002 requires all housing authorities to have a homelessness strategy based on a review of all forms of homelessness in their district. As well as ensuring that accommodation and support are available for people who become homeless or are at risk of doing so, the strategy must aim to prevent homelessness. Housing authorities therefore need to ensure that all organisations, whose work can help to prevent homelessness and/or meet the needs of homeless people in their district are involved, including statutory bodies such as the health service and the wide range of organisations in the private and voluntary sectors whose work helps prevent homelessness or meet the needs of homeless people. Local authority housing departments therefore need to work with social services, Primary Care Trusts (PCTs), Community Mental Health Teams, Crime and Disorder Reduction Teams, Drug Action Teams or Drug and Alcohol Action Teams and other agencies providing health care to homeless people.

For the first time, health inequalities were made a key priority for the NHS in *the Priorities and Planning Framework 2003-06*[6]. The framework stresses the importance of ensuring that the distribution of health benefit 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[7] as one of the vulnerable groups for whom targeted interventions may be needed to address their specific needs and poor health outcomes.

In July 2003, the Department of Health published *Tackling Health Inequalities: A Programme for Action*[8], which sets out the Government's strategy for tackling the wider determinants of health inequalities, such as poverty, poor educational outcomes, worklessness, poor housing, homelessness and the problems of disadvantaged neighbourhoods.

Despite this increased emphasis on addressing the health needs of homeless people, in a recent ODPM survey of PCTs to gauge their involvement in homelessness strategies and provision of services to homeless people, only around a third of all PCTs responded. Whilst these responses showed a good level of partnership working on homelessness issues, it remains unclear whether this is common across the majority of areas.

Shared outcomes for local authorities and health providers

Tackling Health Inequalities - A Programme for Action recognises the role that PCTs can have in working closely with local partners to improve health outcomes for homeless people. Shared health and housing action that both prevents homelessness and meets the health needs of those who do experience homelessness will help towards achieving the *NHS Priorities and Planning Framework* objective of reducing inequalities in health outcomes across different groups and areas in the country.

The ODPM and Department of Health have produced a joint good practice guidance note[9] for all those involved in delivering health services to homeless and vulnerable people - local authorities, Primary Care Trusts, Drug and Alcohol Action Teams, Mental Health Trusts, Supporting People teams, and voluntary organisations - on developing shared positive outcomes. The note suggests five key outcomes that these organisations might adopt:

- improving health care for 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.

The guidance sets out possible actions to achieve these outcomes, together with examples of where these actions are already having positive effects and how performance against these outcomes might be measured. It is for the organisations involved to agree local aims and objectives - and how success will be measured - in the context of their homelessness strategies, supporting people strategies, local delivery plans and drug treatment plans.

Addressing inequalities in accessing services

The NHS *Priorities and Planning Framework* sets out targets to improve access for both emergency care and planned care, with the objective to provide universally high quality primary care services which are accessible and responsive to patients' needs and preferences. The targets include:

- Reduce to four hours the maximum wait in A&E from arrival to admission, transfer or discharge, by March 2004 for those Trusts who have completed the Emergency Services Collaborative and by the end of 2004 for all others.
- Ensure 100% of patients who wish to do so can see a primary health care professional within 1 working day and a GP within 2 working days by December 2004.

Despite these targets it is common for homeless people to experience inequalities in accessing health care, for example:

- only a quarter of rough sleepers are registered with a General Practitioner (GP)[10], and homeless people are 40 times more likely not to be registered with a GP relative to the rest of the population person[11];
- many homeless people have difficulties registering with a GP (which is often the first step to getting help for mental as well as physical health problems) because there is a commonly held belief that they might be difficult or that they need a permanent address to register. Primary care registration rates vary between 24% and 92% for homeless people, the former described in a study of rough sleepers[12] and the latter in families in bed and breakfast accommodation[13];
- homeless people are four times more likely than the general public to turn to Accident and Emergency services if they cannot access a GP[14];
- some homeless people face difficulties in accessing integrated care, which can mean they present late in the pattern of illness with problems that could have been prevented or treated by early intervention through accessing the services of a GP, dentist or health visitor.

The PCT has a new duty to secure the provision of primary medical services to meet the needs of its local population. There are a number of models for improving access to health care which are outlined below and described in more detail in the following sections.

Some of the above are aimed specifically at homeless people, and it is important that such models are implemented where appropriate. However, it is also essential to improve homeless people's access to mainstream health services, so that homeless people are socially included.

National Enhanced Services for homeless people

National Enhanced Services (NES)[15] are designed to provide more specialist services to meet the needs of vulnerable and previously under-served groups, such as homeless people, that are beyond the scope of essential services. The NES for enhanced care of homeless people is aimed at practices that have a critical mass of patients, and covers a range of measures to improve services, including:

- the development and production of an up-to-date register of patients who are homeless;
- liaison with local statutory services and development of joint protocols, for example with the local authority's Homeless Persons Unit;
- flexible registration procedures allowing for permanent registration to anyone who wants it;
- the provision of training to practice staff ensuring an understanding of and sensitivity towards the particular problems faced by homeless people, both health and non-health related;

- provision for appropriate and regular screening assessments based on current research in relation to the health needs and problems of homeless people;
- appropriate referral to counselling and CPN services; and,
- specialist assessment of the physical and mental health of homeless people when registering.

There are also separate NES specifications for Patients suffering from Drug Misuse and for Patients who are Alcohol Misusers, which will also be relevant to homeless people. NES specifications include a service outline setting out what might be provided under them.

PCTs have been drawing up plans for commissioning enhanced services to meet, or exceed, their local spending floor. This is an ongoing, continuous process. These plans will include the six Directed Enhanced Services (access to general medical services; childhood immunisation; influenza immunisation; quality information preparation; services to support staff dealing with violent patients; and minor surgery) and any other enhanced services they have decided to commission in order to meet local needs. In doing so they could draw upon elements from a number of NES as appropriate to meet those needs.

Over £1.1bn has been provided for enhanced services within Primary Care Organisation (PCO) unified budgets for 2003/04, 2004/05 and 2005/06, who will decide how, when and from whom they commission NES and enhanced services in response to local need (Local Enhanced Services). PCOs have complete discretion over specification and price, though they will be expected to use the nationally agreed NES specifications and prices as guidance. PCTs have now been advised of their local floor, which has been updated from the figures detailed in the Health Service Circular 2002/12.

Personal Medical Services

Personal Medical Services (PMS) schemes are designed to allow a flexible approach to address the health needs of particular priority groups, such as homeless people. PMS enables health care professionals to develop different organisational models, which address gaps in delivery or inadequacies in or inaccessibility of existing services. There are a wide variety of PMS models ranging from surgery-based services (which can be GP or nurse-led) to outreach care provided in hostels, shelters or day centres. PMS schemes are negotiated locally with Primary Care Trusts as alternatives to bring about improvements in health and well being for people experiencing difficulties accessing General Medical Services.

There are currently over 100 PMS schemes in England providing medical services for homeless people. The ODPM has produced a homelessness and health information sheet on the role of PMS[16] in helping homeless people access health care, from which the following good practice example is taken. This is the first in a series of information sheets to raise awareness of particular health issues relating to homelessness, and to disseminate examples of existing good practice.

Alternative Provider Medical Services and Primary Care Trust Medical Services

From April 2004, PCTs can commission services from alternative providers (including commercial providers, voluntary bodies, not-for-profit organisations, and other NHS bodies) through the Alternative Provider Medical Services (APMS) contracting route. This provides invaluable opportunities for PCTs to engage in new, strategic thinking in order to provide a joined up approach to providing primary medical services for homeless people. For example, a PCT could work with voluntary organisations working with homeless people in order to provide services in an accessible setting.

PCTs will also be able to provide services themselves by directly employing staff, under the Primary Care Trust Medical Services (PCTMS) route. This will enable PCTs to provide services tailored to the needs of the local population, and to find innovative ways of meeting need in previously difficult to reach areas and populations.

Walk in centres

There are currently 42 nurse-led NHS walk-in centres[17] set up across in England in locations convenient for patients, which are open every day of the year and have extended opening hours.

As well as providing a core service, NHS walk-in centres are helping to improve access for specific groups with particular needs, including young people, homeless people, students, refugees and asylum seekers. Many walk-in centres are tackling inequalities through nurses developing good relationships with support workers and undertaking outreach work with homeless people to inform them about the services available at the walk-in centre.

Outreach health care

Some health care providers, working in partnership with voluntary organisations, are offering health care through hostels, day centres and other non-traditional settings, which treat homeless people's health needs holistically, often alongside other problems which have contributed to or resulted from their homelessness.

Dental care

The British Dental Association (BDA) has produced a report on *Dental Care for Homeless People*[18] that looks at the specific oral and dental health needs of homeless people. Based on a review of available literature and consultation with stakeholders, the report finds that that homeless people have high levels of oral and dental disease, both in absolute terms and relative to the rest of the population. This can be due to a number of factors, including poor diet and dental hygiene, difficulty in prioritising and accessing dental care, and substance misuse.

The report recognises that, hitherto, research on health and homelessness has largely focused on the needs of rough sleepers, and calls for research into the oral and dental health of other homeless people.

The report acknowledges that there can be a general problem in accessing NHS dentistry in some parts of the country. Added to this, other barriers can prevent homeless people accessing dental care, including difficulty in registering due to lack of a permanent address or the attitude of some general dental practices; difficulty in making and keeping appointments due to disengagement from services or chaotic lifestyle; and a perception that costs will be prohibitive or lack of evidence of entitlement to exemption from charges.

The report sets out existing models of care delivery and best practice case studies from around the UK, and highlights the importance of a flexible dental service that responds to the particular needs of homeless people by employing a combination of conventional and outreach locations to deliver care. It also highlights that, wherever possible, dental care should be delivered in a way that enables homeless people to use mainstream dental services.

Although not dealt with explicitly in BDA's report, there are particular issues around access to dental care for homeless families, given the importance of children receiving regular dental checks and consistent care. This is particularly important where children are receiving orthodontic treatment to prevent lasting damage to their teeth. Access to and continuity of care can be difficult for families or homeless young people who may move frequently or become disengaged from services. It is important that tracking and referral systems (see section below on improving partnership working through tracking and referral) for homeless families in temporary accommodation also address access to dental care.

Addressing the health needs of different groups of homeless people

Although there is a large amount of research evidence on the support needs of homeless people without children, there has been much less research into the support needs of homeless families.

In November 2003, the ODPM published *The Support Needs of Homeless Households*[19], which was commissioned to find out more about the support needs of homeless people, including those that are health-related. The study consisted of a review of previous research; interviews with national and regional organisations; a questionnaire to the 100 local authorities with the highest number of homelessness acceptances; and case studies in six local authorities which involved in-depth, qualitative interviews with local staff and homeless people and an analysis of case records.

The study was based on a sample of homeless people who were selected to represent the range of people who apply to the local authority as homeless. Although the sample was not chosen to be statistically representative of all homeless households, the findings provide a valuable snapshot of the health needs of homeless people.

The report concluded that the starting point for effective support services is a comprehensive needs assessment and the production of a support plan, and that this is most effectively implemented by multi-disciplinary teams which bring together the different agencies working with homeless people. The study found that current practice is very variable, with many authorities not having adequate support services for homeless people. In particular, the support needs of homeless families had not been fully recognised in many areas.

The following sections look at the different groups of homeless people, and set out their particular health needs and the action that is being taken to address them.

Addressing the health needs of homeless families with children

At the end of December 2003 there were 95,060 homeless people with children living in temporary accommodation, including 1,680 homeless families with children living in Bed and Breakfast (B&B) accommodation. Of the 32,100 households who were accepted as homeless in the quarter up to the end of December quarter, the presence of dependent children was the primary reason for acceptance in 49 per cent of cases, with a further 11 per cent of households including a pregnant woman. In addition, the primary reason for acceptance in 9 per cent of cases was mental illness and in 6 per cent of cases was physical illness.

The Support Needs of Homeless Households study found that, although very limited, the research into the support needs of homeless families in the UK has identified a range of problems with a relatively high incidence of similar needs to homeless people without children. Many of these problems can persist after rehousing. Most of the families interviewed for the study had at least one form of medium or high level support need (measured by having mental or serious physical health problems, a history of domestic violence, problems with managing debts, substance misuse, children in care or at risk, or with behavioural problems). Many had multiple problems, with two or more of these types of problem. In particular, the study found that drug use - commonly regarded as a problem primarily amongst single homeless people - is seen as a large and growing problem among homeless families in some cities, with staff interviewed estimating that up to 50 per cent of families have such problems.

Meeting health and other support needs to help vulnerable households stay in their own home is the objective of the Supporting People programme. The Government is providing around £350m in 2004-05 to support for homeless people, which will provide housing related support for around 45,000 single homeless people and 14,500 homeless families.

B&B hotels are widely accepted as unacceptable accommodation for homeless families with children as they offer the poorest standards and the highest costs. Living in temporary accommodation can disadvantage children in terms of their educational development because of disruption in schooling from moving to a new area, or from difficulties trying to keep children in the same schools, which can also result in problems with lateness and poor attendance. The lack of space for children to study or play is a particular problem for families living in B&B hotels[20]. Placements in temporary accommodation can lead to social isolation from friends and support networks. This is particularly likely where households are placed a long way from family and friends or where families are placed in B&B hotels. Behavioural problems such as aggression, bed-wetting and over-activity have been found to be higher among homeless children[21]. Communication skills among homeless children have been found to be much lower than among housed children from similar backgrounds[22].

Local authorities are on course to meet the Government's target that by the end of March 2004 no families with children should have to live in B&B hotels except in short-term emergency cases. This target is being incorporated in the homelessness legislation through the Homelessness (Suitability of Accommodation) (England) Order 2003 (laid in December 2003) which comes into force on 1 April 2004. Under this Order, local housing authorities will be unable to place families with dependent children (and households that include a pregnant woman) in B&B accommodation for more than 6 weeks, as a discharge of a homelessness duty.

Although this is a great step forward, it does not mean that the health issues of homeless households with children have been addressed. Other types of temporary accommodation can have a negative effect on the health of homeless families with children because of its quality or location, and the limbo of being in temporary accommodation, regardless of its quality, also has an impact on both the physical and mental health of homeless households.

The introduction of two additional homelessness Best Value Performance Indicators (BVPIs)[23] from 1 April 2004, one on temporary accommodation and one on rough sleeping, will help us measure outcomes achieved by local authorities in tackling homelessness and building sustainable communities. One of the new indicators will measure changes in the number of families with children

placed in temporary accommodation. It will complement the headline indicator for ODPM's Public Services Agreement target (PSA5) on the balance between housing supply and demand. It also mirrors the Department of Health's national headline indicator of the "Number of homeless families with children in temporary accommodation". This is one of a set of 12 national headline indicators contained in *Tackling Health Inequalities: A Programme for Action*[24], and recognises that this group continues to face health inequalities. The Department of Health is using this set of indicators to monitor progress on key areas relevant to tackling health inequalities, and will publish monitoring data for all twelve indicators later in the year.

Child and Adolescent Mental Health Services (CAMHS)

Children in homeless households and homeless young people are more likely to experience mental health problems than the general population. Mental health problems in childhood left unaddressed are likely to persist and become more resistant to intervention unless treated early. Untreated child and adolescent mental health problems can cause severe amounts of distress for individuals and their carers.

Subsequent pressures may also place demands on social services, schools and juvenile justice resources. With joint working across social services, health and education to identify and address problems as they arise, these pressures can be managed more effectively in the long-term. Those working with homeless families and young people need to be able to identify need for specialist help and to establish links with local Child and Adolescent Mental Health Services provision.

The emerging findings of the children's National Service Framework[25] highlights the need for all children to be able to access appropriate Child and Adolescent Mental Health Services regardless of circumstance. Children in homeless households and homeless young people may find it difficult to readily access mainstream Child and Adolescent Mental Health Services provision and are likely to benefit from specialist out-reach services, which may help bridge their contact with services. The Foyer Federation is launching a three year project, *Strong Minded*[26], to ensure the mental health needs of young Foyer residents are met by recruiting five mental health workers to work alongside the staff in 20 Foyers across the country to bring a creative approach to building mental health.

Improving partnership working through tracking and referral

Families with children may be registered with a GP when they become homeless, but may then be placed in temporary accommodation far from the surgery making attendance at child clinics difficult. If the family expects to move to settled accommodation within the next few months, they may not register locally or, if they try, may not be accepted. If there are no arrangements in place to enable them to access health care, such as a local PMS scheme or a health visitor linked to their temporary accommodation, their problems may go unrecognised or they may resort to accident and emergency services as their primary health care source.

There are also child protection risks if people are 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. Relationship breakdown is one of the top three causes of homelessness, and domestic violence is a cause in around two-thirds of these cases.

The Government's Green Paper *Every Child Matters*[27] published in September 2003 set out for consultation a framework for improving outcomes for all children and their families. On 4 March the Government published *Every Child Matters: The Next Steps*[28], which outlines the views that emerged from the consultation, provides an overview of the Children Bill and describes the first steps to implement the Green Paper. The Children Bill will encourage partnership working and sharpen accountability, including through placing a new duty on agencies to co-operate among themselves and with other local partners to improve the wellbeing of children and young people so that all work to common outcomes and by sharpening accountability by requiring all local authorities to appoint a single director accountable for children's services. The director will be responsible for ensuring that

action is 'joined-up' across services in order to achieve the best possible educational, health and welfare outcomes for all children. In taking forward work on Every Child Matters and the Children Bill we will therefore be seeking to ensure that there is close working with housing departments, education and social services and Primary Care Trusts to ensure that all children - especially those who are vulnerable and living in temporary accommodation - are given effective life chances.

ODPM's consultation paper, *Improving the Standards of Accommodation for Homeless Households Placed in Temporary Accommodation* referred to the need for housing authorities to consider what support should be offered to homeless households in temporary accommodation to ensure that they benefit from all the relevant support services, including health, education and social services. As a minimum, authorities will need to consider what systems are needed to ensure that these services are notified when a homeless household is placed in their area. The *Homelessness Code of Guidance for Local Authorities* is currently being revised, and the NOTIFY project below is an example of the type of system which might be considered[29].

Addressing the health needs of single homeless people

In 2002-03 around 48,000 single people and childless households were accepted by local authorities as unintentionally homeless and in priority need.

The Support Needs of Homeless Households confirmed that many single homeless people who apply to local authorities have a wide range of needs including mental ill-health, substance abuse, physical illness, histories of family problems and abuse, educational problems, histories of institutional care and difficulties in sustaining accommodation.

Problems with mental health were the most common need. Almost half of people without children interviewed had applied to the local authority as vulnerable on these grounds, with the mental health problems ranging from depression, episodes of self harm, schizophrenia and paranoid delusions. Almost half of this group also had some form of physical health problem. Most associated the loss of their last home with their mental health problems. Most people with such problems had consulted a mental health professional within the past six months. A large proportion was currently taking medication to help with their problems.

The next most common need was some form of physical health problem for which they were currently receiving treatment. A history of drug use was common and many of those with drug problems thought they would need continuing support. Smaller numbers had problems of alcohol abuse and usually these people thought they would need continuing help to tackle their drinking. A disproportionate number had at least one physical disability or had had been in hospital for at least three months in their lives. Up to half of the homeless people without children who were interviewed for the study had multiple needs, combining two or more of these problems.

Action to tackle drug misuse is co-ordinated locally by Drug Action Teams (DATs), who are responsible for drawing up drug service and treatment plans for their area which should take account of the needs of homeless drug users dependent upon local needs. There are 149 DATs in England bringing together representatives from all the local agencies involved in tackling drug misuse, including primary care trusts, local authorities, police, probation, education and youth services, and the voluntary sector. DATs are responsible for using central government and local funding to pay for or commission services and treatment from NHS and voluntary sector organisations, in accordance with their service delivery plans. In recognition of the key need to address the substance misuse needs, particularly of problematic drug misuse, prevalent amongst members of the rough sleeping and homeless community, *Drug services for homeless people*[30] has been produced by the Home Office, Office of the Deputy Prime Minister, Department of Health, the National Treatment Agency and DrugScope, to help DATs and their partner agencies plan and develop more effective services for homeless drug users. The handbook provides accurate guidance and good practice in tackling these issues.

The National Treatment Agency has recommended that joint commissioners, on behalf of local drug action teams, should review local arrangements for shared care schemes using a mixture of National Enhanced Services and Local Enhanced Services contracts according to local needs. Future commissioning of primary care services should aim to increase the quantity and quality of primary care provision.

Addressing the health needs of rough sleepers

Although the numbers of people sleeping rough on a single night are relatively small - around 500 on a single night now, compared with nearly 2,000 in 1998 - they represent the most extreme form of homelessness and the group with the highest concentration of multiple support needs.

A 2002 report *Addressing the health needs of rough sleepers*[31] found that rough sleepers had:

- poor physical health, for example higher rates of TB and hepatitis than the general population, poor condition of feet and teeth, respiratory problems, skin diseases, injuries following violence and infections;
- mental health problems, for example serious mental illnesses such as schizophrenia, as well as depression and personality disorders. 30-50% of rough sleepers had mental problems.
- high levels of drug and alcohol dependency, with 50% being alcohol reliant and 70% misusing drugs.

ODPM's Homelessness and Housing Support Directorate commissioned a survey of 588 homeless individuals across 20 local authorities with rough sleeping problems in November and December 2003. Although the information gathered only provides a snapshot rather than a comprehensive picture, it shows that the situation is largely unchanged with 61% of respondents reporting a drug problem, 45% an alcohol problem, 32% physical health problems, 31% mental health problems and 14% physical disabilities. 22% reported having both a drug and an alcohol problem.

In some areas Cognitive Behavioural Therapy and other therapeutic services help homeless people with more challenging behaviour deal with their problems. In the case of Cognitive Behavioural Therapy, the theory is that the psychological, emotional and behavioural issues linked to homelessness can be identified and then an intervention developed to manage them. An individual's negative beliefs about their world and their place in it can be described, and behavioural experiments generated in order provide evidence which may overcome, and so change, those beliefs.

Some very vulnerable people, not all of whom are homeless, are dependent on alcohol and resort to drinking on the streets for company or because they have nowhere else to go. Wet Centres, which allow people to consume alcohol on their premises, are one of the options for tackling street drinking, and some local authorities are considering starting up such centres in an effort to curb street drinking and provide more targeted help for drinkers. There are currently only a handful of wet day centres around the country providing support, help and treatment for street drinkers and other vulnerable groups excluded from other services, including people with mental health and drug problems and rough sleepers.

ODPM's Homelessness and Housing Support Directorate and the King's Fund commissioned a review of the function and impact of wet centres, and a guidance manual for setting up and running new facilities. The review studied four wet centres in detail, including the Booth Centre in Manchester. The full report and manual are available on the King's Fund website[32].

Addressing the health needs of other vulnerable people

Supporting People

On 1 April 2003 ODPM launched the Supporting People programme, which offers vulnerable people the opportunity to improve their quality of life by providing a stable environment, which enables greater independence. The programme aims to deliver high quality and strategically planned housing-related support services which are cost effective and reliable, and complement existing care services. Supporting People commissioning bodies have been set up in each administering authority area to take a strategic view of the provision of housing-related support in their areas and bring together the local authority (both the county and district councils in two-tier administrations), Primary Care Trusts and local probation services.

Local authorities are required to submit a Supporting People five year strategy to ODPM by March 2005, which will provide an opportunity to ensure the strategic aims of health, homelessness, substance misuse and housing related support services are jointly developed to provide services which improve prevention and reduce repeat homelessness.

The Supporting People health pilot programme is intended to support commissioning bodies and service providers wishing to use the framework provided by Supporting People to develop their partnerships with health and social care services in new ways, in order to contribute to health objectives. Six pilot schemes are being set up to examine how this can be done, and what impact partnership working can have on the achievement of health objectives.

The health pilots will be evaluated and the results of this evaluation used to demonstrate the impact of partnership working between health and Supporting People teams, and to create an evidence base to feed into priorities for Supporting People five-year strategies.

Hospital discharge

There are situations where homeless people are hospitalised for short-term treatment and then discharged to inappropriate places or back to homelessness, because structured discharge arrangements are not in place or have not been properly implemented. The Department of Health has issued guidance[33] on the discharge needs of people who are homeless, which states that all acute hospitals should have formal admission and discharge policies to ensure that homeless people are identified on admission and their pending discharge notified to primary care services and to homeless services providers. Patients in psychiatric hospitals/units must have a post-discharge care plan drawn up well in advance of discharge and procedures put in place to ensure appropriate accommodation and continuity of care following discharge.

Joint working on health

Development of national and local indicators

ODPM's Homelessness and Housing Support Directorate is working with the Department of Health to consider further national and local indicators to support the headline indicator *in Tackling Health Inequalities: A Programme for Action* of the number of homeless families with children in temporary accommodation. A basket of 70 local indicators has been published on the London Health Observatory website[34], which includes the headline indicator as a local indicator. A list of a further 26 local indicators are under consideration for development, including the number of people who are registered with a GP who do not have a settled home.

Developing shared positive outcomes on health and homelessness

As referred to earlier in this document, the Homelessness and Housing Support Directorate has issued joint guidance[35] with the Department of Health to encourage local authorities, Primary Care Trusts and other health providers to develop shared outcomes on health and homelessness. These will complement the work on national and local indicators for health inequalities, and the two Departments will continue to work together to develop them further.

Supporting People guidance

The Supporting People programme promotes a needs based, partnership approach which facilitates planning for multiple needs groups. *The Supporting People: Guide to accommodation and support Options for Homeless Households*[36] provides information on the various approaches used to tackle homelessness, the role of Supporting People in tackling homelessness and developments in improving service delivery.

Health Equity Audits

The NHS Priorities and Planning Framework requires PCTs to carry out a Health Equity Audit (HEA) to inform NHS service planning and commissioning. The Department of Health has published guidance[37] on how to carry out an effective HEA. This includes addressing the dimensions of health inequalities and aiming to narrow the gap in health outcomes between different groups, for example by narrowing the gap between the majority of the population and vulnerable groups such as homeless people. An effective HEA should identify actions to reduce any identified inequalities, such as speeding up progress on programmes specifically addressing inequalities e.g. services for homeless people.

Mental health services

ODPM's Homelessness and Housing Support Directorate is working with the National Institute for Mental Health in England (NIMHE) to gather information on mental health support for homeless people; promote access to mainstream services for homeless people; and identify examples of effective partnerships between mental health teams and homelessness teams.

This data will be used as a baseline to plan further research and work on improving homeless people's access to mental health care. This work will link closely to implementation of the action plan within the forthcoming Social Exclusion Unit report on mental health and social exclusion, to be published later in the year.

NIMHE is planning a conference on social inclusion to launch the implementation strategy for the SEU's report in June at which one of the key areas to be addressed will be the impact of mental health on homelessness, and the impact of homelessness on existing mental health problems. We expect

subsequently to develop a cross government network to ensure continuing focus on this area and through which positive practice can be developed and disseminated.

Future work

Encouraging greater PCT involvement in Homelessness Strategies

As outlined earlier, a recent survey of PCTs produced a positive but incomplete picture of their involvement in local authority homelessness strategies. The results of the survey have been fed back to PCTs via Regional Directors of Public Health. ODPM's Homelessness and Housing Support Directorate will be working with the Department of Health, Regional Directors of Public Health, and Strategic Health Authorities to identify and address the gaps, and encourage greater involvement, particularly amongst those PCTs that did not respond.

GO Action Plans on Health Inequalities

The co-location of Regional Directors of Public Health in Government Offices creates an opportunity to focus on inequalities in health by bringing together different strands of work, for example on homelessness. Regional Directors have been tasked with producing GO action plans for tackling health inequalities across the broad range of GO activity, with advice from Regional Directors of Public Health, and informed by policy developments across the region.

Follow-up to Supporting People Independent Review Report

The Supporting People Independent Review Report[38] included a number of recommendations that impact directly or indirectly on PCTs and the services they provide, for example those relating to building a robust evidence base, commissioning services, and addressing unmet need. ODPM's Supporting People policy team is putting in place a full work programme to address the issues raised by the Independent Review.

Revision of Comprehensive Performance Assessment (CPA)

The Audit Commission, in their document *CPA - the way forward*[39] (June 2003), signalled their intention to develop a new Comprehensive Performance Assessment (CPA) methodology to be implemented from 2005.

To support this work, ODPM, in conjunction with the Local Government Association, other Government Departments and Inspectorates, orchestrated a number of working groups based around the shared priorities. The aim of these groups was to articulate the role local government is expected to play in achieving a number of specific outcomes, as the basis for linking these high level statements of priorities with the CPA assessment methodology.

One of the working groups focused on Healthier Communities, and their initial paper[40] is available on the ODPM web site. The paper highlights actions for Local Authorities across four themes, including engaging communities and supporting homeless people. The Audit Commission will be consulting on proposals for the new methodology throughout 2004.

Consultation on Public Health

On 3 March the Secretary of State for Health launched a national consultation on how to improve the nation's health and wellbeing. The consultation - *Choosing Health?* - aims to clarify the role individuals want central and local government to play in improving health. Details of the consultation are available on the Department of Health web site[41].

Published: March 2004.

[1] *Who uses services for homeless people? An investigation amongst people sleeping rough in London* Fountain, J., Howes, S., Mars den, J. and Strang, J., Journal of Community and Applied Social Psychology, 12:pp 71-75 (2002).

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

[3] *Supporting People with multiple needs,* Homeless Link Survey, 2002
http://www.homeless.org.uk/db/20021216183953

[4] *Still dying for a home,* Crisis 1996

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

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

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

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

[9] *Achieving positive shared outcomes in health and homelessness*
http://www.odpm.gov.uk/stellent/groups/odpm_control/documents/contentservertemplate/odpm_index.hcst?n=865&l=2

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

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

[12] Leddington S, Sometimes it makes you frightened to go to hospital… they treat you like dirt. *Health Services Journal. 1989 11: 21-22*

[13] Victor CR. Health and Lifestyles of homeless people; Health Educ J 1993; 52 – 79-84

[14] Wake (1992) Homelessness and Street Drinking. London Arlington Housing Association

[15] http://www.bma.org.uk/ap.nsf/Content/__Hub+gmsnes

[16] *Homelessness and health information sheet: Personal Medical Services*
http://www.odpm.gov.uk/stellent/groups/odpm_homelessness/documents/page/odpm_home_025925.hcsp

[17] NHS Local Services Search: Walk In Centres http://www.nhs.uk/root/localnhsservices/wicentres/default.asp

[18] *Dental Care of Homeless People* , BDA Policy Discussion Paper December 2003 www.bda-dentistry.org.uk/

[19] Office of the Deputy Prime Miniosters, *Supporting People: the support needs of homeless households*, 2003
http://www.spkweb.org.uk

[20] Power, S., Whitty, G and Youdall, D. (1996) No place to learn: Homelessness and education, London: Shelter

[21] Health Visitors' Association and the General Medical Services Committee, Homeless Families and their Health, London HVA and GMSC (1988)

[22] Vostanis P. and Cumella S., Homeless Children: problems and needs, Jessica Kinsley (1999)

[23] The duty of best value requires local authorities (and other best value authorities) to seek to achieve continuous improvement by having regard to the efficiency, effectiveness and economy of their service delivery. There is currently one homelessness BVPI (BV183), which measures the average length of stay in (i) bed and breakfast accommodation and (ii) hostel accommodation of households which include dependent children or a pregnant woman and which are unintentionally homeless and in priority need.

[24] See 8

[25] http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenSer

[26] http://www.foyer.net/mpn/story.php?sid=346

[27] *Every Child Matters*, http://www.dfes.gov.uk/everychildmatters/

[28] See 27

[29] http://www.london.gov.uk/mayor/housing/homelessness.jsp#notify

[30] *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

[31] *Addressing the health needs of rough sleepers,* Professor Sian Griffiths, Homelessness Directorate 2002
http://www.odpm.gov.uk/stellent/groups/odpm_homelessness/documents/page/odpm_home_601532.pdf

[32] *Wet Day Centres in the United Kingdom: A Research Report and Manual*, University of Sheffield, October 2003
www.kingsfund.org.uk/grants

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

[34] http://www.lho.org.uk/HIL/Inequalities_In_Health/Basket_Of_Indicators/Basket.htm

[35] see 9

[36] *Supporting People: Guide to accommodation and support Options for Homeless Households*
http://www.spkweb.org.uk/files/Homelessrep.pdf

[37] *Health Equity Audit: A Guide for the NHS*
http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthInequalities/HealthInequalitiesGeneralInformation/HealthInequalitiesGeneralArticle/fs/en?CONTENT_ID=4069085&chk=e2HkS4

[38] The full report and recommendations are available at www.spkweb.org.uk

[39] http://www.audit-commission.gov.uk/

[40] http://www.odpm.gov.uk/stellent/groups/odpm_localgov/documents/page/odpm_locgov_026847.hcsp

[41] *Choosing Health? A consultation on improving people's health*
http://www.dh.gov.uk/Consultations/LiveConsultations/LiveConsultationsArticle/fs/en?CONTENT_ID=4075183&chk=GKclCc