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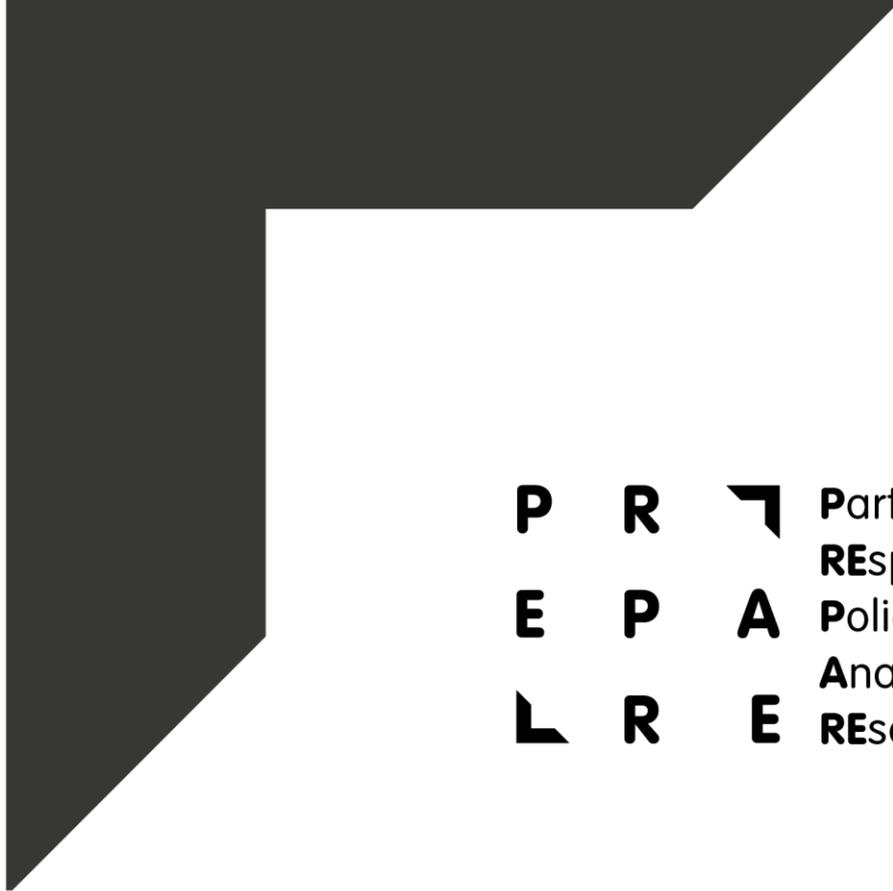


Health and Care Services for People Sleeping Rough: the views of people with lived experience

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This report has been prepared by Professor Nicholas Pleace and Dr Joanne Bretherton, from the University of York.

Contents:

Summary	1
Introduction	2
Background	3
Lived experiences of accessing health and care services	7
Discussion	20

Summary

- In this report, following a review of previous research, the views of people with lived experience of sleeping rough on health and care services are explored.
- Previous research has indicated a high prevalence of mental and physical health problems, addiction, limiting illness and disability among people sleeping rough. These patterns were also found in this research.
- Results of four focus groups are reported. Twenty-three people took part in the four groups, four of whom were women. Respondents were typically in the 30-45 year age range, some were currently sleeping rough at interview, and all had experience of sleeping rough.
- Problems with mental health were the most frequently self-reported treatment need. Respondents also expressed treatment needs in relation to addiction. Neither were universally reported.
- Homelessness services could play an important role in acting as a conduit and referral point to health and care services. Where specialist health services for homeless people were present, awareness of those services among the respondents was universal.
- Information on health and wellbeing was chiefly sought from the internet.
- Use was being made of GP practices, A&E and other services. People sleeping rough were conscious of how they presented themselves and there was a sense that avoiding being seen as 'homeless' was seen as helping to access required treatment and care.
- Mainstream NHS services could be tolerant and flexible in respect of homelessness, but barriers around lacking a settled address and stigmatisation were reported in respect of GP registration, some experiences in A&E and access to dentistry. Physical distance could be an issue if someone retained a GP registration some distance from where they were currently living.
- People sleeping rough did not consistently use specialist NHS services where they were present. Specialist services were always described as sympathetic, accessible and effective, but they could be avoided by people sleeping rough who were not active drug users or drinkers, and some people sleeping rough preferred to use the GP with whom they were registered.
- Reported experiences with mental health services were not positive. Services were seen as uncoordinated, under-resourced and inaccessible, with an emphasis on firefighting, and only intervening when needs became extremely high, at the point where someone was sectioned.
- Findings from this small study are not generalisable, but indicate that a mixed approach could be most effective, including enhancing access to the mainstream services, supporting specialist services and ensuring treatment needs are met within an integrated strategy to prevent and reduce homelessness.

1. Introduction

This report is designed to support and inform a parallel study conducted by the King's Fund and the University of York on health and care services for people sleeping rough, which is in turn designed to support the implementation of the 2018 Rough Sleeper Strategy. Four one-hour focus groups were conducted in four areas in England, nominated by the Department of Health and Social Care. The focus groups involved 23 people with lived experience of sleeping rough.¹ The following section provides a brief background to the issues, followed by findings of the focus groups, which explored different aspects of respondents' experience of accessing and using health and care services while sleeping rough. The final section provides a discussion of the results.

¹ Site A, five respondents (one female); Site B, six respondents (one female); Site C, five male respondents; Site D, seven respondents (two female). Ages ranged from 19 to 63, respondents were typically in the 30-45 age range, male, White and British. All respondents had experience of sleeping rough, 17 were sleeping rough at the time they participated in the focus groups. Responses were anonymised at the point of recording the focus groups and the results were transcribed. Ethical approval was secured via the independent review processes for both health care and social care research at the University of York. The focus groups took place in July and August 2019 and were each approximately one hour in duration.

2. Background

Long-term and recurrent rough sleeping can have a mutually reinforcing relationship with high and complex health and care needs, including severe mental illness, addiction, other limiting illness and disability.² Patterns and causes of homelessness, and the intersections between rough sleeping, health and wellbeing, are complex and varied. For example, addiction can arise before homelessness, during homelessness or be a constant presence during a trajectory that sees someone enter homelessness and then exit it,³ with similar patterns in respect of mental illness. There is longstanding evidence of a small group of people with high and complex needs who experience long-term and recurrent homelessness, sleeping rough on a repeated and sometimes sustained basis. Very high prevalence of severe mental illness and poor physical health, combined with evidence of high rates of problematic drinking and drug use, exist among this small group, as reported repeatedly over time.^{4,5,6,7}

Concern about the human costs for people sleeping rough, particularly in respect of mental and physical health, dates back to the first period in which rough sleeping began to escalate, from the late 1980s. At that time, the issues were seen as centring on access to health services for people sleeping rough, continuity of care, effectiveness of treatment and the financial costs of rough sleeping to the health service.⁸ There was also debate about the extent to which the NHS should seek to meet need through specialist service provision for rough sleepers and other homeless people, and the extent to which mainstreaming, i.e. facilitating access to the NHS services used by the general public, should be pursued.⁹ Specialist interventions, such as the Homeless Mentally Ill Initiative,¹⁰ were developed alongside the Rough Sleeper Initiative programmes that ran from 1990-1999.¹¹

² Kemp, P.A., Neale, J. and Robertson, M. (2006) Homelessness among problem drug users: prevalence, risk factors and trigger events. *Health & Social Care in the Community*, 14(4), pp.319-328.

³ Pleace, N. (2008) *Effective Services for Substance Misuse and Homelessness in Scotland: Evidence from an international review* Edinburgh: Scottish Government.

⁴ Anderson, I.; Kemp, P.A. and Quilgars, D. (1993) *Single Homeless People*, London: HMSO.

⁵ Gill, B.; Meltzer, H.; Hinds, K. and Petticrew, M. (1996) *Psychiatric morbidity among homeless people* London: ONS.

⁶ Fitzpatrick, S.; Pleace, N. and Bevan, M. (2005) *Final Evaluation of the Rough Sleepers Initiative*, Edinburgh: Scottish Executive.

⁷ Fitzpatrick, S., Johnsen, S. and White, M. (2011) Multiple exclusion homelessness in the UK: key patterns and intersections. *Social Policy and Society*, 10(4), pp.501-512.

⁸ Connelly, J. and Crown, J. (1994) *Homelessness and ill health: Report of a working party of the royal College of Physicians*, London: Royal College of Physicians of London.

⁹ Pleace, N. and Quilgars, D. (1996) *Health and Homelessness in London: A Review* London: The King's Fund.

¹⁰ Craig, T.; Bayliss, E.; Klein, O.; Manning, P. and Reader, L. (1995) *The Homeless Mentally Ill Initiative: An Evaluation of Four Clinical Teams*, London: The Department of Health.

¹¹ Wilson, W. and Barton, C. (2019) *Rough Sleeping (England)* Briefing Paper Number 02007, 6 February 2019, London: House of Commons Library.

Barriers to health and care services were identified as follows:¹²

- NHS administrative systems that worked on the basis of someone having a fixed address, sometimes counteracted by homelessness services acting as an address for GP registration and other purposes.
- Attitudinal barriers in some services, based on cultural, historical and mass media images of homelessness, i.e. rough sleepers being assumed to be addicts, criminals and potentially dangerous due to severe mental illness.
- Challenges around providing services in rural areas and other localities in which levels of homelessness and rough sleeping were low, i.e. there was not a clear case for dedicating resources to specialist service provision.
- Longstanding challenges around access to mental health services for people with addiction issues and for addiction services for people with severe mental illness. Researchers advocated the development of interdisciplinary teams that could support people sleeping rough presenting with severe mental illness and addiction in the mid-1990s.¹³
- Attitudinal issues among homeless people and people sleeping rough, including an *expectation* of rejection when seeking help from NHS and other services, which created what amounted to a barrier to services, because they were disinclined to approach them.

A range of challenges to health service delivery were also identified by earlier research. These centred on four main areas:¹⁴

- Problems with maintaining continuity of care when homeless people were mobile, both in the sense of moving between administrative areas while sleeping rough, and in the sense of being moved between areas by local authorities and homelessness services when they sought help.
- Issues with continuity of care where individuals presented with 'chaotic' behaviours, i.e. addiction and severe mental illness which meant that orthodox systems could not keep them engaged, and specialist services, alongside interdisciplinary working, were necessary for treatment to be effective.
- Medical records and data sharing where records were scattered or were very limited, which meant that health services were treating people sleeping rough and other homeless people without access to detailed, or sometimes any, medical histories.
- The inherent ineffectiveness of treatment where adequate, suitable and stable housing was not available, summarised at the time by the expression of being unable to treat someone effectively who was 'living in a cardboard box', with academic and policy research urging comprehensive strategies that integrated health services with housing related support and resettlement

¹² Quilgars, D. and Pleace, N. (2003) *Delivering Health Care to Homeless People: An Effectiveness Review* Edinburgh: NHS Health Scotland.

¹³ Pleace, N. and Quilgars, D. (1996) op. cit.; Pleace, N.; Jones, A. and England, J. (2000) *Access to General Practice for People Sleeping Rough* York: University of York.

¹⁴ Pleace, N. and Quilgars, D. (1996) op. cit.

programmes that enabled a trajectory out of homelessness, ensuring health and wellbeing were maximised to facilitate that process.¹⁵

Previous research also highlighted two other factors that had to be considered when reducing rough sleeping and improving the health and wellbeing of people sleeping rough. The first of these was the nature of rough sleeping itself, particularly the evidence that situations in which someone was sleeping rough on a routine basis, still referred to as an 'entrenched' rough sleeper, were the exception. People sleeping rough were a larger population, characterised by periods in services, in precarious living arrangements with friends, relatives and acquaintances and sometimes periods in housing, while also sleeping rough on an episodic basis. This meant that effective interventions to improve health and wellbeing among people sleeping rough, and to reduce rough sleeping more generally, had to be accessible to those sleeping rough and those who were at heightened risk of sleeping rough.¹⁶

The second factor was the nature of the population who slept rough and who experienced sustained and recurrent homelessness. Earlier research had indicated that very high prevalence of severe mental illness, addiction, disability, limiting illness and extremes of socioeconomic marginalisation, i.e. near permanent workless and frequent contact with the criminal justice system, characterised this group. Research in the late 1990s, however, showed that sampling errors were misrepresenting the population who lived rough; because research was cross-sectional, it took a 'snapshot' of people using services or sleeping rough over a short period of time.

American longitudinal analysis showed that the picture of extremely high prevalence of severe mental illness and addiction among homeless lone adults was incorrect. People with the highest needs were least likely to exit rough sleeping or homelessness services, so any research that took place over a couple of days, or a week or two, inevitably oversampled homeless people with the highest needs.¹⁷ UK data, including the CHAIN database in London, clearly indicated a similar picture here.¹⁸ Later research indicated that patterns of causation were more complex than had been thought, particularly evidence that some long-term and repeatedly homeless people started their trajectory through homelessness with low, or no, support needs and then experienced mental and physical deterioration if they did not exit homelessness quickly.¹⁹ In terms of health service effectiveness, this emphasised the need to focus on *prevention*, now at the core of English homelessness policy since following the 2017 Homelessness Reduction Act, to stop the human and financial costs of allowing homelessness and rough sleeping to

¹⁵ Hinton, T. (1994) *Battling through the Barriers: A study of single homelessness in Newham and access to primary health care* London: Health Action for Homeless People and East London and the City FHSA; Pleace, N. *et al* (1999) *op. cit.*; Quilgars, D. and Pleace, N. (2003) *op. cit.*

¹⁶ Fitzpatrick, S. *et al* (2005) *op. cit.*

¹⁷ Kuhn, R. and Culhane, D.P. (1998) Applying Cluster Analysis to Test a Typology of Homelessness by Pattern of Shelter Utilization: Results from the Analysis of Administrative Data, *American Journal of Community Psychology* 26(2) pp.207-232.

¹⁸ Jones, A. and Pleace, N (2010) *A Review of Single Homelessness in the UK 2000 - 2010*, London: Crisis.

¹⁹ Culhane, D.P. *et al* (2013) The age structure of contemporary homelessness: evidence and implications for public policy. *Analyses of Social Issues and Public Policy*, 13(1), 228-244

become either recurrent or sustained.²⁰ Alongside this, there was a need to find efficient ways to meet the needs of the small, high cost, high risk group experiencing sustained and repeated rough sleeping and homelessness, again reflected in the current policy emphasis on Housing First in England.

Since the first wave of high levels of rough sleeping was experienced in the late 1980s and 1990s, policy and practice have moved on. Significant innovations in service design, centred on Housing First²¹ and related models like Critical Time Intervention, have provided more effective mechanisms to end long-term and recurrent homelessness, including rough sleeping, among people with high and complex needs. Changing practice around prevention of homelessness, including the redirection of resources towards stopping homelessness from occurring and providing rapid rehousing when it does occur, also promises to reduce the flow of people who might be at risk of becoming long-term and recurrent rough sleepers.

Nevertheless, concerns about the prevalence of severe mental illness, poor physical health, disability, limiting illness and addiction among people sleeping rough, persist.²² There are also concerns that health services and systems are not as integrated into homelessness strategy and the specific policy and practice responses to rough sleeping as should be the case.²³

²⁰ Pleace, N. and Culhane, D.P. (2016) *Better than cure? Testing the case for enhancing prevention of single homelessness in England* London: Crisis.

²¹ Pleace, N. (2016) *Housing First Guide Europe* Brussels: FEANTSA

²² Fransham, M. and Dorling, D. (2018) Homelessness and public health, *The British Medical Journal*, January 30th, BMJ 2018; 360: k214 doi: 10.1136/bmj.k214.

²³ Crane, M., Joly, L. and Manthorpe, J. (2016) *Rebuilding Lives. Formerly homeless people's experiences of independent living and their longer-term outcomes*. The Social Care Workforce Research Unit, The Policy Institute at King's College London.

3. Lived experience of accessing health and care services

To explore the experiences of accessing health and care services of people who sleep rough, focus groups were conducted in four areas in England, nominated by the Department of Health and Social Care. The focus groups involved 23 people (four women) with lived experience of sleeping rough. Site A's focus group comprised five respondents (one female); Site B, six respondents (one female); Site C, five male respondents; Site D, seven respondents (two female). Ages ranged from 19 to 63, and respondents were typically in the 30-45 age range, White and British. All respondents had experience of sleeping rough, 17 were sleeping rough at the time they participated in the focus groups. Responses were anonymised at the point of recording the focus groups and the results were transcribed. Ethical approval was secured via the independent review processes for both health care and social care research at the University of York. The focus groups took place in July and August 2019 and were each approximately one hour in duration.

Respondents were not asked to talk about their medical histories or about their own direct experience of treatment. They were also asked not to name any health professionals who had provided them with treatment.

3.1 Experiences of sleeping rough

Reflecting earlier research,²⁴ experiences of sleeping rough were not always sustained and could be intermittent, although all the respondents had some experiences of sleeping outside, and sometimes living in tents, mobile structures and buildings not designed for habitation. There were a few reports of sometimes sleeping in A&E departments:

Yes, I slept in a bus for two weeks near [area] and that was rough and cold as well.

Site B respondent.

Yes, I lost my flat through drugs and didn't have anywhere to go. I stayed round my mates for a while and it wasn't working out, so I left there and went and slept over [local park]. There is a church there where people used to rough sleep and so I slept there. Unfortunately, it was December time, so it was all snowing and everything.

Site D respondent.

²⁴ Anderson, I. *et al* (1993) op. cit.; Fitzpatrick *et al* (2005) op. cit.

I've slept in A&E.

Site D respondent.

They won't put you in, there's no such thing as go down the shelter and get a roof over your head. You assume that, but it isn't.

I don't actually sleep in the city; I sleep outside the city and that's for basically safety reasons. It's just easier, you don't have people coming up to you and stuff like that.

Site C respondents.

3.2 Impacts of rough sleeping on health

The stress and strain of sleeping rough came across very strongly when respondents were asked whether they thought homelessness and sleeping rough had impacts on their mental and physical health. Reports of mental health problems were common across the four groups:

For me, it's 90 per cent mental and 10 per cent physical, because when your mental is not well your physical is not well, do you know what I mean?

Site B respondent.

It makes you run down because you're just in the same rut every day. You're just in a hole and you can't get out of the hole and the hole is getting bigger and bigger and bigger and you're stuck down the bottom. You can't see a way out of it.

Site D respondent.

You just want to end it because it's easier just to be dead than alive, because if you're dead you don't have to worry about where you're sleeping. You're done.

Site D respondent.

Trying to fill your day with something meaningful, so you don't get more depressed or hide out of the rain and cold. If you're cold and wet, that's your death sentence.

Site C respondent.

Yes, and by pushing you around, you're making the homeless person feel disenfranchised and angry and when were you going to feel calm when you've had eight hours sleep? No, you've never had that. Somebody winds you up, the fuse is a lot shorter.

Site C respondent.

I'd say mental health problems, yes. That's, for me, a huge thing that I'm trying to conquer.

Mental health really... It's my first time being homeless.

Site A respondents.

Drug and alcohol use, as other research has indicated,²⁵ was seen as sometimes being a causal factor, often as a response to the experience of sleeping rough and homelessness, a way of coping with the stress, was occasionally reported as self-medication in an attempt to manage mental health problems:

That's right. It's mental because you I tell you what it is, for me, I've been on the street for 40 odd years, do you know what it is, it's mental. It's all about addiction. I'm an alcoholic and that's what I do, I drink. You see when you take that drink away trying to replace that with something it's hard.

Site B respondent.

The reason why there is an addiction is because there's nothing to do, do you know what I mean? When you're homeless you're just out there running wild and the thing is...when you're homeless and sitting out there what are you living for? Nothing, because you've got no home. You've got nothing, do you know what I mean?

Site B respondent.

[Hearing voices] You have to live with them. Now I've got medication for them which is ideal. I'm happy, but when you're homeless you have to live with what problems you've got, and they get more out of hand, so you start drinking more just to get rid of what you...The only trouble is it gets louder. It doesn't go away, so you drink more to get rid of it and it's still there, as I found out.

Site D respondent.

Reports of physical health problems were less common, but two issues that were reported were musculoskeletal problems from sleeping outside, and experience of physical attacks. There were also frustrations about not being able to keep clean, in respect of washing, toilet facilities and keeping clothes clean:

Your legs are going, your hips are starting to ache, you can't get comfortable. You turn one way, your back aches, turn the other way, your hips, and you wake up in the morning, you start walking and your legs are going, don't do this.

I think the hardest thing about being homeless is actually having to lay on something solid every single night of the week. Not being able to stretch out comfortably. Some people have to cramp up in a doorway and things like that.

Site C respondents.

²⁵ Pleace, N. (2008) op. cit.

You have people sleeping on the streets they can't even zip up their sleeping bags because they can't get hold of them fast enough because somebody attacks them. People have been pissed on.

Site D respondent.

Yes, I slept in a tent by the canal and I had three people decided to jump on the tent while I'm in it. So, I was literally getting jumped on inside this tent...I've actually seen people who have been kicked that hard in the head that they've actually got the imprint of the trainer on their face.

Site B respondent.

If you start early in the morning, your job starts early in the morning, you've got to get up from sleeping rough and go straight into work. You can't wash or anything.

Site C respondent.

Nutrition could be an issue for people sleeping rough, with reports of eating out of bins and scavenging for food, within a broader picture of not being able to exercise any control over nutrition, i.e. having to eat what was made available by services and faith-based organisations as there was no alternative. Issues were reported with respect to benefit claims, sanctions and Universal Credit not being accessible to some respondents, something also indicated by previous research.²⁶ Securing and sustaining work while sleeping rough was also reported as challenging by a few respondents:

I've eaten weird and wonderful things. I've eaten soggy chips after it's been raining because I was that hungry. You just find something, and you think it's food.

Yes, I used to eat out of bins all the time. I'd see someone come out of McDonald's...

Site D respondents.

That's another problem as well, they say, 'Go to look for work', you go for an interview or something, they say, the first thing, 'Well, where do you live?' 'I'm not living anywhere', so that's the job gone.

Site C respondent.

²⁶ Beatty, C. et al (2015) *Benefit sanctions and homelessness: a scoping report* London: Crisis; Reeve, Kesia (2017). Welfare conditionality, benefit sanctions and homelessness in the UK: ending the 'something for nothing culture' or punishing the poor? *Journal of Poverty and Social Justice*, 25 (1), 65-78.

These findings are unsurprising. Recent research and analysis conducted over the last 30 years on the health and wellbeing of homeless people and people sleeping rough relative to the general population consistently indicates higher prevalence of serious and limiting mental and physical illness.²⁷

3.3 Homelessness services and access to health and care services

Homelessness services acted as a conduit to health and social care in all four areas. This is not a surprising finding as the core function of most daytime and emergency accommodation, as well as supported housing services, is to provide some form of case management, or at least act as a referral and information point for people needing assistance with accessing required care and support. In Site A, where there was not the same degree of development of specialist health services designed to work with people sleeping rough and the wider homeless population, this role appeared to be particularly important, with services acting as a referral point to mainstream NHS services:

[Service] is like the middle person before the hospital, so if you're not feeling - if you are worried about going to the hospital, [Service] will help you...

Site A respondent.

Knowledge of the presence of specialist health services in the other three areas was universal. However, as is discussed below, the presence of these specialist services did not necessarily mean that people sleeping rough would make use of them in preference to mainstream NHS services. Experience of referral from homelessness services to the NHS and care services was not always positive. Sometimes a referral would receive no response, an issue with respect to mental health services which is explored in more depth below, or there could be a sense of being referred to one service after another, without necessarily getting the support, care or treatment needed from any of them. As one respondent put it:

I think the most favourite word of services at the moment is, we'll refer you. You go to them and they say, 'We'll refer you to them.'

3.4 Information on health

Google.

Site B respondent.

Use of the web was the most commonly reported way in which the respondents sought information on health matters, when not in contact with a health professional. There was no sense in any of the four

²⁷ Lewer, D. *et al* (2019) Health-related quality of life and prevalence of six chronic diseases in homeless and housed people: a cross-sectional study in London and Birmingham, England. *BMJ open*, 9(4), p.e025192.

groups that public health messages around diet, exercise, smoking, drinking or drug use, or regular check-ups with health professionals were being received.

Fear of what might be wrong could be a deterrent to going to the doctor, expressed by a few respondents who thought that issues such as high alcohol consumption were likely to be causing them serious harm. Resistance to the idea of going to the doctor because of what tests might reveal is, of course, not an issue confined to people with experience of sleeping rough:

Everybody knows doomsday is coming so nobody wants to go to the doctors for a check-up. That's why I didn't go for a blood test, because they don't want the bad news.

Site B respondent.

3.5 Flexibility in the mainstream NHS

In all four areas, respondents were using ordinary GP services, attending A&E and making use of other mainstream NHS services. In Site A, there was not really an alternative, mainstream NHS services were the ones available, but while specialist services were available elsewhere, this was not the route that people with experience of sleeping rough always took when seeking health and care.

While the scale of the work undertaken for this research was really too small to draw wider conclusions, there was a sense that presentation could be potentially important. If certain visual cues were not present and someone reported having an address, the NHS reacted the same way as it would with anyone else. In essence, many people sleeping rough do not look like, or present themselves, in the way that mass and social media tends to present a 'homeless person'. When someone is not differentiated in terms of dress or manner or other signifiers, passing as an ordinary citizen might mean a better response, rather than being processed as a stereotypical 'homeless' person who might be assumed to be intoxicated, criminal or even dangerous because of mental health problems, something suggested by earlier research.²⁸

Some of the answers given by the respondents showed this perceived risk of being identified as 'homeless'. A few of those using ordinary GP surgeries reporting that they had retained their doctor, by using the address they had possessed when they originally registered and subsequently lost:

I just haven't told them that I've been homeless. I'm just using the same address that I've always done.

Site C respondent.

²⁸ Pleace, N. *et al* (2000) *op. cit.*

A&E departments were quite often referred to as neutral spaces, in which the sheer volume meant that people tended to all be processed in a very similar way. There was not necessarily time to recognise someone might be 'homeless' and respond differently than to another patient, or these hospital departments just saw a lot of variety of need and simply had an operational ethos that meant equal treatment for all. Again, the fieldwork was at too small a scale to be able to generalise, but this was a potentially interesting finding:

...obviously it depends what you want addressing because you can go to A&E and they'll tell you you've got to go to your GP. It has to be an emergency doesn't it, do you know what I mean?

Site B respondent.

I wouldn't say you were treated any different. It's just the waiting a long time.

Site A respondent.

To tell you the truth I know there's a stigma attached [to homelessness/sleeping rough] and that, but I feel a lot more comfortable going to A&E because I know they're all rushed off their feet. They've all treated so many people.

Site D respondent.

Again, some respondents reported a sense that presentation was important, that how someone behaved in a given situation would influence the kind of support they received. People sleeping rough seeking to present themselves sympathetically, as 'service worthy' individuals, across a range of services has again been suggested by earlier research:²⁹

I think it depends on your own attitude as well. You could be having a really bad day and you could be really angry or you could be coming across as abrupt and that might not be really you, but it's because you're on the street or homeless and you have those issues, that you're actually that way.

Site B respondent.

Experience was varied, however, with a few of the people with lived experience of sleeping rough and homelessness reporting that an ordinary GP had registered them even though they had reported themselves as being homeless.

²⁹ Hutson, S. and Liddiard, M. (1994) *Youth homelessness: The construction of a social issue*. London: Macmillan; Pleace, N. and Bretherton, J. (2006) *Sharing and matching local and national data on adults of working age facing multiple barriers to employment* London: DWP.

3.6 Barriers to mainstream NHS services

On a bus, it's about 40 minutes, half an hour. No, no, from X, it's about 40 minutes from X, it's about an hour on a bus, X, from here, isn't it, but, first of all, I've got to ring up at eight o'clock in the morning to get an appointment. My phone got nicked; I've got no phone. How do I go about doing that?

Site A respondent.

Where registration with an ordinary GP was retained, physical distance and one other logistical challenge, having to have a phone/internet to make appointments, could be barriers to access. Research in the 1990s reported much higher GP registration rates among people sleeping rough than might have been expected, but the reason was sometimes that registrations made earlier in life had been retained with GP surgeries that could be some distance away.³⁰ Among the respondents in the four focus groups, this did not appear to be a widespread issue and again, it needs to be noted that the scale of the research was insufficient to be generalisable. There were still, however, some people sleeping rough whose doctor was some way away and for whom finding the cash to travel to their doctor could be a challenge.

Where outpatient and other services involved homeless people travelling, homelessness services were reported as being able to offer assistance, paying for bus tickets and taxi fares, or sometimes using worker time to help people attend appointments. No issues were reported with respect to ambulance services, when they were called for people sleeping rough, the ambulances always came.

Experiences of barriers to registration with ordinary GP surgeries were reported. In the 1990s, research in London using mystery shopping techniques (actors assuming different guises) found that people presenting with apparent signifiers of being homeless or a rough sleeper were likely to be turned down when they tried to register with a GP, whereas those presenting as ordinary citizens were not.³¹ Later research suggested that it was perhaps less a question of apparent homelessness, than a concern that someone who appeared homeless would be addicted and require a script, some GPs reporting a fear that their surgeries would be 'targeted' by a homeless population, if they were known to prescribe benzodiazepines and methadone.³² There was a clear pattern to these concerns: GP surgeries operating in urban areas with socioeconomic problems did not tend to take this view, it was instead linked to surgeries in more prosperous rural and suburban areas. This suggested that images of people sleeping rough as 'drug users', rather than reluctance stemming from experiences of working with homeless people, was the issue.

³⁰ Pleace, N. *et al* (2000) *op. cit.*

³¹ Hinton, T. (1994) *Battling through the Barriers: A study of single homelessness in Newham and access to primary health care* London: Health Action for Homeless People and East London and the City FHSA.

³² Pleace, N. *et al* (2000) *op. cit.*

Whether these patterns still hold true could not be established by this piece of work, focusing as it did on the lived experience of people sleeping rough with accessing services. In one site, though, a sense of stigma and associated problems with GP registration were reported by several focus group respondents. Although the work is too small in scale to be generalisable, reports of barriers to registration were less common in the other three areas:

Yes, it's all down to the stigma. Once they know you're homeless then there's a stigma to it.

I couldn't register. I was told I couldn't register because I didn't have an address.

[Receptionists in GPs] Yes, when they know that you're homeless or living in a hostel they talk at you, down to you or talking to you like you're stupid. Do you know what I mean?

Site D respondents.

Well, they should just have GPs like they do here that all they want is ID to know who you are. They shouldn't need specific address details. They shouldn't need to know that you're local to the community. You should be able to access GPs anyway.

Site B respondent.

As noted, a few respondents were retaining registration with GPs although they were outside the practice boundary area or lacked a fixed address within the area. However, a GP telling someone to register elsewhere because they were now living outside their area was only reported in one instance:

...my GP was saying I've got to find another GP in [neighbouring borough], but I'm used to them because I've been with them 21 years, so I'm not going to leave them.

Site D respondent.

Attitudinal or bureaucratic barriers to A&E were not widely reported; as noted those respondents who commented on using A&E tended to describe it as a 'neutral' space, where the range and number of people being treated meant they were not likely to be responded to in a different way. There were, however, a few reports of attitudes shifting when someone sleeping rough or experiencing homelessness attended frequently. In a few cases, respondents felt that they had been treated differently because of their characteristics, but this appeared to be more associated with drug and alcohol use than with their position as someone sleeping rough:

...the A&E, depending on what they feel like or who you are, if you've been in so many times before, they can be judgmental against you. This guy's come in because he wants a bed, or he's had an overdose.

Site A respondent.

I just want to say one thing and I'll say it and I'll finish it. I turned up as an alcoholic and I was rattling, and I went to the hospital. I was in bits and do you know what the woman said to me? No local connections. They just gave me one tablet. I was eight hours in that A&E. That's why I won't go to hospital.

Site B respondent.

Access to dentistry was variable, those living in areas with specialist service provision could get access to treatment but finding an NHS dentist and then registering with that dentist could be problematic. Differentiating the specific effects of sleeping rough and homelessness from wider issues around access to dentistry across the general population³³ would require a more detailed study:

You try to register [with a dentist] and the first thing they ask you is address and you say you haven't got an address and they say, 'Well, we can't help you' because that's the first question they ask you, 'What's the address? What's your postcode?' 'I haven't got one.'

Site D respondent.

3.7 Using specialist NHS services

Attitudes towards the specialist NHS services in three areas were generally positive. Services were reported as understanding, sympathetic and thus accessible – perhaps hardly surprising given that they were designed for people sleeping rough and homeless populations, and staffed by health professionals and administrative staff choosing to work in that field. A few respondents compared areas with specialist homelessness NHS services favourably with those that lacked such services. The comments from three Site B respondents typified the attitudes towards specialist services:

There are actually a lot of places you can go...In [area], yes, if you do want help there is to be fair. I'll give them that.

Can I just say this yes? I've lived in a lot of other areas and unless you have a fixed address you can't get healthcare. You can go to the hospital, but you can't get a GP. Unless you've got a registered address, you can't get a GP, because I had it in Cumbria. I had it in Scotland. I had it in Newcastle. I had it in all those areas. Unless you've got a fixed abode yes, you can't go to the doctors.

Any GPs that will take you if you've got no fixed abode is good, yes, of course it is.

Site B respondents.

Patterns of NHS service use were, however, not necessarily what would be expected. There was universal awareness of specialist services, but sometimes that was not the route that people sleeping

³³ Steele, J., Shen, J., Tsakos, G., Fuller, E., Morris, S., Watt, R., Guarnizo-Herreño, C. and Wildman, J. (2015) The interplay between socioeconomic inequalities and clinical oral health. *Journal of Dental Research*, 94(1), pp.19-26.

rough or experiencing homelessness took when seeking treatment. While it was not widespread, a few respondents reported that they did not wish to use specialist services, the reason being that there were other people sleeping rough and street-using populations there who were active drug users, while they were not. It is a common perception that addiction is universal among people sleeping rough, with similar imagery around the prevalence of severe mental illness. In fact, both current and historical data actually indicate much higher rates than in the general population, but *not* that addiction or severe mental illness are uniformly present.³⁴ As the reports could be construed as criticisms of particular specialist services, without those services being given an opportunity to report their own perceptions, quotes from the respondents in focus groups below are not identified by area:

I wouldn't go in there, it's just crackheads and...

I refuse to go in there as well. I won't use it.

Dialogue between two respondents.

That's my problem. I've got my own GP; I've had him since I've been in [city]. I won't go to [specialist service] because of the drug addicts, the alcoholics there. Just won't do that.

Where there was an established relationship with a GP in an ordinary surgery, a few respondents expressed a preference for maintaining that relationship, rather than changing to seeing a GP in a specialist homelessness service. The comments from one respondent in Site B summarised these views:

Because your GP is local to you. Your GP knows you. They know you inside out. If you're in an area for two years and you're in housing, your GP knows you. He knows what you're about. He knows what's wrong with you. He knows how you're feeling.

Site B respondent.

A few of those registered with an ordinary GP surgery did not really see any advantage to using a 'homelessness' service, because they were content with the treatment that they received. One respondent from Site C summed up these views:

I don't think there's much difference because if you're registered with a GP, all you have to do is pick the phone up really and it would be the same as [specialist service]. You just need to pick the phone up.

Site C respondent.

³⁴ Jones, A. and Pleace, N. (2010) op. cit.; Fitzpatrick *et al* (2011) op. cit.; Bowen, M. *et al*, (2019). Multimorbidity and emergency department visits by a homeless population: a database study in specialist general practice. *British Journal of General Practice*, 69(685), pp. e515-e525.

In the 1990s, considerable attention was being focused on health and homelessness, and meeting the treatment needs of people sleeping rough to support the implementation of the Rough Sleeper Initiative (RSI) programmes. Debates about the need for specialist services – given that specialist provision was expensive - against modification of the mainstream NHS to ensure people sleeping rough could access it, were widespread.³⁵ Again, there is a need to be cautious in that generalising from a piece of work at this scale is not really possible, but some questions do flow from these findings. While it is evident that barriers can and do exist to the mainstream NHS for some people sleeping rough and other homeless people, others are able to access mainstream services and are content to do so. There are some dangers, with respect to enabling routes out of rough sleeping and promoting socioeconomic integration,³⁶ in assuming that people sleeping rough are ‘different’ people who require ‘different’ NHS services.

Experience of treatment in specialist NHS services was reported in uniformly positive terms across the three groups in the sites where these services were present:

On the medical side and healthcare side of things are there and minor issues with everything but they are actually quite good. You see the ambulance there and the nurse comes in every Tuesday. You have a physio come in. You have a dentist come in. So, to be fair they are actually quite good that way.

Site B respondent.

There is a homeless doctor's at X, that's around the corner. They're the best ones to go to because they kind of deal with homeless people so they're more understanding and more compassionate, but once you go to a normal GP that's when you start to get treated differently, you understand.

Site D respondent.

Yes, of using [specialist service] now for the last, probably it's 15 years, and always, yes, a fantastic service with nurses and GPs and I've never had any problem, the dentists, and the cleanliness.

Site C respondent.

3.8 Mental health services

There was evidence from the four focus groups with people with lived experience of sleeping rough that mental health services were hard to access, uncoordinated with other services and were perceived by people sleeping rough as being under resourced. As noted, a high prevalence of (self-reported) mental

³⁵ Pleace, N. and Quilgars, D. (1996) op. cit.

³⁶ Pleace, N. (2018) *Using Housing First in Integrated Homelessness Strategies* London: St Mungo's.

health problems reported in current and previous research was found among the people taking part in the focus groups, all of which reported barriers and problems with mental health services.

The perception that mental health services were firefighting, i.e. could only be accessed in extremis, was reported. Mental health services would step in at the point where someone was sectioned, but were not accessible at an earlier point. Additionally, referrals to mental health services from other services, including GP surgeries and the homelessness sector, did not receive a response, or resulted in being placed on what could be a very long waiting list. A formal diagnosis could result in medication, but not necessarily lead to further support or treatment. Some of the respondents from Sites A and C summarised wider experiences:

You've got to be really dire. [mental health service] they only take people who are, have been sectioned, but because I had an assessment by [service] saying my mental health had deteriorated, that's not enough because I haven't been sectioned in the [area], but there are still people wandering around who've been sectioned.

Yes, I haven't got any further than a diagnosis. No one's doing anything. I haven't had medication.

Well, my GP says, 'You're obviously depressed.' Wrote a letter saying that being homeless has severely damaged my mental health and my physical health. Wrote a letter, I handed it in, and they said, 'No, that's not serious enough for us to give you a flat. We haven't got any flats.' What do you mean? Like snakes and ladders. You climb up the ladders, you have a relapse, you go straight down the snake and go back up again. You're going round and round like a rat in a washing machine wheel and they never get off the wheel, so they never get a flat. They haven't got any flats to give out.

Site C respondents.

...because it was a mental health problem, the mental health team didn't turn up, then that's another reason, wait 11 hours.

I think tablets, I don't know, I don't think - they can do you more harm than good I think that. Depends how strong your mind is, doesn't it? I've had tablets before myself and then I stopped, I don't know, you're in a cloud, aren't you? You're in the fog, aren't you? If you start taking tablets, it's like you're in a different world, whether you like it - may as well go and have a drink or something or, I don't know.

Site A respondents.

4. Discussion

I think that I've got a mental health problem, depression, stress, all those things, old age and then physical problems, so everything comes to mental health and then I can't concentrate, I can't do whatever you do. Life is not going well.

Site A respondent.

The analysis has the limits of being a small-scale exercise, and the results are consequently not necessarily generalizable. Key points, however, suggest that there is a need to allow for the nuances in how people sleeping rough use health and care services, and the variations that exist in respect of treatment needs. There is also a case for revisiting earlier debates around where the balance between specialisation and mainstreaming into NHS should lie.

There is some evidence here that easy assumptions should be avoided, a key one being that people sleeping rough are consistently distinct from the general population in how they present themselves, how they behave and what their treatment needs are. Proceeding from the basis that rough sleeping is *always* associated with severe mental illness and/or addiction is not helpful, and the evidence base shows this assumption is incorrect. High prevalence is not the same as universal characteristics, and there is a reality in which people sleeping rough engage with and use the mainstream NHS. Equally, however, barriers clearly exist to some mainstream services, and from the limited evidence gathered here, people sleeping rough and homeless people clearly benefit from the understanding and knowledge of their situation that is offered by specialist NHS services. One size will not fit all, and it seems likely that an optimal strategy will involve both enhancing the capacity of mainstream services to work effectively with people sleeping rough and some provision of specialist support.

A good example of the need for specialist services, which was not highlighted in this particular piece of work but which has been frequently reported elsewhere over more than two decades, is the need for services that can address the needs of people sleeping rough who present with both a severe mental illness and serious addictions. This is a specialist requirement, and while it is not confined to people sleeping rough (there is evidence of need within housed and street-using populations characterised by addiction), but clearly, rates of comorbidity of mental health and addiction are an issue among a significant proportion of people sleeping rough.

If someone sleeping rough needs a GP for direct treatment and access to the wider NHS, however, it seems logical to look first at how to ensure there are systems that mean they can register with ordinary practices. This is not to pass negative comment on existing specialist services, which were clearly valued and, for some people sleeping rough, much more accessible than mainstream services. Nevertheless, in terms of reducing and preventing rough sleeping, ensuring access to a GP is as wide as possible is clearly the best route. In Site A, there was not the critical mass of people sleeping rough to trigger a case for

specialist GP resources to be developed, and this will be the case in much of England; whatever the need of individuals, there are limits to how low the numbers of people sleeping rough can be, before devoting much needed resources to specialist services can be justified.

Integration of NHS and other services is clearly vital. Concerns from the 1990s are equally present today: treatment and care of people sleeping rough will be inherently ineffective, both in terms of reducing the human costs of homelessness and in terms of public expenditure, if systems are not coordinated in a way that provides and enables sustainable routes out of rough sleeping. Meeting the treatment and care needs of people sleeping rough ultimately means building integrated strategies and systems for ending their homelessness. Treatment and care needs among people sleeping rough cannot be addressed by NHS services alone, no matter how those services are designed and commissioned.