Lambeth Vulnerable Adult Pathway

Health Needs Audit

2015

Contents

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Executive Summary

The Lambeth Vulnerable Adults Pathway Health Needs Audit uses responses from 250 individuals to evaluate the health problems and needs of homeless people on the vulnerable adult pathway in the borough. The audit covered approximately 50% of the relevant population and revealed the high levels of health problems this cohort experience compared to the general population as well as the consequent effect on hospital, primary care and community services. This report details the support and treatment that this group report they receive, as well as the barriers to accessing the healthcare services they need. This was complemented by a focus group discussion on specific issues and experiences of this group which was used to inform interpretation and the recommendations.

Physical and mental health

There is a heavy burden of reported ill health in this cohort, with 78% of the group reporting that they had at least one physical health problem. There were also high levels of mental health problems reported. 40% reported a formal mental health diagnosis, but much higher numbers reported other mental health issues.

Lifestyle and substance misuse

The findings from this report demonstrate the fact that those with experience of homelessness are more likely to have lifestyles that are detrimental to their health. This can contribute to or cause long term health problems. In this audit 82% of people reported that they smoke, which is much higher than the general population, and the vast majority were not eating the recommended number of fruit and vegetables per day. Over a third of the participants were drinking more than 3 times a week with high levels of harmful consumption on a typical day of drinking. Furthermore 48% of the audit population answered that they currently take drugs or are recovering from a drug problem, with a smaller subset having injected drugs within the last month.

Support

The positive findings in this report include the very high level of registration with GP services, with 94% stating that they were registered, and very few reporting any problems with accessing GP services. This is further supported by the high levels of agreement with the GP being the preferred source of support for a range of health problems.

When asked about physical health problems, 11% responded that they were not receiving support and would like some. A further 27% stated that they were receiving support but it did not meet their needs. For mental health issues, 16% responded that they were not receiving support and it would help them. A further 24% stated that they were receiving support but it did not meet their needs.

For those with a drug issue, 44% reported find the support they were receiving to be useful. However, 25% felt that they would like more support. For those with or recovering from an alcohol problem, 59% felt the support they received was useful. 14% of respondents felt that they needed more support.

Therefore, over a third of those with a physical or mental health problem and a quarter of those with a drug problem reported that they would benefit from more help. There is clearly an unmet need for additional help in dealing with physical and mental health and substance misuse in this group.

Impact on health services

The above findings are reflected in high levels of service use reported. In the previous 6 months, for instance, 88% reported seeing their GP, often multiple times, 28% had visited A&E and 19% had been admitted to hospital. They were also likely to have relatively long hospital stays. The members of this cohort are heavy users of NHS services when compared to the general population with obvious cost implications for these services. It is therefore vital to ensure that this group have access to the appropriate support levels and health improvement opportunities so that they can reduce their use of acute services.

Recommendations

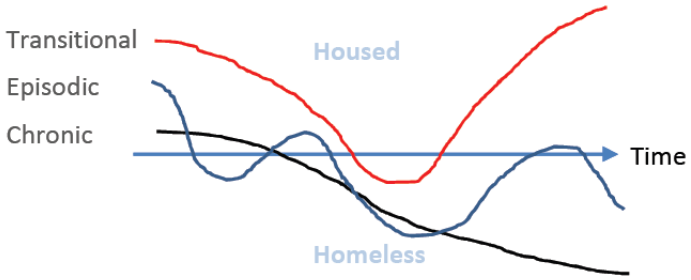
This report highlights the need for intervention across a range of healthcare services to improve the health and wellbeing of this group. Each chapter of this report ends with specific recommendations for each category, including lifestyle interventions, improving access to services and extending the reach of support services in this group. These are summarised at the end of the report, focussing on ways to support delivery of these recommendations.

Introduction

The issue

The term homeless is a broad definition covering rough sleepers, those who are defined as homeless under legislation and those living in temporary accommodation. In addition, many homeless people move between housing and homelessness as shown in figure 1.

Figure 1: Duration and frequency of homeless state



The homeless population tend to have significantly more complex and severe health needs than the rest of the population. In addition the experience of homelessness often further exacerbates existing health conditions, as well as placing people at risk of developing new health problems.

Those who are sleeping rough or living in the hostel system are vulnerable, have particularly high health needs and are hard to reach through mainstream services[1]. There is evidence that those living in hostels or sleeping rough have higher levels of premature mortality – averaging 40-44 years.[2]

Many homeless people may have a tri-morbidity of physical illness, mental health problems and substance misuse. A report by St Mungo's in 2008 found that approximately half of their residents had mental health problems including depression and schizophrenia, emotional and psychological disorders and 'lower level' mental health illnesses. The research also found that 32% had an alcohol dependency and that 63% had a drugs problem.[3]

The reasons for such poor health outcomes may be numerous and include chaotic lifestyles, perception of stigma, low awareness of health needs, barriers to registering with a GP and accessing health and other services[4].

Homeless people should therefore be catered for with appropriate local healthcare arrangements, as not to do so may incur significant cost.

[1] Department of Health Office of the Chief Analyst, Healthcare for single homeless people, 2010
[2] At the Dawn Centre in Leicester, where all patients are homeless at registration but not necessarily rough sleeping, the average age at death for clients who died between 1989 and 2007 was 40.2 years. At the Cambridge Access Surgery, the equivalent figure for 2003-2008 was 44 years. Crisis reported a similar figure in 1996.
[3] 'Homelessness: it makes you sick', St Mungo's, September 2008
[4] Public Health briefing, Southwark Council

Context

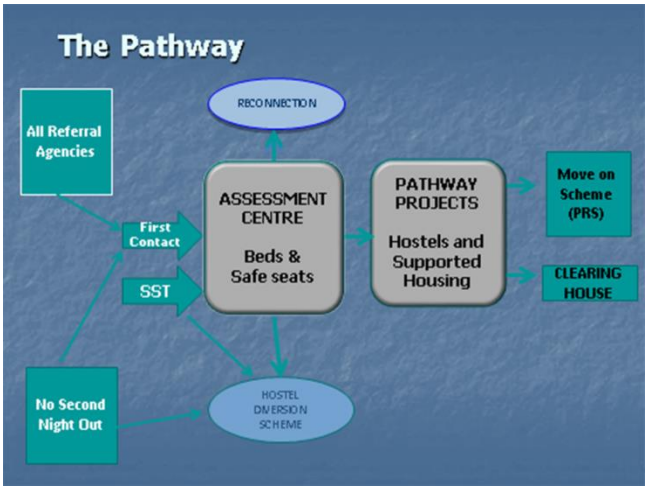
There are a number of arrangements in place in Lambeth intended to service the health needs of the homeless population. These include:

- Five GP practices commissioned to secure registration and primary healthcare access for homeless people, including primary care clinic sessions within local homeless supported accommodation. As well as attending to their general healthcare needs, these practices attend to needs more specifically associated with homelessness such as substance abuse, mental health, poor foot care or cognitive impairment secondary to brain injury or chronic alcohol misuse. The five practices are Hetherington Group Practice, Dr Curran and Partners, Palace Rd Surgery, Mawbey Group Practice and Hurley Group Practice at Pavilion.
- Guy's and St Thomas' Trust (GSTT) Health Inclusion Team (across Lambeth and Southwark) which provides specialist community health provision, including a range of clinical and support services, to predominantly vulnerable populations including homeless people. Their work includes screening for TB and blood-borne viruses, onward referral and facilitating follow up and treatment access and case management when required for patients with multiple complex needs.
- South London and Maudesley/Lambeth Integrated Treatment Consortium-Hostel Team provides access to rapid on-site prescribing clinics for residents at 3 high needs hostels; Waterloo, Graham House and Palace Rd. An alcohol worker also provides sessions for a number of hostels. These two services allow clients to access both medical and psychosocial support for substance misuse including access to inpatient detoxification and rehabilitation.
- South London and Maudesley provided an on site needle exchange service at Graham House and a mobile harm reduction service attends sites in the borough where it is known homeless people and other vulnerable drug users may congregate.
- GSTT Charity funds a pathway hospital discharge team to help homeless people on their discharge from hospital.

The Lambeth Council Vulnerable Adults Pathway aims to ensure that vulnerable and homeless people are actively supported to change behaviour, raise their aspirations, gain meaningful occupation and most importantly move from a state of homelessness and dependence to independent living and social inclusion. This is specifically for Rough Sleepers and Single Homeless people with complex and multiple needs, who may be dependent on substances, vulnerable ex offenders, victims of domestic violence, or those who have low level mental health needs. There are separate pathways for those who are young (16-21) or who have high level mental health needs.

Currently 544 people are on the vulnerable adults' pathway. Referrals are made via the First Contact team or the Rough Sleeper team (SST) and the pathway is shown overleaf.

Figure 2: Lambeth Council Vulnerable Adults Pathway



This project aimed to increase knowledge on the health needs of this particular population and to appreciate the experiences of homeless people trying to access health care.

Methods

Questionnaire

The charity Homeless Link (www.homeless.org.uk) have developed a health needs audit for homeless people. This consists of a questionnaire that is divided into six sections:

- Demographics
- Access to health services
- Health behaviours
- Health and wellbeing (including physical and mental health)
- Substance misuse
- Screening and immunisations

This questionnaire was reviewed by the steering group and some of the generic content was tailored to local circumstances (appendix 2).

A secure online survey link was generated by Homeless Link and this was circulated to hostel staff. Hostel staff then approached clients aiming to capture 40% of their resident population, and a mixture of low to complex health needs.

Before completing the questionnaire, clients were asked to confirm that they understood how the information would be used and that they had not previously filled out the survey at another hostel. The questionnaire was anonymous and no personal details were recorded. The questionnaire was completed with a member of hostel staff inputting data either onto a paper copy of the survey or directly online. The member of staff was responsible for ensuring paper copies were subsequently inputted online. Each questionnaire was estimated to take 20 minutes to complete.

The data was analysed using Microsoft Excel.

Focus group

A topic guide was developed in order to capture information on clients' interpretation of health, experiences of accessing healthcare and the interaction between homelessness and health (appendix 3).

The focus group was conducted by Joia de Sa, from Lambeth Public Health, assisted by Carina McLain and Harriet Sinclair who took notes. The focus group was recorded with informed consent from the participants. The recording was then transcribed in full. The transcript was analysed by two of the team (JdS and CMC) to identify key themes.

Findings

Where possible, data from the local population is presented for comparison. Findings are also compared to the Homeless Link national audit results from 2014. The results were presented to and discussed by the local steering group, who agreed the recommendations.

Section 1: Demographic information

Sample size

The survey was live over a 3 week period from 30/3/15 to 19/4/15. The target number of responses was 218 which represented 40% of the vulnerable adult pathway population.

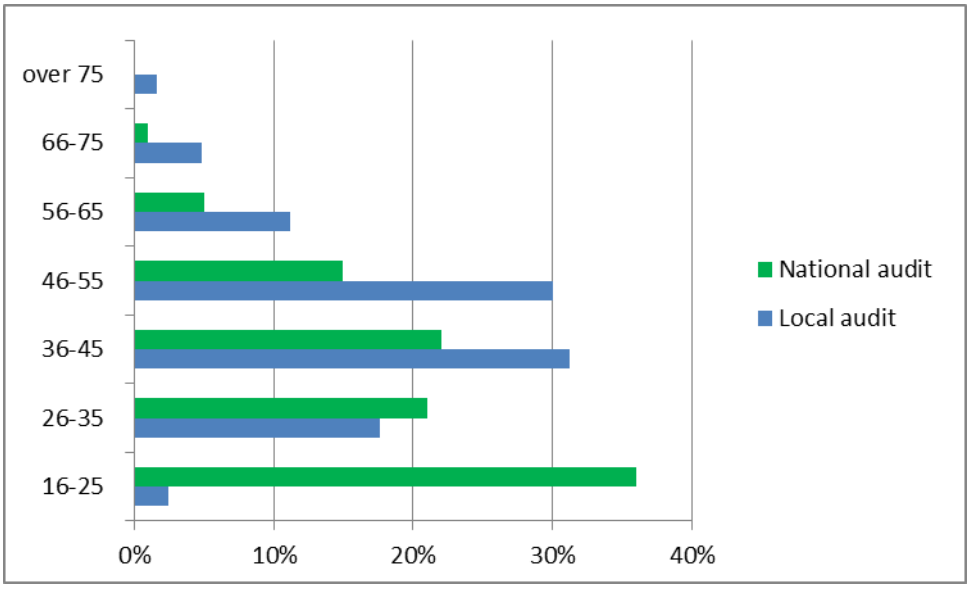
In total 284 responses were received. Of these 250 were complete responses and 34 were incomplete. The 34 incomplete surveys were reviewed. These clients had only answered one or two questions on the survey and so, it was decided to exclude these from the analysis.

Age

A total of 247 people (99%) indicated their age during this audit. These are shown in figure 3, compared to the national audit sample of 2,348 people. There was a broad spread of ages in this sample; however no participants were less than 18 years of age and only 7% were over 65. However, this may reflect the fact that there is a separate pathway for those aged 16-21.

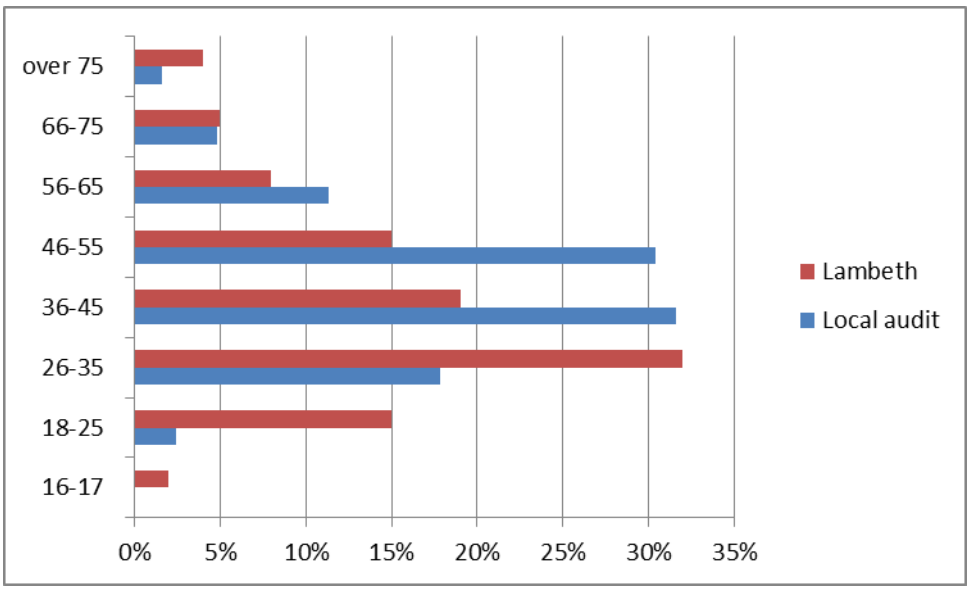
The national homeless health needs audit had an even lower proportion of participants over 65 with only 1.6% but differed in having a much greater proportion of young survey participants with 36% falling into the 16-25 age category.

Figure 3: Age range of survey participants compared to national audit population



When compared to local data, Lambeth has a higher proportion of people in the 26 – 35 year age, while those aged 36-55 are over –represented in the audit group, shown in Figure 4.

Figure 4: Age range of survey participants compared to Lambeth population



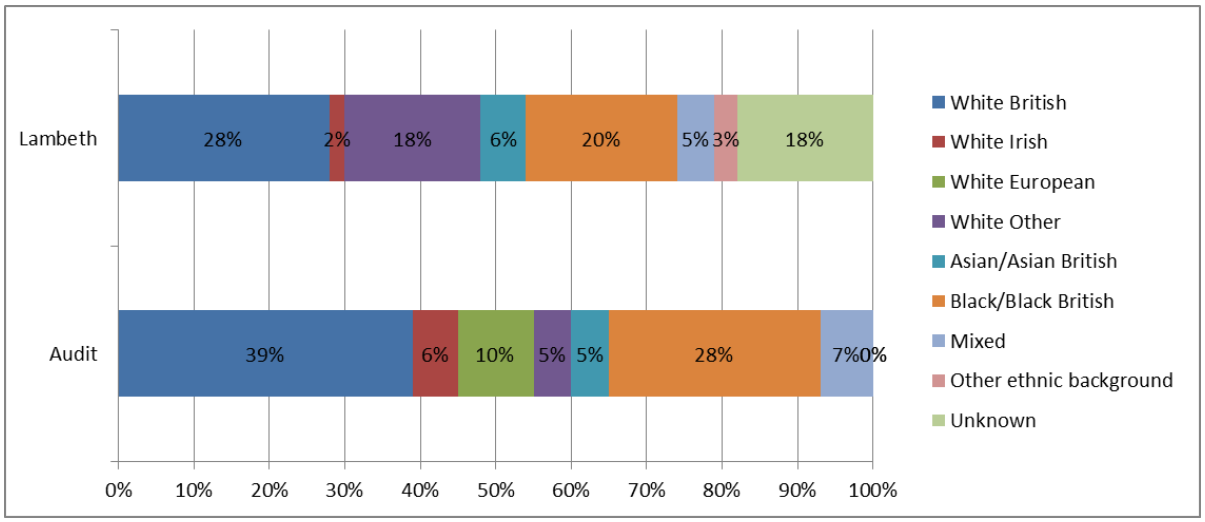
Ethnicity

A total of 240 people (96%) indicated their ethnicity during this audit. This is displayed compared to the Lambeth population[5] in Figure 5.

39% classified as White British and 61 % were from Black and Minority Ethnic groups (all participants who classified their ethnicity as other than White British). Those participants who initially responded as belonging to the White category, but did not further subcategorise this, have been grouped into the 'White other' category.

Compared to the Lambeth population, the audit showed a higher proportion of those classifying as White British, White Irish or Black/Black British, however it is important to note that this may be related to different age ranges in each population.

Figure 5: Ethnicity of participants (%)



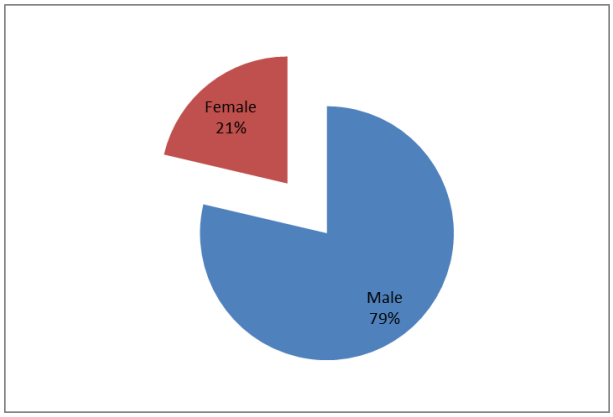
[5] Data source – Enhanced ethnicity data, QMS, 28 February 2014

Gender

A total of 239 people indicated their gender during this audit. Out of these 188 (79%) were male and 52 (21%) were female. This is similar to the national homeless health needs audit where 69% of participants were male.

However, this is markedly different to the Lambeth population where mid-year estimates for 2014 suggest is roughly equally split with 49.7% female and 50.3% male[6].

Figure 6: Gender of audit participants



An additional question asked participants whether they identified themselves as transgender. Out of 227 people providing a response to the question, only 1 person identified as transgender (0.4%).

Accommodation status

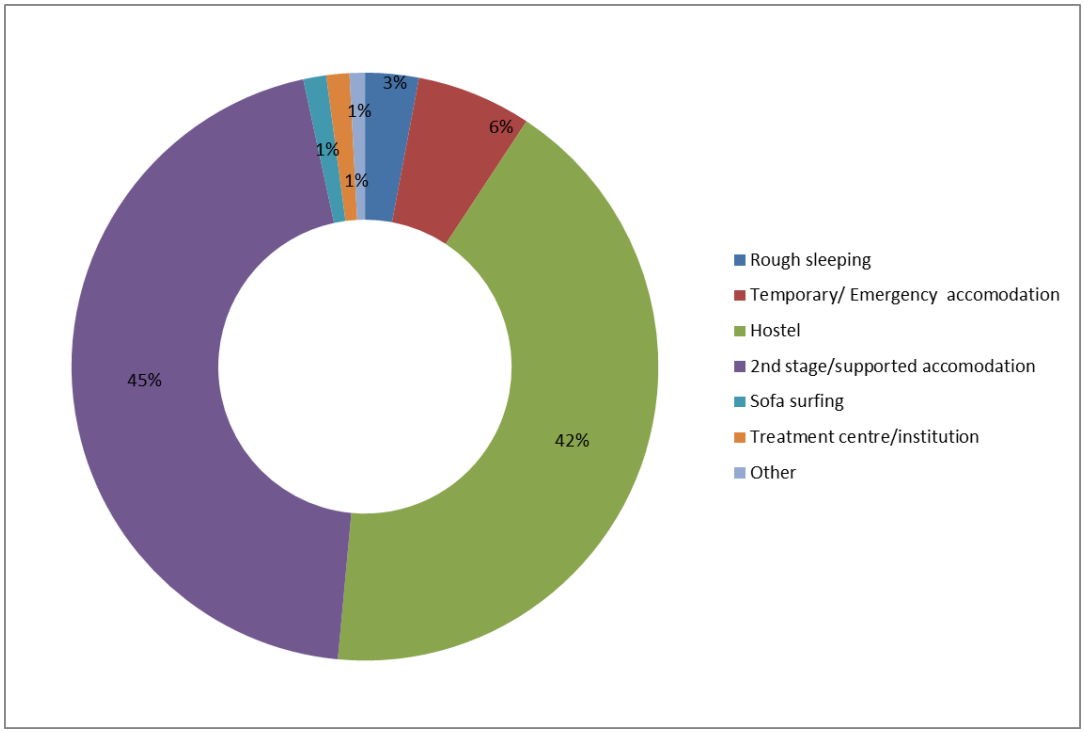
All of the audit participants recruited were currently living in hostels.

A question was included to ask about participants' most frequent type of accommodation over the previous 6 months. A total of 237 people (95%) answered this question. The most common accommodation type identified was 2nd stage/ supported accommodation at 45%, followed by hostels at 42%. Smaller proportions had been rough sleeping or in other temporary forms of accommodation.

The national survey had a slightly different cohort. 20.5% were living in hostels or supported accommodation at the time of taking the survey, with a greater proportion sleeping rough (14.9%). However the national audit population included participants recruited from different living situations.

[6] Greater London Authority, 2014-round SHLAA-capped population projections

Figure 7: Most frequent accommodation of survey participants in the last 6 months.



Background of participants

Out of the 250 people who completed the survey, 32 people (13%) indicated that they were currently employed or in training. 46% of respondents felt that their health stopped them from being able to undertake any training, employment or volunteering.

In the national survey 25.5% indicated that they were employed or in training, with 38% saying that their health was stopping them from undertaking employment, training or volunteering.

Less than 5 people (1%) indicated that they had left care services for young people within the last 5 years. 23 people (9%) indicated that they had left prison within the last 12 months with a further 49 (20%) indicating that they had left prison more than 12 months ago. 36 people (14%) indicated that they had experience of domestic violence. Figures 8 and 9 show a breakdown of the employment status and offending status of the survey participants. Table 1 shows these categories sub-grouped by gender.

Figure 8: Employment status of survey participants

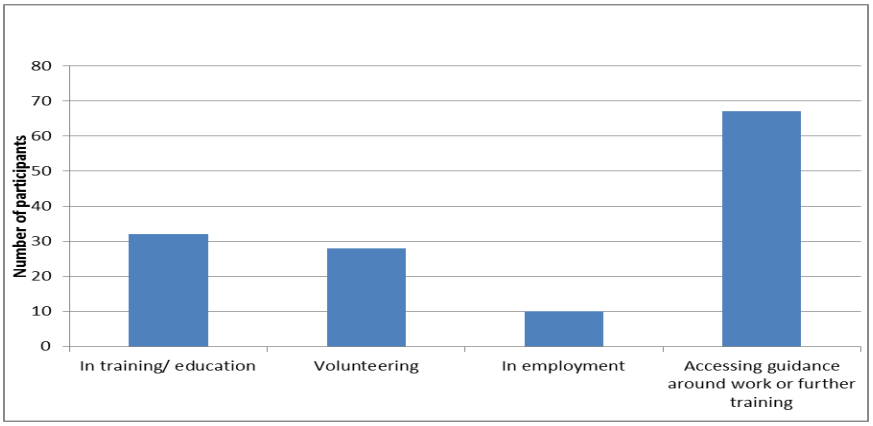


Figure 9: Offending status of survey participants

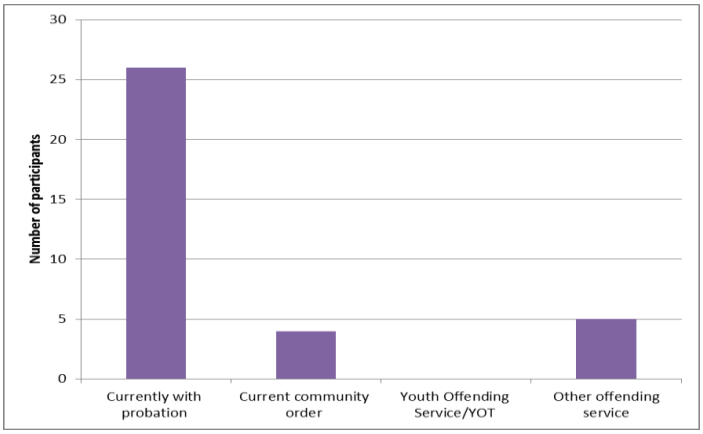


Table 1: Background of participants sub-grouped by gender

Category	male	female
Left prison <12 months ago	18 (10%)	3 (6%)
Left prison >12 months ago	43 (23%)	6 (12%)
Left armed services	9 (5%)	0
Experience of domestic violence	21 (11%)	14 (27%)

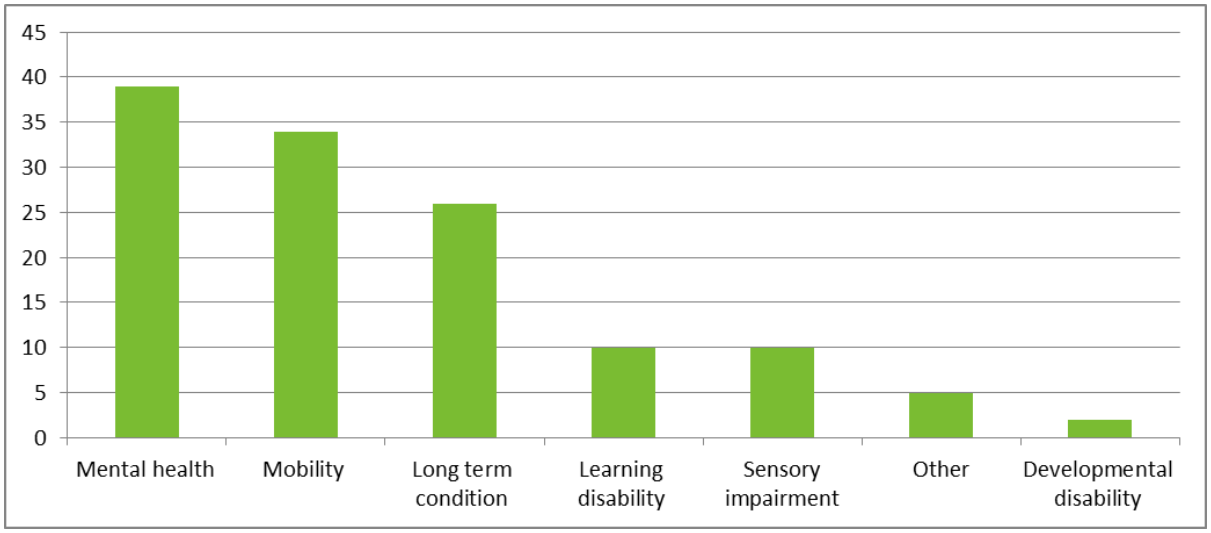
Nearly 1 in 5 (23%) men had left prison more than 12 months ago. Over 1 in 5 (27%) women had experience of domestic violence.

A total of 240 people (96%) indicated their migration status during the survey. 185 people from this total (77%) indicated that they are UK nationals. Less than 5 people indicated that they are seeking asylum or are a refugee.

Disability

A total of 240 (96%) people answered this question. 85 (35%) indicated that they have one or more disabilities. Figure 10 demonstrates the types of disabilities reported.

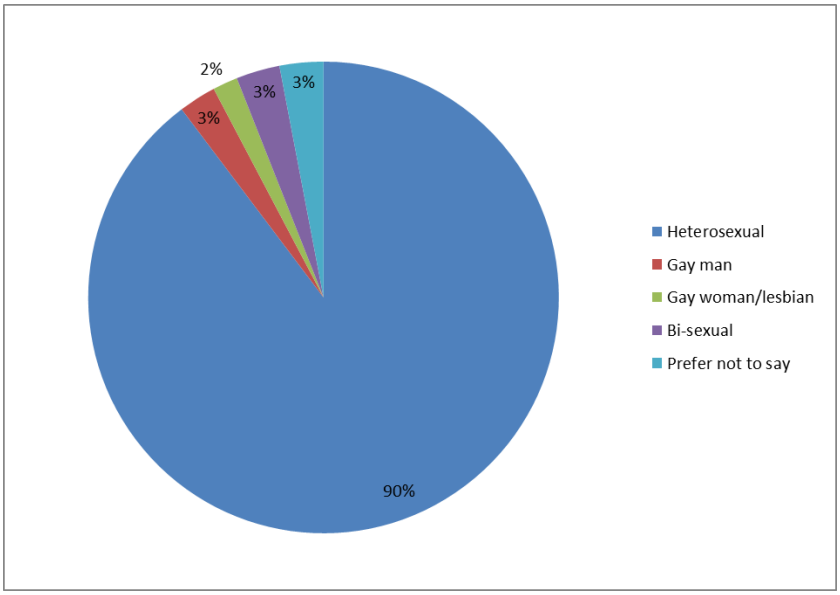
Figure 10: Type of disabilities self-reported by audit participants



Sexual orientation

A total of 233 people answered a question about their sexual orientation with 209 (90%) identifying as heterosexual, 6 (3%) as gay men, 4 (2%) as gay women/ lesbians and 7 (3%) as bi-sexual.

Figure 11: Sexual orientation of participants



Representativeness of the sample

The sample of homeless people who completed this survey was recruited on a non-random basis and was a convenience sample of vulnerable adult pathway clients.

It is therefore important to bear in mind that this audit relates only to the homeless population classified as suitable for the vulnerable adult pathway. These results can therefore not be treated as representative of the whole Lambeth homeless population.

Key points

- This audit sample should be considered representative of those clients on the vulnerable adult pathway and should not be treated as representative of the entire Lambeth homeless population. It however provides useful information on the health needs of those clients on the vulnerable adult pathway.

- The audit population had a higher proportion of those in the 36-55 year age category compared to the Lambeth population.

- Compared to the Lambeth population, the audit showed a higher proportion of those classifying as White British, White Irish or Black/Black British.

- The audit population had a much higher proportion of men (79%) than the Lambeth population (50.3%). The proportion of men was similar in the national audit (69%).

- Nearly half (46%) of respondents felt that their health prevented them from undertaking employment, training or volunteering.

- Over a third (35%) indicated that they had one or more disabilities.

- Nearly 1 in 5 (23%) men had left prison more than 12 months ago. Over 1 in 5 (27%) women had experience of domestic violence.

Section 2: Access to health services

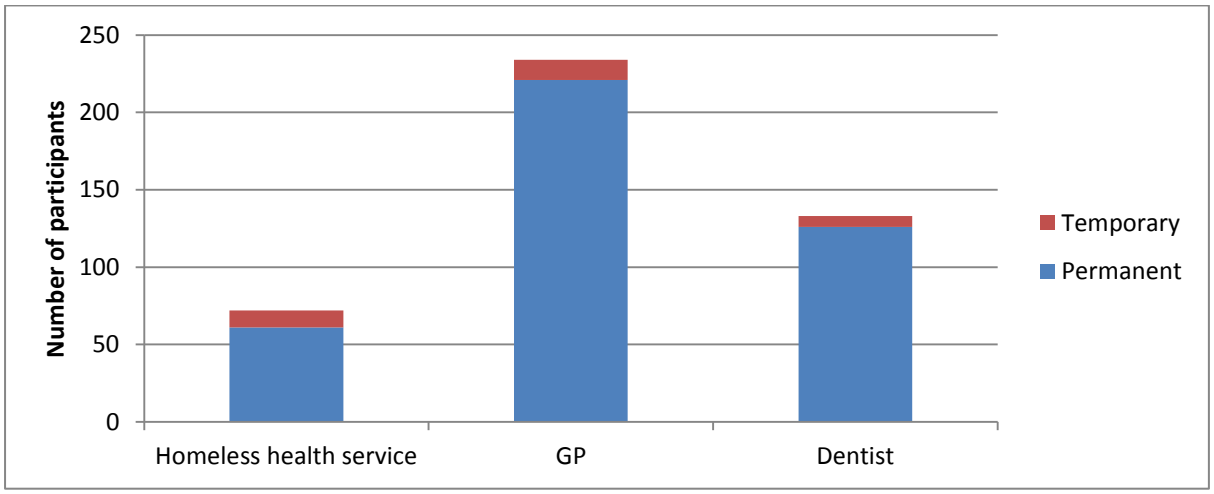
Registration with health services

The audit demonstrates a high level of registration with GP services with 234 participants (94%) stating that they were registered with a local GP either permanently or temporarily.

This is higher than the national homeless audit figure of 90%.

72 people (29%) indicated that they were registered, either permanently or temporarily, with a local homeless health service and 133 people (53%) with a local dentist.

Figure 12: Number of audit participants registered with local health services



Participants were asked about any issues accessing GP or Dentist services.

226 participants (90%) responded to a question about whether they had been refused registration to a GP or dentist in the past 12 months. Out of these respondents, only 7 (3%) indicated that they had been refused registration. This is less than the national homeless audit in which 7% had been refused access in the past 12 months.

229 participants (92%) answered a question asking if they had been barred from these services in the past 12 months. Less than 5 (2%) had been barred.

Use of services

Participants were asked about their use of services in the past 6 months. The responses are displayed in Figure 13.

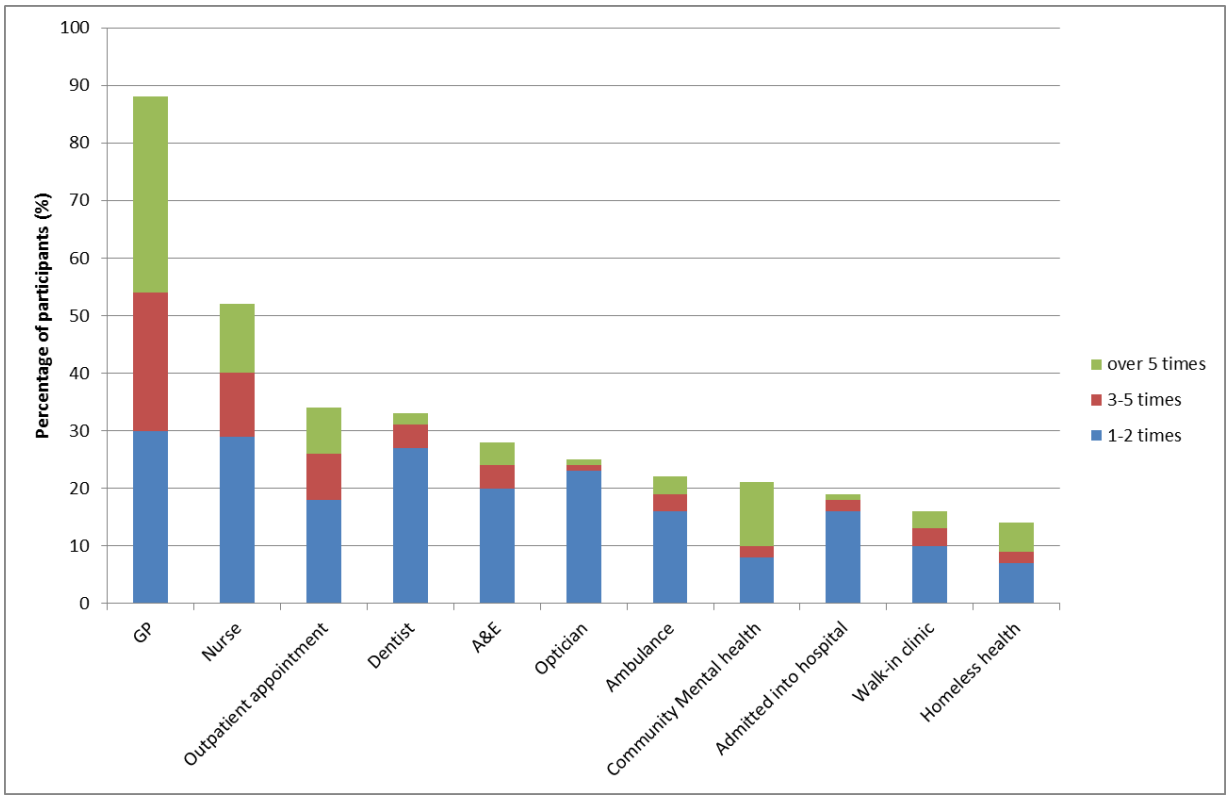
The GP was the most used service with 88% of respondents having used the GP over the previous 6 months. It was also the service most likely to be used multiple times with 34% having used the GP over 5 times.

In comparison to the national homeless audit there was a slightly lower rate of use of A&E in the previous 6 months with 28% of our sample stating that they had used A&E compared to 35% in the national audit. 19% of audit participants stated that they had been admitted into hospital in the

previous 6 months compared with 26% in the national audit. There was similar use of the optician and dentist in both audits. In this survey 25% had used the optician compared to 21% in the national survey, and 33% had used the dentist compared to 32% in the national survey. There was low reported use of community mental health services, given the numbers of participants who self-report as having mental health issues (see section 4).

For comparison, it has been estimated that 7% of the general population will have an inpatient stay during twelve months. It has also been estimated from national data that 13.5% of the general population will attend A&E or an outpatient appointment in a three month period.

Figure 13: Percentage of participants using health services in the last 6 months.



The participants who had been admitted into hospital in the last 6 months had a self-reported length of stay of 5.05 days based on their most recent admission. A Department of Health survey estimated that the average length of stay in hospital for patients with no fixed abode was 6.2 days compared to 2.1 days in the general population aged 16-64 which was felt to be explained by the difference in case mix[7].

Reasons for service use

Amongst the participants who had used A&E in the last 6 months, the most frequently identified reasons for use were mental health and alcohol use.

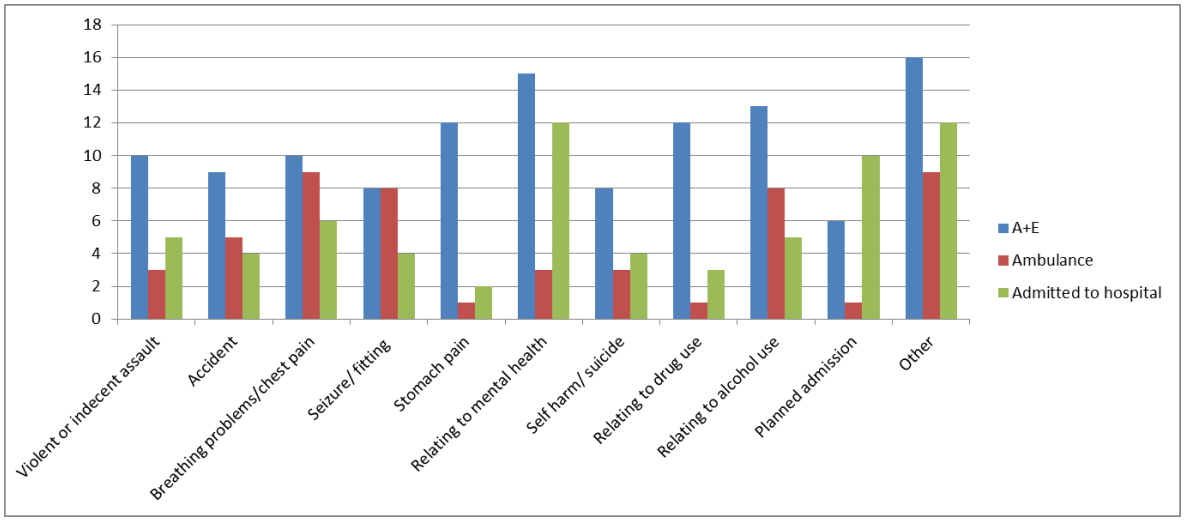
[7] Department of Health Office of the Chief Analyst, Healthcare for single homeless people, 2010

Amongst those who had been admitted to hospital in the previous 6 months the most frequently identified reasons were mental health and planned admissions. Figure 14 displays these results. The 'other' categorisation for A&E attendances included reports of musculoskeletal pain, complications of a TOP, dizziness and blood clots. For hospital admissions examples of the responses given for 'other' included DVT, high blood pressure and due to diabetes. Ambulance use was lower than A&E use for several categories, which may represent patients who self-present to A&E rather than accessing other primary care or community services.

The national homeless audit identified the most frequent reason for use of A&E was violent/indecent assault though alcohol use and mental health issues ranked 4th and 6th respectively.

Violent/ indecent assault accounted for 8% of all of the 119 responses recorded by participants for reason for use of A&E. This can be compared to national A&E data for the general population where assault accounted for 0.8% of all recorded attendances.[8]

Figure 14: Reasons reported for ambulance use, A&E visits and hospital admissions



Discharge planning

Of those who were admitted to hospital in the past 6 months, participants were asked if staff in the hospital made sure they had somewhere suitable to go when discharged. 48 participants answered this question.

Of these, 39 (81%) stated that the hospital staff ensured that they had somewhere suitable to go upon discharge. This compares to the figure of 64% in the national homeless audit.

Of 9 participants (19%) who reported that hospital staff did not ensure they had somewhere safe to go, 2 participants (4%) reported being discharged to the street.

[8] Hospital Episode Statistics: Accident and Emergency Attendances in England 2013-2014, published 28/1/15. Health and Social care information centre. http://www.hscic.gov.uk/catalogue/PUB16728/acci-emer-atte-eng-2013-14-rep.pdf

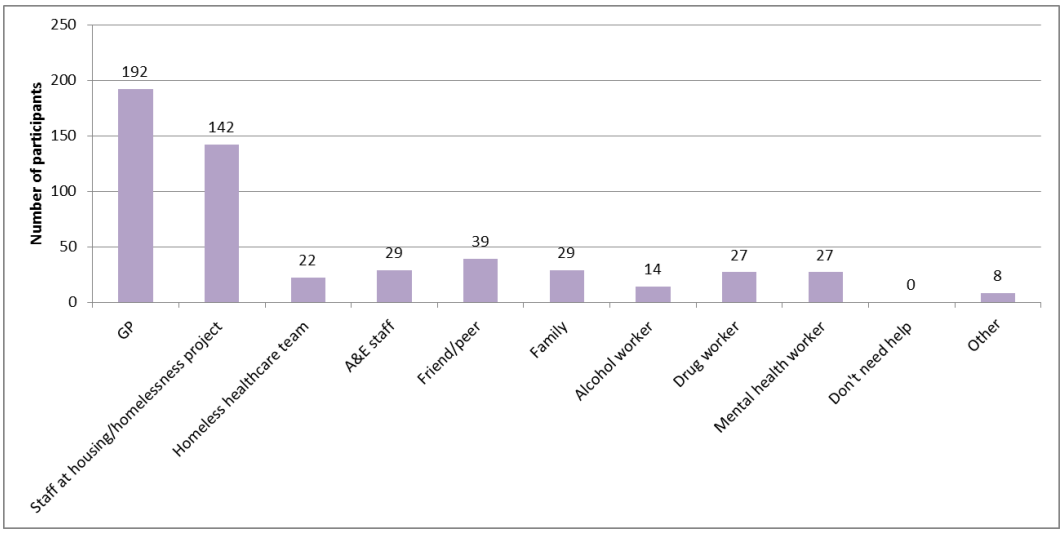
Information about health services

Participants were asked if they had been given information about local health services they can use by their housing or homelessness project. 247 participants responded to this question.

214 (87%) participants had received information. Of these, 179 (72%) said that they had found it useful.

Participants were asked about who helped them most with their health and the responses are displayed in Figure 15. Participants could give multiple responses and the most frequently identified was the GP.

Figure 15: Individuals reported to help most with participant's health.

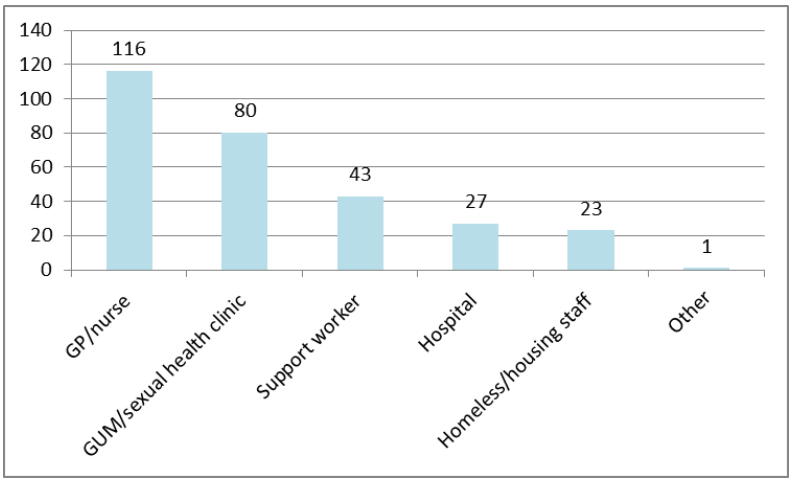


Sexual health advice

Participants were asked about whether they knew where to access sexual health advice.

221 participants (88%) answered this question. Of these 229 (79%) reported that they knew where to access services. Again the GP was the most frequently identified source of advice.

Figure 16: Source of sexual health advice



Key points

- The audit found a high rate of GP registration in the pathway population with 94% being registered. 88% of respondents had accessed their GP in the last 6 months.
- About half (53%) were registered with a dentist and a lower proportion (29%) were registered with homeless health services.
- The self-reported length of stay in hospital was 5.05 days which was slightly lower than the DH study of hospital stay length of those with no fixed abode (6.2 days).
- 28% of respondents had used A&E in the last 6 months, while this is higher than the general population, it is lower than the national audit suggesting access to services other than A&E is better for the Lambeth vulnerable population than elsewhere in the country.
- Reasons for attendance to A&E included mental health issues, alcohol and violent assault.
- The majority of those admitted to hospital stated that hospital staff had found somewhere suitable for them to go after discharge (81%). This may represent a positive impact of the local Pathway discharge planning project.
- A high proportion (87%) of participants had received information on health services from their housing or homelessness project.
- Many participants found their GP and staff at their housing/homelessness project to be helpful in terms of their health.

Recommendations

1) *Continue to maintain high rates of registration with GP and pathways that facilitate registration for this population, as this may contribute to the lower rate of A&E attendance in this group compared to the national audit*
2) *Look at ways of improving registration with dentist*[9]
3) *Build on and further improve local good practice on discharge planning*
4) *Further analyse A&E visits to understand proportion which could have been seen in a different setting and those who may be frequent attenders. Identify if any changes or support needed to first contact services and signposting to these that may help to divert people from A&E.*

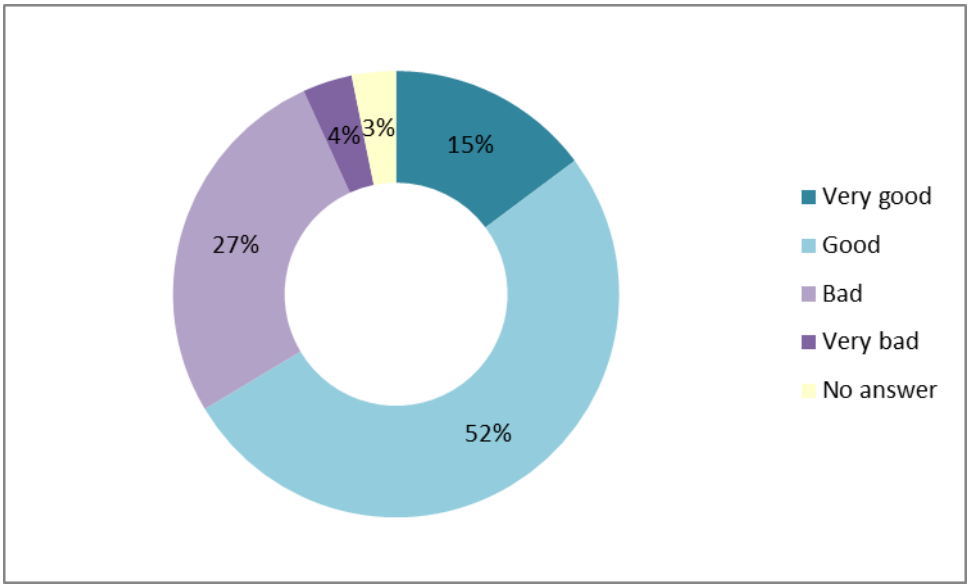
[9] Pathway, 'Improving dental services for homeless people': Summary of findings from exploratory research. 2013

Section 3: Health Behaviours

Overall health

Participants were asked to provide an overall rating of the quality of their health ranging from very good to very bad. The results were fairly positive with 67% rating their health either good or very good. However 31% rated their health as bad or very bad.

Figure 17: Participants rating of their overall health



Smoking

242 participants (97%) answered this question. 205 participants (82%) indicated that they currently smoke. Out of those who smoke, 149 (73%) indicated that they had been offered help to stop smoking but only 66 (32%) indicated that they wanted to stop.

The proportion of smokers in this audit is much higher than that of the adult (over 18) population of Lambeth where 21% are smokers[10].

In the national homeless audit 77% were regular smokers and 41% indicated that they wanted to quit.

Diet

241 participants (96%) answered a question asking if they felt they got enough to eat. Of these, 204 participants (82%) indicated that they felt they get enough to eat.

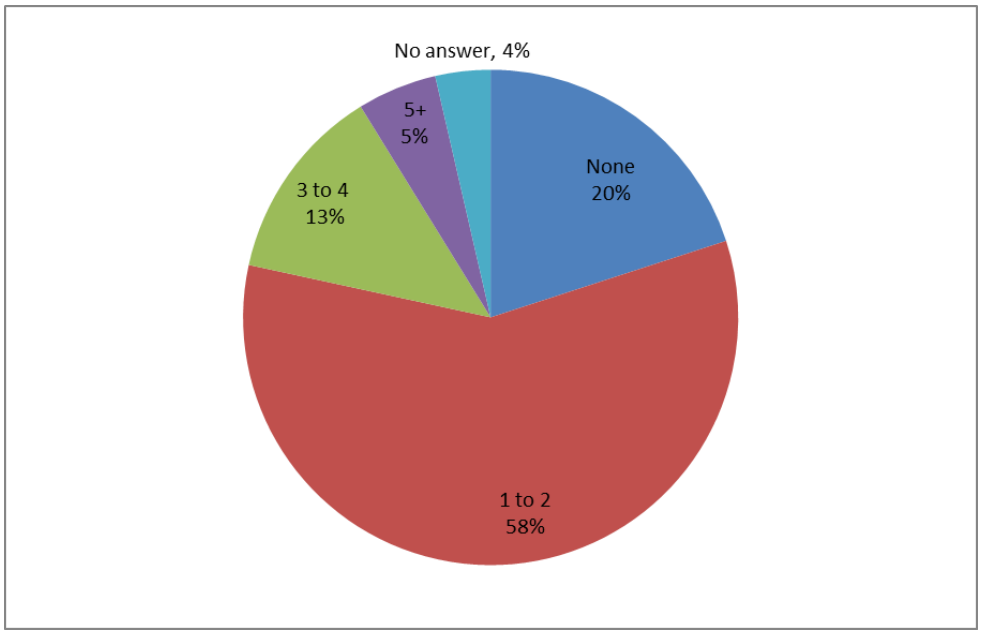
The same number of participants answered a question on fruit and vegetable consumption – the results are shown in figure 18.

Only 5% stated that they eat 5 or more portions of fruit and vegetables a day – the recommended amount. 20% stated that they had no fruit or vegetables at all on a typical day. According to national

[10] Integrated Household Survey, 2012

data from the Public Health Outcomes Framework, in 2014 the general population had much higher levels of fruit and vegetable consumption with 56.3% eating 5 or more portions a day. This figure is slightly lower locally with 47.8% of Lambeth residents eating 5 or more portions a day. The average portions of fruit and vegetables consumed per day by Lambeth residents was 2.37 and 2.13 respectively.

Figure 18: Fruit and vegetable consumption by number of portions



Physical activity

Participants were asked whether they felt that they get enough physical exercise.

142 (57%) responded that they felt they did and 100 (40%) that they did not. Out of those who felt they did not get enough exercise, 50 stated that they would like to.

Key points

- 67% of participants rated their health as good or very good. However, 31% rated their health as bad or very bad.
- A very high proportion (82%) of the audit population smoke compared with 21% of the local Lambeth population.
- A high proportion of smokers (73%) reported being offered help to stop but only 32% expressed a desire to stop.
- Only 5% of participants ate the recommended daily amount of fruit and vegetables with 20% reportedly eating no fruits and vegetables on a daily basis.
- 57% reported getting enough physical exercise, while 40% reported they did not.

Recommendations

1) *Examine whether stop smoking services are targeted appropriately for homeless people, and if needed, amend current service offer to suit this group*
2) *Ensure this population are included in healthy eating and physical activity programmes*
3) *Increase education about and access to fruit and vegetables in hostels*
4) *Identify ways vulnerable homeless people can increase physical activity levels and enable them to do so.*

Section 4: Health and Wellbeing

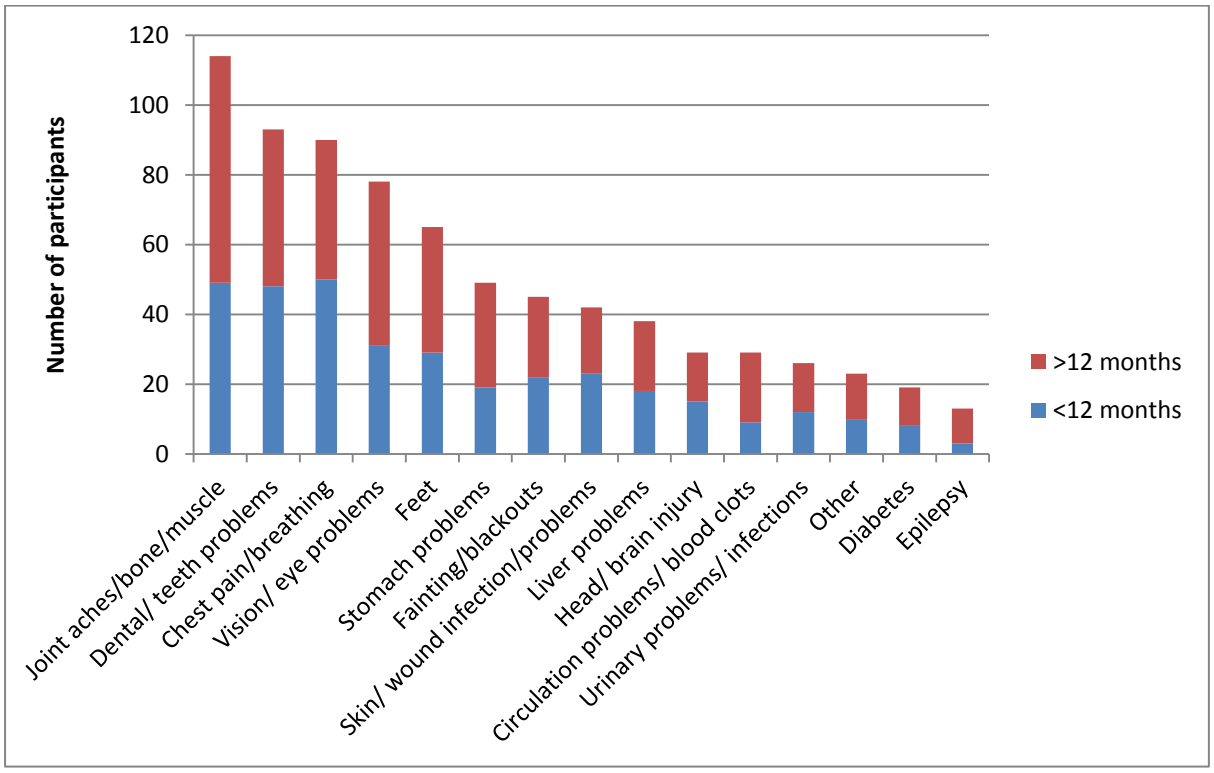
Physical health

250 participants answered the question on physical health problems. 195 participants (78%) reported at least one health problem. 86 participants (34%) reported having more than 3 health problems.

In the national homeless audit, 73% of respondents reported physical health problems and 41% said that these were long-term problems.

Participants were asked whether they suffered physical health problems and for each problem, whether they had suffered from it for less or more than 12 months. The responses are displayed in figure 19. There were high numbers of participants reporting dental problems, which is concerning given low numbers reporting registration with a dentist. The 4th most common physical health problem was vision problems and though less than 30% of participants had seen an optician within the last 6 months (see figure 13). The fifth most common problem was with feet.

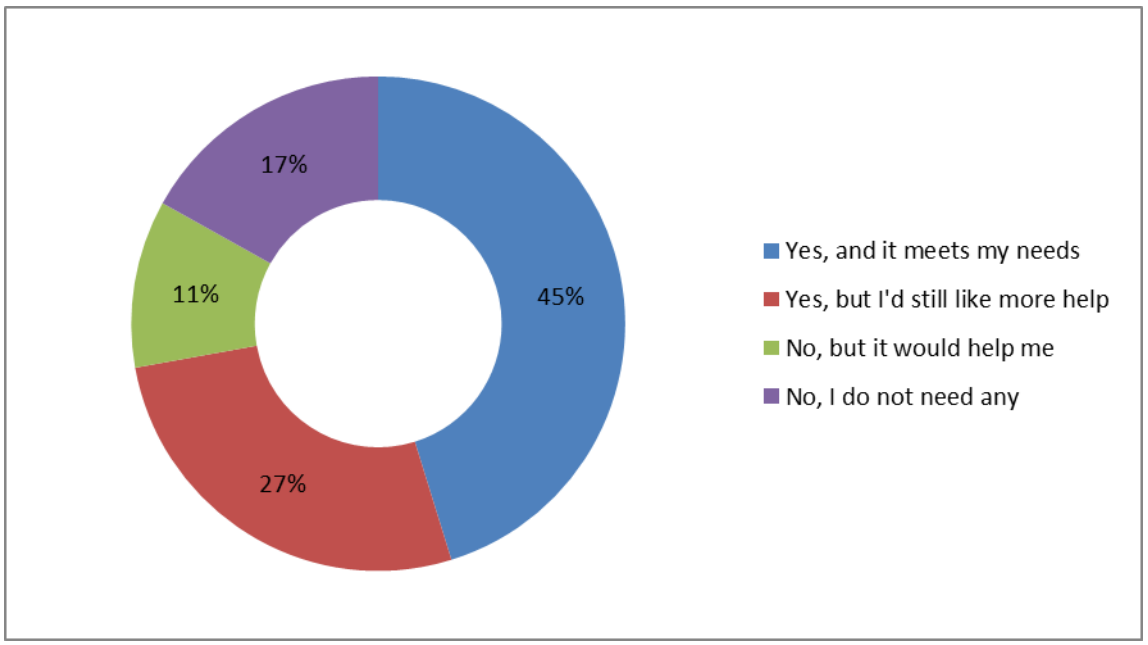
Figure 19: Physical health problems reported by participants



Support

Participants were then asked about support they are receiving for these problems. 219 participants answered the question, out of whom 24 (11%) stated that they were not receiving any support but would like some and 59 (27%) that they are receiving support but would like more help. 99 participants (45%) reported that they were receiving support that met their needs. This is shown in figure 20.

Figure 20: Support received for physical health problems and satisfaction



Those who had answered that the support met their needs were asked what this was – shown in table 2. The most useful support was felt to be regular contact with the GP.

Table 2: Useful support for people with physical health problems.

If Yes, could you please tell us what type of support this is?	Number
Regular contact with with GP	124
Outpatient appointments	54
Regular contact with health worker	42
Regular contact with nurse	41
Other	20

Medication

250 participants answered a question asking if they were on regular medication. 162 participants (65%) reported being on a regular prescribed medication. Of these participants, 151 (93%) reported no problem in getting their prescriptions.

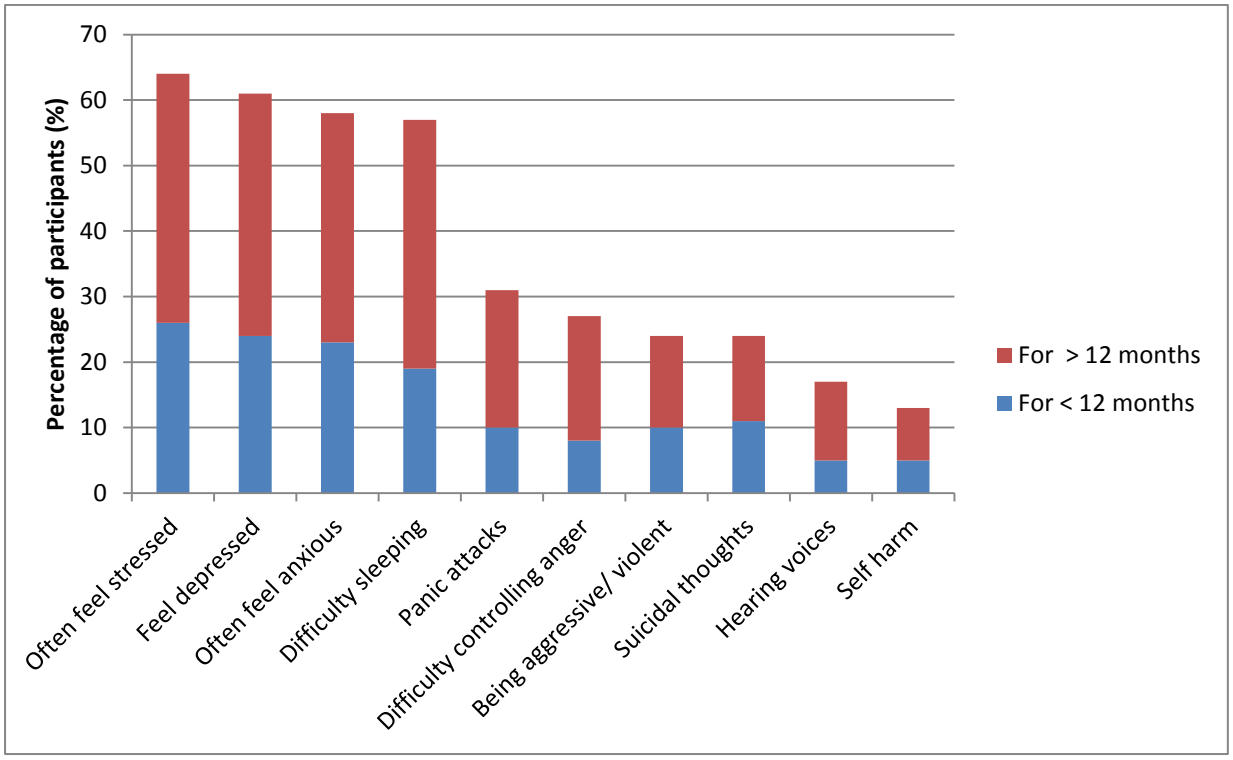
Mental health

202 participants (81%) reported at least one mental health issue and 128 (51%) more than three mental health issues.

In the national audit, 80% reported some form of mental health issues.

Participants were asked about mental health problems that they were experiencing and their mental health needs. The range of responses is displayed below. Mental health problems were more commonly experienced for more than 12 months, rather than less than 12 months.

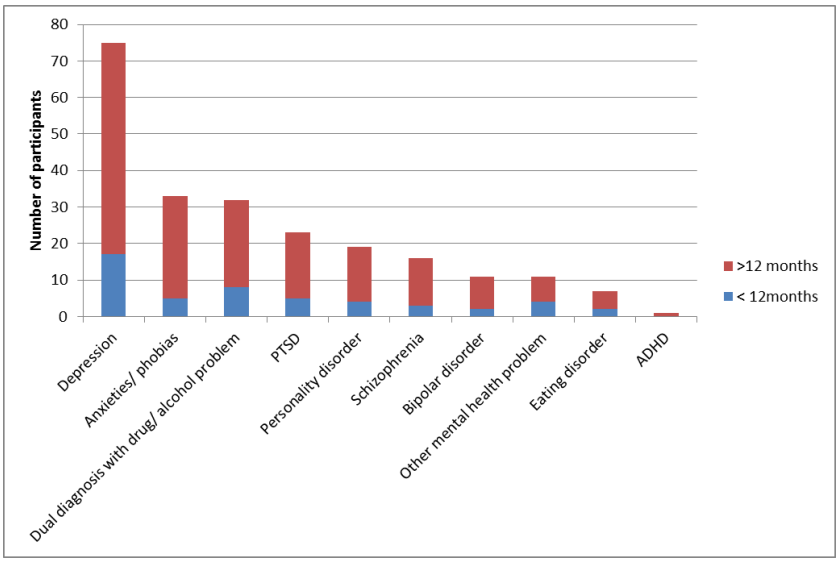
Figure 21: Mental health problems reported by participants



Participants were asked if they had been diagnosed with a mental health condition. 100 participants (40%) reported that they had and the range of diagnoses is shown in figure 22.

This compares to 45% of those in the national audit having a formal mental health diagnosis.

Figure 22: Diagnosed mental health conditions reported by participants



Participants were again asked about the support they receive for their mental health problems, the results are shown in table 3.

Table 3: Usefulness of support received for mental health issues

Do you get support with your mental health?	Number	Percentage
Yes, and it meets my needs	52	36%
Yes, but I'd still like more support	35	24%
No, but it would help me	23	16%
No, I don't need any	33	23%
Total	143	100%

Participants were also asked about what type of support currently helps them with their mental health. This is shown in table 4.

Table 4: Type of support that is helpful to people with mental health issues

What type of support helps you?	Number
Medication	34
Talking therapies/ counselling	26
A specialist mental health worker	23
Practical support to help me with my day-to-day life	22
Activities (eg the arts, volunteering or support)	20
Peer support	14
Services for dual diagnosis	5
Other	4

Those who still felt they need more support were asked what type of help they would like. The responses are displayed in table 5.

Table 5: Type of help requested by those feeling they needed more support with mental health issues

What sort of support would help you?	Count
Talking therapies/ counselling	41
A specialist mental health worker	28
Activities (eg the arts, volunteering or support)	23
Medication	21
Practical support to help me with my day-to-day life	16
Services for dual diagnosis	15
Peer support	14
Other	7

Self-medication

Participants were asked whether they used drugs or alcohol to cope with their mental health. A high proportion – 106 participants (42%) reported that they did.

Only 17 people (7%) reported that they had ever been refused access to mental health services because of drug and/or alcohol use, though this number was lower than expected from anecdotal reports.

Key points

- There are high levels of physical and mental ill-health, with high proportions of these reported to be long-standing.
- Among the 5 most common physical health problems were dental problems, vision problems and feet issues. These are not reflected in service use statistics (figure 13) which may indicate unmet need.
- For those with physical health issues, 45% report being happy with the support they are receiving, however 38% would like more support. The most useful type of support was regular contact with a GP.
- A high proportion of respondents (65%) are on regular prescribed medication and the majority of these are able to access prescriptions with no problems.
- 40% of respondents had a formal mental health diagnosis. This is slightly lower than the national audit population.
- 40% of respondents felt they needed more help with their mental health issues and the most commonly cited source of help they wanted were talking therapies or counselling.
- A high proportion (42%) of respondents used drugs or alcohol to cope with their mental health.

Recommendations

1) *Share results of this survey with homeless health services and general practices and ask them to consider changes to their referral pathways for support*
2) *Share results of this survey with mental health services and drug and alcohol services and discuss ways of increasing support for those who may need it and who are self-medicating*
3) *Train hostel staff to signpost to appropriate services and to offer peer support and practical support, which were both cited as useful for those with mental health issues.*

Section 5: Substance Misuse

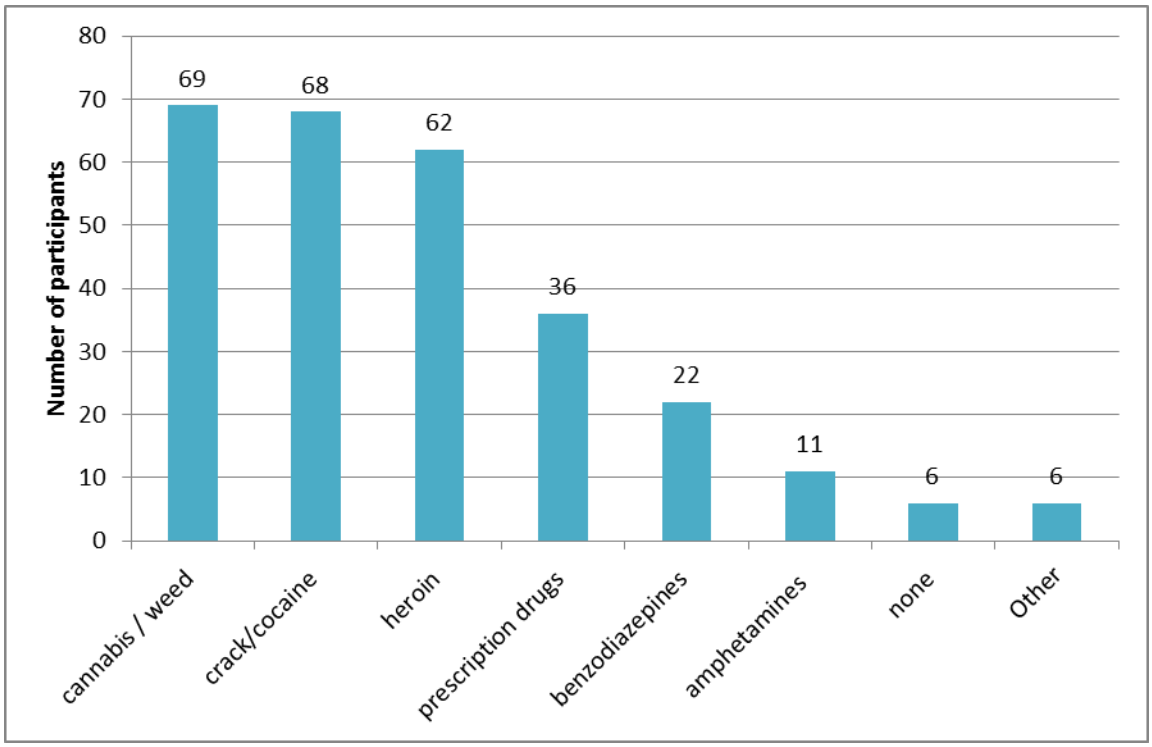
Drug use

120 participants (48%) indicated that they currently take drugs or are recovering from a drug problem. This is higher than the national homeless audit in which 39% said they take drugs or are recovering from a drug problem.

Compared to the general population, around 1 in 11 (8.8%) adults aged 16 to 59 had taken an illicit drug in the last year[11].

Figure 23 shows the drugs that participants reported to have used in the past month. This shows that the most commonly used drugs are cannabis (69 participants), cocaine (68 participants) and heroin (62 participants). Participants could indicate use of more than one drug.

Figure 23: Drug use reported in the month prior to taking the survey



51 participants (20%) stated that they take methadone or another substitution drug, and of these people 45 (88%) stated that this was prescribed to them.

27 participants (11%) also stated that they have injected drugs within the past month although 54% of the sample did not answer the question.

Out of these 27 respondents, less than 5 people stated that they usually or sometimes share injecting equipment, and 22 respondents (81%) said they knew about a needle exchange scheme they could use. 19 respondents (70%) also stated that they knew about advice and training on safer injecting.

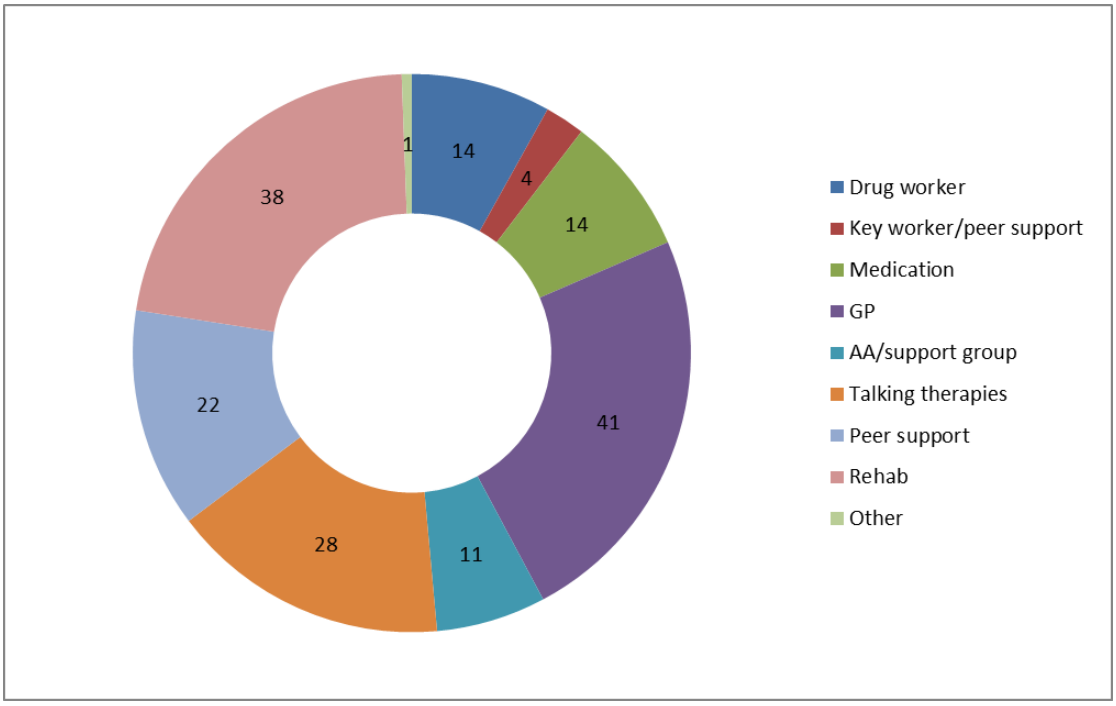
[11] Home Office, 2014, Drug misuse: Findings from the 2013/14 Crime Survey for England and Wales

Support

Out of the 120 participants who stated that they take drugs, 70 (58%) reported that they were receiving support for their drug problem. The types of support received are illustrated in figure 24. Participants could indicate more than one type of support.

Of these, the majority (53 respondents – 44%) felt it met their needs. 17 people (14%) receiving support still felt that they would like more help and 11 people who were not receiving help (9%) felt that they would like support.

Figure 24: Types of support received for drug problems



Those people receiving support were asked how they felt the support they received helped them. This is displayed in table 6.

Table 6: How support has helped participants with drug issues

How does this support help you?	Number
Helps me better control my drug use	34
Helps me to reduce my drug use	30
Helps me to use drugs more safely	20
Helps me to remain drug free	20
Helped me to stop using drugs	13
Other	2

Those who still felt they need more support were asked what type of help they would like. The responses are displayed in table 7.

Table 7: Type of help requested by those feeling they needed more support with drug issues

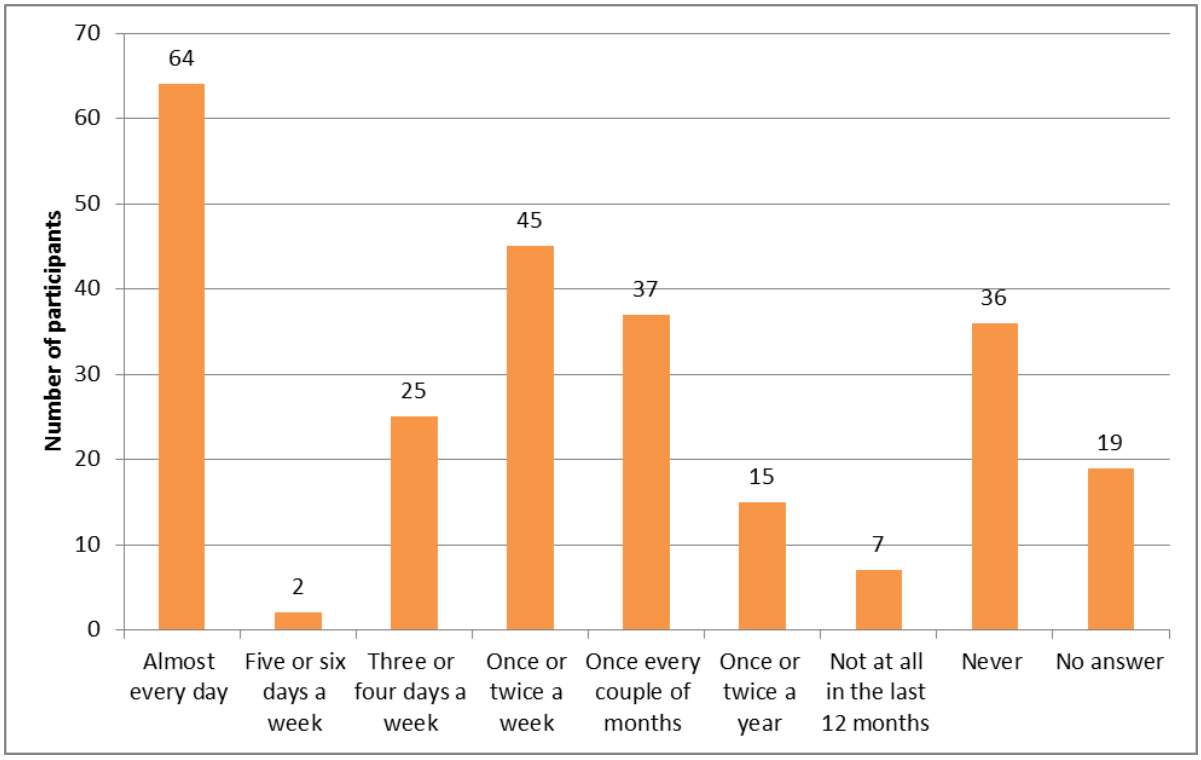
What sort of help would you like?	Number
Help to stop using drugs	13
Help to better control my drug use	11
Help to reduce my drug use	7
Help to remain drug free	7
Help to use drugs more safely	2

More detail on the types of support that participants find useful to deal with drug issues is detailed in the focus group (section 7).

Alcohol use

250 participants responded to this question asking about their use of alcohol shown in figure 25. 64 participants (28 %) indicated that they drink 'almost every day' while 25 participants (10%) indicated that they drink 3 or 4 times a week. This means over a third of the audit population drink on a regular basis during the week.

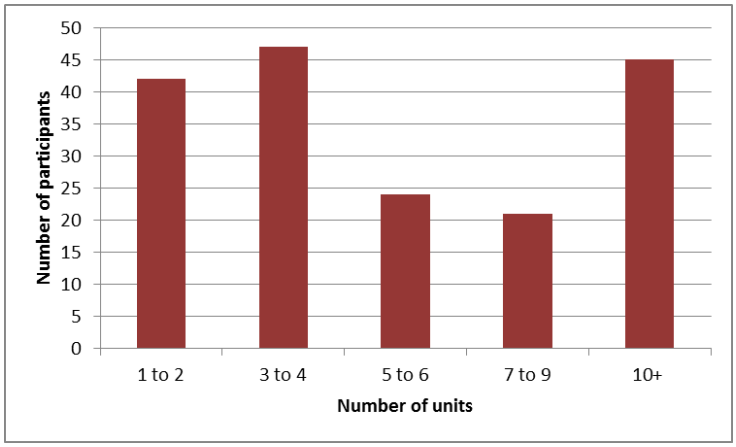
Figure 25: Frequency of alcohol consumption reported by participants



179 participants responded to a question asking about level of alcohol consumption on a typical day of drinking, shown in figure 26. There was a high level of harmful drinking with 45 participants (25%) stating they drink more than 10 units of alcohol.

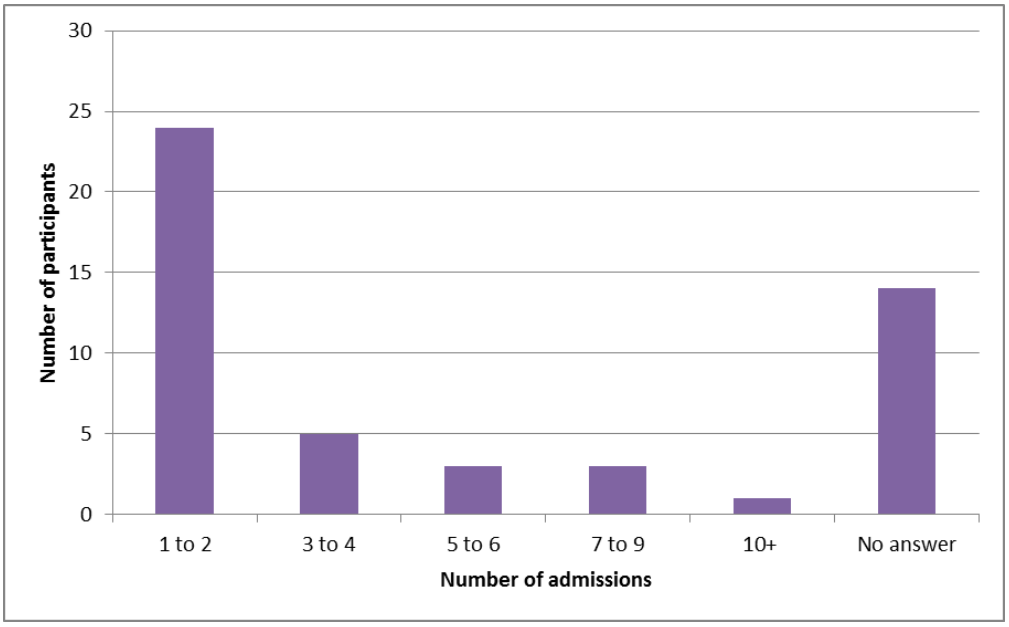
In the Lambeth population, it is estimated that 21% of adults aged over 16 are increasing/high risk drinkers – meaning that they consume 22+ units of alcohol per week if they are male or 15+ units of alcohol per week if they are female[12].

Figure 26: Number of units consumed in a typical day



The high level of harmful drinking is reflected by 50 respondents (20%) said they had been admitted to hospital because of alcohol use, although 179 (72%) stated that they had not. Out of those who had been admitted to hospital, most commonly this was 1-2 times in the last year.

Figure 27: Number of alcohol-related hospital admissions reported in the past year.



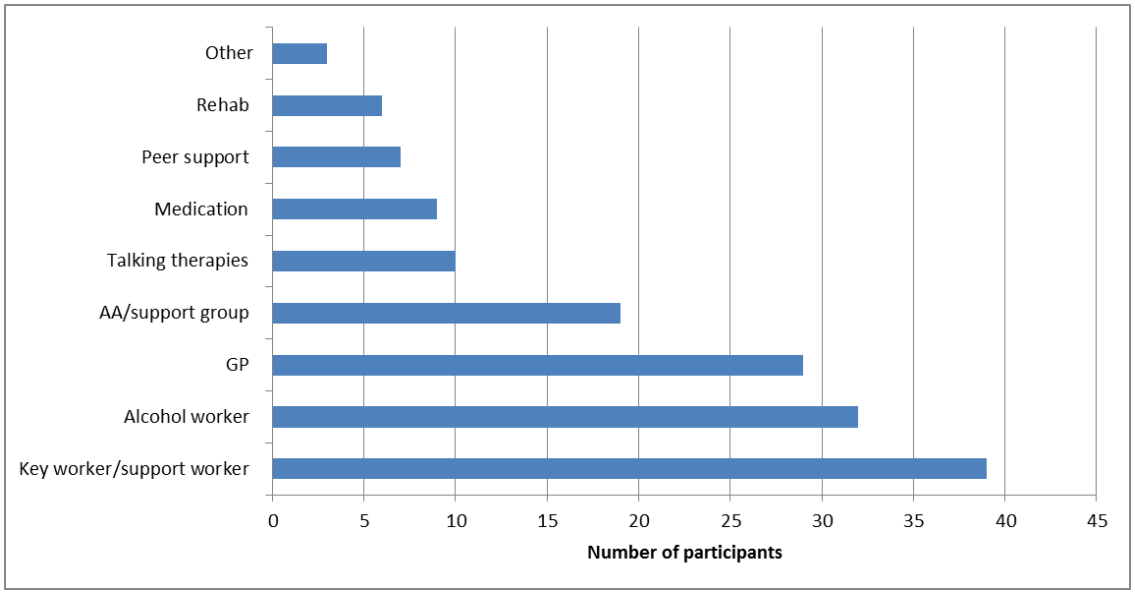
Support

In this audit 87 respondents (35%) stated that they have or are recovering from an alcohol problem. This is higher than the national homeless audit in which the figure was 27%.

[12] Data source: Synthetic LAPE estimates (2009) applied to PCIS 2012-2013, Q3 population

Out of these 87 participants, 61 (70%) stated that they were receiving help for their alcohol use and 51 participants (59%) felt it met their needs. Figure 28 shows the types of support participants have received for their alcohol problem.

Figure 28: Types of support received for alcohol problem



Those people receiving support were asked how they felt the support they received helped them. This is displayed in table 8.

Table 8: How support has helped participants with alcohol issues

How does this support help you?	Number
Helps better control my alcohol intake	24
Helps me to manage the impact drinking has on my health	24
Helps me to stop drinking	21
Helps me to reduce my alcohol intake	20
Other	5

Those who still felt they need more support were asked what type of help they would like. The responses are displayed in table 9.

Table 9: Type of help requested by those feeling they needed more support with alcohol issues

What sort of support would help you?	Number
Help to manage the impact drinking has on my health	10
Help to stop drinking	9
Help to reduce my alcohol intake	5
Help to better control my alcohol intake	3
Other	2

When asked how this support had helped them there was fairly equal level of response for controlling alcohol intake, reducing alcohol intake, stopping drinking and managing the impact of alcohol on their life.

Drug and alcohol use

Those self-reporting a drug problem were cross-tabulated with those self-reporting an alcohol problem, shown in table 10. Of these, 46 participants reported having both a drug and alcohol problem.

Table 10: Participants reporting drug and alcohol problems

Count of id	**Alcohol problem - current or recovering?**		
Drug use or drug problem?	**No**	**Yes**	**Grand Total**
No	66	34	100
Yes	70	**46**	116
Grand Total	136	80	216

Key points

- The audit found high levels of drug use with 48% indicating that they currently take drugs or are recovering from a drug problem. This is higher than the national audit figure of 39%.
- Most commonly used drugs are cannabis, cocaine and heroin. 27 participants reported injecting drugs within the last month, however of these over 70% reported knowledge of safer injecting and needle exchange schemes which is important from a harm reduction perspective.
- 58% of those using drugs said that they were currently receiving support and out of these 44% felt that it met their needs.
- There are high levels of harmful drinking with 36% of participants reporting drinking three of more times a week. 45 participants reported drinking over 10 units of alcohol on a typical day.
- 71% of those with alcohol use said they were currently receiving support and 59% of these felt it met their needs.

Recommendations

1) *Share and discuss findings of this report with drug and alcohol services*
2) *Maintain good awareness of harm reduction techniques*
3) *Consider incorporating cannabis in stop smoking services (may also be applicable to general Lambeth population)*
4) *Consider further work, particularly for those with high level substance misuse and alcohol abuse, to understand how to better target services for this population.*

Section 6: Screening and Immunisations

Immunisations

Participants were asked about their immunisation history for Hepatitis A, Hepatitis B and Influenza. The results are shown in figure 28.

Public health recommendations for the immunisations are shown below in table 10. Some categories are more relevant to the homeless population than others – shown in bold.

Table 10: Recommendations for vaccinations[13]

Vaccine	Recommendations
Hepatitis A	Those travelling to areas of high or intermediate prevalence **Patients with chronic liver disease** Patients with haemophilia Men who have sex with men **Injecting drug users** Individuals at occupational risk
Hepatitis B	Those travelling to areas of high or intermediate prevalence **Injecting drug users** **Those changing sexual partner frequently** **Close contacts of those with acute or chronic hepatitis B infection** Foster carers Individuals receiving regular blood products Patients with chronic renal failure **Patients with chronic liver disease** **Inmates of custodial institutions** Individuals at occupational risk
Flu	**All those aged 65 and over** Children aged 2-4 **Those with underlying medical conditions e.g. chronic respiratory conditions, chronic heart disease, chronic kidney disease, chronic liver disease, diabetes.** Individuals at occupational risk

[13] Public Health England. The Green Book

Figure 29: Vaccination status of participants

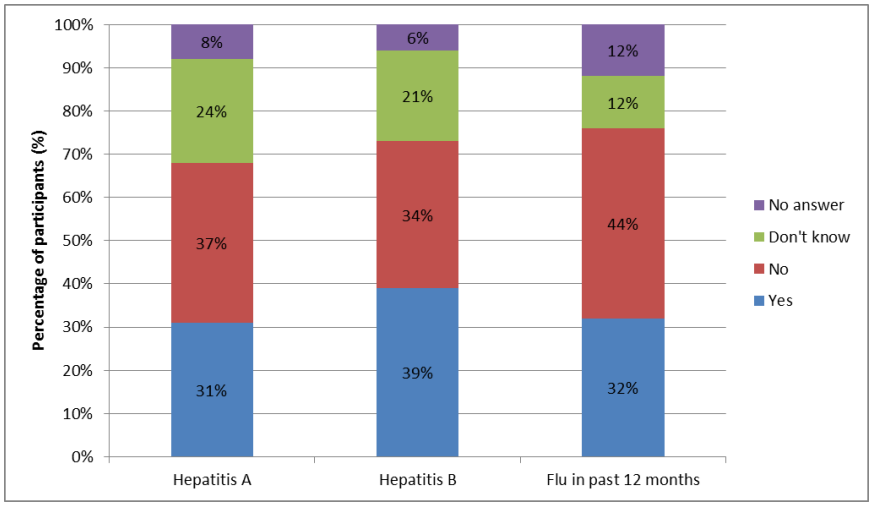


Table 11 below demonstrates the proportion of participants in some of the key groups mentioned above that are receiving flu vaccinations.

Table 11: Proportion vaccinated for flu in the past 12 months by certain key subgroups.

Vaccine indicator	Proportion vaccinated for flu (%)	Count	Total
Aged over 65	69%	11	16
Liver condition	53%	20	38
Diabetes	32%	6	19
HIV positive	31%	5	16
All respondents	32%	79	250

This demonstrates that there are higher proportions being vaccinated in some key groups, particularly those aged over 65, than the general audit population however there are still many going unvaccinated in these groups, risking the virus and its complications. Vaccinations should be obtained through primary care, meaning that despite high rates of registration seen in section 2, this population may be missing out on certain components of the primary care service.

Hepatitis A vaccination rate was also analysed by 2 of the key risk groups mentioned above; intravenous drug use and liver disease. The results are shown in Table 12 and show that a proportion is going unvaccinated in these groups.

Table 12: Proportion vaccinated for Hepatitis A in key risk groups.

Vaccine indicator	Proportion vaccinated for Hepatitis A (%)	Count	Total
IVDU	52%	14	27
Liver condition	45%	17	38
All respondents	31%	77	250

Hepatitis B vaccination is also recommended for intravenous drug users and those with liver disease, as well as for the hostel-dwelling population more generally. The proportion of these groups that have received vaccination is displayed below in Table 13. Ideally all participants should have been vaccinated against Hepatitis B, regardless of other risk groups, so there is a large unmet need in this population.

Table 13: Proportion vaccinated for Hepatitis B in key risk groups.

Vaccine indicator	Proportion vaccinated for Hepatitis B (%)	Count	Total
IVDU	59%	15	27
Liver condition	50%	19	38
All respondents	39%	97	250

Caution should be used when interpreting tables 12-14 as the numbers in certain subgroups are small, the answers self reported and do not reflect how many of the group are offered vaccination and turn it down.

Screening

Participants were asked about their history of screening for Hepatitis C, Tuberculosis and HIV. The results are displayed in Figure 29. Over 50% of participants reported being tested for each condition.

Public health guidance on screening for each condition is shown in table 14.

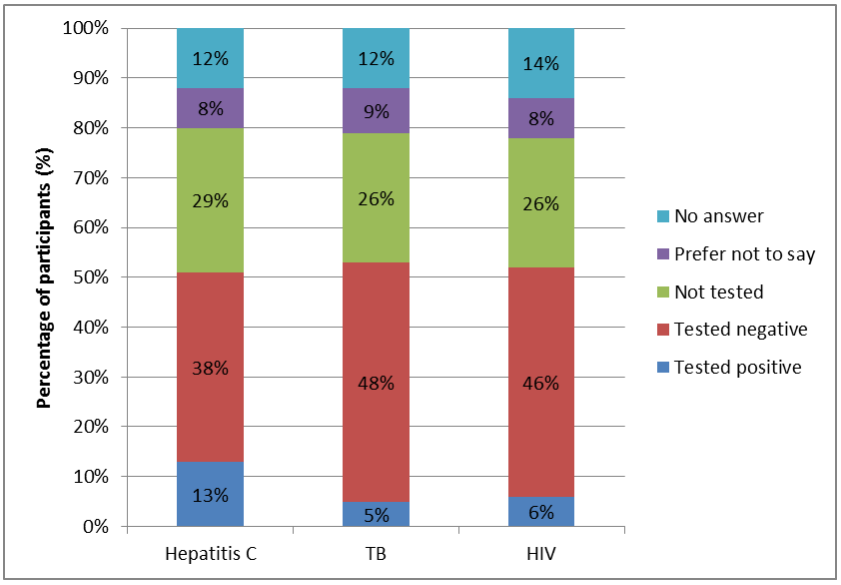
Table 14: Recommendations for screening

Condition	Source	Guidance
TB	NICE[14]	Active case finding should be carried out among street homeless people (including those using direct access hostels for the homeless) by chest X-ray screening.
Hepatitis C	NICE	Recommended for anyone who has ever injected drugs and anyone living in a hostel for the homeless or sleeping on the street.
HIV	BHIVA[15]	All those reporting a history of injecting drug use

It should be noted that Lambeth has the highest prevalence of acute sexually transmitted infections among all local authorities and has a very high prevalence of HIV with 13.9 per 1000 18-59 year olds with diagnosis (national average 2 per 1000). This means that a more pro-active approach to HIV screening would be pragmatic in this population.

[14] National Institute for Clinical Excellence
[15] British HIV Association

Figure 30: Screening status for Hepatitis C, TB and HIV



These results were analysed by the key risk groups mentioned above, to see the proportion of people in these groups that are being screened. As mentioned above, NICE recommends testing for Hepatitis C in IVDUs and anyone sleeping rough or living in a hostel. The results for these groups are shown below. The testing rate is fairly good for IVDUs but suggests less testing in those sleeping rough/ living in hostels Note that all respondents are currently resident in hostels but the subgroup analysis was done by most frequent accommodation type in prior 6 months. However, ideally all participants should therefore have been screened for Hepatitis C according to the criteria and only 51% were, again suggesting an unmet need in this population.

Table 15: Proportion tested for Hepatitis C in certain key risk groups.

Testing group	Proportion tested for Hepatitis C (%)	Count	Total
IVDU	63%	17	27
Liver condition	76%	29	38
Recent history of rough sleeping/ hostel dwelling	47%	49	104
All respondents	51%	128	250

For HIV, national guidelines recommend testing for HIV for all IVDUs. The subgroup analysis below in table 16 also shows the screening status for MSM as this is also a high risk group, although this is a small number of the respondent population. Given the high prevalence of HIV in the Lambeth population, HIV screening is a priority for all populations so there is unmet need again in terms of this health intervention.

Table 16: Proportion tested for HIV in certain key risk groups.

Testing group	Proportion tested for HIV(%)	Count	Total
IVDU	63%	17	27
MSM	82%	9	11
All respondents	52%	130	250

As above, it is important to note for tables 16-17 that caution should be used when interpreting the results as the numbers in certain cohorts are quite small and may not represent the numbers offered testing.

Of those who tested positive for Hepatitis C, participants were asked if they went on to receive any treatment – table 17.

Table 17: Treatment options reported for those testing positive for Hepatitis C

If you tested positive for Hepatitis C, did you go on to receive any treatment?	Number
Yes	14
No, not offered any	10
No, offered but didn't take it up	9
Prefer not to say	13

The same question was asked to those reporting testing positive for TB and HIV – tables 18 and 19.

Table 18: Treatment options reported for those testing positive for TB

If you tested positive for TB, did you go on to receive any treatment?	Number
Yes	9
No, not offered any	5
No, offered but didn't take it up	2
Prefer not to say	13

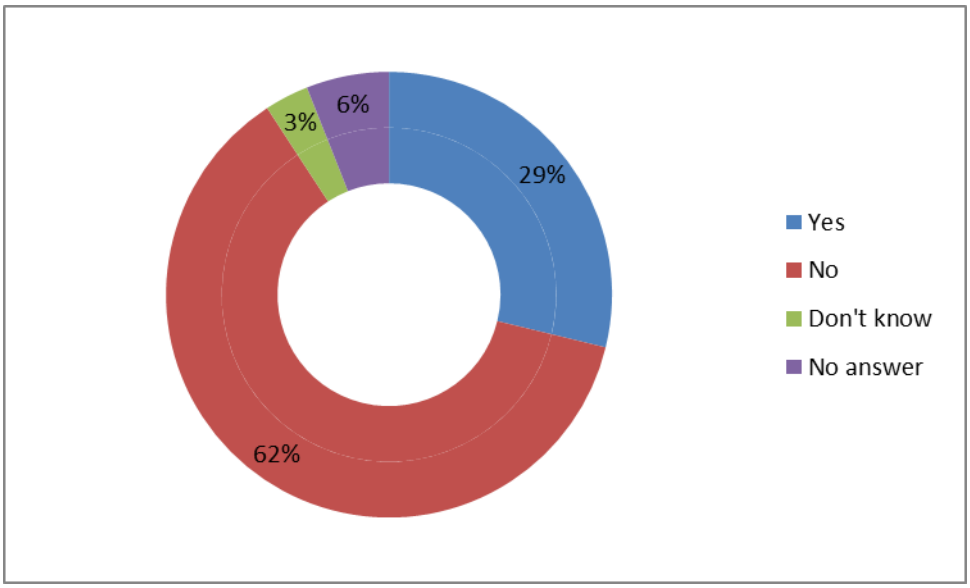
Table 19: Treatment options reported for those testing positive for HIV

If you tested positive for HIV, did you go on to receive any treatment?	Number
Yes	7
No, not offered any	5
No, offered but didn't take it up	2
Prefer not to say	13

Sexual health

Participants were asked whether they had had a sexual health check in the past 12 months and 235 people (94%) answered the question. Of those answering the question, 72 (31%) said that they had – figure 31.

Figure 31: Participants reporting a sexual health check in the last 12 months



Participants were also asked if they had access to contraception. 203 (81%) people answered this question. 80% of respondents replied that they had access to contraception.

Female participants were asked whether they have had access to a cervical smear in the past 3 years and 30/54 (56%) responded that they had. The National Cervical Screening Programme offers all those aged 25-49 screening at 3 year intervals and those aged 50-64 screening at 5 year intervals.

Key points

- Ideally all in this population should be vaccinated against Hepatitis B as they are in a risk population – only 39% reported vaccination. Vaccination rates for flu and Hepatitis C were also lower than expected for those in risk groups.
- All those sleeping rough on the street or hostels or injecting drugs are recommended to be screened for TB and Hepatitis C. The percentages reporting screening are over 50% but not as high as should be expected.
- Lambeth has a high prevalence of HIV and this population should be pro-actively screened, however only 52% reported being screened for HIV.
- Of those reporting testing positive for TB, HIV and Hepatitis C there were several participants who reported not being offered any treatment. It is difficult to validate this but it may suggest a lack of follow-up on the result.
- Only a third of people reported accessing a sexual health screen in the last 12 months. As many of the audit population are of sexually active age, this may suggest an unmet need.
- 80% of participants reported access to contraception which is reassuring.

- However only 56% of women reported accessing cervical screening within the last 3 years which may indicate that they are missing out on important public health interventions.

Recommendations

1) *Agree local pathways to ensure appropriate vaccinations and screening offered to local homeless population, including training hostel staff on the importance of screening and vaccinations and equipping them to signpost to appropriate services.*
2) *Ensure local pathways for TB, HIV and Hep C take account of homeless people and their needs. Pathways should be reviewed to ensure positive screening leads to rapid access to treatment.*
3) *Share findings with local sexual health services and GPs*

Section 7: Focus group

11 people attended the focus group which was held in April 2015. Nine participants were men and two were female. Participants were recruited by hostel managers. All were aware that their comments would be anonymised and may be quoted to illustrate their experience. Participants were given a voucher for their time.

Key themes

Health as a concept and priority

Focus group participants were asked what health or being healthy meant to them. Answers included being on the correct medication, staying clear of drugs and improving understanding of their own body.

Participants were clear that their health ranked high in their list of priorities. One participant felt his health had become more important as he got older. Many participants felt their health was key to improving their life situation:

- *Because [poor health] it stops me from functioning. It stops me from being me.*

- *I want to be in a flat. Forget everything else I just want to be in a flat but I know when I get there I probably won't last in there too long before I end back on the street or something because my mental health won't be that great which a lot of times is because of my physical health or the other way round*
-
- *Sometimes though I ignore it [health] and that's not through not wanting to. It's just depends what else is going on in your life and then things deteriorate but […] it is very important. Cos I find that when I'm on top of it, things seem to fall in place around it. Like they were saying it all comes together.*

Health effects of being homeless

Participants felt that becoming homeless would exacerbate existing health problems and was highly likely to create new health problems.

- *there's no way you could get a decent night's sleep on the street and then wake up and go to work every day and be refreshed and clean. It just wouldn't happen, regardless of health problems. But when you put the health problems into it, you can understand why people get worse in that respect […]*

- *You can go out there quite healthy at whatever age [but] spend a few years out there; you're not going to be healthy. You're not going to eat regularly; you're not going to have a good diet. Obviously a lot of people, not everyone, start delving into chemicals or whatever. That's going to bugger up a lot of times, you're going to get your gear dirty, you're not going to have the cleanest of waters […], you're not going to get a decent night's sleep sometimes you might end up with 6 hours sleep during a whole week and then you've still got to go out and get whatever money you've got to get.*

- *It's made me a bit depressed. And pissed off.*

In addition, participants felt that being homeless meant that certain functions of the health care system were more difficult to navigate. For example, one participant described having a heart attack in prison but never receiving any follow-up care afterwards. Other participants described not receiving results from tests done at hospital. Participants were not clear whether that was a system failure or if their situation i.e. lack of fixed address had contributed.

In addition, many found it difficult to book appointments which necessitated either phone credit or internet access.

Access to help

It was felt that poor health was an enabler in order to access help. Participants felt that often it took having fairly severe or multiple health problems to allow them access to the hostel pathway and other support.

- *Well I got in here because I collapsed […] I wasn't coming round so they got me into hospital and that's how I got in here. That's what it took. It took me nearly to die to get in here.*

This had prompted some participants to feel they had to tell lies about their situation. Participants felt that wellness was therefore a barrier to accessing help.

- *Cos when I was living on the street they would say to me 'Well you ain't sick, you're not dying, you're cleaning up, you can look after yourself so we don't need to worry about you'. And I'm thinking well how's that make a difference? Everybody needs help, regardless of what position they're in or what state they're in.*

- *As long as you're doing alright, people take no notice. As soon as you muck up, then everyone'll put you back in nick and recall you, so they think you're doing okay where you might not be.*

However, it was clear that some of the participants felt that there was also responsibility on the individual to be ready to accept help, both with health problems and with acknowledging their situation. But they wanted support services to be able to understand where they were coming from and not patronise them.

- *you cannot take people's problem away but you sit down with them, try to understand where they coming from.*

- *Sometimes some people don't want to help themselves […] the thing is sometimes people want to help you but you have to kind of be helped yourself.*

- *Some people they ready for the help they just want the help, just finding the right door to people to gonna help. But some people don't want help. When I was drinking a lot, people tell me my health what's going to happen. I don't listen; I just keep on drinking, doing my thing. […] It's up to me.*

- *I mean overall I have had some really good service from hospitals and my local doctor and that you know they're a brilliant surgery where they are. They do help you out but I mean at the end of the day I mean a lot of it if you … feeling a bit depressed or something, just want to stare at the wall all day, a lot of it is your own choice isn't it. Depending on what situation you're in. If you want something then sometimes you have to give yourself a kick up the bum and go and do it, if you know what I mean.*

Health effects of being in a hostel

There were interesting insights from participants on being in a hostel. All participants seemed to acknowledge that being housed in a hostel was a 'first step'.

Some had very positive experiences with the hostel healthcare system, particularly the in-house intermediate treatment and in-hostel psychology services. There were also clear differences between hostels with some clients feeling able to discuss their problems in an open environment.

- *I suffer from depression and I don't come out of my room for days. Days. And it just deteriorates. So it's nice having that here because they kind of like push you that little bit to deal with it.*

- *Yeah it's a good hostel down there cos they got the things there if you've got problems you can sit down and talk to them*

Others cited experience in different hostels where treatment that they accessed elsewhere was then moved to a hostel environment. Participants felt there were always teething problems, which often resulted in difficulties. Two clients told of experiences with in-hostel prescriptions.

- *I used to get my subutex yeah from my doctor until last week and um they started the prescribing thing, clinic thing in the hostel yeah last week yeah. So many people like 5, 6 people started doing with me right yeah because my doctor says you have to do it with the hostel now you know I won't prescribe you any more right. Anyway I couldn't get my subutex that night when I went to the chemist right. [..] lucky enough someone helped me out in the hostel with subutex you know*
- *Why couldn't you get it? Was it*
- *Because they messed up the script. They spelled my name wrong […]*
- *If the script's wrong, it's wrong*
- *When you change over they always have teething problems and you're always going to have your script messed up.*

- *I went to another hostel, they changed the system, my script got messed up and I'm going to end up walking back there to change the script … or ending up with nothing at all that night. So if you've done well for 4, 5 months maybe a year all you've used is your prescription and that, you can't go without it, you have to have that. If you don't then you're going to have to go and buy street drugs yeah. (pause) You think well that's great you spent all that money… and now you're on the floor again*

There were mixed views on the effects of hostels on individuals' health situations. Many participants felt that it was difficult to maintain their own recovery especially with substance misuse and alcohol, when those around them were using substances or drinking.

- *I preferred it better when I was in the street. Because you can keep away from some things you don't want to do but here you can't cos it's fucking right there under your nose.*

- *Since I've been here I seen people come in and they've just deteriorated, deteriorated*
- *And it didn't take that long either*
  No couple of months

- *If you got a structure and you wake up and look forward to your day, life will get really a lot better, really a lot faster. Instead of waking up and thinking oh god geezer shit outside my door, there's piss on the staircase this is just not an environment that's conducive to getting better*

Lack of autonomy and control

Linked to these concerns about the hostel environment, there were frustrations with the way that some hostel healthcare was set up.

- *I think the problem that a few people find is that when you get into hostels is if you've built up a relationship with a GP and you've got something going on in one hospital and that then you get into a hostel and they've got like their set up and they want you to leave that doctor and go to this doctor and it can set you back like six months. Easy. Cos you've made all these appointments, you've got through that, you've got through that and then you move into hostel great oh but your health thing schuuuum (gestures with hand downwards) and you can't do nothing about it. What you going to do? Leave the hostel and then become homeless again? […] A lot of decisions are taken out of your hands.*

Participants expressed feelings of powerlessness when it came to some treatment schemes, even though they had experience of their own, but felt that it was not acknowledged and they had to 'fit' into existing systems.

- *You get shut down in here a lot […]. For certain things like it's set up for and it does it probably really good. But if you're out of that kind of pattern that they want you to be in, that they've set up the help for, then you kind of feel a bit…*
- *So what kind of pattern does it work well for?*
- *So they've got certain […] help for people with drug issues but again you got to do it their way as opposed to saying well I need some help, I know the help I need […]. You can't have that, you can have this or nothing […] you feel like you're in the wrong if you don't do exactly what they want you to do. And you're not in the wrong cos you know a lot of people that come here they've probably spent 25 years on drugs, they've been in every type of detox […] I certainly feel though even though I know what's better, what's the point in saying it because they're [hostel] just going to do what they want*

Some participants felt that they had tried to express these concerns to hostel management but were not listened to, and also felt judged for their behaviour. This seemed to be more of a problem for those in hostels with larger capacity, whereas those in smaller hostels felt more listened to.

Experiences of healthcare – judgement and stigma

Participants were asked about their experiences of healthcare. Most comments centred on people's experience of judgement and stigma within the healthcare environment.

Many participants felt that they received sub-standard treatment because healthcare professionals judged them and their situation.

- *They kept fobbing me off at first. Until I moved out of here until I moved out of here into supported housing and had a different address on top of the piece of paper. My treatment changed to better treatment*

- *It sort of cuts through like you were saying being in [hostel] or being on the street, wherever you are, there's a lot of doctors, receptionists especially they will look down on you, they do look down on you. They don't want to treat someone who smells or who might have been on the street, can't have a bath whatever and they don't want to treat someone like that. So they'll just try and make excuses whatever, take these tablets and go, that's not really helping them out.*

- *They don't even want you in the surgery. In the waiting room.*

- *You guys feel that?*
- *Of course you do*
- *They start moving away you know*
- *They're not that subtle about it*

- *He don't want help, sitting there to beg and take drugs, that's not really a nice lifestyle. He probably doesn't want that, maybe he just can't see anything else at that time. Might be part of a depression or any kind of mental illness or not even a mental illness he's just not in the sort of place to see [his] way out. And the [..] the doctors, psychiatrist whatever, their particular plan for him might not be what he wants. So he doesn't want to live like he is, he doesn't want to live like they want so he wants something else. Just 'cos he doesn't want them two things doesn't mean he's given up.*

One participant described his experience of being taken to an inner London hospital

- *Well I was taken to […] 2013… with bad pain in the chest. I was taken [..] in an ambulance with a piece of paper that said [hostel name] on the top. The doctor who was looking at me… checking my arms for needle marks, between my toes for needle marks I said 'you want to check my bloody groin as well?' I don't take drugs, I've got pain in my sodding chest. Didn't even send me for an X-ray.*
- *Soon as they look at the address they just assume everybody's on drugs*

Participants felt that some of their perceived ill-treatment might have been because they did not have anyone else with them. They felt that if they had a family member or advocate with them, that would encourage the health professionals to act in a different way.

- *it feels to me where people, if you've got no-one hospitals don't care. If you've got backing up, people to back you up, friends, family, they will do everyone they can to help you.*

- *If you've got someone else with you that's going to make a big difference always*

- *You want the right kind of someone with you as well*
- *Your keyworker or something*

- *If you've got someone else like he says to back you then if something goes wrong with you then they have to answer to someone else*

Experience of healthcare - other

Participants mentioned some good experiences of healthcare particularly in GP surgeries and in the hostel system as mentioned above. Some were on waiting lists for hospital treatment but felt that their treatment was not affected by being homeless.

- *Well it all comes down to money and budget don't it, well that's what it comes down to really, funding. I mean I been waiting 2 years now for this new treatment that's coming out but I still have to wait until the government pass it. But in the meantime it leaves me in the middle of nowhere basically. So what can you do? Just wait.*

Many were pleased with the service at their GP and reported experiencing no discrimination or judgement.

Judgement and stigma outside of healthcare

Many participants felt judged because of their situation and that they were treated in a certain way by police and other services. One participant described being searched by police.

- *You get stopped by the police in the street, even if you're doing nothing, as soon as you give them the address where you live, they're going to search you straight away for drugs. Straight away. Whether you wanted it or not. It's just that stigma, that stigma that just sticks to it automatically. So they look at you like you're dirty and you're just horrible, you're disgusting that's the way they make you feel. And then they wonder why they get abuse. Because they're putting you in that predicament*

There were some participants who felt they had a positive experience of hostels and support from other services.

However most others continued to feel an element of judgement:

- *Like it's your intention to be homeless, it's your intention to live like that, it's your intention to have no money, your intention to die on the side of the gutter somewhere*

- *They don't see like that you're actually are trying your hardest. And things work for different people.*

- *Like it's your fault, you drinking that's why you lost everything kind of in a way, so that make you go want to drink more*

Solutions and staying healthy

Participants were asked for their suggestions as to what improvements could be made to the health system to help homeless people. A few suggested that homeless people should have homeless - specific services like a medical team, or hospital. However, many felt that homeless people should be able to access mainstream services, though they may need an advocate or case manager that would help them to negotiate the hospital system.

- *Well I think health should be equal doesn't matter if you're the queen or you're somebody that lives on the street, you should be equal you know in whatever services that you want you know. Really. That's what it should be.*

- *I think you can […] have say like a health keyworker that will [..] look after everything you know if you've got your list of things what you need to do and start bringing them all together for you so yeah you go to normal places not just you know, go to the hostel doctor cos that's the only one that wants to see you, you go to all the different ones and you get all your health sorted.*

Participants wanted to be listened to and have services that would cater for their needs.

- *I mean some they just want to carry on using drugs […] and then things should just should be set up to make it safer for them to do that if you like. And some people want to come off it, have something for them.*

They also mentioned having a more holistic approach to homelessness and health, and recognising that there may be many factors involved.

- *what you were saying about homelessness - it all falls apart together and I think it needs to put back together*

- *I think hostels should really be looking at health as a whole because you know like advice right about certain fruits and vegetables and then you have certain mental health teams and then you have certain, it's not really together so you end up in one bit, another bit and by then you've probably moved on to another hostel so nothing, no-one even gets really*
- *the whole package*

One participant felt that hostels were not the correct solution for people to improve their health.

- *Instead of emptying the prison and putting everyone in [hostel] where do you think that's going to go from there? It's pretty easy to see what's going to happen. Instead of putting them all in decent places getting them out of there, getting their health sorted and giving them a chance to get back into society and have something worth waking up for..*

Participants felt there needed to be more advice on staying healthy especially in terms of nutrition as they may not have had exposure to healthy eating advice.

- *I just buy all fresh veg […] but you know some people they will just waste money on takeaways or just have chips every day or something so you know it's about that side of it where people need to be educated on what nutrition is, vitamins everything you should be taking*

Participants also felt that having a purpose such as finding some employment or developing a skill also helped to take their mind off their health problems and gave them more determination and ability to change their situation.

Limitations

It might have been more beneficial to have two groups separated on a gender basis to draw out differences in experiences of healthcare and homelessness for men and women. However, there was difficulty recruiting female participants.

Key points

- Health is felt to be a priority for this population
- Homelessness was felt to exacerbate existing health conditions and those who become homeless are likely to develop new health problems.
- Experience of healthcare and the environment in hostels is mixed.
- For some people hostel living exacerbated their health problems and recovery, particularly where drugs and alcohol are being used.
- Many participants experienced judgement and stigma when accessing healthcare.
- Many felt a lack of power and control in their health situations.
- Solutions included having more advocacy and reducing stigma.

Recommendations

1) *Share findings with commissioners and hostel pathway staff to inform discussions about how to tackle issues identified.*
2) *Consider sharing results with the Clinical Commissioning Group (CCG) in order to inform staff training about how to better serve this population and address the judgement and stigma experienced by participants*
3) *Consider having a service user panel to be involved in future developments*

Summary of recommendations

Section 2: Access to health services

1) *Continue to maintain high rates of registration with GP and pathways that facilitate registration for this population, as this may contribute to the lower rate of A&E attendance in this group compared to the national audit*
2) *Look at ways of improving registration with dentist*[16]
3) *Build on and further improve local good practice on discharge planning*
4) *Further analyse A&E visits to understand proportion which could have been seen in a different setting and those who may be frequent attenders. Identify if any changes or support needed to first contact services and signposting to these that may help to divert people from A&E.*

Section 3: Health behaviours

1) *Examine whether stop smoking services are targeted appropriately for homeless people, and if needed, amend current service offer to suit this group*
2) *Ensure this population are included in healthy eating and physical activity programmes*
3) *Increase education about and access to fruit and vegetables in hostels*
4) *Identify ways vulnerable homeless people can increase physical activity levels and enable them to do so.*

Section 4: Health and wellbeing

1) *Share results of this survey with homeless health services and general practices and ask them to consider changes to their referral pathways for support*
2) *Share results of this survey with mental health services and drug and alcohol services and discuss ways of increasing support for those who may need it and who are self-medicating*
3) *Train hostel staff to signpost to appropriate services and to offer peer support and practical support, which were both cited as useful for those with mental health issues.*

Section 5: Substance misuse

1) *Share and discuss findings of this report with drug and alcohol services*
2) *Maintain good awareness of harm reduction techniques*
3) *Consider incorporating cannabis in stop smoking services (may also be applicable to general Lambeth population)*
4) *Consider further work, particularly for those with high level substance misuse and alcohol abuse, to understand how to better target services for this population.*

Section 6: Screening and immunisations

1) *Agree local pathways to ensure appropriate vaccinations and screening offered to local homeless population, including training hostel staff on the importance of screening and vaccinations and equipping them to signpost to appropriate services.*

[16] Pathway, 'Improving dental services for homeless people': Summary of findings from exploratory research. 2013

2) *Ensure local pathways for TB, HIV and Hep C take account of homeless people and their needs. Pathways should be reviewed to ensure positive screening leads to rapid access to treatment.*
3) *Share findings with local sexual health services and GPs*

Section 7: Focus group discussion

1) *Share findings with commissioners and hostel pathway staff to inform discussions about how to tackle issues identified.*
2) *Consider sharing results with the Clinical Commissioning Group (CCG) in order to inform staff training about how to better serve this population and address the judgement and stigma experienced by participants*
3) *Consider having a service user panel to be involved in future developments*

Appendix 1: Subgroup analysis results tables

Certain questions have been analysed in more detail, and divided the answers into different demographic subgroups of the audit population to look for variations. Not every participant provided a response to each question, so the total varies. The results of this subgroup analysis are displayed below. Interpreting these results should be done with caution as the numbers of participants in each group can be very small, for instance the 18-25 age bracket contains only 6 participants. It may be of interest however to view the different levels of service use and health problems in each subgroup of our audit population.

A&E use in the last 6 months by population group:

Subgroup	Percentage used A&E (%)	Count	Total
Ethnicity			
White	34%	44	128
BME	31%	26	83
Gender			
Male	29%	55	188
Female	29%	15	51
Age group			
18-25	50%	3	6
26-35	32%	14	44
36-45	21%	16	78
46-55	27%	20	75
56-65	46%	13	28
>65	31%	5	16
Sexual orientation			
Heterosexual	27%	57	209
Lesbian, gay, bisexual	53%	9	17
All respondents	28%	71	250

Admitted to hospital in the last 6 months by population group:

Subgroup	Percentage admitted to hospital (%)	Count	Total
Ethnicity			
White	23%	32	139
BME	16%	16	101
Gender			
Male	20%	37	188
Female	20%	10	51
Age group			
18-25	33%	2	6
26-35	23%	10	44
36-45	13%	10	78
46-55	17%	13	75

56-65	39%	11	28
>65	13%	2	16
Sexual orientation			
Heterosexual	20%	41	209
Lesbian, gay, bisexual	24%	4	17
All respondents	19%	48	250

Used an ambulance in the last 6 months by population group:

Subgroup	Percentage used an ambulance (%)	Count	Total
Ethnicity			
White	23%	32	139
BME	20%	23	116
Gender			
Male	21%	39	188
Female	31%	16	51
Age group			
18-25	33%	2	6
26-35	32%	14	44
36-45	18%	14	78
46-55	19%	14	75
56-65	32%	9	28
>65	19%	3	16
Sexual orientation			
Heterosexual	23%	49	209
Lesbian, gay, bisexual	24%	4	17
All respondents	22%	56	250

Current smoker by population group:

Subgroup	Percentage who smoke (%)	Count	Total
Ethnicity			
White	83%	116	139
BME	80%	81	101
Gender			
Male	82%	154	188
Female	80%	41	51
Age group			
18-25	100%	6	6
26-35	89%	39	44
36-45	86%	67	78
46-55	81%	61	75
56-65	68%	19	28

>65	69%	11	16
Sexual orientation			
Heterosexual	83%	174	209
Lesbian, gay, bisexual	65%	11	17
All respondents	82%	205	250

Diagnosed mental health condition by population group:

Subgroup	Percentage with diagnosed mental health problem (%)	Count	Total
Ethnicity			
White	40%	55	139
BME	44%	44	101
Gender			
Male	35%	66	188
Female	63%	32	51
Age group			
18-25	67%	4	6
26-35	43%	19	44
36-45	40%	31	78
46-55	48%	36	75
56-65	32%	9	28
>65	6%	1	16
Sexual orientation			
Heterosexual	41%	85	209
Lesbian, gay, bisexual	65%	11	17
All respondents	40%	100	250

Participants that take drugs or are recovering from a drug problem by population group:

Subgroup	Percentage taking drugs/ recovering from drug problem (%)	Count	Total
Ethnicity			
White	44%	61	139
BME	52%	53	101
Gender			
Male	46%	87	188
Female	51%	26	51
Age group			
18-25	100%	6	6
26-35	66%	29	44
36-45	51%	40	78
46-55	52%	39	75
56-65	18%	5	28

>65	6%	1	16
Sexual orientation			
Heterosexual	50%	104	209
Lesbian, gay, bisexual	59%	10	17
All respondents	48%	120	250

Participants who drink more than 3 times a week by population group:

Subgroup	Percentage who drink more than 3 days a week	Count	Total
Ethnicity			
White	47%	65	139
BME	23%	23	101
Gender			
Male	39%	74	188
Female	27%	14	51
Age group			
18-25	0%	0	6
26-35	23%	10	44
36-45	31%	24	78
46-55	43%	32	75
56-65	50%	14	28
>65	63%	10	16
Sexual orientation			
Heterosexual	38%	79	209
Lesbian, gay, bisexual	41%	7	17
All respondents	36%	91	250

Appendix 2: Questionnaire

Double-click image to view full version

HOMELESS HEALTH NEEDS AUDIT

PRINTABLE VERSION OF THE SURVEY

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

This survey asks clients questions about their health needs and access of health services in your local area. Interviewer: Please refer to **Information for Interviewers (R5)** to help you carry out the survey. Make sure the client has read **Information for Clients (R6)** and understands how this information will be used.

INTRODUCTION

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

☐ I (the client) understand how this information will be used and am happy to go ahead

1 ACCESS OF HEALTH SERVICES

1 **ARE YOU REGISTERED WITH THESE SERVICES IN YOUR LOCAL AREA?**

	yes, permanent	yes, temporary	no
A homeless health care or health service	○	○	○
GP	○	○	○
Dentist	○	○	○

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

	Not used	1-2 times	3-5 times	over 5 times
GP/doctor	○	○	○	○
Dentist	○	○	○	○
Optician	○	○	○	○
Nurse	○	○	○	○
Walk-in clinic	○	○	○	○
Outpatient appointment	○	○	○	○
Homeless health	○	○	○	○
Community mental health care	○	○	○	○
Visited A&E	○	○	○	○ number of times.....
Used an ambulance	○	○	○	○ number of times.....
Admitted into hospital	○	○	○	○ number of times.....

1

Appendix 3: Focus group topic guide

Introduction

"We would like to find out more about homeless people and their health. We are very interested to hear about your experiences and ideas about health and healthcare.

This session will last about 1-2 hours. We will start by asking you about your health and experiences of healthcare and then ask you questions about being homeless and how you think this affects your health.

We will be taking notes and using a tape recorder to record the discussion. We will make sure that nothing you have said can be linked with you.

This information will be used to inform the people who design health services in Lambeth. It is a good opportunity to tell us about things you think they should know.

We will never use your name or anything else that might identify you. However we would like your permission to quote your comments.

Please tell us if at any point you want to stop participating. You do not have to give us a reason."

Icebreaker

Questions
- What do you understand by 'health'

- Tell us about a time when you had a problem with your health? What did you do?

-What is your experience of accessing health care services?
Any particular services? GP? A&E?
Tell us about a service that is good – what is it that makes it good?
What are the barriers to accessing health services?
(Does location / geography makes a difference?)

- How has being homeless affected your health?
Do you think your health contributed to you becoming homeless?
How do you manage if you have a long term condition?
How is your mental health? (if not mentioned)

- Thinking about your life, what would improve it most? Where would your health rank in your list of priorities?

- How could health services for homeless people be improved?
Do you want to access 'normal' or mainstream services? Or do you think that there should be specific services for homeless people?
What would good services look like?
Where would they be located?
What would they cover?
Do you think different for men and women?

Appendix 4: Hostels participating in audit

Answer
Graham House (A1)
Waterloo Project (A2)
Chrysalis Project (A3)
Robertson Street (A4)
Brixton Step (A5)
Camberwell New Road (A6)
Latch House (A7)
Ferrini House (A8)
Wix's Lane (A9)
Knatchbull Road (10)
Hope Worldwide (11)
Kairos (12)
Lambeth Assessment Centre (13)
Lambeth Vulnerable Adults (St Mungo's Broadway) (14)
Lambeth Vulnerable Adults (Look Ahead) (15)
Lambeth High Street (16)