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**Delivering Health Care to
Homeless People: An
Effectiveness Review**

May 2003

Deborah Quilgars and Nicholas Pleace, Centre for Housing Policy,
University of York

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Deborah Quilgars
Nicholas Pleace

Centre for Housing Policy
University of York
www.york.ac.uk/chp/

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Summary

The review

This report reviews evidence on the provision of effective health services for homeless people. It draws on a literature review encompassing Scottish, English and international research and on a small number of focus groups and interviews with health professionals, homelessness workers and other interested parties conducted in Edinburgh, Perth and Kinross and Argyll and Bute during the Spring of 2003. Local authorities, NHS Health Boards and 103 organisations involved in providing homelessness services in Scotland were also asked to submit relevant evidence and reports. A search of relevant websites was also conducted.

Although levels of rough sleeping are falling, overall homelessness in Scotland is increasing. Two thirds of the people assisted under the previous homelessness legislation were lone adults, with the remaining third mainly being composed of homeless families with children. There has been a growth in the use of temporary accommodation for households awaiting permanent rehousing, including homeless families.

Access to healthcare for homeless people

The evidence base is quite well developed on access to healthcare among people sleeping rough and lone homeless people living in emergency accommodation in Scotland (and in England). There is less information available on access to healthcare among other groups of homeless people, such as homeless young people, homeless families and homeless people with a Black or minority ethnic background.

The main barriers to healthcare for homeless people include the administration of the NHS, which is in part dependent on patient's having a permanent address. Homeless people can also encounter attitudinal barriers, including negative attitudes or refusal of service by some administrative staff or medical professionals. There is some evidence that homeless people may be reluctant to use health services because they anticipate a hostile reception and that low self-esteem can lead individuals to neglect their health. In some cases, mental health problems, drug or alcohol dependency, or a combination of the two, can make it difficult for some homeless people to effectively access healthcare or maintain contact to ensure continuity of care. Homeless people may also face more immediate 'survival' needs, such as food and shelter, which can mean that all but the most pressing healthcare needs are ignored.

Location can have a marked impact on the provision of health services for homeless people. It is logistically more difficult and more expensive to provide health services in rural areas of Scotland, where homelessness is relatively dispersed. In contrast, the comparatively high concentrations of homelessness in Scotland's major cities makes the development of specialist services more practical.

Homeless people can find it difficult to access mental health and Drug and Alcohol services in Scotland. There can be particular problems for homeless people with multiple needs (a drug/alcohol dependency and mental health problems).

Access to healthcare for different groups of homeless people

Homeless women often experience sexual assault while homeless. Many women have become homeless following an experience of domestic violence. They may need services that ensure they feel secure and may be reluctant to engage with services that have a predominantly male patients.

Homeless families may encounter difficulties in accessing healthcare if they are resident in temporary accommodation. Temporary accommodation may also undermine the health status of homeless families. Families may in some instances find it difficult to access healthcare because they face a range of more immediate needs or need some support in accessing health services.

Homeless young people may not prioritise health needs unless they become debilitating. There is some research evidence that they may be reluctant to approach health services because they anticipate a hostile reception or because they have difficulty in tasks like completing forms. There is also research evidence that very low self-esteem among some young homeless people may contribute both to becoming involved in behaviour that places their health at risk and towards a tendency to neglect their health. There are particular concerns about the numbers of care leavers who become homeless and the rising levels of young people sleeping rough in Scotland. In addition, there is some research suggesting very high rates of heroin use among homeless young Scots.

There is little research evidence on access to healthcare, or the health needs, of homeless people who are members of minority groups. This includes homeless people with a Black or minority ethnic background and homeless people who are lesbian, gay, bisexual or transgender.

Health services for homeless people

The evidence base on specialist health services for homeless people in Scotland is not always very well developed. Existing studies tend to be descriptive, rather than evaluative, and some aspects of healthcare provision for homeless people have not been researched. English research is similarly descriptive and patchy. The most rigorous and systematic research in this field tends to be North American.

Health services for homeless people in Scotland and in other countries in the UK range from small, informal alterations to mainstream NHS services through to the provision of specialist primary care services for homeless people offering GP and nursing services alongside complementary services such as drug and alcohol workers, dentistry, podiatry and opticians. As the detailed operation and range of services varies considerably, it is difficult to categorise these services, but it is possible to view them as being positioned along a continuum that ranges from 'informal' responses to full specialist primary care services.

The main urban areas of Scotland tend to have more comprehensive health services for homeless people. Edinburgh, for example, has The Access Point, a full primary care service offering nurse, GP, community mental health and substance misuse services. In some smaller towns and cities, such as Aberdeen, Perth and Dundee,

there has been a tendency to offer smaller, mobile nurse-led teams for homeless people, although there is a tendency toward expanding these services. In rural areas of Scotland, there are sometimes specialised workers and health professionals who enable and support access to the mainstream NHS for homeless people. For example, a health visitor and Community Psychiatric nurse are employed by a homeless day centre in Inverness.

Informal alterations to mainstream services are thought to be relatively commonplace, but this is not an area that has been researched in Scotland. They include GPs allowing homeless people to use the address of their practice for the purposes of permanent registration, or the decision by an individual doctor to provide treatment for homeless people living in a nearby hostel.

Training can be provided to improve the response of mainstream services to homeless people. Some research in London has suggested that improvements in patient's satisfaction and staff's attitudes towards homeless people can result from training.

In some instances, hospitals employ staff to improve discharge arrangements for homeless people, as unplanned discharges can lead to poor outcomes for homeless patients. A number of these services have been developed in Scotland. Research suggests the importance of having systems that record whether an inpatient is homeless, planning in advance for discharge and working cooperatively with housing and social care agencies.

Comprehensive primary care services can operate from a fixed site and/or provide outreach services. Most of these services in Scotland are funded through Primary Medical Service (PMS) arrangements. Many primary care services are increasingly integrated with other services as part of multi-service responses aimed at preventing homelessness and effectively resettling homeless people.

Research suggests that comprehensive primary care services that work flexibly have high levels of patient satisfaction. Services that are successful in providing access to healthcare for homeless people also tend to have a 'paternalistic' contract between medical professionals and their patients, which contrasts with the 'patient as consumer' contract between the general public and the mainstream NHS. Services also aim to provide non-threatening, non-judgemental and open environments. Research also indicates that health services should work jointly with social housing and social care services, as part of a holistic multi-service response to homelessness. There have been few studies that have examined the clinical effectiveness of these services.

Facilitator services are mobile services that provide some direct healthcare to homeless people in the community. These services can be nurse-led or they may employ a specialist health visitor. Some research has suggested that these services can run into some operational difficulties when there are problems in referring homeless people on to the mainstream NHS or when the role of the service is restricted, for example because a nurse-led service cannot prescribe. However, these flexible services, which aim to work positively with homeless people, are often

valued. Not many of these services have been evaluated, but the available research suggests that they have improved contact between homeless people and the NHS.

Research suggests that outreach dentistry services can be effective in reaching homeless people and can also encourage homeless people to return for repeat treatments. Services did however need to be flexible, provide reassurance and, where possible, work in ways that allowed homeless people to access them quickly. There has been little research on physiotherapy services for homeless people, one study finding positive effects overall, but also reporting difficulties in providing continuity of care. Research has not been conducted on opticians services or podiatry for homeless people.

Mental health services for homeless people have been increasingly developed as part of the strategic response to rough sleeping, both in Scotland and in England. Some of the first UK services encountered problems in successfully resettling rough sleepers with mental health problems after they had been contacted by outreach teams, as there was a lack of suitable services to which they could be referred. Again, flexibility, the ability of services to adapt to the changing needs of their patients and joint working with other services were reported as being important. Research from the United States suggests that services based around assertive outreach may be effective in meeting the needs of 'hard to reach' homeless people, such as some people sleeping rough.

There is some emerging evidence that services that involve homeless people, as mentors or through peer-support schemes, can be effective in counteracting drug use among groups like homeless young people. North American research suggests that drug and alcohol services that are prepared to be open, tolerant and flexible may be more effective than services that place many expectations and rules on homeless people. There is some evidence that services linked to permanent accommodation may be more effective than some community based services. An assertive outreach model, being used in Edinburgh, has also helped homeless people address drug and alcohol dependency. There is research evidence that multi-disciplinary specialist services offering targeted support can reduce levels of drug use among homeless people, but that in order to achieve this an integrated approach covering housing stability and other health problems, as well as offering a broad programme of treatment, is necessary.

Research suggests that comprehensive, tolerant and flexible services, addressing a range of needs, are required to successfully meet the needs of homeless people with multiple needs (both a mental health problem and a drug or alcohol dependency).

Evidence on health promotion among homeless people is mixed. There have been some attempts at disease control and monitoring, mainly focused on tuberculosis, which have met with varying success. Health education has been undertaken with some groups of homeless people and reported different degrees of effectiveness.

Modifications to the NHS designed to increase accessibility for socially and economically marginalised Scots, such as some social rented tenants, refugees and travellers, may also benefit homeless people. However, the extent to which

innovations like Healthy Living Centres may benefit homeless people is unclear at the moment.

The overall effectiveness and role of health services for homeless people

As the evidence base on access to health and health needs among people like homeless families, homeless young people, homeless women and homeless people from an ethnic or sexual minority is underdeveloped, our understanding of the range of interventions that may be needed is not as full as it should be. In contrast, there is a danger that health status and access to healthcare among people sleeping rough and lone homeless people in emergency accommodation is becoming over researched.

High quality evaluative research on specialist health services for homeless people and on the effectiveness of modifications to the mainstream NHS to make it more accessible for homeless people is rare. It is consequently difficult to develop health services using models that have demonstrable effectiveness based on a high quality evidence base.

It can be argued that health services for homeless people have inherently limited effectiveness. Homelessness constitutes such an intensive set of compound risks to health that no homeless person or household can ever be 'healthy' in the sense of enjoying physical, mental and social well-being, as well as an absence of disease. Some argue that promoting 'health' among homeless people not only extends beyond meeting medical needs, but that some other basic needs have to be met *before* medical needs can properly be addressed.

The development of multi-service or 'more than a roof' responses to homelessness, involving joint working between health, housing and social care services lies at the heart of Scotland's response to homelessness. This policy recognises the basic argument that the healthcare needs of the homeless population can ultimately only be addressed through preventing homelessness where practicable and in supporting the resettlement of homeless households and individuals with appropriate multi-service packages.

Health services for homeless people need to balance their role carefully within multi-service responses to homelessness against their prime responsibility to meet the clinical needs of homeless people. Both mainstream and specialist health services may have a role within multi-service responses, but they should not be expected to function as 'one-stop' solutions for homelessness. Equally, it needs to be clear that homeless people should be given the option to pursue routes out of homelessness, but not expected or required to enter resettlement as a condition of seeking healthcare, as this could act as a barrier to services.

1. Background to the review

This report presents the findings from a desk-top based review of the effectiveness of health care services for homeless people in Scotland. The review was commissioned by the Health Education Board for Scotland (now NHS Health Scotland) and the Scottish Executive and undertaken by the Centre for Housing Policy, University of York in early 2003. This first chapter outlines the background policy context to the review, as well as describing the aims of the study and research methods.

1.1 Homelessness and health in Scotland: Policy context

Homelessness in Scotland

Homelessness has been recognised within Scotland as a major social issue. Since the establishment of the Scottish Parliament, the Scottish Executive and allied agencies have made concerted efforts to address homelessness. A Homelessness Task Force was set up in 1999, and following a comprehensive programme of research, recommended wide-ranging legislative reform. The Housing (Scotland) Act 2001, but particularly the Homelessness etc (Scotland) Act 2003, have brought in some of the most progressive homelessness legislation in Europe.

The Housing (Scotland) Act 1987, amended by the Housing (Scotland) Act 2001, defines homelessness as where someone has no accommodation, or cannot occupy that accommodation in the UK or elsewhere. A person may also be potentially homeless if it is likely that they will lose their present accommodation within two months. Presently, households also have to be assessed for whether they are in 'priority' need, they are intentionally homeless, and they have a local connection.

However the recent legislation has substantially improved the rights of homeless people. Firstly, the Housing (Scotland) Act 2001 extended the duty on local authorities to provide temporary accommodation to all applicants assessed as homeless (where they previously only had to provide advice and assistance). More significantly, the Homelessness etc (Scotland) Act 2003, over a ten year period, will eliminate the test of 'priority need', extending the right to permanent accommodation to all homeless people. In addition, the duty of investigating intentionality will be replaced by a discretionary power and the local connection test will be suspended. In the first phase of the Act, priority need will be extended to all 16 and 17 year olds and most households that authorities currently 'have regard to' under the 1998 Code of Guidance on Homelessness (for example, those who have been discharged from an institution).

It is generally accepted that, despite problems with defining and measuring homelessness, the incidence of homelessness has risen in Scotland over the last decade. In 2001-02, 46,380 applications were made to local authorities under the homeless persons legislation, a 24% rise since 1990-91 (Scottish Executive, 2002 (See Table 1.1)). Homelessness presentations are highest in urban areas, with Glasgow and Edinburgh accounting for 38% of the presentations in 2001-2. Approximately three quarters of applicants were assessed as homeless in the 1990s, and just over two fifths of applicants assessed as being both homeless and in priority need. A further rise in homelessness presentations, and acceptances, is expected as a greater range of households become eligible for assistance under the new legislation.

Table 1.1: Applications made by households (and assessment made) to local authorities, 1990-91 to 2001-02

Period	Number of applications	Assessed as homeless or potentially homeless	
		Number	% of all applications
1990-91	35,061	23,500	67
1991-92	40,623	27,800	68
1992-93	42,822	30,100	70
1993-94	43,038	30,900	72
1994-95	41,495	31,600	76
1995-96	40,936	30,300	74
1996-97	40,989	30,700	75
1997-98	43,135	32,500	75
1998-99	45,723	34,200	75
1999-00	46,023	34,100	74
2000-01	45,172
2001-02	46,380

Source: Scottish Executive (2003) *Operation of the homeless persons legislation in Scotland, quarters ending 31 December 2001 and 31 March 2002*: www.scotland.gov.uk/stats/bulletins.

Unlike England, the majority of households presenting as homeless to local authorities in Scotland are single people, although families have been more likely to be accepted for assistance. At the end of December 2002, 5,047 households were in temporary accommodation awaiting rehousing, some 29% more than reported for the end of December 2001 (Scottish Executive, 2003). Just over half (52%) of the households were in local authority owned dwellings and 28% in hostels. Three in ten (29%) of households in temporary accommodation were families with children, with 7% of these households being placed in bed and breakfast accommodation.

The Rough Sleepers Initiative was extended to Scotland in 1997 to address the very significant problem of street homelessness, particularly in urban areas. Data on rough sleeping and use of hostels for single homeless people are not very precise, however a count of people sleeping rough for the Rough Sleepers Initiative in Scotland recorded 404 people who had slept rough at least once a week in October 2002, compared to 471 people the previous year. The Rough Sleepers Initiative Common Monitoring System, used by 80 homelessness projects in Scotland, recorded 3300 clients using their services between April and September 2002, with over half of people having a history of rough sleeping (Glasgow Homelessness Network, 2002). The majority of individuals using the services were white men, with an average age of 30.

1.1.1 Health and homelessness: the link

The link between poor health and homelessness is well established (Pleace and Quilgars, 1996; Homelessness Task Force, 2001). Successive studies in both Scotland and England have demonstrated that homeless people have very poor health status in an absolute sense as well as relative to the general population (Anderson *et al*, 1993; Bines, 1994; Pleace and Quilgars, 1996; Kershaw *et al*, 2000; Homelessness Task Force, 2001; Love, 2002). For example, only 22% of homeless people in Aberdeen assessed their health as 'good', compared to 77% of the general population using the Scottish Health Survey (Love, 2002).

Homelessness is associated with poor physical health including higher rates of chronic conditions and infectious diseases (Richman *et al*, 1991; Connelly and Crown, 1994; McMurray-Avila *et al*, 1999), as well as stress, anxiety and other mental health problems (Amery *et al*, 1995; Gill *et al*, 1996; Vostanis *et al*, 1998). These health problems affect both lone homeless people and homeless families. A significant minority of lone homeless people also have a drug or alcohol dependency (Pleace, 1998; Kennedy *et al*, 2001). There is also evidence of premature death among people sleeping rough and formerly homeless people (Keyes and Kennedy, 1992; Brimblecombe, 1998; Shaw, 1998). The ONS survey of homeless people in Glasgow (Kershaw *et al*, 2000), the most comprehensive health survey of lone homeless people undertaken in Scotland, found that:

- ☞ 73% of respondents had experienced one or more neurotic symptom in the last week (rising to 89% of those aged 16-24), with 44% being assessed as having some form of neurotic disorder;
- ☞ 29% had attempted suicide during their lifetime (40% of young people), and 18% had self-harmed;
- ☞ over half of respondents reported hazardous drinking behaviour, with one quarter of respondents dependent on at least one drug;
- ☞ 65% of respondents had some form of longstanding illness.

It would be incorrect to view homelessness as a 'cause' of poor health because experience of homelessness does not guarantee that an individual will develop health problems. In addition, some individuals, such as people with a mental health problem, have health problems that sometimes predate their arrival in the homeless population. However, homelessness does mean an *increased risk* of developing health problems because of exposure to various known risk factors. These include extreme stress, cold, accidents, poor diet and the risk of addiction to drugs and alcohol (HVA and GMSC, 1988; Fisher and Collins, 1993). Homelessness also means experiencing *compound* risks to health, as various risk factors combine when someone is sleeping rough or homeless.

Considerable research has also demonstrated that homeless people often experience severe difficulties with accessing services to treat health problems; this poor access also impacting on health status. Voluntary sector agencies, such as Health Action for Homeless People (Hinton, 1992 and 1994), as well as academic research has shown very similar patterns of poor access to GPs and other health services (Fisher and Collins, 1993; Collins, 1997; Pleace and Quilgars 1996; Pleace

et al, 2000). Research also suggests extensive use of accident and emergency services in hospitals by homeless people occurs because of difficulties in accessing GPs (Scheuer *et al*, 1991; Fisher and Collins, 1993) (see Chapter Two).

1.1.2 Addressing health and homelessness in Scotland

Within the UK, Scotland is leading the way in developing responses to tackle the poor health of homeless people. Guidance issued by the Scottish Executive (2001) placed a new requirement on local NHS Health Boards to produce health and homelessness action plans, outlining local health needs and provision for homeless people and a strategy for addressing unmet needs. The action plans took effect from April 2002 and are designed to be linked into the new homelessness strategies, drawn up by local housing authorities, as introduced by the Housing (Scotland) Act 2001, as well as with Community Plans. The Scottish Executive has appointed a national Health and Homelessness Coordinator, and a Steering Group has been established to oversee the new arrangements, with representatives from government, health, local authorities and the voluntary sector.

The Homelessness Task Force Report (2001) made a series of recommendations with respect to health provision for homeless people, all of which have been endorsed by the Scottish Parliament and will be taken forward by local health and homelessness action plans. These included:

- 👉 **Primary care:** ensuring registration of homeless people with a GP practice;
- 👉 **Planning:** NHS Boards should ensure that strategic planning includes the needs of homeless people;
- 👉 **Children's services:** homeless families should be able to access the full range of universal children's health services;
- 👉 **Mental health:** addressing the provision of mental health services to homeless people (being free from substance misuse should not be a pre-condition for access to services);
- 👉 **Co-ordination:** there is a need for a single, co-ordinated assessment approach, particularly for people with multiple needs (commonly those with drug misuse and mental health problems);
- 👉 **Service delivery:** specialist services should be seen as a transitional stage for the vast majority of homeless people; the general approach should be to establish access to mainstream services;
- 👉 **Training:** training on homelessness for health staff, supported by the Health and Homelessness Co-ordinator.

Scottish health policy, more generally, has recognised the health needs of homeless people within the broader remit of addressing health inequalities. The White Paper, *Our National Health: A plan for action, a plan for change* (Scottish Executive, 2000), highlighted the need to improve the health of homeless people. NHS Scotland has developed frameworks to promote better services for those at risk of marginalisation, for example through the Framework for Mental Health. In addition, the Health Improvement Fund is designed to tackle social exclusion, with partnership initiatives

such as Healthy Living Centres and Sure Start aiming to improve the health of disadvantaged communities.

Local health and homelessness needs assessments have been undertaken in many areas of Scotland. These profiles are being used as a basis for service development locally and document both the health profile of local populations and problems with accessing health services. Health and homelessness assessments have been undertaken in rural as well as urban areas (for example, NHS Argyll and Clyde, 2002) as well as for specific groups of homeless people, including young people (for example, Centre for Health and Social Research, 1999 in Fife; a Glasgow study by Thomson, 2003), and families (for example, Hall et al, 2000 reporting on East Lothian).

Initiatives designed to address the health of homeless people were first developed in the UK in the 1970s, such as the house doctor service in Edinburgh and the Great Chapel Street Clinic in London for single homeless people. Health visitor services for homeless families were also developed quite early on in London. Since the increase in homelessness in the 1990s, the development of health care service provision for homeless people has occurred across urban areas of the UK. A range of services have developed both operating from a fixed site, or more commonly, organised on an outreach basis delivering health care to homeless people via hostels and day centres. The Rough Sleepers Initiative and the Homeless Mentally Ill Initiative also heralded the setting up of health teams for people with particular health problems. Adaptations to mainstream health services have also been considered in some areas, including A&E discharge workers (Pleace and Quilgars, 1996).

Considerable research has been undertaken on the health needs of homeless people. However, to date, research evidence on the efficacy of both adaptations to mainstream services and specialist services has not received the same attention by researchers and reviewers as other aspects of health and homelessness. This review was commissioned to fill this gap in knowledge.

1.2 Research aims and methods

The overall aim of the review was to identify and analyse effective practice in meeting the health needs of homeless people. The review findings will be utilised by NHS Health Scotland and the Scottish Executive to inform the development of a training programme for NHS staff. There were also a number of more detailed objectives:

- 👉 to identify and analyse effective practice on both a national and international scale;
- 👉 to assess the transferability of effective practice to Scotland;
- 👉 to review specifically the delivery of health care to rural homeless people;
- 👉 to identify any distinct issues which are involved in the delivery of health services to young people;

- ☞ to explore the views of health professionals in relation to health delivery.

The primary research method was a desk-based review of relevant national and international literature on the delivery of health care to homeless people. This was supplemented by a small number of focus groups with health professionals in Scotland.

1.2.1 A comprehensive literature review

Although it was not possible to undertake a systematic literature review¹ within the timescale, the review attempted to be as comprehensive as possible in scope and detail.

The literature review was international in scope, however a particular emphasis was placed on British, and within this, Scottish evaluations of effective health care delivery. The review included studies that were undertaken since 1980.

The review was concerned with health care for all homeless people, including both statutory and non-statutory homelessness, and those using temporary accommodation and those predominately sleeping rough. In addition, the review paid particular attention to the delivery of health care to homeless young people, delivery of services in rural localities and health care for homeless people of different ages, genders and ethnicity.

A full range of types of potential health care interventions were covered by the review including:

- GP/ nursing services (primary care);
- Accident and Emergency services;
- Inpatient services (secondary and acute);
- Mental health services;
- Alcohol and drug services;
- Professions Allied to Medicine;
- Health promotion.

Definitions and measurement of effectiveness vary. Primary outcomes of health care interventions, such as improved health outcomes, were obviously of key importance to the review, however process factors were also considered. For example, health care delivered by a GP may provide improved health outcomes but if problematic

¹ Systematic literature reviews are widely used in the health field. They involve the identification, retrieval and critical appraisal of studies, usually including only those studies that meet certain types of study design and evaluating the strength of the evidence in an unbiased and rigorous fashion.

access issues means that few homeless people can utilise this service, effectiveness will be reduced. The review therefore sought evidence in the following three areas:

- *Outcomes:* Do the interventions lead to improved health outcomes for homeless people (on both clinical and subjective measures)? Are there secondary outcomes as a result of the service (for example, helping people to maintain their accommodation)?
- *Access:* Are services effectively reaching their target group? Do people find it easy or difficult to access services? Where services aim to reintegrate homeless people into mainstream provision, is this being achieved?
- *Delivery:* Are services being delivered in a format that is acceptable to users? For example, is the service ethos culturally sensitive? Is the service delivery format acceptable to service providers and commissioners? What are the attitudes of service providers and how does this affect the success of the service? What are user preferences with respect to service delivery?

Three key methods of obtaining information were utilised:

- Key social science and health related databases were searched. (Details are provided in Appendix A);
- A search of relevant Internet sites on both health and homelessness. (Details are provided in Appendix A);
- A request for information from key agencies in Scotland to identify any reports that may have been commissioned in this area. A letter from the review team was sent to:
 - The health and homelessness lead officer in the 15 Health Boards in Scotland;
 - The housing strategy officer in the 32 local authorities in Scotland;
 - 106 key health and homelessness providers across Scotland.

1.2.2 Interviews with health professionals

The literature review was supplemented by key interviews with health and homeless professionals to highlight new and developing practice in the area. Interviews were held in three locations in Scotland: an urban area (Edinburgh), a smaller town with a rural hinterland (Perth) and a rural location (Argyll and Bute). In each area, a small number of key professionals working for both statutory and voluntary sector organisations were either invited to a group discussion, or interviewed over the telephone.

1.3 Report structure

The report is presented in four chapters. Chapter Two outlines the research on access to health services for homeless people, identifying the key factors that make it difficult for homeless people to access mainstream health services. Chapter Three reviews the evidence base on the effectiveness of health care interventions for homeless people. This chapter examines both specialist services as well as

adaptations to mainstream services. Chapter Four analyses the gaps in the existing evidence base on healthcare for homeless people and presents the conclusions from the study.

2. Access to healthcare: outlining the issues

This chapter reviews the research evidence on poor access to healthcare for homeless people in Scotland and also draws on the results of the fieldwork conducted for the review. A discussion of the main causes of poor access is followed by an overview of the specific needs of different groups of people in the homeless population.

2.1 The problem of access

2.1.1 Primary care

There is a longstanding recognition in Scotland that homeless people can encounter difficulties when trying to permanently register with a GP. Research conducted in the 1980s in Edinburgh suggested inappropriate use of Accident and Emergency services by lone homeless people because they lacked access to primary care services (Powell, 1987). As a consequence, some specialised GP services for homeless people have been provided in Scotland since the 1970s, such as the visiting GP service covering a number of hostels for single homeless people developed in Edinburgh in 1977 (Maclean and Naumann, 1979; Powell, 1988).

Over the last decade, a range of research in Scotland has indicated an ongoing problem of poor health status and poor access to healthcare among people sleeping rough and lone homeless people living in emergency accommodation (Macmillan *et al*, 1992; Newton *et al*, 1994; Geddes *et al*, 1994; Collins, 1997; Toal and Crawford, 1997; Spicker *et al*, 2002). One study of homeless people in Aberdeen found that only 71% were permanently registered with GP with 19% having temporary registration, while 10% were not registered at all (Love 2002). A study of homeless people with mental health problems in the same city found that only two out of group of 24 homeless people suffering from schizophrenia or depression were receiving treatment (Sclare, 1997). Research in Glasgow found that almost one third of lone homeless people were either not registered with a GP, or never used the GP with whom they were registered (Collins, 1997). There is evidence of particularly poor access to the NHS among rough sleepers, as Rough Sleepers Initiative (RSI) funded projects in West Dunbartonshire found that of 121 users, only 34 reported that they were registered with a GP (28%) and only 29 (24%) actually used the GP with whom they were registered during 2000-01 (Greater Glasgow National Health Service Board, 2002). Similarly, in North Lanarkshire, RSI funded projects reported that of 162 users, only 29 were registered with and using a GP (18%), during 2000-01 (Greater Glasgow National Health Service Board, 2002). It is in response to this enduring difficulty in accessing the NHS that a number of specialised primary care services have been established throughout Scotland, alongside the new requirement for NHS Health Boards to produce health and homelessness action plans (see Chapter One).

Research in England has reported similar findings (Anderson *et al*, 1993; Allen and Jackson, 1994; Pleace and Quilgars, 1996; Pleace *et al*, 2000; Crane and Warnes, 2001). One study of 117 GP practices in Bristol found that only 27% were prepared to permanently register a homeless person and although one third would offer temporary registration, almost one quarter would only offer emergency treatment (Wood *et al*, 1997). Hinton used actors posing as homeless people to monitor

responses from GP surgeries in Hackney in London, and found that 60% refused permanent registration to an 'obviously' homeless male (Hinton, 1992). A survey of *Big Issue* sellers in Manchester, Leeds and Liverpool, found that only 71 per cent were registered with a GP (Big Issue, 1998). One study of five nightshelters in small towns across England found that levels of GP registration fell as experience of rough sleeping increased, with 70% of people who had not slept rough in the last year being registered, compared to 44% of those who had spent three or more months of the last year sleeping rough (Pleace, 1998).

Most of the existing Scottish research has been focused on people sleeping rough or lone homeless people in emergency accommodation. It is also the case that many policy responses and service developments in Scotland and in England have been focused on this group (see Chapter Three). While the evidence base is less well developed for other groups of homeless people, the existing studies do suggest that difficulties in accessing healthcare can, or may, exist for groups such as homeless young people and homeless families. An overview of access issues for different groups of homeless people is presented at the end of this chapter.

2.1.2 Accident and Emergency

Access to A&E services by homeless people has often been regarded as evidence of inadequate access to primary care. In Scotland and England, there has been a longstanding concern that A&E departments are dealing with homeless patients with health problems that should be handled by a GP (Powell, 1987; Collins, 1997). Recent research in Aberdeen found that 48 per cent of a sample of 169 homeless people had made use of A&E in the previous 12 months, a higher contact level than they reported with some specialised health services for homeless people (Love, 2002).

There has also been a corresponding concern that inadequate discharge arrangements have created a 'revolving door' situation, with homeless people repeatedly needing to return to A&E services because their situation makes it difficult to recuperate or causes further health problems (Victor *et al*, 1989; Scheuer *et al*, 1991; Jankowski *et al*, 1993; Stein, 1993; Little and Watson, 1996; Ferguson, 1997).

These studies need to be balanced against other work that has made two quite important points. The first is that 'inappropriate' use of A&E is not unique to the homeless population, many housed people go to A&E with health care needs that can and should be handled by the GP with whom they are registered. The second is that, while homeless people may present with more minor problems, significant numbers do present appropriately, because they have experienced trauma or are seriously ill (North *et al*, 1996).

2.1.3 Mental health and drug and alcohol services

Research in Scotland has demonstrated high levels of unmet mental health needs and poor access to mental health services among lone homeless people (Newton *et al*, 1994; Geddes *et al*, 1994; Sclare, 1997; Burley *et al*, 2002; Love, 2002; Beaton, 2001; Spicker *et al* 2002). Similarly, there are high levels of drug and alcohol use, but sometimes quite poor access to drug and alcohol services (Hammersley and Pearl, 1997; Neale, 2001; Kennedy *et al*, 2001; Jones *et al*, 2002). As one focus group

participant commented, delays in accessing services could be a particular issue when homeless people sought to end a drug dependency:

That's where we see a big gap as well it's this window of opportunity for people, particularly people with addiction problems, we can work with them, get them to the stage where yeah, I'm thinking about it, I really need to get into rehab, I need to go into detox, and in Edinburgh it's almost impossible to access these services quickly and .. and to get them funded. By the time the machine, by the time the system has rolled into operation the guy has gone and back worse than what he was before. That's a big issue, a big omission (Homeless agency worker)

There is strong evidence of a relatively high level of multiple needs² among lone homeless people, which commonly describes someone with a mental health problem and drug and/or alcohol dependencies. Research in Glasgow, for example, found that one quarter of lone homeless people had some form of drug dependence and that 18 per cent were heroin dependent. The same research also found that one in four had mental health problems (anxiety and depressive disorders, panic and phobias and other neurotic disorders) at a level severe enough to suggest a need for treatment (Singleton, 2000).

Particular difficulties can exist for homeless people with multiple needs seeking services that are able to address both mental health problems and a drug or alcohol dependency, as services can sometimes be focused on detoxification or mental health, as opposed to addressing both sets of needs (Kennedy *et al*, 2001; Love, 2002). Very similar findings have been reported in English research (Gill *et al*, 1996; Pleave and Quilgars, 1996; Holland, 1996; Pleave *et al*, 2000).

2.1.4 PAM services

Professions Allied to Medicine (PAM) services include dentistry, opticians, physiotherapy and podiatry (chiroprody). Scottish research indicates poor dental health and poor access to dentistry among lone homeless people in Glasgow (Kippen and Pollock, 1998 and see Chapter Three). These findings are mirrored by research conducted in England in both London (Daly, 1991; Cembrowicz and Farrell, 1992; Daly, 2001) and Birmingham (Waplinton *et al*, 2001).

Research on access to, and use of, opticians services, physiotherapy and podiatry is limited in Scotland and in the other UK nations. However, specialist health services for homeless people in Scotland (see Chapter Three) have tended to find that when they provide services like podiatry, physiotherapy and opticians, the need among their service users is often very considerable (Greater Glasgow Primary Care NHS Trust, 1996; Dawes, 2002). The importance of such services was underlined by one participant in the focus groups:

...podiatry is actually quite a big issue for basic foot care to be honest and you can understand why that would be for a population group that's transient, that's going to walk around, maybe their shoes are ill-fitting,

² Multiple needs were formerly referred to as a 'dual diagnosis'

they're not actually buying things themselves anyway, they're relying on things for handouts...Another thing is glasses for eye care, access to opticians for, I mean you can get a, you can get an eye test I'm sure through Section 12 money through Social Work, I think you can access them through there but it's quite hard to immediately get, to get, to get replacement glasses. I know we've had problems with this. (Health service administrator).

2.1.5 Secondary and acute care

Recent research in Glasgow has suggested that homeless people do not have a higher admission rate than the general population to hospital and that there may even be an underutilisation of hospital care by homeless people, given their morbidity. Homeless people were admitted for injuries and poisoning (including overdose) significantly more frequently than the general population, but admissions for heart disease and cancer were lower than the general population (Glasgow Homelessness Partnership, 2002).

Research in the early 1990s reported hesitancy about admitting some homeless adults in London hospitals, based on worries that they might be seeking a hospital bed as accommodation, suggesting potential issues around access to secondary care (Martin *et al*, 1991). Despite there being little recent work on access to secondary care among homeless people, it must be noted that the major route by which secondary care is accessed, referral by GP, is difficult to access for some homeless people. Referral to outpatient services may also be restricted when a homeless person or household lacks GP registration.

2.1.6 Health promotion

Conveying healthy living messages to a population that sometimes finds it difficult to access the NHS for medical services is clearly problematic. Messages about the risks to health associated with behaviours like smoking, illegal drug use or unprotected sex with multiple partners may not reach a group of people who may not always even have regular access to mass media like television or radio.

This is not an area that has been extensively researched in Scotland, but English studies do indicate that 'healthy living' messages are sometimes treated with low priority by homeless people, as considerations around immediate survival take precedence (Power and Hunter, 2001 and 2002). Researchers have also noted that little work has been done on how health promotion might be effectively undertaken among homeless people (Power *et al*, 1999).

2.2 The causes of poor access

The most commonly described causes of poor access to healthcare in the literature include:

- organisational barriers; both in the sense that some homeless people find it difficult to engage with the bureaucracy of mainstream health services and in the sense that mainstream health services find it logistically difficult to adapt their bureaucracy to homeless people;
- *attitudinal barriers*; this applies when homeless people find it difficult to access services because those administering or delivering those services have hostile attitudes towards homeless people, attitudinal barriers can also be significant in terms of a homeless person's self image, with feelings of worthlessness, or an anticipation of rejection, leading some homeless people not even to approach health services;
- *mental health and drug and alcohol dependency*; where mental health, a dependency or multiple needs, creates in some homeless individuals an inability to engage with healthcare without specialised support being present, or undermines their ability to stay in contact with health services to ensure continuity of care;
- a focus on *immediate problems of survival* while homeless, leading to homeless people sometimes delaying presenting with health problems until they have become debilitating and not presenting with what they interpret as minor ailments.

2.2.1 Organisational barriers

NHS Scotland operates largely on the basis that the people using it will have a permanent address. As many studies have noted, simply lacking a permanent address, or in a few instances, any sort of address, creates difficulties for a service that is organised around permanent registration with a GP surgery based on one's place of permanent residence. NHS Scotland is a service under constant pressure, always managing a very high demand for its services, while at the same time trying to ensure coordination of services and continuity of care for its patients, something which *necessitates* the use of a uniform administrative system. Address based GP registration, in areas like the transfer of medical records and in other respects, is a system of proven effectiveness in meeting the needs of the bulk of Scotland's population.

In many respects, it is perhaps surprising that the NHS is able to respond as flexibly and as imaginatively as it does to the needs of homeless people, through modification of its mainstream services and the creation of new forms of service (see Chapter Three). Many factors need to be taken into account when examining the causes of poor access to health for homeless people, but it is important that the pressures that the NHS faces in Scotland, and its administrative needs in delivering effective healthcare to the general population, are recognised.

The organisational issues for the NHS in meeting the needs of homeless people do not end with the difficulties that exist with regard to providing access. Delivering treatment can also be difficult, as the organisational need of the NHS for someone using it to have an address, even for something as simple as arranging an outpatient appointment, or to ensure proper arrangements on hospital discharge, can be a

major difficulty for mainstream services in trying to work with homeless people (Stern, 1994; Connelly and Crown, 1994; Pleace and Quilgars, 1996; Pleace *et al*, 1999; Wright, 2002).

Barriers may also exist due to genuine misunderstandings of existing administrative systems. A GP receptionist using a database that expects an address, which may even refuse to permanently register a patient without the address field being completed, may honestly, albeit mistakenly, report to a homeless person that it is not possible to give them a permanent registration (Stern, 1994).

2.2.2 *Locality issues*

Homelessness in Scotland tends to be most concentrated in the major cities. This situation creates both problems and opportunities, as it becomes logistically much more practical for the NHS to develop more extensive medical services for homeless people where they are quite numerous and relatively close together. In rural Scotland, however, the situation is quite different. Population density is low and while homelessness is present in these areas, it is likely to either be scattered or to be focused on the nearest population centre of any size (NHS Highland, 2002). The dispersal of homelessness across a wide area makes the delivery of services expensive and logistically difficult. As two interviewees noted:

I think as well from sort of managing a team I mean it's very resource intensive when you've got a demography, you know, like we have because, you know, responding to a referral in a rural area could take a member of staff a whole morning for one referral because of the amount of travelling and so and it's involved in that. So therefore you're asking for a bigger resource, you know, than you would normally say if it was like Glasgow and Edinburgh, wherever, everybody's concentrated in the city...(Medical professional).

...the problems are in providing the solutions, in other words, the problems are very common, I think, between rural populations and heavily urban populations, you run into the same problems, the rurality comes in when you try and solve them...(Medical professional)

Research in England suggests that people becoming homeless in rural areas head towards market towns and other regional population centres, as these are the only places in which affordable accommodation and services are available. It has also been reported that the population in English rural areas tend to be less sympathetic, viewing homelessness as being caused by individual action, an attitude that can block access to services and prevent the development of services (Cloke *et al*, 2001; Cloke *et al* 2000).

A recent review found that between 1980-2000, rural homelessness applications have increased by 144 per cent and there is evidence of significant growth in recent years (Kemp *et al*, 2001; Highland Council, 2003). The NHS in Scotland has developed homelessness services in rural areas in response, but these services are smaller in scale and scope than those developed in Scotland's major cities for logistical reasons (see Chapter Three).

2.2.3 *Attitudinal barriers*

Attitudes towards homelessness

In England, there is some evidence of straightforward prejudice towards homeless people by some GP practices, refusing permanent registration on the basis that someone is, or appears to be, homeless (Hinton, 1992 and 1994). Some researchers argue that negative popular images of homelessness undermine self-confidence and esteem to a point where lone homeless people become reluctant to use healthcare because they have experienced a hostile reception or been refused services in the past. Day to day experiences of negative attitudes from the general public may similarly undermine self-esteem. This, it has been argued, created a situation in which some homeless people do not approach mainstream NHS services on the *assumption* that they will not be able to access them (Shiner and Ledington 1993; Stern, 1994; Shiner, 1995; Pleace *et al*, 2000).

As one participant in a focus group reported, the potential for miscommunication between homeless people and those providing or administering healthcare is considerable, when both parties start to interact with preconceived ideas of how the other will behave.

...it's not always to do with it being a bad receptionist, sometimes it's quite often to do with, you know, two people who will never understand each other being a bit wary and a bit scared of each other and just, you know, that kind of conversation never works because somebody might be drinking and think, you know, I'll just have a wee bit more extra Dutch courage cos I'm going to see the receptionist and I know she doesn't like me and the receptionist thinks, "oh here we go"...(Medical professional)

These arguments are associated with some evidence that some lone homeless people present with health problems only at the point at which a health problem has become debilitating or difficult to manage. This is because the psychological barriers to access - essentially an anticipation of rejection when seeking help - mean that many wait to see if a problem will go away, or simply endure discomfort, rather than seeking healthcare (Pleace and Quilgars, 1996; Klee and Reid, 1998).

Some research has argued that popular attitudes to homelessness and the experience of homelessness itself also form a barrier to health services through undermining the self esteem of homeless people. It is argued that in some instances a homeless person's sense of self-worth may become sufficiently undermined to mean that they do not seek treatment, or become involved in behaviour that places their health at risk (Shiner, 1995; Pleace *et al*, 2000). This was a view shared by some focus group participants:

Going back to what our health needs in its base sense, I think for people who are disadvantaged, disenfranchised, socially isolated, there's a whole issue around personal neglect which I think underlies a lot of this and it relates to food, it relates to personal hygiene and it relates to actually how you live your life, healthy living in a very, very broad sense, healthy well-being, and also what you do when you have minor injuries, and I think a lot of the bottom line bit about this is actually trying to turn people's lives away from what is the problem

which is really sort of underlying the basis of homelessness, whatever that might be, if it's one or thirty problems, so that actually starts to develop some elements of self-esteem which requires some kind of reconsideration about your worth and developing some of it about having a feeling that actually doing something about this cut in my leg is worthwhile because it'll mean x, y and z after that. (Homelessness service provider)

'Pigeonholing' or stereotyping homeless people

Clearly, some homeless people are more difficult for health services to engage with than others, a homeless toddler living in bed and breakfast is a very different prospect to a verbally abusive and obviously disturbed young man with a heroin addiction who has been living in a squat or on the street (Hinton, 1992 and 1994; Pleace and Quilgars, 1996; Pleace *et al*, 2000). This has led, in Scotland and also in England, to the idea that there is a hard to reach core of 'long term' rough sleepers and other homeless people, who often have multiple needs and challenging behaviour (Noble, 1997; O'Leary, 1997; Griffiths, 2002; Laird, 2003), while other groups of homeless people are seen as having less pronounced needs and being easier to engage with.

However, some research strongly suggests that whether or not a homeless person or household is deemed to be 'difficult' by a service may be something that is only *partly determined* by the behaviour that person or household exhibits. There is a tendency for service providers to develop shorthand ways in which to classify individuals or households into certain broad 'types' and to allocate services accordingly (Hutson and Liddiard, 1994; Wardhaugh, 1996; Harding, 1999). This can create problems for homeless people seeking services because they may not be properly represented, or indeed represented at all, in the processes involved in determining whether they are classified as a 'cooperative' or 'difficult' patient, or as someone who is 'suitable' or 'unsuitable' for a service.

Some American literature refers to this as the construction of 'service worthy' homeless people, a potentially unfair 'pigeonholing' of homeless people by service providers that determines who does and who does not receive a service (Marvasti, 2002). In the US, there is quite a strong research literature indicating a marked tendency among service providers to see homeless people as 'cooperative' or 'difficult', with some commentators arguing that even the way in which homeless people come to see themselves and their situation is influenced by the way in which service providers pigeonhole them (Lyon-Callo, 2000; Hocking and Lawrence, 2000; Hegamin *et al*, 2002).

This is a more complex and subtle process than services deliberately 'cherry picking' those homeless people who are easy to work with, because it may actually be, at least partly, as a result of *unconscious* actions by professionals or workers. However, just as some mainstream services might classify all homeless people as potentially 'difficult' and refuse all of them a service, so other, supposedly more 'accessible' services, might assume certain traits are present and summarily pigeonhole homeless patients into 'cooperative' or 'difficult' categories, perhaps without any concrete justification for their decisions.

2.2.4 Mental health and drug and alcohol dependency

The extent to which lone homelessness, which includes people sleeping rough and people resident in temporary or emergency accommodation, is popularly equated with drug use, means it is sometimes difficult to separate out a distinct attitude towards 'homelessness' among service providers in Scotland (Kennedy *et al*, 2001; Love, 2002; Spicker *et al*, 2002). English studies have found a reluctance among GP practices to register lone homeless people because of assumed drug dependency rather than negative attitudes towards someone just because they are homeless (Pleace and Quilgars, 1996; Wood *et al*, 1997; Pleace *et al*, 2000; Wright, 2002).

A dependency may also, in certain circumstances, make it difficult for users to engage with services when the substances they are using disorientate them or cause chaotic behaviour (Kennedy *et al*, 2001). As one focus group participant noted, the extent to which a dependency can dominate a homeless person's life may also mean that they can lose focus on other issues.

People who've got an addiction problem, then the addiction becomes the absolute priority, if it's heroin, if it's alcohol, it doesn't matter what it is, and someone who's a binge drinker will tell you that they'll drink for three weeks and not eat at all, they will not eat a thing...the drink or the drugs become the predominant issue, as you say food just goes right out the, and health just goes right out the window. (Homeless agency worker)

There is sometimes a tendency to view homelessness as being 'caused' by 'mental health problems' with the implication that mental health service interventions lie at the root of any solution to homelessness itself. However, US research has found evidence that mental health problems can develop during, rather than prior to, homelessness and has questioned the emphasis placed on mental health as a 'cause' of homelessness, given most people with mental health problems do not ever experience homelessness (Snow and Anderson, 1987; Winkleby and White, 1992; Cohen and Thompson, 1992; Mossman, 1997). Scottish research has also emphasised the importance of structural factors, alongside individual characteristics in the causation of homelessness (Kemp *et al* 2001). It is also important to note that while there is a high prevalence of mental health problems in the homeless population of Scotland, this is not at all the same as all homeless people having mental health problems (Macmillian *et al*, 1992; Newton *et al*, 1994; Geddes *et al*, 1994; Sclare, 1997; Singleton, 2000; Love, 2002).

It is not possible to draw a clear line between low self-esteem and an actual mental health problem, but the issues that may arise when seeking access to services are similar. Someone with a mental health problem may find it difficult to engage with others, handle bureaucracy or present themselves in the 'public' context of seeking a service from a GP or other health services (Pleace *et al*, 2000). When severe mental illness or multiple needs are present, any engagement with the mainstream NHS, or even some specialist services, may not be possible until someone has received care and support from a mental health service. Equally, ensuring continuity of care will be difficult when someone exhibits chaotic, challenging or confused behaviour (O'Leary, 1997; Pleace *et al*, 2000).

Some research has suggested that homeless people with a severe mental illness or multiple needs are still able to engage with the most open form of NHS services, the A&E departments in Scottish hospitals (Love, 2002). Similar findings have been reported by English research, with some homeless people expressing a preference for A&E over specialised homelessness services (Scheuer *et al*, 1991; Jankowski and Mandalia, 1993; Little and Watson, 1996). Research in France, the US and Canada has similarly suggested a high use of A&E (Emergency Room) services by homeless people with severe mental illness and multiple needs (Brucker *et al*, 1997; Lang *et al*, 1996; Padgett *et al*, 1995; D'Amore *et al*, 2001). As one US study notes, from a vulnerable homeless person's perspective, A&E services are perhaps utilised because they make no demands of their patients and may be the only place that will always accept and treat anyone who approaches them without question (Padgett *et al*, 1995). However, the accessibility of these services to homeless people with multiple needs or severe mental illness needs to be balanced against the appropriateness of their use for highly vulnerable homeless people, given the difficulties that can arise in providing continuity of care to this group when they are discharged from hospital (Stein, 1993; Ferguson, 1997).

2.2.5 The immediate problems of survival

Some US research has reported that homeless people may delay accessing healthcare simply because they have more pressing needs to attend to, such as seeking shelter and food. This research does not argue that inappropriate or inadequate services, or psychological barriers, are unimportant, but it does note that a focus on simple day to day survival may explain why health problems are not dealt with until they become difficult or impossible to ignore (Macnee and Forrest, 1997; Ensign and Gittelsohn, 1998; Gelberg *et al*, 2000; Nymathi *et al*, 2000; Klein *et al*, 2000; Ensign and Panke, 2002). This focus on other, seemingly more pressing needs, may well be an important factor in explaining poor contact with health services by some homeless people in Scotland.

2.3 The problems faced by specific groups of homeless people

2.3.1 Gender differences

Approximately two thirds of households accepted as homeless under the legislation in Scotland are lone person households, of whom one third are women. Around one fifth of all acceptances are one parent households headed by a woman (source: Scottish Executive).

Women frequently report being sexually assaulted and raped while homeless. Homeless women who have mental health problems may also experience sexual abuse by homeless men (Attenborough, 1998; Attenborough and Watson, 1999; Jones, 1999). Women's experience of homelessness is also strongly linked with experiences of domestic violence from male partners. In Scotland, women often become homeless as a direct result of escaping a violent male, quite often in the company of their children (Rosengard *et al*, 2001), as is the case elsewhere in the UK (Jones, 1999).

Access to regular cervical smear tests, contraception and contraceptive advice is often assumed to be poor for homeless women, but this is an area that has not been well researched in Scotland or elsewhere in the UK. Obstetric outcomes are also

assumed to be relatively poor for homeless women, but again, the evidence here is limited (Paterson, 1990).

US research suggests that women may be reluctant to use services in which there is a male dominated atmosphere (Macnee and Forrest, 1997). As some primary care services focused on people sleeping rough have a largely male user group, it would be anticipated that this might deter some women from engaging with those services. Some women sleeping rough tend not to use mixed services such as night shelters, where these lack clear and effective security arrangements, for fear of being the victim of attack by male residents (Jones, 1999). Some agencies provide separate emergency accommodation services for women on this basis.

In the US, research suggests that homeless women may be more likely to engage with some medical services than homeless men (Padgett *et al*, 1995) and some research among homeless young people in England has also reported this pattern (Reid and Klee, 1999). Some research in England and the US has suggested that masculine reactions to homelessness can include a tendency toward attempting to 'cope' entirely on one's own, particularly among groups such as ex-service men (Highgate, 1997), whereas women may be more likely to both recognise a need for help and to seek it (Jones, 1999; Gelberg *et al*, 2000).

2.3.2 *Homeless families*

Research on access to healthcare for homeless families in Scotland is relatively restricted. One study of 94 homeless families in temporary accommodation in Glasgow found that because female headed families were often escaping violence or abuse, they had moved away from their home area and the GP practice with which they were registered (Lamb, 2001). A similar pattern would be expected elsewhere in Scotland and throughout the rest of the UK. The same study reported that illegal drug use by families could form a barrier to permanent registration with a GP (Lamb, 2001). Another study, conducted in East Lothian, found families living in sometimes poor quality temporary accommodation, which was having a negative impact on their health status (Hall *et al*, 2000) as did a small study conducted in Dundee (Robbie, 2001). Some healthcare services have been specifically developed for homeless families in Scotland, for example the Homeless Families Health Care Service, which has been operational in Glasgow since 1996.

Research from elsewhere in the UK has had similar findings, although much of this material is over a decade old, having been undertaken in London during the peak in the use of bed and breakfast accommodation for homeless families by local authorities (General Medical Services Committee, 1988; Victor *et al*, 1989; Victor, 1992; Scheuer *et al*, 1991; Camden and Islington FHSA, 1993; CARIS, 1994). These London studies drew attention to inadequate access to the NHS (Lee and Goodburn, 1993) and it was also found that homeless children were more likely to be admitted to hospital than their housed peers because clinicians felt there was a higher risk to their well being and recovery than among housed children (Lissauer *et al*, 1993). A number of services, such as specialist health visitors and mobile clinics, were developed for homeless families in temporary accommodation in London during the early and mid 1990s (see Chapter Three).

In Scotland, of the 4,704 households in temporary accommodation at the end of September 2002, 1,490 were families with children. This represented a 9 per cent increase in the number of families in temporary accommodation at the end of September 2001. Overall numbers of households actually in Bed and Breakfast accommodation were small, but had increased by 243 (52%) compared to the end of September 2001 (source: Scottish Executive).

Existing research has tended to focus on health status and access to healthcare while families are technically still homeless and living in temporary accommodation. More recent work focused on the resettlement of homeless families has suggested that some may have an ongoing need for support in accessing healthcare and other services. Mental health problems may be present in adults and children, which may make it difficult for some families to engage with mainstream services like GPs (Vostanis *et al*, 1998). Homeless families may in a few instances have chaotic and challenging behaviour, among both children and adults, and experience difficulties in managing a home and using a range of services (Dillane *et al*, 2001; Vostanis *et al*, 1998; Hinton, 2001; Jones *et al*, 2002). Some American research suggests that self-image, fear of authority and a focus on the immediate problems of survival all form barriers to healthcare for homeless families in that country (Duchon *et al*, 1999; Weinreb *et al*, 1998; Gallagher *et al* 1997; Klein *et al*, 2000; Sachs-Ericsson *et al*, 1999; Kushel *et al*, 2001).

2.3.3 Young people

Young people who become homeless are disproportionately from the most marginalised and vulnerable backgrounds. There are longstanding concerns that young people leaving care are more likely than young people in the general population to experience homelessness (Banister *et al*, 1993). One survey of rough sleeping in Edinburgh found that 40% of people sleeping rough aged under 26 reported having been in care (Owen and Hendry, 2001). The over representation of care leavers within the homeless population has led to recent legislative changes in Scotland, extending the duties of social work departments and widening the scope of the homelessness legislation.

There is also a more general concern that rising numbers of young people have been found among people sleeping rough over the last decade or so. Surveys have reported that one third of people sleeping rough in Edinburgh were aged under 25 in 2001 and that 39% were aged under 25 in 2002 (Owen, 2002).

There is evidence of high levels of drug use among young people who become homeless. Research has suggested that a longstanding pattern of alcohol dependency among people sleeping rough has been replaced by an increasing tendency toward heroin dependency among younger people who are sleeping rough or using emergency accommodation. One study in Glasgow found that 27% of people sleeping rough aged 16-24 were heroin dependent, rising to 51% among people aged 25-34, but falling among older age groups who were more likely to be alcohol dependent (SWSI, 2001).

Research in Scotland also suggests that young homeless people do not seem to prioritise health. One study reporting that only 28% of young homeless people (aged 16-25) in Glasgow said that they would go to a GP with a health problem, with 43%

saying they would only seek medical advice in emergencies. A small proportion reported they would either endure the problem, or resort to drugs or alcohol to try to manage painful problems. This was despite one half of those participating in the research reporting one or more physical or mental health problems. Just over one half were registered with a local GP. The barriers reported by young people included difficulties in dealing with NHS administration, sometimes linked to literacy, and attitudinal barriers from receptionists and sometimes from medical professionals, though views of specialised health services aimed at young people tended to be more positive (Barnardos, 2003). Research in East Fife also found a wide range of health and social needs among homeless young people, although it also reported a greater tendency to seek medical help when health problems arose, though some young people still seemed unwilling to use health services (CHSR, 1999). Participants in the focus groups also noted a tendency not to prioritise health among young homeless people:

...the kind of main problem we find is prioritisation, young people do not prioritise any form of health at all unless it becomes a crisis for them, unless it becomes something that prevents [them] from getting access to somewhere...young people just don't prioritise it at all, and it's fascinating, like I could be having a conversation with somebody on a street corner who's got a broken arm but they'll be standing talking about something else which has got nothing to do with their broken arm...if they're choosing to ignore it, you know (Homeless agency worker)

Some English research with young homeless people suggests that this failure to 'prioritise' health may be more closely linked to very low self-esteem than it is to young people having other priorities. As noted above, low sense of self-worth may contribute to both a tendency to participate in 'risky' behaviours that may damage health and also towards a failure to self-care, linked to feelings of 'worthlessness'. Equally, esteem issues may block access to the NHS, if a young person anticipates rejection, a hostile reception or is humiliated by, for example, being unable to complete a form. Reid and Klee (1999, p.24) note: *'Given the lack of confidence exhibited in a number of areas by the sample of young people represented here, work around building confidence and self-esteem may be particularly apposite for the young homeless'*.

It may also be the case that young people who have been in care, or perhaps run away from home, may be ill equipped in terms of knowing where to find and how to access services. While they are not children, they may nevertheless be no better equipped than a child when it comes to day to day living and using services. As one interviewee noted:

... this sounds very pejorative, but many young people are basically simply incompetent...(Medical professional)

It is important to note that young people are not simply a discrete group of homeless lone teenagers with shared characteristics. Many homeless families are headed by young or relatively young women with small children.

2.3.4 *Minority groups*

Relatively little is known about the particular barriers that may be faced by homeless people with a Black or Minority Ethnic (BME) background or who are Lesbian, Gay, Bisexual or Transgender (LGBT) either in Scotland or in the other countries in Britain. The concern is that in addition to the other barriers they may face to healthcare, they may also be barred, or deterred, by racism or homophobia from either those administering or providing services, or from other homeless people using those services. There may also be other barriers related to cultural differences and, in some instances, language, that may make it difficult for some people with a BME background to engage with the NHS or specialist healthcare services for homeless people. Work in England among homeless people with BME backgrounds suggests the same poor access and poor health status as among other homeless people (Tower Hamlets Health Strategy Group 1995; Small and Hinton, 1997). English research presents some evidence that hostile attitudes are sometimes faced by homeless people with a Black or minority ethnic background, or by homeless people who are lesbian, gay, transgender or bisexual. There may be reluctance among these groups to use services in which the main user group is White and male (Julienne, 1998; Dunne *et al*, 2002).

3. Reviewing the evidence: Health care interventions to meet the needs of homeless people

This third chapter reviews the evidence on the effectiveness of health care interventions designed to meet the needs of homeless people. The chapter begins with an overview of the main types of health service interventions that have been developed in the UK. The chapter then moves on to consider the evidence found in the Scottish, UK and international literature on the effectiveness of different types of interventions.

3.1 An overview of service interventions

It is not possible to provide an exact system of classification for health service interventions for homeless people, as models have been developed over time and in response to local need. However, a broad description of the types of services is possible derived from the review literature. This description can be seen as a continuum in the sense that it pictures a range of interventions that start with small modifications to mainstream NHS provision, through to services that amount to full primary care or specialist services that are specifically and solely for homeless people.

Health service interventions for homeless people can, in broad terms, be described as one of four broad types:

- *Adaptations to mainstream services.* These include initiatives designed to help mainstream services cope more effectively, for example specified link workers in Accident and Emergency Departments, or training for GPs and reception staff. It may also include modifications to administrative procedures or quasi-informal measures that make it easier for homeless people to engage with a mainstream service, for example, a GP practice allowing homeless people to permanently register with it by using the practice's own address. Another example would be a decision by an individual doctor, or GP practice, to register residents at a local homeless hostel.
- *Primary care services.* Services that involve primary health care professionals providing specific services for homeless people. These services can be wide-ranging, being more or less comprehensive in scope, primarily fixed site or outreach in approach, with more or less of an emphasis on re-integration into mainstream provision. Very broadly, services tend to fall into one of two main service types:

Comprehensive primary care services. Services that offer a full range of primary care facilities for homeless people including nursing, GP and professions allied to medicine (eg podiatry). In Scotland and elsewhere in the UK, these services have become increasingly comprehensive in recent years, tending to also provide some specialist healthcare, such as drug and alcohol services and mental health services (including Primary Medical Service (PMS) pilots for homeless people). They may be provided jointly by the NHS, Social Work (Community Care) service commissioners, social landlords and the voluntary sector or will, at least, tend to involve some joint working between health, social care

providers and social landlords. For logistical reasons, many services will tend to undertake most of their work from a fixed site or sites, offering in effect a GP practice for homeless people. However comprehensive, multi-disciplinary outreach based services have also been developed.

Facilitator services. Services that are commonly based around one or two specially appointed health workers involving some direct healthcare, but which also often has a central role in facilitating access to the mainstream NHS. Workers often have an advocacy and key worker-type role with clients. Services are typically delivered on an outreach services, such as specialist health visitors working with homeless families in temporary accommodation or nurse led services delivered in hostel settings.

- *Specialist services.* Specialist services include mental health teams for homeless people, drug and alcohol teams and services for homeless people with multiple needs. In Scotland and in other countries in the UK, these services have been developed in urban areas in the last decade and have been primarily aimed at meeting the healthcare needs of rough sleepers.
- *Health promotion.* Health promotion services for homeless people have only recently started to be developed in the UK. These may include peer led education initiatives, group work (eg smoking reduction projects, healthy eating initiatives) and health screening programmes. Health promotion initiatives can be delivered in any setting, including hostels, day centres and directly on the street.

A fifth type of service intervention might be added to this list, primary care services that are designed to provide improved access to healthcare for the general population and/or targeted at vulnerable groups of people including homeless people.

- *Wider NHS developments.* Services aimed at reducing health inequalities and improving access within local populations, such as healthy living centres. Some services may be intended for a number of groups that may have difficulty accessing primary care, such as homeless people, travellers or socioeconomically marginalised housed populations.

The literature on the effectiveness of the above types of interventions are reviewed below.

3.1.1 Present pattern of services in Scotland

The health and homelessness action plans provide details on existing and planned health care provision for homeless people throughout Scotland. The plans³ reveal a clear patterning of provision across Scotland with key differences by locality:

³ The Health Board Health and Homelessness Strategies were not analysed in detail for this study, and therefore only a broad overview of evident types of provision is given here.

- *Urban areas:* Large cities tend to be characterised by comprehensive primary care services for homeless people, including specialised mental health and substance misuse services for homeless people. For example, Glasgow has a physical health team (nurses and health support workers providing direct acute care, screening and chronic disease management), a homeless mental health team, homeless addictions team, a homeless families service (including health visitors and GPs) as well as a range of other services including podiatry, physiotherapy and mobile dental services. A dedicated GP, PMS practice is also being proposed. Edinburgh has a dedicated PMS Homeless Practice, located within the Access Point and Cowgate Clinic which provides a range of primary care and community mental health and substance misuse services.
- *Mixed urban/ rural areas.* Health Boards with medium sized towns tend to offer a more restricted primary care service, usually employing a number of specialist nurse and other health workers. For example, Aberdeen, Perth and Dundee have all provided nurse-led teams of dedicated services for homeless people. However the tendency here is towards the development of comprehensive targeted services, for example Health Care for Homeless People in Perth is becoming a PMS, already employs a substance misuse worker and will soon employ GPs in a fixed site practice that will complement its primarily outreach focus. Aberdeen is also moving to a similar, though smaller, model. Dundee has also recently developed a specialist GP service. There tends to be little if any services provision in adjacent rural areas.
- *Rural areas.* Most rural local authorities do not have any specially targeted health care services for homeless people. However, specialised, often lone, workers with an emphasis on advocacy and facilitating work are sometimes employed within some Health Board areas. For example, a health nurse in Oban (Arygll and Bute) based in a purpose built four bedded night shelter, and also in other hostels, provides direct health care to local homeless people (including a podiatrist clinic), but with advocacy as the main focus to assist people in accessing mainstream services. In Inverness (Highland), a health visitor and CPN are employed in a local day centre, again with a key aim of improving access to mainstream services.

English health care for homeless people tends to follow a similar pattern to Scotland. In a 2000 English audit of health care provision for homeless people (Griffiths, 2002), it was found that 78% of health authorities in London and all health authorities outside London with high concentrations of rough sleeping, provided some specialised health care services. Just under half (44%) of health authorities with lower concentrations of people sleeping rough had specialised provision. In great part, the variability in provision was explained by the size of local homeless populations.

3.2 Adaptations to mainstream services

Few studies have been undertaken that explicitly evaluate interventions providing adaptations to mainstream health care services that aim to improve services for homeless people (Pleace and Quilgars, 1996). The small, mainly descriptive,

literature tends to focus on three related areas: discharge arrangements, link workers and training programmes for health staff.

3.2.1 Discharge arrangements

A number of publications have described discharge arrangements and the employment of specific workers in Scotland and England (Martin et al, 1992; Pleace and Quilgars, 1996; London Standing Conference Nurses, Midwives and Health Visitors Nursing and Homelessness Group, 2001; Dundee City Council and NHS Tayside, 2001). In the Scottish context, Dundee City Council and NHS Tayside (2001) conducted a detailed investigation into the hospital discharge arrangements for homeless people in Tayside, highlighting unplanned hospital discharges and inadequate joint working and understanding. The report noted a number of developments that have been made in other areas of Scotland to address these issues:

- *West Lothian*: Homeless Services organised a seminar for hospital staff and social work to raise awareness of homelessness, resulting in an agreement that no patient would be discharged without prior notice to the homelessness team via a named social worker based at the hospital;
- *Glasgow*: Procedures have been put in place whereby homeless people being discharged from hospital are assessed by a caseworker from Homeless Services.
- *North Lanarkshire*: Patients are discharged from acute psychiatric care through a process of consultation with the Homeless Person's Accommodation Officer.
- *Inverclyde*: Discharge protocol from acute hospital wards following an appointment of a housing officer to the Community Mental Health Team.

A number of papers have identified key factors needed to make discharge planning work adequately. Stein (1993) notes that difficulties can arise when low status nurses are left to organise discharge arrangements and how effective coordination both within the medical services as well as with housing and social services are paramount. User representation also needs to be incorporated into these processes. Joint working and the need for holistic services are also stressed in Ferguson's (1997) review of discharge planning in A&E. Dundee City Council and Tayside NHS concluded that the following factors needed to be present if effective discharge procedures are to be achieved:

- vulnerability to becoming homeless is identified on admission to hospital;
- discharge planning starts from the time of admission;
- no discharge before support has been arranged;
- an agreed protocol or procedure for coordination and communication between agencies, sometimes via a dedicated worker;
- good cooperation between health, housing and social work;
- time allowed for proper assessment of needs (including community care needs and user involvement);

- housing referral/ discharge forms devised jointly by social work, housing and health;
- key member of team acts as a keyworker or overall coordinator.

The international literature provides evidence of the importance of coordinated community care assessments for homeless people on discharge from hospital. In Melbourne, Australia, a multi-disciplinary Care Coordination Team (CCT) for emergency department patients proved successful in assisting homeless people, along with other vulnerable client groups, to be appropriately discharged (Moss et al, 2002). As part of routine emergency department care, a risk screen was implemented to determine referral to the CCT. In the first 12 months, the CCT saw 2532 patients (6% of all emergency department attendances) and nearly half of these patients were discharged home with referrals to community service providers. The study found that the rate of hospital admission from the emergency department fell significantly over a twelve month period. A high level of user satisfaction, as well as that of service providers, was also recorded.

3.2.2 *Link workers*

In the USA, Witbeck et al (2000) evaluated a pilot program that employed a link worker in the emergency room who provided outreach and intensive case management services to homeless clients. Although only a small sample, they found that use of emergency services decreased in the subsequent year for the service clients, whereas no change in use was found in the case of a control group.

A pilot link worker system was developed by the Dundee Social Work Department Drug and Alcohol Team (2003) to liaise with hostel and day centre staff and offer a social work link to potential service users. The service was not formally evaluated however an internal report found that service users had been assisted with a range of issues (eg benefits, housing, general health), as well as alcohol and/ or drugs. However, relatively few referrals were received (14 over 6 months), with decreased referrals over time and the service was withdrawn after the six month period. This was thought to perhaps reflect the low turnover in hostels as well as increasing waiting lists for people to receive assessments from drug and alcohol providers.

3.2.3 *Training on homelessness for health workers*

Scottish Health and Homelessness Action Plans reveal that a number of Health Boards are currently conducting, or planning to conduct, training on homelessness for health workers (as well as training on health for homelessness workers). However, only one study was found that had evaluated a British scheme of this nature.

Clarke (1994) undertook an evaluation of the Homelessness and Health Training Project in Camden and Islington which comprised two courses aiming to provide participants with (i) an understanding of homelessness, access issues and strategies for improving access, and (ii) knowledge and skills to improve discharge planning for homeless people. Reported outcomes included improvements in patients' satisfaction, staff understanding, attitudes towards homeless people, joint working, information giving on GP registration, and improvements in discharging planning.

3.3 Primary care services

Despite the UK-nation wide development of primary care services for homeless people, there is a relative paucity of high quality information available on their effectiveness (Hewett, 1998). Most of the published material is descriptive and represents expert opinion rather than robust, independent evaluations. Below, literature on the efficacy on primary care service for homeless people, including comprehensive primary care services and facilitator services, is reviewed. Professions Allied to Medicine, such as physiotherapy and dental services, usually form part of a comprehensive service response and are described separately.

3.3.1 Primary care services: GP and nursing services

Comprehensive services

The most comprehensive primary care services for homeless people tend to operate from a practice base, although outreach may also be offered. The advent of Primary Medical Services (PMS) has meant an increase in dedicated health centres for homeless in Scotland. Primary Medical Service (PMS) pilots are a key element of the government's modernisation programme for the NHS, attempting to provide more flexible ways of offering primary care services. PMS pilots are able to negotiate directly with the commissioner to vary services to meet patient need, including addressing the needs of particular groups such as homeless people. A national evaluation of the first wave of PMS pilots (PMS National Evaluation Team, 2002) reported that PMS pilots targeting vulnerable groups, including homeless people, experienced high levels of success in achieving their objectives (with the exception of pilots targeting minority ethnic groups where progress was slow). Key findings included:

- Half of the PMS sites reported improved access to healthcare (through a variety of methods including open access, outreach and community work);
- Flexibility and the ability to work holistically were key to nurses' success working with vulnerable clients;
- There was a high level of user satisfaction;
- Homeless people's use of PMS pilots was characterised by a paternalistic relationship between professionals and homeless people rather than as 'consumers' of health.

The research (PMS National Evaluation Team, 2002) concluded that PMS pilots had managed a shift from a predominantly medical model of health care treatment towards a social holistic model. This approach was seen as facilitating an improvement in access for groups such as homeless people and a first step towards addressing inequalities in health.

Early developments in primary health care in Edinburgh were documented by Maclean and Naumann (1979). A three year experimental service, the Edinburgh Primary Health Care Scheme for Single Homeless Hostel Dwellers, provided a 'house-doctor' and nursing service for homeless people, with an early evaluation describing the success of the scheme, despite some deficiencies. A fuller evaluation of the service a decade on (Powell, 1988) revealed that the development of a primary health care team working from a central surgery was proving more acceptable to both providers and recipients than the original 'house doctor' scheme. However, the

original service had succeeded in reducing the number of inappropriate use of A&E facilities by homeless people (Powell, 1987).

Williams (1995) provided a review of 35 English comprehensive primary care projects for homeless people funded by Department of Health Section 56 monies. Whilst the review relied on practitioner' views of achievements, the study identified a number of key elements of primary care provision that appeared to represent good practice in this area, including:

- clear management arrangements, lines of communication or sufficiently senior staff in post;
- services should be flexible and provided on an outreach basis to meet needs, with outreach sessions held at times that fit in with user' lifestyles;
- the service needs to establish a non-threatening and non-judgemental environment;
- good networks need to be established in the community with local GPs and with statutory and voluntary agencies involved in providing health care, housing and social care services;
- wherever possible, services should be integrated for maximum effectiveness (eg one stop shops);
- discharge arrangements from hospital should be established;
- user involvement in service delivery should be maximised;
- services should reach all sections of the homeless population, including homeless women, minority ethnic groups, refugees and so on, who are sometimes not well-represented in scheme use.

Wright (2003) highlighted the importance of good practice organisation in primary health care services for homeless people both for improved patient care and the reduction of stress in amongst clinicians. Clear job roles for team members is crucial, as is the prioritisation of team working. The use of information technology is also highlighted to aid the smooth running of the practice and assist in patient continuity of care. This view was supported by focus group respondents who stressed the need for a common assessment and filing system but discussed the difficulties in record keeping as GP files have to be part of a national system (nursing and other services can contribute to a generic file). Computer systems capable of talking to each other across service sector was also felt to be crucial if integrated services were to be achieved.

The importance of an outreach facility as part of a comprehensive primary health care response was also stressed by the focus group interviewees. One respondent was disappointed that a fixed site service could not presently offer this outreach facility:

I cannot understand why it's a visit only service, the homeless practice will not come out to a hostel if somebody is really sick or ill, that person has to walk to the service or find their way via Accident & Emergency having sat for goodness knows how long.... But there's just no provision for the homeless, to visit homeless people in their accommodation...we've seen cases where, in fact we had a case not long ago, where a man with a gangrenous foot had to walk along every morning to get it dressed, now that cannot be right. (Homelessness agency)

UK studies of primary care services have not tended to evaluate the potentially different levels of satisfaction with services for different groups. US literature draws attention to the need to ensure that primary care services for homeless people are inclusive. For example, a retrospective review of 1,467 records from clients seen between 1991 and 1994 in a specialist health clinic (Macnee and Forrest, 1997) found that women, people from BME groups, and those living in some type of shelter were less likely to re-use the clinic. Another study highlighted the potential value of complementary and alternative medicine (CAM) (Breuner et al, 1998) for young people. A clinic for young homeless people in Seattle, USA offered CAM and found that it was frequently used and accepted by homeless young people, concluding that the integration of CAM into health centres might entice youth into mainstream health care.

Nursing, facilitator services

A number of nurse-led, outreach services have been documented in the literature, although not all services have been fully evaluated.

Hinton (1994) evaluated a model of service delivery that used community nurses, working in hostels and day centres, to link homeless people with mainstream primary health care services in Hammersmith and Fulham, London. The service was found to be positively valued by both homeless people and service providers, particularly the holistic approach offered by the nurses. A number of issues were however raised, including the difficulties in dealing with on-going health needs of users outside clinic hours, and the need for specialist mental health service input and counselling services more broadly. Misunderstandings also occurred amongst homelessness services about the nurses' role, indicating the need for clearer information and accountability procedures.

More recently, the Healthcare for the Homeless Service (2001a) conducted an in-house evaluation of a six-month outreach project that involved attaching a nurse to an established outreach and resettlement team. The service's remit included both streetwork and visiting clients in resettlement accommodation. The project successfully reached out to some homeless people who were seldom in contact with any services including existing health care services for homeless people. Working alongside a project worker appeared to foster a trusting relationship, allowing early identification of healthcare needs. The service found that clients seen in resettlement accommodation still required intensive support. Continuity of care when people are rehoused was also stressed by study interviewees:

I think the positive side of that as well is when people do obtain a tenancy, we support them with that transition period as well, we don't sort of go "Oh well, you've got a house, the door's closed" it's, we support and make sure they access it.. So they're sort of supported during that period as well. (Health professional)

A description of an in-house community nursing team for homeless people in Aberdeen (NHS Grampian, 2001) documents delivery of services in a number of locations and the importance of extending services to homeless families. Similarly, an advanced nurse practitioner service using outreach work to help bring people

sleeping rough into contact with a local drop-in services in Lanarkshire has also been described (though not evaluated) in the literature (Armstrong, 2001).

A couple of small studies have also reported on the advantages and disadvantages of mobile clinics. A three month pilot nurse-run mobile clinic for homeless people in Manchester attempted to assess health needs, provide initial treatment and assist with access to mainstream services (Gaze, 1997). This model, however, was not particularly successful as the nurse could not prescribe medications and the service was not coordinated with drug and alcohol services. As a result a GP surgery was set up in the Manchester Big Issue offices to provide daily access to a GP, which was reported to be more satisfactory (McIntosh, 1999). Other studies (eg Hault, 2000) have also noted a problem where nursing services are not able to prescribe for all homeless patients. Ramsden et al (1989) reported on a more successful mobile surgery model delivering primary health care to two sites where people sleep rough in central London. Over one third of the users from one site attended a drop in surgery for homeless people within a month of visiting the mobile surgery, suggesting that a mobile facility may provide a first step in assisting people to engage with health provision.

The predominant model of health care provision for homeless families has been the health visitor role. For example, Lee and Goodburn (1993) describes a health visiting service offered to homeless families in Camden, North London where the basic function is to facilitate access to mainstream services, as well offering a range of other services such as a strategy for breast feeding, child safety advice and provision of information packs in several languages. For this type of service, inter-agency working was crucial to enable a coordinated and integrated level of service to be achieved. The study concluded that the advocacy role of health visitors is often the most effective means of improving the lives of homeless families. Some models offer greater levels of direct health care (Parsons, 1997), for example, a combination of specialised health visitors, advising on healthy living, a nursing auxiliary and a 'health mobile' (caravan) has been used in North London to encourage hesitant BME families to engage with services, employing a Bengali speaking health advocate and woman doctor.

Overall principles for primary care health service delivery for homeless people

Successful specialist primary care services for homeless people need to offer a high quality, flexible, tolerant and individually tailored responses to medical need (El Kabir, 1996). This usually means an open access system, although some services find that a combination of open access and appointments can also be effective:

What I've found most successful is instead of making an appointment, which is never successful working with homeless, is that they know I'm accessible at any time, and they'll just stop me when I'm passing and speak to me on a hear and now basis, I've had more success with that than anything else..... A consistent service that is so totally flexible and available, with very little time structure....(Health professional)

One of the difficulties we were identifying with open access is that, obviously there is a queue forms outside and you're taking names, there can be intimidation in the queue, with people who are perhaps particularly vulnerable who were perhaps at the front of the queue may be kicked to the back of the

queue and may not be seen, so we can be sensitive and we can actually give people appointments.... Another reason for introducing the appointment slot is to help people get used to that transition to mainstream services. (Health professional)

With both comprehensive and primarily nurse-led primary health care services, the relationship between the health professional and homeless person appears to be key to the successful delivery of healthcare. A socially orientated approach to healthcare is needed that allows a conversation between the homeless people and the health professional that extends further than a focus on medical problems.

....being able to develop a relationship, a professional relationship that gives them unconditional respect, you know that they let you down yesterday but you're still here for them today. And it doesn't happen overnight, its maybe 2, 3, 4 meetings before the actual stories start to appear. (Healthcare professional)

Effective joint working and, where possible, full integration of health services with social services and housing is also of paramount importance:

Of course the big bonus is the integration of health, housing and social work, that really does make a huge difference, I mean if you go to national conferences and people are talking about the way they would like to develop things and you say 'well we do that'... (Healthcare professional)

I think its also important we're sort of not precious with our clients and don't work in isolation and think how our team can do it all, we do a lot of collaborative work and a lot of networking... its a very open system that we've got "Just phone us any time that you've got any query" and just give that support in that way so that they know they're doing the right thing or whether they need another appropriate intervention, but we do do a lot of networking and sort of inter-agency working. (Healthcare professional)

3.3.2 Professions Allied to Medicine (PAMs)

Dental services

A number of pilot dental services for homeless people have been reviewed within the UK literature (Cembrowicz and Farrell, 1992; Kippen and Pollock, 1998; Waplington et al, 2000; Healthcare for the Homeless Service, 2001b), all suggesting that specialist dental services are generally well-received by homeless people and also lead to improvements in dental health, at least in the short term.

An early feasibility study (Cembrowicz and Farrell, 1992) on the delivery of dental services within a hostel environment in Bristol concluded that it was practicable to deliver a service with minimal facilities (in this case, a waiting room chair and a bicycle lamp in a small room in the hostel). The service successfully reached patients with significant pathology and difficulties with access to conventional services. Twelve patients needed some dentures which were provided at the hostel (all twelve completed this treatment). The service also successfully facilitated users to access mainstream dental care via referral and the hostel providing minibus transport for further treatment at main dental surgery.

Kippen and Pollock (1998) reviewed a community dental service at a drop-in centre for homeless men and women in Glasgow. Dental examination and treatment were provided from a mobile dental unit parked on the street outside the drop-in centre. The study concluded that despite chaotic lifestyles that made it difficult for people to obtain regular dental treatment, when the service was taken to them it was well received. Three fifths (61%) of those seen returned for subsequent visits. The City Mission staff reported that the relief of pain and improved appearance helped to restore confidence and self-respect for their clients who made use of the dental service.

Waplinton et al (2000) reported on a pilot whereby the local Community Dental Service had provided a dental service to homeless people 1.5 miles away from a hostel in Birmingham. They found that patients needed immediate appointments if they were to use services, and some refused to visit the clinic. As a result, portable dental equipment is now being piloted at the hostel. Using a behaviour rating index, the authors suggested that many residents needed reassurance before even simple treatment was given, requiring that dentist staff possessed special patient management skills.

Finally, in Perth, the Healthcare for the Homeless Service (2001) reported on a scheme providing free dental health packs to homeless children, pregnant women and young people as well as rough sleepers. This was part of a wider initiative, including a pilot mobile dental outreach service and also open access to Community Dental Service based in the local health centre (the outreach service is currently being evaluated). Baseline information showed very poor dental health care and low levels of registration (eg 17% of homeless children). Over 500 packs distributed with agencies being made more aware of options for clients.

Opticians for homeless people

No studies were found in the review that evaluated opticians or associated services for homeless people.

Physiotherapy for homeless people

Only one study was found that addressed physiotherapy for homeless people. Dawes et al (2002; 2003, forthcoming) describes the development of a unique dedicated physiotherapist service for homeless people in Glasgow. The pilot service employed a half-time physiotherapist (split between two staff) and provided services in three weekly self-referral drop-in centres. A domiciliary service was also provided for those unable or unwilling to attend clinics, with referrals from health or social care workers. An evaluation of the service that included interviews with homeless people and health and social care workers reported a very positive response to the service. The service was found to be easy to access, the delivery was very acceptable to users and the treatment appeared to help symptoms. However there were difficulties in providing continuity of care - many patients were only seen once making it difficult to deliver a course of treatment. The inclusiveness of the service was also questioned as most of the 206 new patients were male, with access for homeless women now being examined. From October 2002, funding was awarded for 1.5 WTE and a generic assistant, as part of the development towards a Primary Medical Service (PMS) for homeless people in Glasgow.

Podiatry (chiroprody)

Podiatry is often delivered alongside nurse and GP primary health care services for homeless people. However, no specific evaluations of these services were found in the literature.

3.4 Specialist mental health and substance abuse services

This section reviews the literature on specialist mental health services, substance misuse services and services for people with multiple needs.

3.4.1 Specialist mental health services

The main type of model that has developed to provide specialist mental health services to homeless people has been assertive outreach (Timms and Borrell, 2001). This model usually relies on specialist workers attempting to engage with homeless people on the street, or in hostels or day centres. The most well known model is the work of specialist teams set up under the Homeless Mentally Ill Initiative (HMII) in 1990 in London. However, mental health outreach workers may also be employed as part of a comprehensive, specialist primary health care response to homelessness.

Much has been written about the extent and nature of mental health problems in the homeless population. However, with the exception of the HMII, most of the evidence on the efficacy of services intervention models derive from US literature.

Specialist services for people sleeping rough/ lone homeless people

Five specialist mental health teams were set up in London under the HMII, with two main evaluations being conducted on the service (Craig et al, 1995; Croft-White, 1998). The model involved potential clients being contacted, assessed, followed by direct treatment involving assistance with basic shelter and benefits prior to more intensive therapeutic and housing interventions. The ultimate aim was to reintegrate homeless people into mainstream services. The first evaluation (Craig et al, 1995) collected information on 2,175 people referred to the teams, and tracked 574; after twelve months, they found that a quarter of clients were still complying with treatment, and more than half of cases had been successfully closed with arrangements for continuing care in place. However there was a shortage of move-on accommodation and resettlement support was difficult for those with high support needs. The service also largely neglected the needs of young people, women and those from ethnic minority services. Croft-White (1998) noted a lack of coordination between the various teams but confirmed that resource-intensive, multi-disciplinary teams had successfully been established.

A specialist service designed to meet the need of homeless people with mental health problems has been set up and evaluated in Aberdeen (Wood et al, 1999; Sclare, 2003). A dedicated CPN was employed to identify and engage with homeless people with serious and enduring mental health problems. Over time it was found that appropriate referrals diminished to the point that the original scope of the service was no longer viable. However, there was continued demand for both counselling and for support with substance misuse, though these did not meet the original referral criteria. This experience suggests the need for flexibility in the delivery of specialist services and a willingness to adapt to changing needs.

The US literature provides a large evidence base that demonstrates the effectiveness of assertive community treatment models for homeless people. For example, Lam and Rosenheck (1999) showed that clients contacted through street outreach showed improvement on nearly all outcome measures after three months, equivalent to those clients contacted in shelters and other service agencies, despite the former being more severely impaired and less motivated to seek treatment. Wolff et al (1997) also found that assertive community treatment was more effective than brokered case management (purchase of services) for people with mental illness who were homeless or at risk for homelessness. A couple of studies also demonstrated that assertive community treatment was more cost-effective compared to traditional services (Lehmann et al, 1999; Wolff et al, 1997).

Service models characterised by greater flexibility, responsiveness to clients' needs, and service user involvement were reported as more effective than more traditional, rigid models of psychiatric rehabilitation. For example, the Choices programme in New York (Shern et al, 2000) offering a flexible and tolerant service was more effective when compared with standard services in terms of gaining engagement and service use. Fisk and Frey (2002) described a scheme which employed two part-time formerly homeless persons on a community-based mental health outreach team to participate in social activities with "difficult to engage" homeless individuals, suggesting that this model can be an important tool to decrease social isolation and engage people into mental health treatment and independent housing.

One study (Tsemberis, 1999) suggested that assertive community treatment programmes that provide immediate access to permanent rehousing may be more effective, compared to those providing step-by-step placements to more independent living (84% housing-retention was achieved over a three year period, compared to 60% over a two year period).

3.4.2 Services for people with personality disorders

One ethical dilemma associated with mental health outreach work involves the offering of a service to someone who has not asked for assistance, the 'risk of stigmatising people by attributing pathology where none exists', and ultimately the medicalisation of homelessness (Timms and Borrell, 2001). Conversely, it is also possible that specialist services may assist those who otherwise have a low priority within mainstream services. A recent study in Edinburgh (Burley *et al*, 2002) found that homeless people with personality disorders rarely receive a diagnosis and have erratic service use histories, with more care contacts in different care locations than other homeless people with mental health problems. The eight month project provided a basic assessment and treatment model, involving a clinical and assistant psychologist, based at both the local NHS Trust and the main specialist health care team for homeless people in Edinburgh, The Access Point. The model was highly valued by other professionals, with referrers suggesting longer term treatments to improve the pilot service. The service was not fully evaluated but provided an interesting model worthy of further investigation.

3.4.3 Support following discharge from psychiatric facilities

Some studies have suggested homeless people face problematic discharge arrangements following a stay in a psychiatric unit (Taylor et al, 1992; Koffman and Fulop, 1999; Lowens, 2000). A three year specialist service, Connections, aimed to

improve support and access to housing for those at risk of homelessness on discharge in Lanarkshire (Scottish Development Centre for Mental Health, 2002). The service involved two practitioner posts who provided a person centred, assessment and care management approach to 58 clients. The study demonstrated a demand for such a service, with agencies very supportive of the approach and hoping for the continuation of a dedicated service. A number of proposals resulted from the study, including the need to refocus referrals on both those in hospital and the community, and the establishment of liaison posts within each housing office to help address the poor housing being offered to users. The study also concluded that some of the Connections features could be replicated within mainstream services such as better joint working with housing staff, and housing being made part of the community mental health team remit.

3.4.4 Specialist services for homeless women and children

The majority of specialist mental health services have been set up for people sleeping rough and/or other single homeless populations. However, one particularly robust study has been undertaken on a mental health outreach service that was established for homeless children and families in Birmingham (Tischler et al, 2002). The hostel-based service was delivered by a clinical nurse specialist with expertise in child mental health, who offered assessment and brief treatment of mental health disorders in children; liaison with agencies; and training of homeless centre staff. Comparing 27 children in 23 families who used the service, with those in other hostels where no such service was available, found that children in the experimental group showed improved mental health (measured on a reputable Strengths and Difficulties Questionnaire (SDQ)). Although there was no significant impact on parental mental health (measured by the General Health Questionnaire), homeless families and staff expressed high satisfaction with the service. Whilst the primary aim of the service was to improve child mental health problems, the service also met the social and practical needs of families.

3.4.5 Specialist services for young people

Whilst there is a large literature that identifies the poor mental health of homeless young people, there have been relatively few evaluations of targeted initiatives. A couple of reports have however highlighted the need for more service development in this area. Watson (1999), provided information on three projects (London Connection; Pele Tower Project, Newcastle; St Basils, Birmingham) designed to develop or improve mental health services for young people, but concluded that there was a lack of specialist accommodation and services for this group, and called for a more strategic approach providing diverse models of provision. An early study, also conducted at St. Basils, Birmingham (Commander et al, 1998) noted that both young people and service providers expressed a preference for improved access to mainstream youth services and improved support within hostels, rather than increased provision of mental health specific accommodation.

3.4.6 Specialist services for BME groups

Although some US literature has indicated poorer outcomes for people from BME groups compared to white users of services for homeless people with severe mental health problems (Ortega and Rosenheck, 2002), there is a lack of literature on the effectiveness of specialist mental health services for BME groups in the UK.

3.4.7 *Substance misuse services*

A number of studies examined services for homeless people with alcohol problems in the 1990s (eg Morrish, 1993), but until recently there were no studies on specialist drug misuse services. It has been generally accepted that access to drug services, including detoxification, is poor throughout the UK, particularly for homeless people (see Chapter Two). This situation was confirmed by the professionals interviewed in Scotland for this study. Recently responsibility for planning and commissioning services for all people, including hard to reach groups, has been given to the newly formed Drug (and Alcohol) Action Teams (DATs).

3.4.8 *Good practice guides*

Evaluations of substance misuse services for homeless people are rare (see below), however two key good practice handbooks have been produced (Kennedy et al, 2001; Randall and Drugscope, 2003). Whilst these guides are not based on a comprehensive evidence base, they represent important sources of expert opinion, drawing on existing practice and providing examples of services that represent good practice.

Randall and Drugscope (2003) identify both improvements needed to mainstream services to enable homeless people to successfully access and utilise treatment, as well as good practice in services targeted specifically at homeless people. For example, the guide recommends that DATs should:

- consider priority treatment for homeless people;
- have effective links with homelessness services, and housing providers;
- where possible operate an open door policy;
- provide a flexible service that allows for relapse;
- ensure that other support needs of homeless people are met, including psychological needs.

Specialist services for homeless people may be required alongside better access to mainstream services, for example:

- street outreach and day centre services, particularly focussed on harm reduction programmes and resettlement options;
- hostel based services that may also include specialist units, including detoxification and rehabilitation.

Kennedy et al (2001) identified a number of strengths of existing provision including: flexibility in approaches; well-trained staff; and the provision of holistic services providing practical, social and emotional support. However, a number of gaps in provision were also identified including;

- shortage of services willing to work with those not ready to address their drug use;
- limited services for those under the age of 16 or over 25;
- lack of services for those using crack and recreational drugs;
- lack of tenancy sustainment support;
- lack of accommodation for women with children;

- lack of services for those with multiple needs;
- lack of daytime, employment and leisure opportunities
- lack of services in rural areas.

Specialist substance misuse teams/ workers

The limited literature that exists suggests that outreach-based substance misuse services offer an effective way of reaching homeless people and offering successful treatment programmes, particularly for drug use.

Drugscope (2002) evaluated 23 alcohol and drug treatment services for people sleeping rough that were funded by the Homelessness Action Programme, under the Rough Sleeper's Unit. The services included multi-disciplinary teams that offered packages of integrated assistance with substance misuse and resettlement support. Whilst the success of projects was variable, overall targeted support was found to offer significant benefits to people sleeping rough in terms of reduced drug use as well as wider improvements in health and quality of life. The majority of those using the services (90%) reduced their drug use, with nearly half of users giving up their present drug use. This included dependency on hard drugs such as heroin; the programme achieved a reduction in injecting heroin users from 88% to 10%. Projects that demonstrated success tended to already be working with the user group, and have good pre-existing joint working arrangements. In addition, they were able to offer an integrated approach that included a focus on housing stability and other health problems, as well as offering a broad programme of treatment options including harm reduction and detoxification and rehabilitation. However, whilst successes with drug treatment were considerable, this was not achieved for those dependent on alcohol with the overall number of alcohol users increasing during the treatment periods.

An assertive outreach model has recently been evaluated in Edinburgh (Langley et al, 2002). For a fifteen month period, two CPNs (one for alcohol and one for drugs) and an Occupational Therapist provided interventions in clients 'home' environments for alcohol misuse and assessment and 'fast-track' referral to the Community Drug Problems Services and/ or Harm Reduction Team. Treatments included relapse prevention, motivational interviewing, supportive counselling, health education, life skills and access to detoxification services. Outcomes included referrals to methadone programmes, alcohol problems services, work training programmes, adult education, counselling services, social work etc. High levels of satisfaction were found with the service, with links to other service providers being key to effectiveness. Twenty four homeless people returned a questionnaire with 88% feeling that the service had helped them to address alcohol/ drug problems. A small number of qualitative interviews also suggested that the service had helped develop their confidence and decision-making ability. Interviews with professionals for this study confirmed that a particular value of a specialist service of this nature was that clients could be fast-tracked into service without the need to be referred by a GP.

US literature also points to the success of outreach models. Tommasello et al (1999) compared the characteristics of outreach recipients of a program of substance abuse treatment to walk-in clinic users in Maryland. The service successfully located homeless people with significantly higher levels of substance abuse than walk-in clients. Two fifths (42%) subsequently became service treatment recipients. The

authors concluded that outreach could be a successful method of targeting and engaging a segment of homeless substance abusers who were otherwise difficult to engage in treatment.

Residentially based services

Randall and Drugscope (2003) provide examples of how residentially based systems need to offer flexible programmes of treatment. This is supported by the US literature that suggests that many existing residential models of substance abuse treatment are not particularly effective for homeless people because of the strict regimes used. One review (Orwin et al, 1999) of fifteen detoxification services found that because providers were unwilling to compromise on the inflexible rule-laden approach, with high motivation being expected, services achieved completion rates of no more than a third of homeless clients (and sometimes as low as 2%). The services offering the most flexibility were most popular, and those offering accommodation retained more users, but it was not proven that these were more effective. The authors concluded that services needed to be quicker, more responsive and orientated to the needs of users. Devine et al (1995) evaluated a residential drug/ alcohol treatment programme specifically for homeless people, and whilst finding that effects were in the expected direction, particularly for those remaining in treatment for more than a few months, they were rarely significant.

The literature however suggests that hostel-based therapeutic community (TC) treatments can be successful in the *short-term*. Liberty et al (1998) evaluated the Dynamic Recovery Project situated within pre-existing homeless shelters and found dramatic decreases in drug and alcohol use at follow-up, with length of time in treatment accounting for decreased alcohol and drug use. One hostel trained peer counsellors and staff to try and reduce drop-out but this had no significant effect on outcomes. However, there were no significant differences between TCs and the comparison group on post-treatment drug use, criminality, or depression.

The Housing Support Project, part of Coventry and Warwickshire Substance Misuse Initiatives, offered dedicated tenancies to drug users with housing problems, conditional on the involvement of a support worker to help them address substance misuse and related offending problems (Sandham, 1998). The evaluation found that, despite some evictions, that there was a significant move to use of less serious, and legal, drugs by tenants, a reduction of money being spent on drugs (average of £235 a week to £54), and associated health gains. Whilst evidence on re-offending was not clear, this housing-based project appeared to offer some success in addressing serious drug use.

Services for young people

Fors and Jarvis (1995) reported on an evaluation of a US Drug Prevention in Youth risk reduction program in shelters for runaway/homeless youths, that compared peer-led, adult-led and non-intervention groups. The study found that peer-led groups were the most successful intervention, particularly for the youngest group of shelter clients. It was concluded that mentoring by well-trained and motivated peer/near peer leaders have particularly valuable contributions to make with regard to drug abuse risk reduction for shelter clients.

Services addressing multiple needs

Evaluations of services addressing multiple needs, most commonly mental health and substance use (formerly referred to as 'dual diagnosis' services), in the UK are rare; most relevant studies are from the US with few successful models documented.

Recently Wright et al (2003) have suggested that the trend towards specialisation in secondary care has disadvantaged people with multiple needs, arguing for a more coherent approach within policy and practice. One interviewee considered that an institutionalised 'mono- problem' culture within the health service was a real issue in terms of developing services for people with multiple needs, whilst a couple of people warned against a situation where people potentially ended up with too many workers in their lives:

...because of the isolated or specialist nature of the services provided what I will do in practice is that I will go to the service that will deal with the problem that I think is my most serious problem at the moment, namely my broken arm, and I will turn up at A&E who will set the bones, put a plaster on it, and discharge me, the fact that I have a serious alcohol problem, no home, no job and the fact that I've just been thrown out of the house by my partner, is not addressed.... what we've got is structural isolation of services and problems, where the reality is that many of these people have multiple problems, and they as I say require multiple and long term solutions. (Health professional)

..it just becomes so big, suddenly people have got five or six health care workers in their lives now and before they had none, do you know what I mean, so you have to keep an eye on it in terms of, you know, how specialists are becoming. (Health provider)

O'Leary (1997) examined how services for homeless people with multiple needs could be improved. It suggested that many people with multiple needs required specialist accommodation on a long term, and often permanent, basis. It also stressed that homeless people with combined mental health and dependency problems required innovative services, which were geared towards harm reduction rather than traditional resettlement and rehabilitation.

The US literature raises many similar questions to the evidence available on substance abuse services more generally. One US study (Burnam et al, 1995) compared the effectiveness of a hostel based programme for homeless people with multiple needs, to a floating support service. Interventions were designed to provide three months of intensive detoxification, psychiatric and AA12 step approach treatment, and three months of nonresidential maintenance. The study suggested that hostel-based treatment had positive effects on outcomes at three months, but that these effects were eroded by six months, and that clients' progress differed little from control subjects suggesting that the services were largely ineffective. Take-up of rule-based models of assistance was also low. Despite the integrated approach to substance misuse and mental health, the authors concluded that the intervention lacked a fully holistic approach to addressing issues of poverty and housing.

Another study (Clark and Rich, 2003) however did suggest that residentially based services led to better outcomes for persons with high psychiatric symptom severity

and high substance, when compared to case management alone. However, persons with low and medium symptom severity and low levels of alcohol and drug use did just as well with case management alone, suggesting that homeless people with mental health problems cannot be treated as a homogeneous group.

Access to, and completion rates of, specialist services was also identified as an issue in the literature. Rahav et al (1997), in a large study of 1,924 homeless men with multiple needs in New York found very low take up rates among potential service users (only 326 people entered treatment) and very low completion rates among those entering detoxification programmes. This study explained much of this failure on homeless people's challenging behaviour and lack of engagement.

Gonzalez and Rosenheck (2002) compared baseline characteristics and clinical improvement after twelve months among homeless people with mental health problems and with and without a co-morbid substance use disorder, for 5,432 homeless persons participating in the Centre for Mental Health Services' Access to Community Care and Effective Services and Supports (ACCESS) programme. The study found that homeless people with dual diagnoses had poorer adjustment on most baseline measures and experienced significantly less clinical improvement than those without dual diagnoses. However, those with dual diagnoses who received 'extensive' substance abuse treatment showed improvement similar to those without dual diagnoses at twelve months (with those attending self-help groups for alcohol management having the best outcomes).

Integrated approaches offered some success. Drake et al (1997) examined the effects of integrating mental health, substance abuse, and housing interventions for homeless persons with co-occurring severe mental illness and substance use disorder. Integrated treatment was compared with standard treatment for 217 homeless, dually diagnosed adults over an 18-month period. The study found that the integrated treatment group had fewer institutional days and more days in stable housing, made more progress toward recovery from substance abuse, and showed greater improvement of alcohol use disorders than the standard treatment group.

3.5 Health promotion

The World Health Organisation (WHO) has defined health promotion as a process of enabling individuals and communities to increase control over the determinants of health, thereby improving their health. It is only since the later 1990s that health promotion has been discussed with respect to homeless people, and most publications in this area are recent. There are a number of generally accepted models of health promotion (Power et al, 1999a):

- educational (eg peer education);
- behaviour change (eg substance misuse programmes);
- client-centred (eg. community-led initiatives);
- medical (eg screening);
- social change (eg anti-smoking campaigns).

Whilst health promotion initiatives may incorporate a number of these approaches, most developments for homeless people have been characterised by an educational

(eg peer education, healthy eating initiatives, sexual health) or medical focus (eg screening).

Recently, Crisis and Health Action for Homeless People (Hinton et al, 2002) produced a guide to promoting health amongst homeless people in hostels. A number of key good practice lessons emerged from the research including: the acceptance that much health promotion can require long-term work, effectiveness depends on developing a positive relationship with individuals, learning needs to be appropriate to people's needs and that users should be involved in the planning process. A number of areas were also identified that required health promotion interventions including: diet and nutrition; personal hygiene; exercise; alcohol and drugs; smoking; sexual health; women's health, and positive mental health.

Peer education

The use of peer education to reduce drug-related harm has been investigated in an action research programme with vendors of the Big Issue in England (Hunter and Power, 2002). A one-off training session was run in Brighton and the West Midlands with 15 vendors. Vendors were then asked to pass on information about drug use in the course of their daily activities. Interviews with vendors six weeks later found that some information had been passed on but people were vague about the specifics of the advice. The study suggested that the impact of such one-off training was short-term, pointing to the need for longer term interventions and support. Importantly, it was also found that health promotion advice sometimes differed between the NHS trainer and homeless people (for example, what to do in the case of an overdose), pointing to the need for greater user involvement in the design of such training.

Healthy eating education

Some small-scale initiatives have focussed on promoting health eating. For example, the Healthcare for the Homeless Service in Perth, developed healthy eating starter packs for families and young people in hostel and refuge accommodation (Healthcare for the Homeless Service, 2001b). Over a six month period, a project worker (working 8 hours a week) provided a pack of healthy food valued at £20, along with healthy eating information, to nearly 100 households. An in-house evaluation noted a high uptake for the initiative, with the vast majority of homeless people finding the initiative helpful, whilst about a third of participants trying new foods. Similarly, the same organisation developed a healthy eating, 'Big Breakfast' initiative where 10 young homeless people living in a hostel were supported in shopping for and cooking a free, nutritional breakfast over 4 months (Healthcare for the Homeless Service, 2001b). Some young people commented how they felt better and less hungry, however although some planned to continue with cooking breakfast, others felt that the expense prevented them from doing so.

Some interviewees for this study also stressed the value of healthy eating initiatives, and thinking about food as one tool for tackling homelessness. For example, the initiative Fairshare has developed in England and Scotland to distribute surplus fresh food from food retailer to homelessness projects, also delivering nutritional and cooking programmes and involving users in the projects. Whilst the project has not been formally evaluated, a representative commented:

The whole project is run by a team of about sixty volunteers of which fifty percent or more have been homeless or are still homeless and still have problems with alcohol, drugs or mental health or other issues of low self-esteem or lack of confidence. So the very fact that we can use these people and allow them to run the service, gives them tremendous support and a focus and a feeling of value, they become, the helper has to help the helped and it's great to see that the common sense project of collecting food which was going to waste and giving it to homeless people who so badly need it can actually be achieved through homeless people themselves. (Homelessness provider)

Sexual health and HIV/ AIDS

Some early work focussed on health promotion with respect to HIV/ AIDs for young homeless people (Aggleton and Warwick, 1992), leading to a resource work-book to support the development of HIV and AIDS education with this client group (Warwick and Whitty, 1995). The publications report examples of projects that have adopted such approaches, but no formal evaluations are available in this area. However, a number of potentially important points are made including highlighting the need for multi-faceted interventions as experience suggests that focussed work on risk reduction can only occur if a range of other needs are met (Duncan (1992), Daniels (1992) and Tomlinson (1992) in Aggleton and Warwick). Tomlinson reporting on work with street-based men who have sex with men explained:

No matter how good our communication skills, no matter how relevant the safer-sex material, no matter how available are condoms and lubricant, the immediate and pressing need to feed and clothe oneself outweighs the potential threat of infection. The fundamental problems of homelessness, having no regular source of income, food, clothing and shelter, must be addressed before homeless young people can take responsibility for their health.

Similarly, American research (Gelberg et al, 2002) has identified substantial deterrents to homeless women using appropriate contraception, particularly Black women and drug users, and the need for reproductive health services that are both integrated with other provision and culturally competent.

Screening programmes

A number of evaluations have been undertaken on screening for Tuberculosis (TB) in England (Stevens et al, 1992; Citron et al, 1995; Southern et al, 1999), producing some contradictory evidence. In the early 1990s, a prospective experimental screening exercise was undertaken with 547 people in eight London hostels, where single homeless people were encouraged to attend chest X-ray and active follow-up. This study did not identify any new cases of active TB and it was concluded that mass miniature X-ray screening of the single homeless (hostel residents) was not a cost-effective means of controlling pulmonary tuberculosis (Stevens et al, 1992). However, in the late 1990s, an observational study in London hostels and day centres for homeless people, found that 0.5% were identified as having active pulmonary TB, most of these by chest X-ray, concluding that targeted chest X-ray screening was a useful screening method, with incentives important for take-up and case management for good compliance with treatment (Southern et al, 1999). Similarly an earlier study (Citron et al, 1995) had found that X-ray screening was of

value in London, but only where it was accompanied by education and targeted incentive to encourage participation in treatment; otherwise compliance with treatment was very poor.

A European study in Barcelona (Diez et al, 1996) and two USA studies in San Francisco (Pilote et al, 1996; Lorvick et al, 1999) provided further evidence of the importance of effective follow-on interventions to secure compliance with TB treatment. Diez et al found that a social care and health programme providing treatment and accommodation was successful in enabling 80% of homeless patients to complete their treatment. Lorvick et al reported that a community-based directly observed preventative therapy project for street dwelling drug users succeeded in a 96% treatment completion rate over a 6 month period by twice-weekly contact at a community office with a \$10 cash incentive at each visit. An earlier study by Pilote et al, using a randomised control trial of those using attending TB treatment with a monetary incentive (\$5), being allocated a peer advisor, and a control group receiving neither intervention found that a monetary incentive was most successful in ensuring adherence to a TB clinic appointment (84% attended), followed by a peer advisor (75% attended) and then no intervention (53%).

Smoking

Amos et al (1999) reports on two initiatives that appeared to provide a valued approach to addressing smoking issues among women who had experienced homelessness. Ayr Barnardo's Homelessness Service aimed to provide a programme of sessions which allowed women to try new activities and reflect on their attitudes to smoking and personal choices. The group was well-supported and a number of women cut back on their smoking (one or two giving up) as a result of this user-led and controlled initiative. Dundee Women's Aid ran a smoking support group which developed a smoking policy and supportive materials for their refugees.

3.6 Mainstream NHS developments

The evidence base on the effectiveness of relatively new mainstream NHS developments, particularly with respect to the potential benefits for homeless people, is sketchy. In the case of the newer types of service delivery, such as NHS Walk-in Centres in England, the services have become operational so recently that research to date necessarily only describes the early operation of services and potentially not their final operational form.

Healthy Living Centres and similar models

Healthy Living Centres attempt to bring a more holistic approach towards health to more marginalised sections of society. They have tended to be sited in deprived neighbourhoods, concentrating on health promotion as well as more traditional primary health care. In 2001, a healthy living centre was set up in West London specifically for homeless people as part of the Broadway project (also incorporating a day centre and the West London CAT team). As well as providing a district nurse, podiatrist and optician, alternative treatments are available such as shiatsu or reiki. The work of the centre has been described in the Crisis publication *Outcry* (Evans, 2002) but no evaluation material is available.

Health and homelessness representatives interviewed for this study felt that there were a number of wider health models that could usefully be considered for homeless people. Respondents described healthy living centres and other specialist projects that had been developed for young people, like the Rock Trust in Edinburgh, that placed a focus on overall well-being and offered a comprehensive programme of services including advice services, activity-based services (eg football teams), specialist group-work (eg young women's groups), health promotion initiatives such as healthy eating and smoking cessation groups as well as primary health services, counselling and so on (Rock Trust, 2002). This holistic approach was felt to maximise user engagement and lead to sustainable improvements in health outcomes.

NHS Walk-in Centres

NHS Walk-in centres were announced in April 1999 as an initiative to promote general access to health care in England (they have not been extended to Scotland). There are approximately 40 centres across England, and they tend to be located in medium-large towns and cities. Patients can access nurse-led practices for non-urgent ailments (and in some cases, GPs as well) from early in the morning to about 10pm at night on an open access basis. In theory, such centres could potentially offer a flexible, non-appointment led service to homeless people and other groups with particular needs such as refugees.

The review did not retrieve any studies examining the use of Walk-in Centres by homeless people. The main evaluation of the programme (Salisbury et al, 2002), however, has suggested that overall users have tended to come from slightly more affluent members of the local population. The evaluation found that almost all users were registered with a GP, were more likely to be educated post-18 and owner occupiers and less likely to come from minority ethnic groups. The evaluation however did note improved use by young and middle aged men.

It is possible that NHS Walk-in Centres could prove to be an important resource for homeless people in the future, at least in England, however specific studies would be needed to assess their accessibility and acceptability for homeless people.

US research

The health care system in the States is obviously radically different to that in the UK. However, an interesting study was undertaken that compared the use of a major community ambulatory health centre in West Los Angeles designed to serve both homeless people and low-income domiciled adult patients (Gelberg et al, 1996). Data collected over twelve months revealed that homeless patients were provided with as many outside laboratory tests, returned for more visits and were provided with more procedures and services, referrals and medications. Many of the procedures and services received by the homeless were for non-medical assistance and preventive health services such as tuberculosis skin tests. Whilst it is difficult to translate these findings to the UK context, the study indicated that homeless patients receiving care from a model program designed to address their special needs in a community health centre will return for follow-up visits and will utilize services at least as much as low-income domiciled patients.

3.7 Conclusion

Overall, the evidence base on the effectiveness of health care services for homeless people is poorly developed in the UK. Few studies provide robust information on health outcomes, although more studies provide overall assessments of the success of delivering services specifically to homeless people. Very few evaluations of adaptations to mainstream services, in particular, were found. A number of key factors however emerged from the evidence base that appeared to be associated with successful services, including flexibility, outreach work, a holistic approach, inclusive practices, user involvement, effective joint working and integrated solutions. The next chapter considers the overall value of the evidence base in more detail.

4 Improving access and effectiveness

This chapter draws out some of the key findings of the review on access to health for homeless people and on the delivery of health services to homeless people. The chapter then considers the overall effectiveness of current health services for homeless people and reviews the role of health services within coordinated multi-service responses that are designed to provide routes out of homelessness. The chapter also considers the need that some formerly homeless households may have for ongoing support in using the NHS. The chapter concludes with a discussion of the role of health services in counteracting homelessness.

4.1 The evidence base

Access to healthcare for homeless people

On the surface, there appear to be quite striking consistencies between the findings of research undertaken in Scotland and the findings of English, European and North American studies. As Chapter Two showed, homeless people in Scotland often seem to encounter the same barriers to healthcare as are encountered by homeless people elsewhere in the economically developed world.

However, the similarities in research findings are in part explained by the tendency of studies to focus on rough sleepers and lone homeless people in emergency accommodation. People in this situation tend to have very similar characteristics to their peers in other countries. Just as this part of the homeless population in Scotland tends to have a high level of mental health problems, drug and alcohol dependency, multiple needs, poor self-esteem, poor physical health and particular difficulties in accessing healthcare, so does the equivalent population in the US, Canada, France, Germany or Japan.

The tendency to focus research on this group of homeless people, which is as pronounced in Scotland or England as it is elsewhere in the economically developed World, is in part a result of their very poor health status and their poor access to health. As a pronounced social problem, the poor health of street homeless populations naturally attracts extensive research.

The difficulty with this research, focused as it often is on the most extreme, perhaps in some senses the most 'spectacular' problems faced by homeless people in accessing healthcare, is that it is not very representative of homelessness or homeless people as a whole. People sleeping rough and people in emergency accommodation are unrepresentative of homelessness in Scotland in two senses. First, this is a group of people with uniquely poor health status. Groups like homeless families may have relatively poorer health status than poor, housed families (Victor, 1992), but their health status is comparable to housed populations in a way that the health status of rough sleepers is not. Second, this is a group of homeless people that, although its composition has changed over time, remains predominantly White, male and tending toward early middle age.

Most of the homeless population in Scotland is not made up by people sleeping rough and living in emergency accommodation. Most homeless people are unsuitably or badly housed, and they do not spend time on the street or in emergency accommodation (see Chapter One). The same pattern is found in other

economically developed nations, although their definitions of what constitutes 'homelessness' vary. Both in Scotland and internationally, these larger groups of homeless people are less well researched, both in terms of understanding their access to healthcare and in terms of understanding their health status and healthcare needs.

As Chapter Two showed, the existing research suggests that homeless women, homeless families and groups like homeless young people may encounter not only some of the same obstacles faced by people sleeping rough to healthcare, but that they may also face particular difficulties linked to their own experiences and characteristics. Like rough sleepers, young people may have very low self-esteem linked to their life experiences and may not have the life skills needed to interact successfully with healthcare providers. It is not difficult to imagine that some young homeless people simply would not be able to organise themselves around appointments in the way that most people can. Families may be caught up in trying to deal with multiple pressures. Again, it is not difficult to imagine that a temporarily housed homeless mother with small children might be too overwhelmed to present with anything other than a very pressing health problem, especially if it involves the expense and difficulty of conveying herself and young children any distance on public transport. A woman who is homeless may well be disinclined to use a healthcare service which is dominated by male users.

Yet to some extent it is necessary to speculate about what kinds of problems groups other than rough sleepers and people living emergency accommodation may face in relation to accessing the NHS, the kinds of health need they may have and the kinds of services they may require. As has been suggested in relation to research on homelessness more generally in the UK (Fitzpatrick *et al*, 2000), it is arguable that we have reached a point at which health status and access to health among people sleeping rough and people in hostels and other emergency accommodation has become over researched. However, not enough is known about homeless families, homeless young people, the differences between the needs of the two genders, homeless people with a Black or minority ethnic background and lesbian, gay, bisexual and transgender homeless people.

The lack of research on some parts of the homeless population may mean that there are currently gaps in specialist service provision, or that modifications need to be made to mainstream services to better serve some parts of the homeless population. Needs across the whole of the homeless population need to be better understood, in order to ensure the NHS in Scotland is reasonably accessible to all homeless people. It may be that no further modifications or specialist services are required, but the pattern of need must be understood before this can be established.

The effectiveness of specialised health services for homeless people

As Chapter Three showed, the evidence base on the clinical effectiveness of specialised services for homeless people in Scotland and in the other countries in the UK is not particularly well developed. Large scale longitudinal studies of homelessness services that use rigorous research methods to track both clinical effectiveness and continuity of care are relatively unusual across the UK. In contrast, US studies tracking treatment outcomes for large groups of homeless people over quite long periods and that compare the outcomes for those using a specific service

with a control group who are not in contact with that service, are relatively common. Such research can provide interesting and useful insights, as is illustrated by the way in which successive US studies found that many specialised detoxification services for homeless people were often ineffective, in both retaining and treating patients, to the extent that those using the services often fared no better than the control groups who were not in contact with them (Burnam *et al*, 1995; Rahav *et al*, 1997; Orwin *et al*, 1999; Shern *et al*, 2000).

Equivalent research into Scottish and other British health services for homeless people is rare. Quite a substantial part of the available literature is more or less descriptive, explaining how a service works, the characteristics of those who use it and the kinds of treatment that it delivers or arranges access to. Available statistics from specialised health services, such as primary care services, tend to focus on recording the number of times specific health problems have been treated, rather than reviewing the pattern of treatment being received over time by a group of patients. There is little information that can be used to assess the extent to which many services are able to provide continuity of care to their patients and little information about clinical effectiveness more generally.

It is reasonable to presume that outcomes for homeless people using a specialist GP service will be better than those for homeless people using ordinary GPs or an A&E for healthcare. A specialist service offers doctors and nurses with experience of working with homeless people, will probably hold records for each patient, may offer permanent registration and will be tuned to the specific needs of the people with whom it works. In contrast, an ordinary GP surgery may offer no more than one-off emergency treatment, while an A&E, though it may modify its services slightly to accommodate the needs of homeless people, is primarily concerned with serving the entire population in the surrounding area. Yet, at the same time, there is no systematically collected and evaluated evidence that can be drawn upon to demonstrate that this assumption is indeed correct, as there are no truly rigorous studies on which to draw. It is not known whether the outcomes for homeless people using specialist primary care services are actually better than for homeless people who simply attend the nearest A&E, or who seek emergency treatment from the GP surgery that they happen to be closest to.

The more systematic US research in this field does suggest some need for caution, as it has been clearly demonstrated in research findings from that country that 'specialised' health interventions cannot be assumed to be effective simply because they are targeted towards homeless people (see Chapter Three). It is not enough to establish a service for homeless people, it also has to be clear that any service is, insofar as can reasonably be established, clinically effective.

The difficulties with the evidence base on existing services in Scotland and elsewhere in the UK also extend into problems with assessing the extent to which these services are accessible to their intended patients. Research has focused on the characteristics of the homeless people who use specialist services as a proxy measure of ascertaining the extent to which they are reaching their target populations. This technique can provide information on whether a service intended for a group like people sleeping rough is being used by people sleeping rough, but it cannot establish what proportion of an entire population is using the service.

Accurately establishing the size and composition of a homeless population is difficult, because these populations are mobile and have a dynamic membership, and there have been few studies that have taken a homeless population as a starting point and then looked at their use of a specific specialist health service. By extension, it is equally apparent that research that focuses on a service, rather than the population served by that service, is only able to report the extent to which beneficial health outcomes are produced for those using its service, rather than on its impact on population health as a whole.

The evidence base is rather stronger in respect of our understanding of the patterns of service delivery that are effective in making services accessible to homeless people. Qualitative research has shown that service delivery that is flexible, tolerant and open and in which there is an attempt to develop and maintain a trusting relationship between patient and services is clearly effective in working with homeless people (see Chapter Three). In part, this finding is unsurprising, as services have obviously been developed or modified to counteract the known attitudinal and organisational problems that were blocking access to the NHS for homeless people. As was shown in Chapter Three, many specialist services have developed a different kind of 'contract' between medical professionals and their homeless patients, reflecting both a more paternalistic and a more flexible relationship, something that contrasts with the 'patient as customer' focus of mainstream NHS services.

Research from Scotland and from other countries also suggests that there is scope for increasing user involvement in design, operation and delivery of some health and health related services. Peer mentoring and user involvement, for example, seems to have beneficial effects when providing services for young homeless people (see Chapter Three).

Studies can play an important role in confirming whether or not specialist or modified services are fulfilling their intended role and can point out where barriers to access and inconsistencies in the quality of services exist. It also needs to be remembered, as was illustrated by the findings of the US research on homeless detoxification services referred to above, that specially designed services should never simply be assumed to be accessible or effective.

Adaptations and modifications to mainstream NHS services

The evidence base is less well developed in relation to small scale modifications to NHS services, both on an informal and formal basis. It may be the case that informal practices, such as allowing homeless people to use a practice's own address for the purposes of permanent registration, or individual GPs taking a decision to care for the residents of a local homeless hostel, are important sources of healthcare for homeless people. A large scale study of access to primary care among people sleeping rough in England found that many of the homelessness services, such as daycentres, nightshelters and direct access hostels, that reported good access to healthcare for their users, relied on *informal* relationships with local GP surgeries (Pleace *et al*, 2000). It would be useful to establish the extent to which such arrangements are currently important to providing healthcare to homeless people in Scotland. Encouragement of such small scale, informal, modifications may be the

most effective response in some areas, such as some rural communities with very low densities of homelessness.

Equally, there is not a good evidence base on low level formal modifications to mainstream services, for example the employment of liaison nurses or homelessness workers by A&E departments with a large number of homeless users, in Scotland or elsewhere in the UK. It is known that such modifications are made by some A&E departments to improve access and, particularly, discharge arrangements for homeless people, but the extent and effectiveness of such services has not been systematically examined.

Other modifications to the NHS

Another area that may require further examination is the extent to which modifications to mainstream NHS organisation that are aimed at improving access for the general population of an area might also improve access for homeless people. Any service offering greater ease of access to the general public may also be more accessible to homeless people. Examples might include Healthy Living Centres or any PMS pilots that are not aimed specifically at homeless people, but which provide GP services in a more flexible way. At present, Scotland has not followed England in developing NHS 'walk-in' centres, though it was anticipated that these services might be more accessible to groups like homeless people and travellers as well as the general population, although this is something that is yet to be demonstrated (see Chapter Three).

4.2 Reconsidering effectiveness

Understanding the limits of effectiveness

Both specialist and mainstream services face a particular difficulty in seeking to improve the health status of homeless people. This difficulty centres on the implications of experiencing homelessness for health status.

The NHS cannot make the general population of Scotland 'well', as the population is constantly exposed to external risks to health and well being, contains individuals who do not exercise, who smoke, drink too much and eat poor diets. It is also a population that is ageing. Nevertheless, public health services like NHS Scotland can and do make populations healthier than they would otherwise be, through treatment, preventative monitoring groups of the population at risk of certain diseases, through immunisation programmes, promotion of healthier living and so forth.

Attempting to improve the health status of the homeless population in a similar way is an uphill struggle (Pleace and Quilgars, 1996; Pleace *et al*, 2000; Wright, 2002). Effective treatment, preventative monitoring, immunisation and health promotion are all more difficult. This is for two main reasons:

- people who are homeless are exposed to heightened risks to their health and well being on a constant basis;
- people who are homeless may have characteristics, or be in situations, that make it difficult to successfully provide continuity of care.

Homeless people are constantly facing risks to their health and well-being. Homelessness can mean constant exposure to poor living conditions, be it the street, a crowded hostel, or inadequate housing that is cold or damp. Homelessness also means exposure to all the risks to health associated with relative poverty. Homeless people are also often characterised by a lack of sexual relationships, friendships, family relationships or other social supports and, through their situation, exposed to near constant stress. For women, homelessness can mean exposure to violence, sexual assault and rape and there are also physical dangers for groups like young people and for people sleeping rough. Risks to physical and mental health are added to by the ways in which homelessness can be associated with alcohol dependency, drug dependency and other 'risky' behaviours, such as cigarette smoking and, among young people, unprotected sex with multiple partners (Pleace and Quilgars, 1996). As one focus group respondent noted, even maintaining a reasonable diet becomes problematic once homeless:

...it's no disrespect to a lot of soup kitchens and day centres, but in terms of the food that they provide, it's not nutritious, you know, it tends to be rolls and sausages, it tends to be cakes, chocolate, it's not fruit and it's certainly not fresh food either, you know. So in terms of people's diet, even if they are eating it's not nutritious in any shape or form (Homeless agency worker).

It can be difficult for health services to effectively treat homeless people because they are living in such an unhealthy situation. Simply keeping warm, dry and well fed can be difficult. Finding a safe and suitable environment to recuperate from illness may be very difficult for a homeless person or household.

The characteristics and the experiences of some homeless people sometimes make it difficult for them to sustain contact with even specialist health services and can also make it difficult for those services to work successfully with them. Ensuring continuity of care among groups like homeless people who are highly mobile, or young homeless people who may find it difficult to keep to schedules, can be very difficult. A few homeless people may also have quite chaotic behaviour, linked to mental health problems, drug or alcohol dependency or multiple needs, making it difficult for them to regularly attend or contact services, or to undertake tasks like completing a course of drugs. Homeless people may also be moved around by service providers, such as social landlords, or be forced to move between services, for example when using first come first served emergency accommodation (Pleace and Quilgars, 1996).

Compliance with treatment with for tuberculosis among people sleeping rough is perhaps the most extreme example of the kinds of difficulties that can be encountered in seeking to provide continuity of care. In New York, the quite frequent failures to complete drug courses among some homeless people was linked to the rise of drug resistant TB, a major public health concern (Concato and Rom, 1994).

After a number of initiatives that met with mixed success, some homeless people with TB were eventually effectively imprisoned in hospital until they had been successfully treated (Feldman *et al*, 1997).

Another example is in the difficulties reported by diabetic homeless people in managing their condition while homeless. Continuity of care, regular health checks and support in self medication are clearly essential to managing diabetes successfully, as is access to the proper diet. As one Canadian study has found, all of these issues are instantly problematic, perhaps even impossible for some homeless people to manage successfully (Hwang and Bugeja, 2000).

Many studies conducted in the UK have pointed to these issues and argued that even specialised health services for homeless people have *inherently* limited effectiveness. Even if specialised services can provide better access to healthcare, it has been argued that these services can only partly surmount the difficulties in providing proper continuity of care and effective treatment to homeless people. Many studies have consequently concluded that it is only through providing a permanent route out of homelessness that the health care needs of many homeless people can ultimately be addressed (Hinton, 1992 and 1994; Stern, 1994; Connelly and Crown, 1994; Pleace and Quilgars, 1996; Pleace *et al*, 2000).

For more than a decade, much of the homelessness research that has been conducted has argued that only multi-service responses can provide a route out of homelessness (Fitzpatrick *et al*, 2000). As Chapter Three shows, many health services are now being provided that either work in close cooperation with other services to provide a multi-service response, or that directly combine health services with social housing and/or Community Care services. Combinations of resettlement support, suitable housing and access to required health and social care services are seen as the best means by which homelessness can be addressed. In turn, effective solutions to their homelessness are expected to produce improved health status among formerly homeless people. This is a view shared by some medical professionals working with homeless people in Scotland, as interviewee noted:

...if the lack of a job is my most pressing problem, I'll go to the Jobcentre, who will not do anything for my alcohol problem, my lack of social support....and the mirror image of that is when I turn up at the A&E department, they will see me through a health prism, they will see a man with a broken arm because that is what they are good at, that's what they are supposed to be doing...and so we get specialisation of service provision...(Medical professional)

American research has sometimes reached very similar conclusions. Systematic attempts have been made to assess how specialised services can best engage with homeless people and provide continuity of care, but effectiveness has quite often been found to be ultimately limited. As one US study notes '*...the use of [specialist health service] care may not have a major impact on health outcomes for the homeless, given the harshness of their environment and the current state of healthcare available to them*' (Gelberg *et al*, 2000, p. 1296). Similarly, relative failure by various detoxification services has been linked in part to the difficulties presented by homelessness itself: '*While long-term support for sobriety may increase positive*

outcomes among the homeless dually diagnosed, we think it unlikely that any program, formal or self-help, is likely to produce long-lasting benefits unless issues of housing and income support are also resolved for this population' (Burnam et al, 1995, p.132).

These arguments are strongly linked to the wider question of what is meant when the 'health' of homeless people is discussed. A standard definition of health, which is often cited, is that adopted by the World Health Organisation in 1948: *'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'*⁴. Clearly, according to this, or any similar definition, someone who is homeless is unlikely to be 'healthy' as they lack proper shelter, social and emotional support, are subject to constant stress and have little income (see Chapter One). In essence, it can be argued that there are too many negative factors stacked against the likelihood of a homeless person also being a 'healthy' person, meaning that a lasting improvement in health status can only ultimately be secured through bringing an end to their homelessness. The argument that promoting 'health' among homeless people not only extended beyond meeting medical needs, but that some other basic needs had to be met *before* medical needs could properly be addressed, was advanced by several medical professionals who took part in the focus groups:

I mean although this is a medical model in the sense it's a health team, the social model aspects of how this team works is really I think key about making this something about, it's not just saying "Here's a plaster, there's your cut" it's much more about "How did you get the cut? How did it happen?", you know, "Where are you living?" (Medical professional).

...I would strongly advise...do not use a medical model of health, you'd be much better off with Maslow⁵ or somebody like that with a social model of health and when you are dealing with the homeless, you are right down the bottom of his pyramid, you're talking security, warmth, food and water, stuff the self-actualisation, that can come a lot later, and that is why rehousing people who have been skipping is difficult if only for one thing, most housing providers will not accept large Alsatians - if you are skipping, you want your large Alsatian across your feet when you are asleep, because when you are asleep you are very vulnerable so a large Alsatian is very useful for your life.... they have cottoned on to what they need is security, you know, you don't ask them if they are brushing their teeth twice a day....or indeed eating five pieces of fruit a day or any of the other things. I mean all I am asking is the introduction of a reality check...You start at the bottom of the pyramid...(Medical professional)

⁴ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

⁵ See Maslow, A. (1970) *Motivation and Personality* New York: Harper & Row, 1970.

The rise of the multi-service response to homelessness

Over the last decade, homelessness has come to be seen increasingly in terms of requiring 'more than a roof' solutions involving coordinated multi-service responses. Scotland is at the forefront of the development of these strategic multi-service responses to homelessness (see chapters one and three).

There had originally been some concerns that specialist health services might 'reinforce' homelessness through providing access to health care that homeless people could use while maintaining their lifestyle (El Kabir, 1996). However, the role of health service interventions for homeless people has been reexamined in Scotland, as increased emphasis has been placed on the role that NHS services might play in the preventing homelessness and in the resettlement of formerly homeless households. As Chapter Three shows, 'specialist' health interventions are increasingly defined by their roles and relationships in relation to addressing both medical need and towards assisting with the provision of routes out of homelessness. This reorientation towards prevention and resettlement has started to make arguments that specialist health services possibly 'reinforce' homelessness look increasingly redundant.

These trends have led to the development of services like The Access Project (TAP) in Edinburgh, which combines primary care, drug and mental health services in a jointly run project with social housing and social work services. In this well developed service, the NHS both provides healthcare to homeless people and contributes to a package of care and support services that are designed to provide routes out of homelessness (see Chapter Three). This is still a specialist medical service providing primary care for homeless people, but through its coordination with other agencies, it is also a starting point from which homeless people can find routes out of homelessness. As a individual or household starts to move away from homelessness, they are encouraged to use the mainstream NHS as their source of healthcare.

As is described in Chapter Three, smaller scale services like nurse-led facilitator services have been developed that support access to the mainstream NHS for homeless households. These services may not only seek to reintegrate homeless people with the mainstream NHS, but may also liaise or provide a starting point from which other services can be accessed.

A similar comprehensive and coordinated 'multi-service' approach is intended as a core feature of local authority homelessness strategies, the Supporting People programme and the development of health and homelessness action plans by the Health Boards in Scotland. The existing coordination of some Scottish services was reported by interviewees as being ahead of developments elsewhere in the UK:

Of course the big bonus is the integration of health, housing and social work, that really does make a huge difference, I mean if you go to conferences and people are talking about the way they would like to develop things and you say 'Well, we do that'...(Health service manager)

Similar approaches to service delivery have sometimes been adopted in other countries in the EU, with packages of housing, support, personal care and health services being used to attempt to address the needs of homeless people, one example being French services designed for homeless people with mental health problems (Simonnet *et al*, 2000). American responses have sometimes been slightly different, in that specialised medical services may be in a situation in which social housing, social care and public health services are more restricted in scale and scope than is the case in countries in Western Europe⁶. As there may be relatively few other services to coordinate with, some specialised services for homeless people have become increasingly comprehensive, providing not only healthcare, but supported housing, social work services and a range of other housing related support (Plescia *et al*, 1997; Tsemberis, 1999; Culhane *et al*, 2002).

Balancing accessibility and clinical effectiveness with a multi-service role

Medical practitioners who work in specialist primary care services for homeless people stress the importance of working flexibly to produce high quality, tolerant and individually tailored responses to medical need (El Kabir, 1996; Gray *et al*, 2002; Wright, 2002). Health services for homeless people must be open and offer minimal barriers to access, especially if they are to engage with those homeless people who will find it most difficult to use the NHS (see Chapter Three).

Clearly, if a specialist medical service is able to build up trust between medical practitioners and a homeless person or household through the provision of treatment, routes by which that household can access packages of support that may provide a pathway out of homelessness should be available. At the same time however, it is equally important that medical services remain focused on clinical role in relation to their patients, as their function is the delivery of healthcare. Health services can serve as a referral point and coordinate with other services, they cannot function, on their own, as an 'one-stop' solution to homelessness.

Equally, it needs to be clear that using specialist medical services does not place a homeless individual or household under pressure to take up a multi-service package that may assist them out of homelessness. Placing an expectation on patients that in order to use specialist medical services they have to enter a resettlement process, could create a barrier to specialist healthcare for some homeless people. As one interviewee commented:

...the idea as far as I am concerned is that you put choices before people and even encourage them, you certainly don't prescribe, but you do let people know, and in our experience if you give folk positive choices then they tend to take them...(Health service manager)

American failures in attempting to provide specialist services to people sleeping rough with drug or alcohol dependencies again provide a cautionary tale in this respect. Research linked the often very poor performance of these services with the excessive rules and expectations placed on homeless people (Rahav *et al*, 1997; Orwin *et al*, 1999; Shern *et al*, 2000).

⁶ Welfare services are planned and administered at state level in the US, which means that provision varies across the country

Providing treatment and care may, in itself, facilitate routes out of homelessness for some people, but the primary role of specialist services in ensuring accessible healthcare, must not be compromised. However, just as specialist services will, when judged appropriate, seek to enable homeless people to begin using the mainstream NHS again, so they might also encourage homeless people and households to access packages of care, housing and support that can provide a route out of homelessness.

4.3 Health following homelessness

For more than a decade, there has been a growing recognition that many of the effects of homelessness can persist after rehousing takes place. High levels of abandonment led social landlords to develop resettlement services for vulnerable lone homeless people, designed to enable them to run their own homes and to help them access required NHS and Community Care services. Poor coordination between social housing services, the NHS and Community Care was found to be associated with tenancy abandonment and returns to homelessness, as issues like mental health problems or severe mental illness, drug dependency or multiple needs were sometimes not adequately addressed (Pleace, 1995; Franklin, 1999).

There is increasing research evidence of tenancy abandonment and repeat homelessness among other homeless households, such as homeless families, sometimes linked to similar support needs (Hinton, 2001; Jones *et al*, 2002). Other groups, such as homeless and potentially homeless young people, often require similar forms of support, such as those provided by floating support services for young people or the foyer network.

There is some evidence that former rough sleepers continue to engage with specialist health services following rehousing (Pleace *et al*, 2000). This may be explained in part by these services being trusted and familiar, but there may also be ongoing obstacles to the mainstream NHS for some former rough sleepers.

Some households may have an ongoing need, either to remain with specialist health services in the short term, while they adjust to being rehoused, or for some assistance in accessing the mainstream NHS. Clearly, ongoing drug dependency or issues of low self-esteem may continue to block access to mainstream health services even after the basic problem of lacking a permanent address has been overcome. Ensuring access to healthcare can be an essential part of effective rehousing and resettlement. As one interviewee noted:

...the point is that people with multiple problems do not recover quickly, you cannot expect people like that, even if all the services are working 100% networked, people do not shift from being severely disadvantaged because of their multiple problems to being 'normal', white middle class members of society in two weeks....people who are recovering from this sort of situation often feel like and sometimes behave like teenagers, whatever their age, and many of them have said to me, you know, when I was recovering from whatever it was, domestic abuse, serious addiction, whatever, they say, 'doc, you know when I was recovering I felt as though I was a teenager having to grow up again', and that is I think an extremely useful analogy because not even

the most dogmatic parent would expect their 13 year old to suddenly acquire the maturity of a 19 year old overnight, I mean they often wish that it would happen! - but it doesn't. And in many ways, we often wish that our homeless people, our addicted people, our ex-prisoners, our people in the community with mental health problems, we often wish that we could wave a magic wand and turn them into respectable subjects of her majesty, overnight, but in fact you can't - they require time and constancy and so on...(Medical professional)

The Supporting People programme in Scotland will provide scope for the development of a range of floating support services, including tenancy sustainment services for homeless families, young homeless people and lone homeless people. The role that these services need to undertake in facilitating access to both mainstream and specialist health services, as well as Community Care, must be carefully considered.

4.4 The roles of health services for homeless people

It must be acknowledged that the development of specialist health services, or the modification or augmentation of mainstream NHS services to better cater for the needs of homeless people, places an additional burden on NHS resources. The NHS in Scotland is subject to a great many pressures in meeting the health needs of the general population and the resources it can devote to any one group of people with specific needs, such as homeless people, are finite.

The NHS is not in a position to develop extensive specialised services, nor significantly modify mainstream services, for the benefit of homeless people, in every corner of Scotland. As is already happening in Glasgow and Edinburgh, it can develop specialist services where there is a relative concentration of lone homeless people with particularly poor health status and poor access to primary care. Yet in much of Scotland, the relatively low density of the homeless population does not make the development of such services practical. It will often only be realistic to develop outreach health services that may provide some treatment, but which will seek to meet many health needs through facilitating access to the mainstream NHS for their patients, in such settings. The scope for more informal arrangements by mainstream NHS services might also be explored in the most rural areas.

This situation might be seen in creating a difficulty in fully recognising the needs of those parts of the homeless population whose current access to healthcare is not fully understood, including homeless women, families, young people and other groups. This is because a significant increase in specialist provision or considerable modification of mainstream services may be impractical.

However, the potential tension between resources and recognition of the needs across the whole homeless population needs to be balanced against the likely extent of need within the homeless population. It is very important to note that even among the most marginalised (and most extensively researched) group of homeless people, those who are sleeping rough, that access to the mainstream NHS is not *universally* poor. In any given population of people sleeping rough, some remain registered with a GP and in contact with the mainstream NHS. It is true that rates of permanent registration are much lower than the general population and that the actual rate of

permanent registration with a GP that can easily be reached by a rough sleeper may be lower still, but this is not the same thing as all people sleeping rough experiencing total exclusion from the mainstream NHS. The available research suggests that there may be a similar pattern among other groups of homeless people, such as young people or homeless families, some of whom may find it particularly difficult to use or access the mainstream NHS, but some of whom may not encounter real difficulties (see Chapter Two).

Although the extent of the problems that some groups of homeless people may have in accessing healthcare are not wholly understood at present, it is not unreasonable to surmise that a need for extensive and specialised assistance in accessing healthcare will not exist across the whole homeless population. While available resources are limited, particular problems in accessing healthcare may be confined to a part of the homeless population. If this assumption is correct, then quite limited modifications to mainstream services and the development of even small specialist services can potentially make a real and positive difference to the problem of poor access to healthcare for homeless people.

At the same time, it does need to be clear that any modifications to mainstream services or any specialist provision that is developed is, insofar as possible, an evidence-based response. Services need to be built on evidence of effectiveness, in terms of meeting clinical need, in terms of re-engaging homeless people with the mainstream NHS and in terms of facilitating the pursuit of routes out of homelessness, while retaining a clear focus on delivering healthcare.

At present, the evidence base on effectiveness of different healthcare services for homeless people is insufficiently developed, just as the needs of some groups of homeless people are not fully understood. This creates a need to evaluate the effectiveness of new services, ideally according to standardised measures to allow cross-service and cross-area comparisons, in order to determine that the right sorts of intervention are being developed and implemented. Existing models of health services for homeless people, or modifications to mainstream services, should never be unquestioningly adopted, even if the model is some decades old, because many services have never been subjected to rigorous evaluation.

Finally, there perhaps needs to be a greater consideration of the roles of both informal modifications to health services and wider modifications designed to improve access to the NHS for all socially and economically marginalised groups. Small scale, quasi informal, modifications to mainstream practice might be the best solution at local level, particularly in rural areas. It may be productive to evaluate quasi informal schemes, like the decision by GPs in Glasgow to opt to target the enhanced payment scheme toward homeless people registered with a GP practice, to see if they might be more widely adopted (Greater Glasgow National Health Service Board, 2002). Equally, PMS pilots designed for all groups that find it difficult to access primary care, be they social housing tenants, travellers or homeless people; services like Healthy Living Centres and services like NHS 'walk-in' centres (should they be developed in Scotland) may prove effective in meeting the needs of homeless people. It may be that changes in the NHS like these can help meet the needs of homeless people and reduce the need to develop some forms of specialist homelessness services. However, this must be in the context of recognising the

requirement for coordinated multi-service responses to address the needs of some homeless individuals and households.

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Appendix A: Database and internet searches

1. Databases

Web of Science (WoS) databases

Social Science Citation Index: International multi-disciplinary index to 1,500 social science periodicals, plus social science articles from a further 3,000 journals. 1981 onwards. Updated weekly.

Science Citation Index: International multi-disciplinary index of science periodicals.

York DataNet

ASSIA Plus (Applied Social Sciences Index and Abstracts): Indexes and abstracts about 600 English language social science journals, providing information on areas such as social services, health, education, employment and race relations. 1987 onwards. Updated quarterly.

SIGLE (System for Information on Grey Literature): SIGLE is the source of grey literature for the UK, the largest component being the British Library Document Supply Centre's collection of reports and theses. Database covers the EU. 1980 onwards. Updated twice a year.

Silverplatter

Health Management Information Consortium (HMIC) - includes DHData and Kings's Fund databases.

Ovid

Medline - The main abstracting service for the medical sciences. 1966 onwards. Updated monthly.

2. Web-sites

Government departments and agencies

The Scottish Executive (www.scotland.gov.uk/)

Communities Scotland (www.communitiesscotland.gov.uk)

ODPM (www.odpm.gov.uk/)

Department of Health (www.doh.gov.uk) and (www.nhs.uk)

Home Office supported multi-agency crime reduction site (www.crimereduction.gov.uk)

Cross Departmental drugs site (www.drugs.gov.uk)

Housing Corporation (www.housingcorp.gov.uk) and Innovation and Good Practice Research database (<http://cig.br.co.uk/igp>)

Tai Cymru (www.tc-hfw.gov.uk)

NHS Health Development Agency (www.hda-online.org.uk)

Health Education Board for Scotland (<http://www.hebs.org.ukwww.hebs.scot.nhs.uk/>)

Homelessness/ housing voluntary sector and allied organisations

Shelter and Shelter's homelessness act website (www.shelter.org.uk / www.homelessnessact.org.uk)

Homeless Link (www.homeless.org.uk/)

Homeless pages (www.homelesspages.org.uk)

Crisis (www.crisis.org.uk/) and Health Action at Crisis

(www.crisis.org.uk/research/health.php)

The CRASH website (www.crashindex.org.uk/) which includes a searchable online version of the CRASH/ JRF supported review of single homelessness research undertaken by the University of Glasgow (Fitzpatrick et al, 2000)

Health organisations/ agencies

The Royal College of General Practice (www.rcgp.org.uk)

British Medical Association (www.bma.org.uk)

Medical Research Council (www.mrc.ac.uk)

World Health Organisation - Europe (www.who.dk)

Research funders

JRF (www.jrf.org.uk)

Kings Fund (www.kingsfund.org.uk)

Regard (ESRC database on research) www.regard.ac.uk

Academic institutions

Housing

CRESR, University of Sheffield (www.shu.ac.uk/cresr)

CURS, University of Birmingham (www.spp3.bham.ac.uk/curs/)

Department of Urban Studies, University of Glasgow (www.gla.ac.uk/Acad/Urban/)

Housing Policy and Practice Unit, University of Stirling (www.stir.ac.uk/Departments/HumanScience/AppSHousing/index.htm)

Health

Division of Primary Health Care, University of Bristol

(www.bris.ac.uk/Depts/PrimaryHealthCare/)

Institute of Health Sciences, University of Oxford (www.ihs.ox.ac.uk)

Nuffield Institute for Health, University of Leeds

(www.nuffield.leeds.ac.uk/content/home/home.asp)

National Primary Care Research and Development Centre, University of Manchester

(www.npcrdc.man.ac.uk)

European/ International organisations

Health Care for the Homeless Information Resource Centre (www.hchirc.com/):

Health Care for the Homeless (HCH) is a USA Federal program with sole responsibility for addressing the primary health care needs of homeless people.

FEANTSA (www.feantsa.org/): the European Federation of National Organisations working with the Homeless is currently placing research resources onto its website.

European Network for Housing Research (www.enhr.ibf.uu.se/)