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Access to General Practice for People Sleeping Rough

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RESEARCH REPORT

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Executive Summary

- The Centre for Housing Policy at the University of York was contracted to determine which areas of England had particularly poor access to General Practitioner services for people sleeping rough in October 1998. The research also aimed to ascertain the reasons for poor access and assess the quality of health care received by people sleeping rough.

- Previous research has indicated that people sleeping rough have very poor health status compared to the general population, with severe mental illness, drug and alcohol dependency, risks of infection, exposure to cold and damp and very poor diet being particular problems. Previous research has also indicated that access to health services is poor for this group. The current research reinforced the findings of previous studies.

- Access to mainstream GP services for people sleeping rough was poor throughout England. While there was some variation between areas in reported access to GP services, there was also considerable variation *within* areas with a rough sleeping problem. The variations in access reported by different projects in the same area may have indicated a general lack of strategic planning.

- There was strong evidence that people sleeping rough had worse access to GP services than any other group in the homeless population.

- There was heavy reliance on primary care services targeted on people sleeping rough and single homeless people in those areas where such services were available.

- Access to community mental health services, chiropody, opticians and NHS dentistry also appears to have been poor for people sleeping rough and single homeless people throughout England. Access to drug and alcohol services was also often highly problematic.

- Attitudes towards people sleeping rough and homeless people formed a barrier to GP services. Some GPs were apprehensive that people sleeping rough would be disruptive or challenging or cause problems in the waiting room. There was evidence of prejudice against homeless people from a few receptionists, nurses and doctors.

- Drug dependency formed a barrier to GP services. Some GPs were reluctant to register people sleeping rough or prescribe certain drugs because of concerns that they would become a target for other drug users if they were known to prescribe certain drugs.

- Many people sleeping rough suffered from low self-esteem and depression. This was regarded by respondents as contributing to an acceptance of ill health and increasing the chances of risky behaviour such as drug use and unprotected sex with multiple partners.

- Many people sleeping rough avoided going to the doctor because of fears about how they would be treated or a belief that they would be refused a service because they were homeless. The possibility that an already poor self-image would be further reinforced by being treated with contempt by medical services was something many people sleeping rough were not prepared to risk in order to gain access to medical services.

- People sleeping rough often had more pressing priorities than their physical health, such as securing food or shelter or maintaining a drug or alcohol dependency. Unless a health problem was very painful or debilitating, they might sometimes put other matters before visiting a GP.

- The administration and operation of many GP surgeries acted as a barrier to more marginalised and chaotic people sleeping rough. Some GPs who did treat homeless people were only prepared to register them temporarily because of uncertainty about GP payments and confusion over rights to permanent registration, which some practices thought required a permanent address.

- Many GPs were concerned about the quality of care they were able to deliver to people sleeping rough. The concerns centred on medical records often not being available and maintaining continuity of care with people who might move away from an area after seeing a doctor once or twice. Compliance with drug regimes and ensuring attendance at outpatient appointments, particularly if these were arranged weeks or months in advance, were also seen as problems.

- Most respondents thought that a mix of services was necessary to ensure access to services for people sleeping rough. The most common models were services targeted on homeless people, advocacy services and adaptations to mainstream services.

- Targeted services were seen as essential to ensure that the most marginalised and alienated people sleeping rough got access to primary care. However, they were seen as limited by often having restricted hours and not being able to offer permanent registration.

- The absence of permanent registration in targeted services was seen as undermining the quality and continuity of care for people sleeping rough, particularly because individual's medical records were not available to the GPs. This also made it problematic for these services to treat drug users, as they had no records to establish the legitimacy of requests for drugs that might be abused.

- The importance of a holistic response to rough sleeping of which health services are a part was often stressed. The resettlement of people sleeping rough was seen as likely to fail unless there was access to appropriate medical services.

- Equally, the research emphasised that improvements to medical services alone are inadequate if the health status and general situation of people sleeping rough is to be improved. GP services cannot help someone off the street by themselves and there is a role for social landlords, the voluntary sector and in some instances for social services.

- Improved coordination between GP services and homelessness services could be achieved at relatively low cost by improving training and by the development of resource directories, information for people sleeping rough and agreed systems for taking referrals from other agencies.

- At strategic level, the extent to which Primary Care Groups will take a sufficient interest in ensuring access to GP services for people sleeping rough needs to be ascertained and consideration given as to whether service delivery to people sleeping rough needs to remain with health authorities in some instances. There is the related possibility that PMS pilots might have a potential role in meeting the needs of people sleeping rough.

Introduction

In July 1998, the Social Exclusion Unit published its *Rough Sleeping Report* in which it stated its aim to reduce the level of rough sleeping in England by two-thirds by 2002. The *Rough Sleeping Report* also contained an undertaking to "..identify areas where rough sleepers and homeless people are having persistent problems in gaining access to GPs" (para 4.31), which led to the commissioning of this report from the Centre for Housing Policy by the Department of Health in the Autumn of 1998.

The objectives of the research were simple. First, it was to produce maps of England showing those areas in which people sleeping rough were having persistent problems in gaining access to GP services. Second, it was to investigate why these problems in access were arising. Third, although the concentration of the research was to be on access to GPs, some assessment of the quality of care being received by people sleeping rough was to be undertaken.

People sleeping rough generally need access to health services if their resettlement into housing is to be successful. The high prevalence of severe mental illness and drug or alcohol addiction among people sleeping rough often means that they will be unable to sustain themselves in a tenancy without medical and practical support. Access to GP services can therefore be a prerequisite for effective resettlement.

The research had three stages. The first stage was an extensive literature review, the findings of which are presented in **Chapter One**. The second stage of the research was a survey designed to map access to GPs for people sleeping rough across England. The survey concentrated on projects for people sleeping rough and single homeless people. Most homelessness projects have at least some involvement with trying to arrange or provide medical services for their users. Just over 1,000 projects responded to the survey and the results are discussed in **Chapter Two**.

The third and final stage of the research was the fieldwork. This stage was comprised of interviews with people sleeping rough, workers in homelessness projects, GPs, other medical professionals and representatives of health authorities. The fieldwork was aimed at understanding the issues that arose when people sleeping rough tried to access GP services. Fieldwork took place in seven case study areas; Bristol, Gloucestershire, Lambeth, Manchester, Nottingham, Southampton and Westminster. One hundred and twelve people were interviewed for the research. This included 12 GPs, seven health authority representatives, six health workers, 19 project workers and 64 people sleeping rough. Four national level interviews were also conducted with individuals with a background or special interest in rough sleeping and homelessness, representing a range of different organisations. The results of the fieldwork are reported in **Chapter Three**.

The research concludes with a discussion of the findings, the advantages and disadvantages of various models for providing GP services to people sleeping rough and the role that primary care services can play in reducing overall levels of rough sleeping.

Acknowledgements

The research was wholly based on the cooperation of a large number of individuals and organisations and could not have taken place without their contributions. More than 1,000 projects took the time to complete the survey and the research team are grateful to all of them. The research team is particularly grateful to the people sleeping rough and homeless people who gave up their time to be interviewed, and to the GPs, health authority representatives and project workers who found time in their busy schedules to participate. Particular thanks are due to the following organisations, which participated in the fieldwork and in many instances helped arrange interviews with people sleeping rough.

The Passage Daycentre, Victoria.
St Mungo's Hostel, Greek Street, Soho.
Great Chapel Street Medical Centre.
West London Day Centre.
North Lambeth Daycentre.
Lord Clyde Nightshelter, Lambeth.
The Three Boroughs Primary Health Care Team.
University College Hospital.
The Homeless Health Care Team, Southampton.
English Churches Hostel, Southampton Street, Southampton.
Gloucester Open House.
Glofysh, Gloucester.
Forest of Dean Young Single Homeless Project.
The Hub, Bristol.
25 St Nicholas Street Hostel, Bristol.
Victoria Street Direct Access, Bristol.
Dean Crescent Hostel, Bristol.
Handel Street Wet Centre, Nottingham.
Canal Street Nightshelter, Nottingham.
Emmanuel House Daycentre, Nottingham.
The Salvation Army, Manchester.
Cornerstone Daycentre, Manchester.
Counted In, Manchester.
The Big Issue in the North, Manchester.
The Royal College of General Practitioners.
Health Action for Homeless People.
Primary Care for Homeless People
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1 Health and Access to GPs

Introduction

This chapter presents an overview of rough sleeping within the wider social problem of homelessness and briefly examines the health care needs of people sleeping rough. The second section of the chapter discusses the results of previous research that examined access to GPs for homeless people.

Rough Sleeping and Homelessness

Homelessness in England is usually discussed in terms of statutory homelessness and non-statutory homelessness. The statutorily homeless population includes all those homeless households that qualify for rehousing by local authorities. This includes all homeless households containing children and homeless households defined as 'vulnerable' under the terms of the homelessness legislation, because they cannot be expected to fend for themselves[1]. Households who do not qualify for rehousing under the homelessness legislation are referred to as non-statutorily homeless, but because the great majority are lone individuals, the term 'single homeless people' is generally used to describe them. A small part of the single homeless population spends some or most of the time without any accommodation and this group is referred to as people sleeping rough. Research suggests that there are three broad groups of people sleeping rough (Anderson *et al*, 1993; Randall and Brown, 1993; Vincent *et al*, 1993 and 1995; Pleace, 1998a; May, forthcoming):

- **Habitual rough sleepers**. People who have spent prolonged periods sleeping rough over several years. This small group of people is seen by most service providers and researchers as the most marginalised and difficult to reach. A handful of this group spend all of their time outside, but most sleep rough for quite prolonged periods and also spend time in accommodation such as direct access facilities.

- **Very insecurely accommodated single homeless people**. This refers to a section of the single homeless population who spend most of their time in very insecure temporary accommodation like direct access hostels and nightshelters. This group is characterised by spending periods on and off the street. They can be described as a population which is likely to have been sleeping rough and which is likely to sleep rough again, although on any given night the majority of them will be in some form of accommodation. This group forms the bulk of the rough sleeping population and most studies have used this population to understand the characteristics of people who sleep rough.

- **Infrequent or 'one-off' rough sleepers**. Newly homeless people may temporarily join the rough sleeping population because they do not know where to go for assistance. People in this group will tend to have just one or two short experiences of sleeping rough before being rehoused.

The population who are likely to sleep rough during the course of a year is much greater than the population sleeping rough on any given night. This is because most people sleeping rough, even habitual rough sleepers, tend only to sleep rough when they cannot find suitable accommodation. Most direct access accommodation offers beds on a first come first served basis, so securing a place one night is no guarantee of one the next, and it is possible even in London for provision to fill up more or less completely so that not everyone who needs a bed can get one. In some areas people will sleep rough because there is no nightshelter or direct access available. Individuals may also be barred from accommodation if they break the rules and then have to sleep rough. In addition, the living conditions in a few nightshelters and hostels are such that sleeping outside can seem a rational alternative. A few schemes for homeless people are unsanitary, crowded and sometimes very frightening places and there is certainly anecdotal evidence that women and people from ethnic minorities may sleep rough rather than use them (Anderson *et al*, 1993; Vincent *et al*, 1992 and 1995; Pleace and Quilgars, 1996; Pleace, 1998a).

Recent statistical evidence indicates that approximately 1,850 people sleep rough each night in England, including 621 in Greater London (DETR, 1999, see appendix two). It has been estimated that approximately 2,400 people spend some time sleeping rough in London over the course of a year and that 1,800 of these are new arrivals. Outside London, estimates indicate that some 2,000 people sleep rough each night, with perhaps 10,000 drifting in and out of rough sleeping over the course of a year (SEU, 1998, paras 1.1 to 1.3).

People sleeping rough often tend to be very mobile, particularly habitual rough sleepers. The reasons for this mobility range from looking for services, accommodation and work through to travelling to alleviate boredom and to provide a sense of purpose (Vincent *et al*, 1993 and 1995). Younger people sleeping rough may also sometimes be in flight from difficult family circumstances or abuse. This mobility means that it is only possible to determine the locations within which people sleeping rough tend to congregate and limits the extent to which rough sleeping can be seen as a ‘local’ problem, particularly in cities like London (Whynes, 1991; Pleace, 1998a). According to the most recent figures from DETR (see appendix two) the greatest concentrations of people sleeping rough are found in inner London, with quite high levels in Birmingham, Brighton, Bristol and Manchester. There are also quite high numbers in Cambridge, Nottingham, Oxford and some ports and seaside towns. Rough sleeping appears to be less common in some cities like Liverpool and Newcastle and in most rural areas.

People sleeping rough tend to be single, male, white and middle-aged. More recent data suggest an increased number of young people, especially young women, but they remain a small element of the population (Drake *et al*, 1981; Anderson *et al*, 1993; Randall and Brown; 1993; CRASH, 1996; Pleace, 1998a). Anecdotal, but plausible, evidence (see Chapter Three) suggests street counts may under represent women and people from ethnic minorities because they hide themselves for fear of attack when sleeping outside. People sleeping rough often lack friendships, sexual relationships and family support, they are generally excluded from the formal economy. Rough sleeping is associated with disrupted childhoods and adult relationship breakdown, low educational achievement, mental health problems and drug and alcohol dependency (Dant and Deacon, 1989; Anderson *et al*, 1993; Vincent *et al*, 1992 and 1995).

Government began to pay particular attention to rough sleeping when levels in London began to rise very noticeably in the late 1980s. The main policy response was the 1990 Rough Sleepers Initiative (RSI) which was focussed exclusively on London. Phase I ran from 1990 to 1993 and involved expenditure of around £100 million on developing outreach work, direct access accommodation, hostel places and other services. RSI II also focussed on London and placed more emphasis on resettlement. RSI III extended the programme outside London to other towns and cities. To date, expenditure on RSI has been over £200 million. To help address the needs of people sleeping rough with severe mental illness, the Homeless Mentally

Ill Initiative (HMII) was also introduced in 1990, involving the development of outreach teams and an expenditure of £35 million focussed on London.

The health status of people sleeping rough

When someone sleeps rough they expose themselves to a number of known risks to health. These include poor diet, prolonged exposure to cold and damp and difficulty in keeping oneself and one's clothing clean. Living in very close proximity to other people in often quite unsanitary conditions can also increase the risk of infection. Very stressful events often precede homelessness, such as relationship breakdown, loss of a home or an experience of abuse or violence. The experience of rough sleeping is also stressful because of society's attitudes towards homeless people and because of the physical danger of being on the streets at night (Fisher and Collins, 1993; Connelly and Crown, 1994; Pleace and Quilgars, 1996). The level of stress experienced by people sleeping rough may undermine mental and physical health (Taylor and Bloor, 1994; Elstad, 1998) and it may also lead to increasing dependency on drugs or alcohol.

Most studies have focussed simply on homeless people using health care services and are limited by not looking at the whole homeless population and by not comparing homeless people with a similar housed population. Some studies are also limited by using 'self-reporting' of health problems which is much less reliable than using medical professionals to diagnose problems (Victor, 1992 and 1997; Pleace and Quilgars, 1996). However, while these studies have methodological limitations, they do all suggest that people sleeping rough have particularly poor health compared to the general population.

A range of studies have found a prevalence of serious mental illness of between 12 and 26 per cent among single homeless people, with 30 to 50 per cent having some sort of mental health problem (Connelly and Crown, 1994, p.97). Reed *et al* (1992) interviewed people sleeping rough using a cold weather shelter and their findings suggested that psychosis was present in 8 per cent of the people interviewed and possibly present in another 4 per cent. The largest study of psychiatric morbidity among people sleeping rough in recent years was conducted by Gill *et al* (1996). Fifty-seven per cent of people sleeping rough using day centres were assessed as having a mental health problem and there was also a high prevalence of dual diagnosis (presence of both mental health problems and a drug or alcohol dependency). Bines (1994) found that people sleeping rough were 11 times more likely than the general population to report suffering from 'depression, anxiety or nerves'. Baker has suggested higher than average suicide rates exist among people sleeping rough (1997).

People sleeping rough are also much more likely than the general population to have a drug or alcohol dependency. Gill *et al* (1996) found that 37 per cent of people sleeping rough were using drugs and 18 per cent were dependent on opiates (heroin and derivatives). They also found that only 15 per cent of people sleeping rough were classified as non drinkers and that 36 per cent had severe alcohol dependence. Pleace (1998a) found that 8 per cent of nightshelter users self-reported being dependent on class A drugs and 12 per cent self reported themselves as alcoholics. A study of the use of an Accident and Emergency room by homeless people found they were eight times more likely than the general population to attend with a drug overdose (North *et al,* 1996). Intravenous drug use carries with it the risk of HIV and hepatitis and research by the Big Issue (1998) found that 13 per cent of vendors were sharing needles and that 7 per cent had hepatitis C and 5 per cent were HIV positive.

Asthma, chest and breathing problems seem particularly common among people sleeping rough. Bines (1994) found these occurring at three times the rate found in the general population and Allen and Jackson found 26 per cent of people sleeping rough had chronic chest problems (1994, pp.145-146). Other research has had similar results (Fisher *et al*, 1993; Connelly and Crown, 1994; North *et al*, 1996; The Big Issue, 1998). Citron *et al* (1995) found that tuberculosis was 25 more times prevalent among people sleeping rough than the general population, but as Connelly and Crown (1994, p.64) note this was because levels in the rough sleeping population had never really fallen in line with those of the general population. Muscloskeletal problems, difficulties in walking and poor general mobility have also been found to be prevalent among people sleeping rough. Allen and Jackson found almost a quarter of people staying in resettlement units for people sleeping rough had difficulty in walking (1994, p.145-146) and Bines (1994) found high rates of such problems. There is also evidence of a high prevalence of fits and loss of consciousness and skin disease among people sleeping rough (Pleace and Quilgars, 1996).

Some research indicates high levels of mortality among people sleeping rough. Keyes and Kennedy (1992) examined the death certificates of people sleeping rough and concluded that they were 150 times more likely to be fatally assaulted than the general population and 34 times more likely to kill themselves. The average age of death among people sleeping rough was 47, compared to an male life expectancy in the general population of 73. More recent research funded by Crisis suggests that since Keyes and Kennedy's 1992 study, the average age of death among people sleeping rough has fallen to 42 (Grenier, 1996). Shaw (1998), in her study of variation in mortality levels in different areas of Brighton, concluded that high mortality in certain wards was due to the presence of formerly homeless people who had been rehoused in the area. Brimblecombe (1998) in a similar study of Oxford, found that male mortality was at its highest among the group of people she referred to as 'vulnerably housed', which included the homeless population of the city.

People sleeping rough and access to GPs

Previous research has suggested that the anxieties about homeless people which some GPs and receptionists have can act as a barrier to services. Both GPs and hospital doctors have also been reported as being concerned that homeless people might prove to be challenging and difficult, and that their presence might make visiting the doctor difficult for other patients (Martin *et al*, 1992; Connelly and Crown, 1994; Pleace and Quilgars, 1996).

Existing research has also suggested particular problems for people sleeping rough when they try to register with a doctor. Using three homeless people as researchers, Hinton sent a man sleeping rough, a middle class woman living in a squat and a Kurdish homeless man to try to register at GP surgeries in Hackney. None was treated especially well, but the individual who was sleeping rough consistently got the worst reception, only being offered permanent registration by two out of 30 surgeries and being refused registration outright by 60 per cent of surgeries (Hinton, 1992). Among people sleeping rough and people squatting in Hackney, Hinton found that only 60 per cent were registered with a doctor and she also found that, in expectation of a hostile reception, only a fifth of unregistered people squatting or sleeping rough had tried to register. In a later study in Newham (Hinton, 1994) she found that 83 per cent of single homeless people were registered, compared to 98 per cent of the housed population and only 66 per cent of people sleeping rough or living in squats. Among the latter group, Hinton found that 43 per cent of those who were registered were not registered with a doctor in the borough. Connelly and Crown (1994, p.94-95) cite a similar study in east London by Stern *et al* from the late 1980s among users of a health care project for homeless people, this found 83 per cent of hostel residents were registered compared to only 35 per cent of people sleeping rough, most of whom had never tried to register.

In their national study of homelessness, Anderson *et al* (1993) found that only 61 per cent of people sleeping rough were registered with a doctor. Approximately a quarter of people sleeping rough who had a health problem reported that they were not receiving treatment for that problem (Anderson *et al*, 1993, para 2.67). Allen and Jackson (1994) found that 43 per cent of rough sleepers were not registered with a GP. Most of this group had not tried to register, but 13 per cent reported that a GP had refused to register them.

A 1994/95 survey covering 117 GP practices in and around Bristol found that only 27 per cent would permanently register a homeless person, while a third offered only temporary registration and 24 per cent would treat homeless people only on an emergency basis. GPs tended to view a lack of medical records and drug and alcohol misuse as problems that arose when treating homeless patients. A majority also reported that dealing with complex health problems and mental health problems was an issue in registering and treating homeless people. GPs working in inner city areas were more likely to be prepared to register homeless people than those working elsewhere. The authors speculated that this might be explained by their greater experience in dealing with highly marginalised groups (Wood *et al*, 1997).

A recent study of five nightshelters found that only 56 per cent of people who reported a health problem were being treated for it. Of those reporting a health problem, 68 per cent said that they were registered with a GP, but only 37 per cent reported that their GP was within 10 miles of their current location. The likelihood of registration appeared to fall with experience of rough sleeping. Only 44 per cent of people who had spent three months or more of the last year sleeping rough were registered with a GP, compared to 60 per cent of those who had slept rough for a shorter period and 70 per cent of those who had not slept rough for a year (Pleace, 1998a).

Recent research found that only 71 per cent of *Big Issue* vendors were registered with a GP (Big Issue, 1998). Some variation was found between different areas, with 78 per cent of vendors in Manchester being registered, compared to 70 per cent in Leeds and 63 per cent in Liverpool. Among those who were not registered, the most common reason given was ‘moving around a lot’ (22 per cent), closely followed by ‘difficulty in registering’ (20 per cent) and ‘no need to register’ (19 per cent). Seven per cent reported ‘difficulties due to drugs’ when trying to register and a small percentage (3 per cent) reported that they did not know how to register.

Shiner (1995) found a reluctance to use GPs among people sleeping rough. This was strongly associated with a perception among rough sleepers that GPs looked down on homeless people. Shiner argued that seeking treatment is always a decision based on the risks someone perceives to their health against the perceived costs and benefits of seeing a doctor. In the case of people sleeping rough, the perceived ‘costs’ (being refused a service or looked down upon because of one’s homelessness) outweighed the perceived ‘benefits’ (treatment might be ineffective because of living on the street). Shiner found that habitual rough sleepers tended to use provision targeted on homeless people rather than mainstream services and to be more critical of mainstream services. Newly homeless people sometimes used services targeted on homeless people as soon as they became homeless, on the assumption that they would be rejected or mistreated by ordinary GP surgeries. Shiner also reported that as some individuals moved away from rough sleeping and into accommodation, they began to use mainstream services again.

Some research into access to GPs for homeless people has drawn attention to GP payments as a possible barrier to permanent registration. The argument goes that GPs will lose money if they permanently register someone who moves on very soon afterwards, whereas a temporary registration for three months will guarantee income for that person. Temporary registration means poorer quality of care because medical records are not transferred. Similarly, some have argued that the ‘cost’ of dealing with someone sleeping rough, who might present with drug or alcohol dependency, mental health problems, severe skin disease or other infections (or quite possibly all of them at once) acts as a deterrent. The literature review revealed that these arguments seem to be quite widely used, but that there has not really been enough systematic research to demonstrate the validity of either (see Chapter Three on the findings of the current research).

Some studies have advanced the idea that homeless people make inappropriate use of Accident and Emergency services in hospitals because they are not registered with GPs (Scheuer *et al*, 1991). Martin *et al* (1992) found that A&E staff often viewed homeless people as ‘inappropriate attenders’ presenting with health problems that should be dealt with by a GP. They also found that there were negative feelings towards homeless people among some hospital staff who felt that the medical problems of homeless people were to some extent self-inflicted (eg through drug and alcohol misuse). Singling out homeless people as ‘inappropriate attenders’ at A&E is difficult because there is considerable evidence that many people who are permanently registered with a GP use A&E inappropriately (North *et al*, 1996, p.24-25). One study found that hospital record keeping systems made it difficult to determine whether or not homeless people attending A&E were registered. Among those homeless attendees on whom registration details were available, it was found that 63 per cent were in fact registered, 9 per cent were ‘registered’ with a homelessness medical centre and that 28 per cent were not registered on at least one visit to the A&E (North *et al*, 1996, p.25).

Summary

There is not a distinct ‘rough sleeping’ population as the majority of people who sleep rough are single homeless people who tend to spend some time in accommodation and some time sleeping outside. Within this group, there are a relatively small number of habitual rough sleepers who spend several months sleeping outside during the course of a year. Individuals who are part of the population who sleep rough, which is dynamic in the sense that people constantly enter it and leave it on both a temporary and permanent basis, are characterised by generally very poor health status. Drug and alcohol dependency and severe mental illness are particularly over-represented, although high rates of many physical illnesses and infectious disease are also found among this group. High levels of stress, poor diet, exposure to damp and cold and many other risks to health are experienced by people sleeping rough.

A number of research projects have indicated that people sleeping rough have poor access to GP services. Much of the research that has been conducted has emphasised the importance of negative attitudes towards homeless people as a cause of poor access to services and as a reason for low rates of permanent registration. In addition, some research has suggested that the more alienated and marginalised sections of the homeless and rough sleeping populations may find the environment and rules within a GP surgery difficult to cope with. There is also evidence that people sleeping rough may be apprehensive about using ordinary GPs because of the attitudes towards homelessness and homeless people that they fear they will encounter. Existing research also suggests some issues around GP payments when a patient is someone who is sleeping rough and some confusion around rights to permanent registration. The next chapter examines the pattern of access to GPs and other health services reported by projects working with people sleeping rough and single homeless people in England.

2 Access to GPs and health care services in England

Introduction

This second chapter reports the results of the postal survey conducted for the research. The chapter begins with a brief discussion of the research methods and then examines the main findings. The chapter then considers the extent of geographical variation in access to GP services for people sleeping rough.

The postal survey

Voluntary sector, charitable, housing association and local authority projects for single homeless people and people sleeping rough in England were surveyed at the beginning of 1999. Direct access hostels and nightshelters, daycentres, resettlement services and soup runs were included in the survey. Most of these projects have a role in arranging access to health services and a considerable number are involved in delivering health services. This role in arranging or providing medical services has developed because of the very poor health status of many people sleeping rough and single homeless people. Targeted medical services for homeless people were also included in the survey. A copy of the postal questionnaire can be found in appendix one.

Although the aim was to survey all the homelessness projects in England, establishing a reliable database of addresses proved problematic and there may have been a few omissions. An overall response rate of 57 per cent was achieved (1,019 projects out of 1,794 surveyed). The response rates from each part of the country were almost all over 50 per cent. High response rates were achieved from most cities, although the response across London was slightly disappointing at just over 50 per cent. This may have reflected some degree of research fatigue as central London projects are inundated with research requests. The best responses were achieved in Manchester and Sheffield, where all the projects replied to the survey. Seventy-four per cent of the projects reported that they frequently tried to get access to GPs and other medical services for their users. A further 20 per cent reported that they sometimes tried to get access to health services .

Most homelessness projects working with people sleeping rough and single homeless people provide some form of accommodation. Just over a quarter of the projects that responded to the survey were direct access (27 per cent) and 46 per cent were hostels (just under half of which also provided resettlement, day centre or other services in addition to accommodation). Thirteen per cent of the projects were resettlement services and 10 per cent were daycentres and a smaller number were soup runs (2 per cent). Just under a fifth of these projects provided some form of GP service or had access to a visiting GP service in addition to their other services. Targeted medical services for homeless people, with no other function than the provision of primary care, were also surveyed and represented 2 per cent of responses.

Most projects work with all homeless individuals rather than focussing solely on rough sleeping. Fifty-four per cent of projects reported up to a third of their users were people sleeping rough and 17 per cent reported that more than a third of their users were sleeping rough. The remaining 29 per cent of projects reported that they did not provide services to people who were currently sleeping rough, although in practice these services would have been dealing with at least some former rough sleepers and some people who might have subsequently joined the rough sleeping population. Hereafter projects that reported that none of their users were currently sleeping rough are referred to as **low use projects**, those in which up to a third of users were people sleeping rough are referred to as **medium use projects** and those in which a third or more of users were people sleeping rough are referred to as **high use projects**.

Use of Accident and Emergency

People sleeping rough are often thought to make high use of A&E because they cannot get access to GPs. Almost a third of all the projects (30 per cent) reported that their clients made more use of A&E than GPs. **Figure 2.1** shows that as the proportion of people sleeping rough catered for by projects increased, the reported use of A&E also increased. Low use projects (which reported that none of their users were people currently sleeping rough) reported that 21 per cent of their users were using A&E more frequently than GPs. This compared to 31 per cent of medium use projects, (where up to a third of users were people sleeping rough), and 41 per cent of high use projects (where a third or more of users were people sleeping rough).

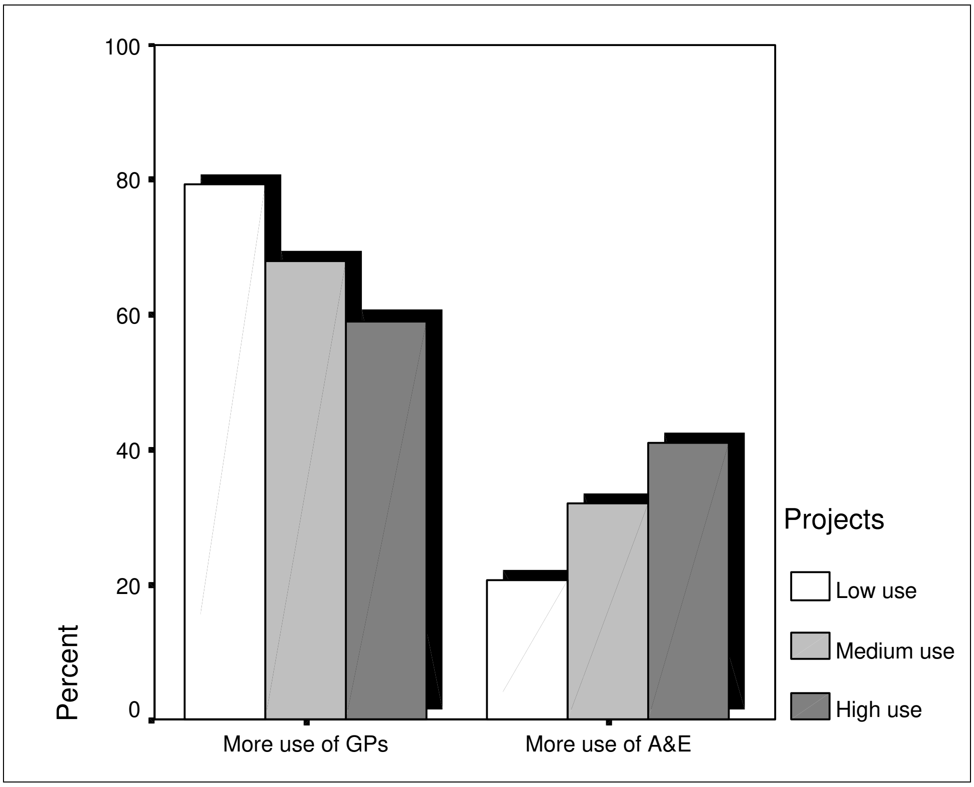

Figure 2.1 Whether A&E was more frequently used than GPs Source: Postal Survey, Base: 687 projects

There were also some variations by type of project. Daycentres (51 per cent) and soup runs (40 per cent) were more likely than other services to report that their users made more use of A&E than GPs. Daycentres and soup runs tend to offer environments in which there are very few rules or expectations, which can suit habitual rough sleepers and other highly marginalised homeless people more than some other services. Some research evidence suggests that the more marginalised homeless people become, the less likely they are to engage with GP services (see Chapter One).

Registration

Only 46 per cent of the projects reported that permanent registration with a GP was generally available for their users, with another 40 per cent reporting that temporary registration was available and 14 per cent reporting that registration was generally not available. **Figure 2.2** shows that 56 per cent of low use projects reported that permanent registration was available. This compared to 41 per cent of medium use projects and 38 per cent of high use projects. Nine per cent of low use projects reported that registration was generally not available, compared to 16 per cent of medium use projects and 17 per cent of high use projects. These findings are similar to those of previous research (Chapter One).

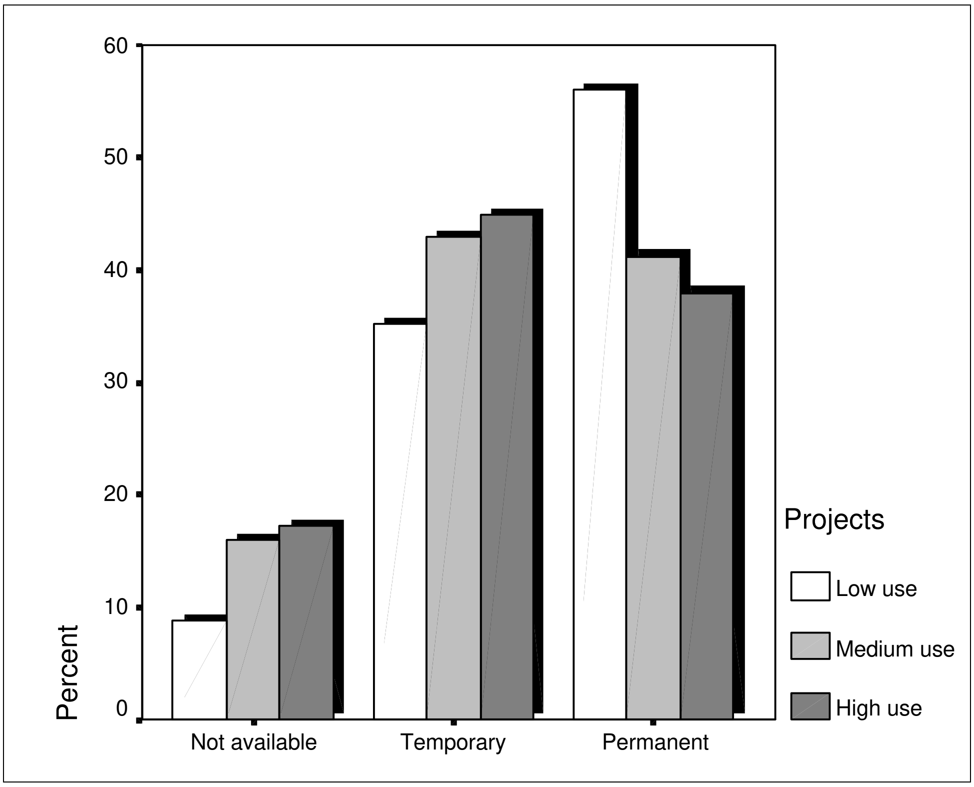

Figure 2.2 Access to registration Source: Postal Survey Base: 896 projects

Daycentres were less likely to report that permanent registration was available (26 per cent) and more likely to report that registration was unavailable (26 per cent), which again may reflect the tendency of highly marginalised people to use such services. Direct access accommodation and soup runs were also less likely to report that permanent registration was generally available (36 per cent and 20 per cent respectively).

Access to GPs

Overall, 42 per cent of projects reported that access to a GP was 'easy' for their users and another 42 per cent reported that it was 'variable'. Sixteen per cent of projects described access to GPs as 'difficult' for their users.

Figure 2.3 shows that 55 per cent of low use projects reported access to GPs was 'easy', compared to 36 per cent of medium use projects and 36 per cent of high use projects. Low use projects were more likely to report that access to GPs was variable (47 per cent) than medium (33 per cent) and high use projects (38 per cent). Again, access for people sleeping rough appeared to be particularly poor, with high use projects more likely to report access to GPs was difficult (26 per cent) than medium use (17 per cent) or low use projects (12 per cent). These findings are similar to those of previous research.

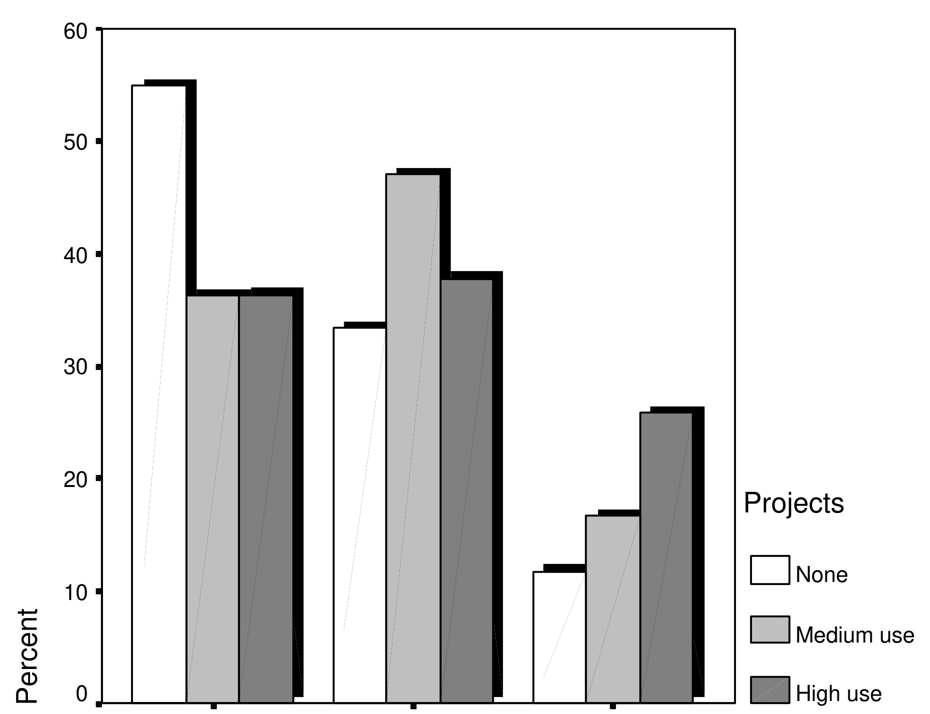

Figure 2.3 Access to GPs Source: Postal Survey Base: 887 projects

There was again quite a strong relationship between types of service provision and reported access to GPs. Hostels (49 per cent) were most likely to report that access to GPs was easy. Daycentres (13 per cent) and soup runs (27 per cent) were less likely to report easy access and more likely to report it was difficult (26 per cent and 33 per cent respectively). Again, these findings may be linked to the most marginalised people using day centres and soup runs.

Geographical variations in access to GP services

Access to GP services across England was generally poor and while there were variations in how accessible GP services were, these were much less significant than the central finding of *generally poor access in **all** locations*. **Figure 2.4** is based on the responses from all the projects and uses quartiles of a simple score derived from the questions on registration with GPs and access to GPs. Areas in which projects were more likely to report that access to GPs was easy and that permanent registration was generally available are shown in the lightest red (best reported access or the 1st quartile) and those which projects tended to report access was difficult and that registration was generally not available are shown in the darkest red (worst reported access or the 4th quartile).

Particular problems in access were reported by projects working in the population centres in Berkshire, East Sussex, Kent, Lincolnshire and Lancashire as well as Bath and North East Somerset. Projects working in York, Hull, Derby, Milton Keynes, Southampton and Portsmouth also reported problems (4th quartile or 'worst reported access'). In contrast, projects working in areas like North Yorkshire, Shropshire, Hampshire and Dorset were the least likely to report problems (1st quartile or 'best reported access').

Table 2.1 summarises the differences between the areas shown in Figure 2.4. Projects in areas with the worst reported access were three times more likely to report that registration was not available than those in the areas with the best access.

Table 2.1 Geographical variations in access to GPs (All Projects)

	1st Quartile: Best reported access	2nd Quartile: Next best reported access	3rd Quartile: Next worst reported access	4th Quartile: Worst reported access	All projects in all areas
Access to GPs easy	59%	48%	35%	17%	42%
Access to GPs variable	35%	38%	48%	55%	42%
Access to GPs difficult	6%	15%	18%	29%	16%
Permanent registration generally available	69%	49%	39%	31%	46%
Temporary registration generally available	23%	40%	46%	41%	40%
Registration not generally available	8%	12%	15%	28%	14%

Figures refer to the percentage of projects in each quartile. Percentages are rounded. Source: Postal Survey Base for question on access to GPs 963 projects, base for question on registration 972 projects.

The generally poor access to GP services across England is apparent from Table 2.1. On average, only 69 per cent of projects in areas with the 'best' reported access were reporting that permanent registration was generally available, while only 59 per cent were describing access to GPs as 'easy'. Poor reported access seems to have been matched by higher use of A&E. Projects in areas in the 1st quartile tended to report that their users made more use of GPs than A&E (79 per cent), with lower figures for areas in the 2nd quartile and 3rd quartile

(72 per cent and 68 per cent respectively). Projects in areas in the 4th quartile were much less likely to report that GPs were more frequently used that A&E (55 per cent).

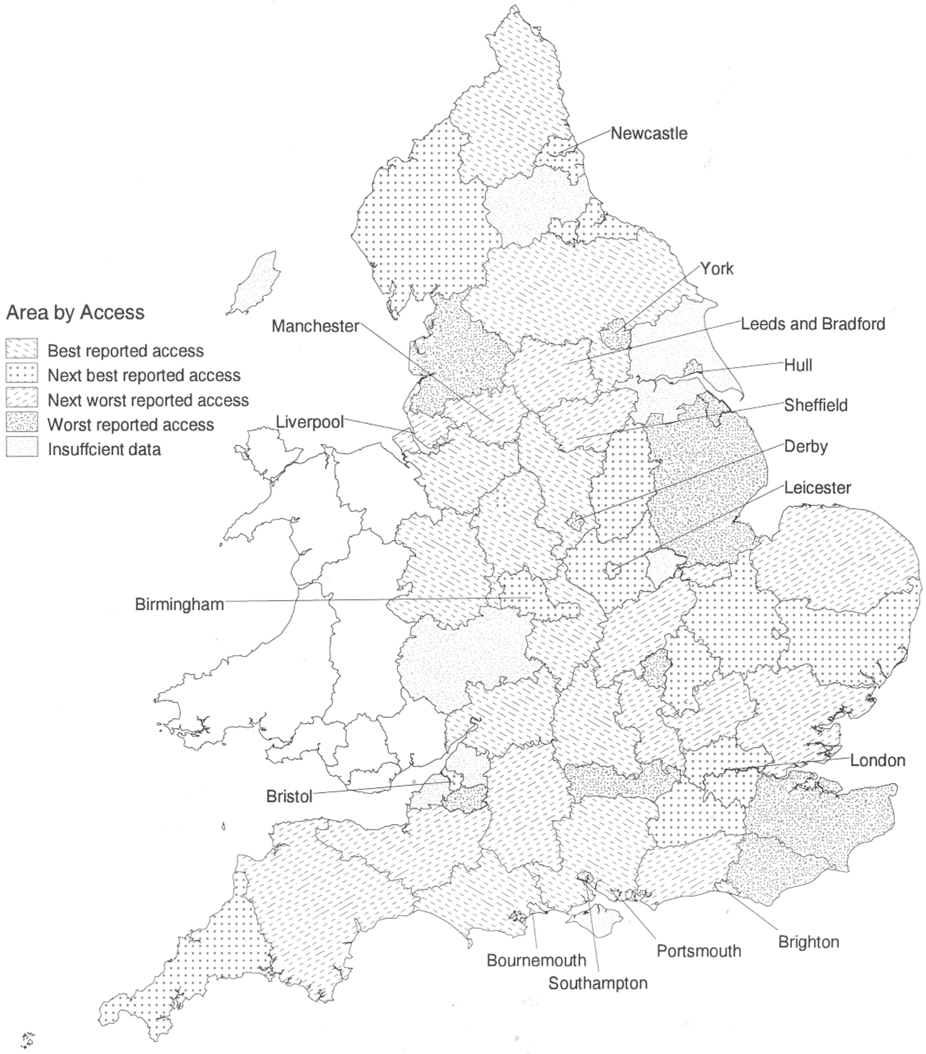

Figure 2.4 Access to GP Services by Area (Source: Postal Survey)

Access to GPs in towns and cities outside London with high levels of rough sleeping

A number of towns and cities outside London have a particular rough sleeping problem identified by recent rough sleeper counts (DETR, 1999 and see appendix two). **Table 2.2** lists these areas and shows the reported access to GP services in each of them.

Table 2.2 Access to GPs in towns and cities outside London with a rough sleeping problem

Area	Street Count*	Access to GP easy	Access to GP variable	Access to GP difficult	Base**
Bath	12	-	67%	33%	3
Birmingham	56	51%	37%	11%	35
Blackpool	15	25%	50%	25%	9
Bournemouth	44	75%	25%	0%	8
Brighton	44	57%	14%	29%	7
Bristol	42	17%	79%	3%	29
Bury (Greater Manchester)	12	33%	33%	33%	3
Cambridge	30	70%	10%	20%	11
Canterbury	11	-	100%	-	5
Exeter	27	50%	50%	-	4
Gloucester	16	17%	50%	33%	6
Leicester	20	42%	32%	26%	41
Liverpool	17	42%	46%	12%	26
Manchester	31	37%	52%	11%	28
Northampton	13	-	100%	-	3
Nottingham	14	56%	44%	-	16
Norwich	19	40%	60%	-	6
Oxford	39	63%	37%	-	10
Plymouth	13	22%	56%	22%	10
Portsmouth	21	27%	58%	15%	8
Reading	13	33%	50%	17%	6
Sheffield	15	46%	54%	-	12
Southampton	22	23%	47%	29%	17
Stoke-On-Trent	20	60%	20%	20%	6
Swindon	17	50%	50%	-	2
York	12	42%	40%	17%	6

Source: Postal Survey. Percentages are rounded. ** Base refers to projects responding to the postal survey * See appendix two. Areas which had a street count of 10 or less have been excluded as have areas with a street count of 11 or more from which there was an insufficient response to the questionnaire to allow statistics on access to be generated (eg. Fareham, Great Yarmouth and Slough).

The general pattern of poor reported access to GP services (Figure 2.4) was repeated across towns and cities outside London with a particular rough sleeping problem. Table 2.2 shows that a majority of projects reported that access to GPs was ‘easy’ in only six (23 per cent) of these 26 towns and cities. In two areas, Bournemouth and Cambridge, access appeared to be relatively good. Elsewhere, including large cities like Birmingham, Leicester and Manchester, access appears to have been much more mixed.

Table 2.3 shows the access to registration reported by the projects in the same locations. Again, the findings mirrored those at national level (Figure 2.4) with poor access to registration being reported in most of these towns and cities. A majority of projects reported that access to permanent registration was generally available in only eight (30 per cent) of the 26 locations. Again, some areas such as Brighton and Bournemouth appeared to have relatively good access to permanent registration. However, the findings of the fieldwork in the Gloucester area, in which 86 per cent of projects reported that permanent registration was generally available, suggest that these figures need to be treated with an element of caution (see next chapter). As with access to GPs, access to permanent registration in most of these towns and cities is best described as variable, given the diversity of responses from projects located in the same town or city.

It is important to continually stress that the postal survey was based on the responses of organisations working with people sleeping rough and single homeless people rather than on a survey of the rough sleeping population. However, bearing this caveat in mind, tables 2.2 and 2.3 are of particular interest because they suggest variation in access *within areas* was perhaps sometimes greater than the variation *between areas* (Figure 2.4).

This variation may be partly explained by the extent to which GP practices and homelessness services have been able to establish relationships with one another. To some extent, this may be a matter of luck for some projects, as they may find a sympathetic GP practice nearby or a practice that is not sympathetic. These variations may also be explained by the extent to which projects have worked at establishing relationships with local medical services and how receptive those medical services have been.

Table 2.3 Registration with GPs in towns and cities outside London with a rough sleeping problem

Area	Street Count*	Registration generally not available	Temporary registration generally available	Permanent Registration generally available	Base**
Bath	12	-	100%	-	3
Birmingham	56	9%	46%	45%	35
Blackpool	15	13%	37%	50%	9
Bournemouth	44	13%	25%	62%	8
Brighton	44	14%	-	86%	7
Bristol	42	3%	45%	52%	29
Bury (Greater Manchester)	12	33%	-	66%	3
Cambridge	30	18%	27%	55%	11
Canterbury	11	60%	40%	-	5
Exeter	27	-	75%	25%	4
Gloucester	16	-	20%	80%	6
Leicester	20	21%	26%	53%	41
Liverpool	17	20%	40%	40%	26
Manchester	31	11%	41%	48%	28
Northampton	13	-	100%	-	3
Nottingham	14	-	81%	19%	16
Norwich	19	17%	66%	17%	6
Oxford	39	10%	20%	60%	10
Plymouth	13	-	70%	30%	10
Portsmouth	21	14%	72%	14%	8
Reading	13	33%	33%	33%	6
Sheffield	15	-	82%	18%	12
Southampton	22	18%	65%	17%	17
Stoke-On-Trent	20	-	60%	40%	6
Swindon	17	-	100%	-	2
York	12	25%	25%	50%	6

Source: Postal Survey. Percentages are rounded. ** Base refers to projects responding to the postal survey * See appendix two. Areas which had a street count of 10 or less have been excluded as have areas with a street count of 11 or more from which there was an insufficient response to the questionnaire to allow statistics on registration to be generated (eg. Fareham, Great Yarmouth and Slough).

London

Thirty-four per cent of the people sleeping rough in England on any given night are in London (DETR, 1999). **Figure 2.5** shows the level of reported rough sleeping across the city, while **Figure 2.6** uses the quartiles from Figure 2.4 as categories and shows the variations in access to GP services that the projects in different boroughs reported.

The pattern of poor access found across England was repeated in London. Westminster, which has many people sleeping rough and a number of London's main medical services and centres for homeless people, was among those areas of England with some of the worst reported access to ordinary GPs. Projects in Islington and Tower Hamlets also reported poor access. The poorest levels of access were reported by projects in an outer borough without a very high level of rough sleeping, Waltham Forest.

Table 2.4 examines the access to GPs and registration reported by projects in those boroughs in which a recent count has identified a rough sleeping problem (DETR, 1999 and see appendix two).

Table 2.4 Access to GPs and permanent registration in London Boroughs with a rough sleeping problem

Borough (base* shown in brackets)	Street Count **	Access to GP easy	Access to GP variable	Access to GP difficult	Registration generally not available	Temporary registration generally available	Permanent registration generally available
Barnet (3)	2	33%	33%	33%	-	-	100%
Brent (9)	29	55%	33%	11%	11%	57%	32%
Camden (23)	59	52%	38%	10%	19%	38%	43%
Croydon (6)	25	33%	66%	-	-	67%	33%
Ealing (8)	24	63%	37%	-	12%	38%	50%
Hammersmith (13)	11	46%	31%	23%	9%	36%	55%
Haringey (7)	8	57%	43%	-	14%	14%	72%
Hounslow (4)	20	50%	50%	-	-	50%	50%
Islington (15)	13	42%	25%	33%	27%	18%	55%
Kensington (11)	23	36%	46%	18%	18%	36%	45%
Lambeth (23)	20	67%	19%	14%	9%	44%	47%
Tower Hamlets (11)	31	44%	33%	22%	10%	50%	40%
Waltham Forest (7)	6	14%	57%	29%	43%	43%	14%
Westminster (46)	237	47%	18%	35%	22%	44%	33%
LONDON (258)	**-**	**50%**	**32%**	**18%**	**15%**	**35%**	**49%**

Source: Postal Survey. Percentages are rounded. * Base refers to the number of projects responding to the postal survey ** See appendix two. Boroughs where there was an insufficient response from projects to generate statistics have been excluded (eg. City and Richmond Upon Thames).

Figure 2.5 Estimated Rough Sleeping Levels in London (Source: Postal Survey)

Figure 2.6 Access to GP Services in London (Source: Postal Survey)

Note: Maps in this publication are based on copyright digital map data owned and supplied by Harper Collins Cartographic and used with permission.

Table 2.4 shows that considerable variation in access appeared to exist within individual London boroughs, reflecting the variation found within towns and cities with a rough sleeping problem (tables 2.2 and 2.3). While the projects in some boroughs were more likely to report that access to GPs was easy, as in Lambeth and Ealing, there was no really clear pattern of reported access in any of the boroughs. Thus, while projects in Westminster, Barnet and Islington were the most likely to report that access to GPs was difficult, this was less interesting than the tendency of different projects in the same borough to report differing experiences. The same pattern also held true with regard to access to permanent registration with a GP.

The extent of variation within the boroughs might be interpreted as a consequence of the absence of a clear strategy or policy towards arranging registration and access to GPs for homeless people. Again, the findings may suggest that ad hoc arrangements and an element of chance may come into play when projects attempt to arrange access to GP services for their users.

Access to GP services targeted on people sleeping rough and homeless people

Eighteen per cent of projects provided a GP service targeted on homeless people or had a visiting service. Daycentres, soup runs and direct access accommodation were more likely than other projects to provide a GP service. Another forty per cent of projects reported that a targeted GP service was available in their area. Overall, 58 per cent of projects reported that they either had a GP service or that a targeted service was available in their area.

Projects in the major cities and areas receiving funding from the Rough Sleepers Initiative were more likely than those elsewhere to report that a GP service targeted on homeless people was available in their area. Projects in areas known to have high levels of rough sleeping tended to report that a targeted GP service was available, most frequently in Bristol (93 per cent), but also quite frequently in inner London (75 per cent) and Birmingham (69 per cent). Projects in some cities with a less pronounced rough sleeping problem also tended to report the presence of targeted GP services, such as Sheffield (92 per cent) and the Leeds/Bradford conurbation (82 per cent). Projects in smaller towns and cities receiving RSI III funding (which were also those towns with a recognised rough sleeping problem, such as Brighton, Cambridge or Oxford) were much more likely than those in other smaller towns and cities to report the presence of targeted GP services (73 per cent against 39 per cent). Projects in Liverpool (52 per cent) and Manchester (44 per cent) were less likely than those in other major cities to report the presence of targeted GP services.

There was high use of targeted services, indicating that they were an important source of health care. Just under half the projects in areas where these services were present (48 per cent) reported that their users were more likely to use targeted health services as a source of primary care than either A&E *or* GPs. Whereas under a third of projects reported that A&E was more frequently used than GPs (30 per cent), 41 per cent reported that targeted health services were more frequently used than GPs.

Figure 2.7 shows the access reported by projects to GP services that were targeted at homeless people.

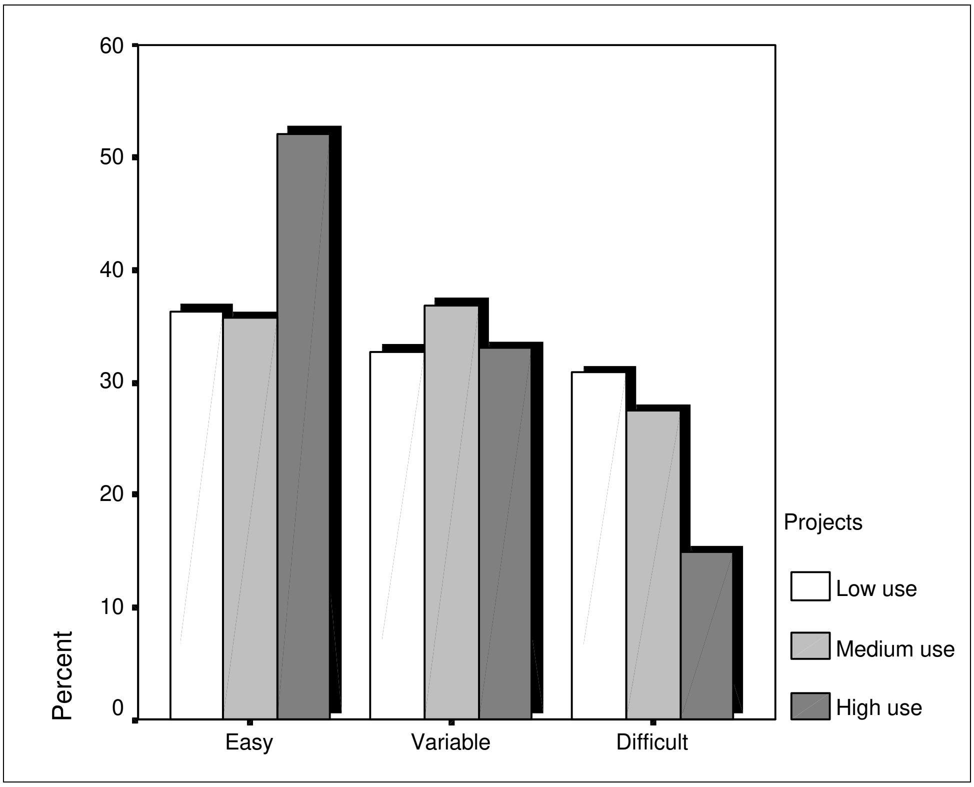

Figure 2.7 Access to GP services targeted at homeless people Source: Postal Survey Base: 459 projects (excludes areas where no targeted service was present)

GP services targeted on homeless people appeared to be easier to access for the users of projects working with a high number of people sleeping rough than they did for homeless people using other projects. Fifty-two per cent of high use projects reported that access to targeted GP services was ‘easy’, compared to 36 per cent of other projects. High use projects were also less likely to report that access to these services was ‘difficult’ for their users (15 per cent) than either medium use (28 per cent) or low use projects (31 per cent). These findings indicate that targeted services were effective at reaching the most marginalised element of the homeless population, people sleeping rough. The contrast between reported access to ordinary GP services for the users of high use projects and the reported access to targeted services is quite striking (Figure 2.3).

Access to other health services

Access to other services was often poorer than access to GP services. Access to mental health services, nurses, dentists and chiropodists was particularly poor according to the projects. **Table 2.5** shows the access to other health services and drug and alcohol services reported by the projects and the proportion of projects reporting targeted services were available.

Targeted drug and alcohol services and mental health services were more commonly reported as present than targeted GP services and nursing services by the projects. However, targeted dental services and chiropody services were less common. As with GP services, other targeted services tended to be reported by projects in major urban centres and areas with known rough sleeping problems. For example, only 50 per cent of projects in rural areas, smaller cities and towns reported the presence of targeted mental health services, compared to 84 per cent of projects in areas receiving RSI funding and 81 per cent of projects in inner London.

Only 30 per cent of projects described access to nursing services as easy. Again, access to mainstream NHS services appeared to worsen with the proportion of people sleeping rough using projects, while access to targeted services improved. Thirty-six per cent of low use projects reported that access to a nurse was easy, compared to 28 per cent of high use projects. In contrast, only 33 per cent of low use projects reported access to a targeted nursing service was easy, compared to 52 per cent of high use projects.

With only 21 per cent of projects reporting that access was easy, chiropody was apparently the most inaccessible of all health services. Chiropody has importance for people sleeping rough, as their feet can be wet or cold for prolonged periods and they may also spend much more time walking than people in the general population. The same pattern of access was again repeated, 28 per cent of low use projects reported access to chiropodists was easy, compared to 18 per cent of medium use projects and 19 per cent of high use projects. Again, high use projects (37 per cent) were more likely than low and medium use projects to report that access to chiropody services targeted on homeless people was easy.

Access to opticians was generally poor. Fifty-two per cent of low use projects reported that access to an optician was easy for their residents, compared to 33 per cent of medium use and 28 per cent of high use projects. Daycentres and soup runs were somewhat more unlikely than other services to report that access to opticians was easy (18 per cent and 20 per cent).

Table 2.5 Access to other services reported by the projects

Service (base shown in brackets)	Percentage of Projects reporting service present	Access easy	Access variable	Access difficult
Nurse (786)	-	30%	50%	20%
Nurse for homeless people* (462)	60%	44%	33%	23%
Chiropodist (677)	-	21%	36%	44%
Chiropodist for homeless people* (415)	47%	28%	34%	38%
Optician (734)	-	38%	37%	25%
Optician for homeless people* (385)	40%	26%	34%	39%
Dentist (779)	-	31%	36%	33%
Dentist for homeless people * (402)	43%	25%	35%	40%
Mental health services (823)	-	30%	48%	22%
Mental health services for homeless people* (488)	66%	37%	38%	24%
Drug and alcohol services (828)	-	37%	44%	19%
Drug and alcohol services for homeless people* (511)	71%	41%	38%	21%

* Percentages on whether access was easy, variable or difficult are based on areas in which such services were present. Percentages are rounded. Source: Postal Survey. Base shown in brackets on each line.

Under a third of projects reported that access to a dentist was easy for their users. Again, high use projects were less likely to report that access was easy (25 per cent) than low use projects (46 per cent). However, there was not a strong relationship between the proportion of people sleeping rough using a project and the reported access to dental services that were targeted on homeless people. Daycentres and soup runs (48 per cent and 64 per cent) were more likely to report access to dentist was difficult. There was some regional variation, with projects in Tyneside (56 per cent) and Leicester (49 per cent) being more likely to report access was easy than projects located in some other areas. Projects in Bristol and Sheffield (18 per cent and 17 per cent) were the least likely to report access to dentists was easy. There was also some variation in terms of dental services targeted on homeless people. These variations may reflect the number of NHS dentists in different areas (see Chapter Three).

Access to mainstream mental health services was poor, with only 30 per cent of projects reporting that access was ‘easy’. High use projects were much more likely to report that mental health services targeted on homeless people were easy to access (54 per cent) than medium (34 per cent) or low use projects (33 per cent). There was quite strong variation by area. All the projects in Sheffield described access to targeted mental health services as easy, followed by Tyneside (53 per cent) and then inner London (51 per cent). This pattern appears to reflect the targeting of mental health services on people sleeping rough through the Homeless Mentally Ill Initiative (Craig *et al*, 1995) and other local initiatives. Interestingly, projects located in inner London and outer London were more likely than those located elsewhere to report access to mainstream mental health services was easy (37 per cent and 35 per cent), perhaps suggesting that the outreach teams established using HMII funds have made trusts re-examine their provision of mental health services for homeless people.

Only 37 per cent of projects described access to drug and alcohol services as easy. There was some variation by area, with projects in Bristol and the Leeds/Bradford conurbation being less likely to report access was easy (19 per cent and 15 per cent) than those in Leicester and outer London (44 per cent and 42 per cent). There were also quite marked differences between areas with regard to access to drug and alcohol services targeted on homeless people. Projects in inner London were the most likely to report that access to these services was easy (55 per cent), followed by Leicester (52 per cent) and Birmingham (50 per cent). Projects in Bristol (26 per cent) and Tyneside (25 per cent) were less likely to report that access to these services was easy.

Summary

It is important to acknowledge that the postal survey was completed by projects and agencies working with people sleeping rough and single homeless people and that it dealt only with their perceptions of access to GP services. However, the strengths of the data set generated by the postal survey should not be overlooked. Most homelessness projects would be unable to function without some links with GPs and other medical services because of the very poor health status of many single homeless people and people sleeping rough. This is reflected in the fact that all but 11 of the 1,019 projects that responded to the survey had some role in arranging or providing medical services for their users.

The results of the survey indicate that access to GP services is poor for many single homeless people and even worse for many people sleeping rough. In addition, there appears to be quite high use of Accident and Emergency services for primary care and a heavy reliance on medical services targeted on homeless people, where such services are present. Geographical variation is not particularly pronounced, as problems of access appear to exist to some degree across England. However, more detailed analysis of towns and cities and London boroughs with a rough sleeping problem indicates that significant variations in access to GP services appear to exist within quite small areas. This finding suggests a lack of overall planning in many areas and that where good links between homelessness projects and GP services exist that they are either restricted in scale or have arisen through ad hoc arrangements or even by chance, such as via a sympathetic GP happening to be near a project. The next chapter examines the views of people sleeping rough, GPs, and homelessness project workers on access to GP services and other health services.

3 The Views of People Sleeping Rough, GPs and Project Workers

Introduction

This chapter begins with a brief description of the fieldwork. The chapter then moves on to consider the effects of rough sleeping on health and this is followed by an examination of access to GP services for people sleeping rough. Views on the quality of care received by people sleeping rough and their access to other health services are then discussed. The chapter ends with an examination of a range of views on the best means to provide primary health care to people sleeping rough.

The case study areas

The fieldwork took place in the inner London boroughs of Lambeth and Westminster and Manchester, Bristol, Nottingham and Southampton. These areas were selected because they had rough sleeping problems and a sufficient range of projects to allow the fieldwork to be effectively conducted. Areas were also selected on the basis of the responses of their projects to the postal survey (Chapter Two). Projects in Manchester reported relatively high use of A&E as a source of primary care in their responses to the postal survey (40 per cent) and the city was also of interest because of recent initiatives by the health authority and the Big Issue in the North. Projects in Southampton were likely to report high use of targeted medical services (64 per cent said they were more frequently used than GPs or A&E) and poor access to mainstream services, which made the city of interest. Westminster was included because of its very high level of rough sleeping and also because its projects were among the most likely to describe access to GPs as difficult (36 per cent).

Projects in Bristol and Nottingham were among the least likely to report that access to GPs was difficult and this made the cities of interest. Lambeth was similarly of interest to the research, because projects reported relatively good access to GPs compared to other inner London boroughs, including Westminster. Sixty-seven per cent of projects in Lambeth reported access to GPs was ‘easy’ (compared to 47 per cent of projects in Westminster). As was stressed in Chapter Two, nowhere in England appeared to have good access to mainstream GP services for people sleeping rough and single homeless people. The fieldwork was divided between three areas were access was relatively poor; Manchester, Southampton and Westminster and three slightly better performing areas; Bristol, Lambeth and Nottingham. In order to ensure that rural areas were represented, a seventh smaller case study based in Gloucestershire was added to the study.

The interviews

Each of the six case studies was to include the following set of interviews:

- Two focus groups, each with five people sleeping rough
- Two interviews with GPs working with people sleeping rough

- At least one interview with a GP not working with people sleeping rough
- Up to two interviews with homelessness project workers and managers
- At least one interview with a health authority representative

Securing cooperation from GPs not working with people sleeping rough proved problematic and not all the planned interviews were conducted. The focus groups also proved difficult to organise in London, so 20 individual interviews with people sleeping rough were conducted instead. The Gloucestershire fieldwork was on a smaller scale and involved interviews with three homelessness workers, one health worker and six people sleeping rough.

One hundred and twelve people were interviewed for the research. This included 12 GPs, seven health authority representatives, six health workers and 19 homelessness workers. Interviews were also conducted with representatives from the Royal College of General Practitioners (RCGP), Health Action for Homeless People (HAHP) and the Community Practitioners' and Health Visitors' Association Special Interest Group on Homelessness (SIGH). Sixty-four people sleeping rough were interviewed and their characteristics are shown in Table 3.1 below.

Table 3.1 The Characteristics of people sleeping rough who were interviewed for the research

Age	Male	Female
18-24	15 (29%)	3 (25%)
25-34	16 (31%)	4 (33%)
35-44	13 (25%)	3 (25%)
45-45	3 (6%)	2 (17%)
55+	5 (10%)	-
All	**52 (100%)**	**12 (100%)**

Percentages are rounded.

The sample was representative of people sleeping rough in that it was dominated by White males, but it was perhaps slightly younger than the rough sleeping population in general (Chapter One). The research team deliberately included a direct access project working with women to ensure some representation of women sleeping rough. Only three Black people and one Asian person were interviewed, reflecting the very low representation of these ethnic groups among people sleeping rough. All the interviewees had experience of rough sleeping, many of them for prolonged periods.

Health and homelessness

The living conditions and lifestyle associated with rough sleeping, the physical danger of being on the street, the impact of drug and alcohol dependencies and the associations between mental ill health and rough sleeping were the four broad themes that interviewees talked about when asked about the impact of rough sleeping on health.

The living conditions associated with sleeping rough were damp, cold, poor diet and an increased risk of infection. Asthma was widely reported, along with other chest problems, including some cases of tuberculosis. People sleeping rough often talked about constant fatigue, coughs and colds and a general lack of well being. Skin diseases and insect infestations, brought on largely by poor access to sanitation, were common.

> *..they get lots of feet problems, lots of teeth problems, lice and boil problems, loads and loads of horrid skin problems where they are not able to wash and that, chest problems...just general malaise really, I suppose that's how I would describe it.* Project Worker, Southampton.

> *The cold...and lack of food, you're always on the move...you're getting a couple of hours a night sleep, because you're frightened or because of the cold, so you're always feeling run down.* Man in his 20s, Southampton.

> *Its hard to get a good diet, lots of fried food, chips and that in the day centres, its hard to get fruit and veg..so you eat what you can get and after 30 days of rubbish your body suffers.* Woman in her late 20s, London.

General Practitioners reported that people sleeping rough quite often presented with several health problems at once. It was not uncommon for someone to have a skin disease, a drug or alcohol dependency and perhaps a problem like depression when they saw the doctor.

> *Very rarely does anyone present with a single problem...I suppose a common combination would be a psychiatric diagnosis with or without drug and or alcohol problems, if not current then very often a past history of. And very often respiratory problems, asthma, pretty common, and then I suppose skin problems really.* GP, Southampton.

> *Almost every health problem is over-represented. There are higher rates of respiratory disease, cardiovascular disease, dermatological disease, much higher rates of violence from others and self inflicted trauma; higher rates of mental health problems; higher rates of drug and alcohol use. Everything that happens, happens more.* GP, London.

Project workers and GPs were also concerned about the sexual behaviour of young people who were sleeping rough. Unprotected sex with multiple partners with its attendant risks of sexually transmitted disease was often talked about. The potential abuse of vulnerable young women and unwanted pregnancy among young women were also concerns.

> *..there are a lot of unwanted pregnancies or inappropriate pregnancies for young girls who are using intravenous drugs and who are chaotic, malnourished and living on the street.* GP, London.

There were also concerns about the long term health of women because of poor access to screening for breast and cervical cancer.

Physical danger was a constant theme of the interviews. One concern was people sleeping rough being attacked by young men. Another concern was that young women sleeping rough were particularly vulnerable to rape.

> *I've been raped a few times and kicked a few times, it is awful.* Woman in her 40s, Bristol.
>
> *I've had people coming along and kicking my cardboard shelter. Cardboard is not safe. I've seen someone being set fire to.* Man in his 40s, Manchester.
>
> *I've had clients who have sustained injuries that were so severe that they died...hit on the head with iron bars, a client of mine was kicked to death.* Nurse practitioner, London.

Drug misuse was widespread. Intravenous drug use was associated with infection and the spread of disease via shared needles, particularly hepatitis C. Some people sleeping rough would simply take whatever drug they could find, often including prescriptions that were sold on. Those who used drugs were aware of the potential damage to health, but quite often stressed the importance of drugs as a means of coping with homelessness.

> *The major ones are around drug use, needle stick injuries, infections through needles which they don't do anything about so it gets worse and worse. Had a few that have had open wounds from groin to knee..when they've used up their arms and legs the last place is their groin, easy to get an infection or hit an artery and get blood everywhere.* Project worker, London.
>
> *Just doing an audit, in the last three years tested 550 people and less than ten had HIV...But over 50 per cent of drug users have got hepatitis C, probably passed through the sharing of equipment, but its not clear how. In some age groups as many as 90 per cent have hep C and if someone has been injecting for three or four years you can almost guarantee they've got hep C.* GP, London.
>
> *A lot of people do it just to block out problems which they've got with everyday life or problems that they've had in the past, just to get away from it, rather than face it. Its just an escape route, a quick escape route.* Man in his 20s, sleeping rough, Gloucester.

Alcohol misuse was also widespread. Those with a long history of use suffered from damage to their liver, nervous system or brain. Again, people sleeping rough stressed the importance of alcohol as a means of coping with their situation. Some interviewees commented that the easy availability and low cost of drugs was causing some long term rough sleepers who were heavy drinkers to experiment with heroin. People dependent on both drugs and alcohol were seen regularly by project workers and GPs.

> *Alcohol related problems..when you nerve endings are fried, cirrhosis of the liver. With nerve endings, they start losing their balance, not being able to pick up knives and forks and cups...*Project Worker, London.

> *I think the majority of people have got a compound problem, more so the alcoholics..most of them are tampering with drugs as well, probably a bit less with the younger people who are using drugs who still sort of frown on alcohol a bit..they probably drink, or are under the influence of alcohol a lot less, but if they haven't got the drug of choice, then they would probably come in drunk or whatever, trying to block out the feelings of withdrawal..*Project Worker, Gloucester.

Drug and alcohol dependency made the diagnosis of mental health problems and severe mental illness difficult for GPs, because it was not always possible to tell whether someone's behaviour was a function of their dependency or a mental health problem. Dual diagnosis (the presence of mental health problems alongside a drug or alcohol dependency) was seen as a particular problem among people sleeping rough. Homelessness project workers generally reported what they took to be high rates of mental health problems among their users.

> *I mean, there is a fair amount of psychiatric illness..the majority is really depression, but there is a certain amount of psychotic illness as well, and that may or may not be related to the two major problems that I suppose we deal with, which are alcohol and drug use, and that certainly seems to be high.* GP working with people sleeping rough, Southampton.

> *Now what happens very often is that they take alcohol as an anti-depressant. That masks their mental illness so no one, not even a trained mental health worker, could assess someone accurately if they were inebriated most of the time.* GP working with people sleeping rough, London.

> *It varies, you'll have like your diagnosed schizophrenics coming in and then you'll have people, and I would say the percentage is quite high, about 80 per cent, that are on anti-depressants and they are seeing the doctor for either anxiety or depression.* Project worker, Southampton.

People sleeping rough often reported feelings of stress, anxiety and depression which were associated either with homelessness itself or with events preceding homelessness. The physical hardship, poor diet and danger of being on the streets all had a stressful effect, but it was perhaps the isolation of homelessness and the attitude of society towards them that they found the most difficult.

> *I feel dysfunctional, you know in ordinary situations like in the Arndale or St Anne's Square, you see families together and we are all alone...what we have in common here is that something has gone wrong and we are alone.* Man in his 30s, Manchester.

> *Very suicidal. Couldn't wash, couldn't clean..I was staying down in Earl's Court, found myself standing on tube stations thinking should I or shouldn't I? Seriously, desperately.* Man in his 50s, London.

> *You know, its like you're constantly being rejected by everybody, which is what puts you even more into a bigger pit, which gives you an even bigger problem than when you first started.* Man in his 20s, Gloucester.

These feelings of rejection, depression and alienation could lead to a dependency on drugs and alcohol or to the worsening of an existing dependency. Previous research has indicated that sleeping rough can lead to extreme alienation and that individuals sleeping rough lose social skills and tend not to have friendships and sexual relationships (Chapter One).

Accessing GPs: the views of general practitioners, health authorities and health professionals

As noted in Chapter Two access to GPs for people sleeping rough is generally poor in all parts of England and this next section considers some of the reasons for this.

Overall GPs and other health professionals felt that permanent registration was preferable for their patients for a number of reasons including continuity and quality of care, preventative health care and access to secondary care. Although permanent registration was generally favoured, there was sometimes confusion about who was entitled to it. Some GPs who did not work regularly with homeless people believed that patients had to have a permanent address to be permanently registered for example, although other GPs suspected that this sometimes was used as an excuse not to permanently register people sleeping rough.

> *We keep sending out information to GPs in the area and keep on trying to make it very clear that you do not need an address, the message has not got across. You absolutely do not need an address to register, it can be care of wherever. I think it may be 'We don't want to do it' and 'this is why we don't do it'.* GP, Lambeth.

There were other problems for GPs with regard to permanent registration related to financial arrangements. Some doctors believed that they would not get paid for registering patients without an address, others worried that they would leave the area or not attend appointments and affect their targets, for example for immunisation.

> *From a GP's point of view it's a difficult balance. If someone says they are going to be around permanently you could register them permanently... they probably get paid more for seeing them as a permanent patient because they then get a registration fee, but it affects things like target payments* [for example] *for smears. So if people don't comply and don't turn up then the GP won't meet the targets* GP Contracts Manager.

> *When I did have a couple of homeless people as patients we had terrible problems actually getting our finances sorted out with the health authority*

> *because we were not able to state an address and they couldn't pay us the capitation fees because we couldn't put them on our list. Whether things have changed since then..because we did complain about that, but we haven't challenged them since. This happened in 1992 or 1993.* GP, Westminster.

The reason given most often for some GPs' reluctance to register patients who were sleeping rough was that they feared they would be drug users and would abuse prescriptions. GPs were also concerned that they would become a target for other drug users if they were known to prescribe Valium, benzodiazepines or methadone. Without an accurate record of the patient's history GPs found it difficult to discern genuine cases and as a consequence some doctors would never prescribe drugs which might be misused.

> *I think the main problem for people sleeping rough is not so much the GPs willingness to register as the GPs willingness to prescribe methadone*. Health Authority representative.

> *I'm well aware that if I have one person that's abusing drugs and they think, or get the impression that I'm a soft touch.. Word gets round and you find suddenly there's more and more of them cropping up.* GP, Westminster.

> *We don't prescribe benzodiazepines, Valium and opiates because it leads to such difficulties in the relationship. People who are after drugs can become highly manipulative..in the environment of the West End, with a lot of chaotic homeless people, we just don't want to take that on. We know a lot of it will be diverted to the market. Just don't want to contribute to that or to deal with the drug seeking behaviours. I think it would make the surgery very difficult to manage and mean it would be difficult to keep staff.* GP, Westminster.

GPs who worked regularly with people who were sleeping rough thought that they could sometimes be difficult, but no more so than many other patients. Often these doctors worked in practices in socially and economically deprived areas and were very concerned that all their patients were treated equally.

> *I don't think there's anything different, just more, and frequently multiple problems in one person. Because there may have not been good access to health care previously, quite a lot of things may have become symptomatic and quite a lot of things may require attention at once, so you may have to deal with quite a lot of multiple health problems, many inadequately assessed and treated previously.* GP, Lambeth.

> *I would hope that anyone who comes to the practice will get registered and treated properly...one is always a little bit anxious that what doctors think happens may not actually be what truly happens on reception...We register them care of the surgery so people can get in to see us and get normal health care* GP, Lambeth.

GPs who worked with people sleeping rough had felt threatened ‘once or twice’ by homeless patients, usually drug users, who wanted treatment or a service which the doctor thought inappropriate. This behaviour was attributed to the addiction or to mental health problems or the patient’s poor communication skills. As previous research has suggested the expectation that people sleeping rough would have difficult behaviour was thought to be one reason why many GPs chose not to work with people sleeping rough.

> *GPs like someone coming in on time, turn up, be nice..and the reason people are on the streets is often because they haven’t been able to fit into that, they can’t button their lip when they need to, turn up on time or articulately ask for an appointment without getting into a barney with the receptionist.* GP, Westminster.

> *There is a perception that homeless people are going to cause problems, and disruption in the waiting room is extremely unsettling both for the practice staff, the receptionists who have to deal with it, but also for the surrounding patients...whether it is actually an issue is debatable but that is the perception.* GP, Southampton.

> *I think it’s mostly myth and I feel a lot of it is how you manage your service anyway, like having a waiting area that people feel is comfortable, having a reception that is reasonably welcoming...I think if people are treated well, they mostly behave well* GP, Lambeth.

Even where GPs had experienced some problems this did not deter them from accepting homeless patients, they also believed that their receptionists and other patients became more tolerant as they became used to people sleeping rough using the practice.

> *...we have had a few problems but not with other patients worried about a tramp in the waiting room or a drunk asleep across the floor, they seem to be very accepting of it, they’re used to it as it has been going on a long time....* GP, Nottingham.

In all the areas outside London, where there was far fewer primary care services targeted on homeless people, the fieldwork suggested that only a handful of practices were dealing with people sleeping rough. As GPs became known as sympathetic their work loads grew, as projects and other GP practices referred patients to them.

> *Our GP is taken advantage of, everyone knows he is a sympathetic GP so everyone sends their clients here, he gets called out at weekends and they are not even his patients, he can’t stay here all day as he has his own surgery to go to. You can see how stressed our GPs get but because they are nice they find it hard to say no.* Health advocacy worker, Manchester.

Many of the GPs’ concerns regarding patients who were sleeping rough stemmed from their own perceptions of adequate and appropriate care, they often felt that they were merely treating the most acute problems and not providing preventative or long term care which patients needed. Another concern which GPs repeatedly voiced was that they did not possess the necessary skills or knowledge to deal with patients with complicated health problems, addictions and mental health problems. Many of the GPs who worked with people sleeping rough had 'inherited' the work from a predecessor and learned from experience, none said that they had any training which related to homelessness.

> *I used to go out with an outreach team and I used to feel really awkward as I didn't know whether I was doing a good job, a bad job, there is no measure, no follow up.* GP, Westminster.

> *I feel very vulnerable in the sense that I don't feel able to follow up a problem that I've unearthed. OK the responsibility is partly with the patients to chase up the result, but legally as well there is also an onus on the doctor to chase up the patient*. GP, Westminster.

Accessing GPs: the views of people sleeping rough and project workers

People who were sleeping rough had varying experiences of accessing GPs. Not surprisingly, the fewest problems were reported in areas where there was targeted provision for people sleeping rough. As previous research and the survey findings suggested, the more marginalised homeless people were, the more difficulties they experienced when trying to access health care. It was also found that in areas where access was generally described as easy, this was often because projects and homeless people relied on a small number of local practices or the services of one or two GPs who visited hostels and day centres. Some project workers reported that they always used the Health Authority's allocation procedure, this was not something they liked having to do and people sleeping rough did not want a doctor who they felt had been forced to register them.

> *Getting to see a doctor isn't a problem, getting registered is and you have to be registered to get access to other services. I know people who have tried for weeks to get registered, we know where to go to see a doctor, we know the friendly ones.* Focus group, Nottingham.

> *I think everything is more difficult to access for habitual long term rough sleepers...you've got more problems accessing anything for that group than for an ordinary homeless person.* Project workers, Gloucester.

> *We fill in a form if they haven't got a GP and the Health Authority allocates them one...Generally when it is an allocated GP it is very difficult to get them to do anything...and whether they are sympathetic is another question.*
> Support worker, Bristol.

In some cases, people sleeping rough had been told that they could not register without an address, many others reported being told that the list was full. In other cases people sleeping rough were able to register with GPs but only on a temporary basis, which could in fact, last for many years.

> *I tried to see a doctor...said come back when you have a permanent address, till then we're full, we don't take people who are living on the streets.* Woman in her 30s, Lambeth.

> *I was given a list of local GPs, I picked one and went and registered on a temporary basis. That was seven or eight years ago. I'm still there, as a temporary and have to fill in a form every three months. They won't change this until I have a permanent address.* Man aged 29, Lambeth.

A number of respondents said that they invented an address in order to register with a doctor, others remained permanently registered with their family GP or their previous doctor. In some cases the practice was in the locality but, as earlier research has found, it was not uncommon for people to have a GP in another town or city. Sometimes this meant that people had not seen a GP for years but a few people travelled to see their doctor. This was inconvenient and expensive and meant that they were not able to receive a full service, but some people preferred to see their own GP.

> *My doctor is OK, because he has known me all my life, he knows me as a person and not as homeless.* Man aged 23, Nottingham.

A few respondents said that they 'saw doctors all over' and were registered temporarily in a number of practices or saw different doctors in various projects. This was usually for convenience and to ensure that they would be able to access a doctor.

> *It is easy to see a doctor if you want to. There's a medical centre in the West End for homeless people...I'm registered with quite a few and I just registered with another one this morning. Because everywhere I'm living at the time, I go and register...so like I've got quite a few doctors in London that I can use.* Man, Lambeth.

> *There is a bus that goes round, there's doctors and nurses and that but not everyone knows about them and they only come around twice a week. You have to be ill on Tuesday or Thursday.* Focus Group, Manchester.

Despite the often severe health problems experienced by people sleeping rough discussed earlier there was a reluctance to visit GPs or to access other health services. This was the case even when there was special provision for homeless people available in the area. The reasons for this were not always clear, there was some indication that people lacked motivation or that they had different priorities, such as trying to find food and shelter. In some cases the reluctance to seek health care appeared to be related to a mental health problem or to drug or alcohol dependency. In many cases it appeared that a combination of low self esteem, a lack of confidence, low expectations, past experience of unsympathetic treatment and embarrassment deterred people from trying to access GPs. Some project workers felt that it was easier to persuade clients to see the doctor or nurse if the service visited the project and some people sleeping rough shared this view. A few people sleeping rough, women in particular, were too frightened to leave their hostel for fear of physical attack.

> *Practical things as well, someone might not have the 10p to 'phone or the skills to talk and make an appointment or they have had bad experiences. I know someone who visited a GP then three days later was sectioned, he might have needed to be, but that's left him terrified of doctors.* Resettlement team, Manchester.

> *If I didn't have a doctor here I wouldn't go. When the doctor stopped coming here I didn't see a doctor for a year and lots of people are the same. I know people won't bother if the doctor doesn't come here they won't go and find another one, they wouldn't even go to the Big Issue* [GP Surgery], *probably wouldn't even know where it is.* Man aged 42, Manchester.

> *You can't blame people for not sorting themselves out, their self esteem is so low. When you are down you don't really think about your health. If you are depressed then you can't even be bothered to get out of bed.* Man aged 20, Bristol.

> *They often have horrendous problems...but don't access any care at all...We had a patient with hepatitis B and he was very jaundiced, very ill but did not think to get help...perhaps because of low expectations or bad experiences or they see GP surgeries as inaccessible.* GP, Bristol.

Most people who needed medical attention when sleeping rough said that they had felt very embarrassed because they were dirty and unkempt. They were conscious of the reaction of doctors, receptionists, nurses and of other patients in the waiting room. Those who were able to access day centres would have a shower and change their clothes before visiting the doctor, even if this meant delaying treatment for a few days.

> *After sleeping rough even for 24 hours, well you are dirty and after six months, well you're honking and if you are sitting in a waiting room next to a well dressed lady with her beautiful children...well would you sit next to them?...It's so embarrassing.* Man aged, 42, Manchester.

> *I hurt myself once, I broke my toe...I wouldn't go and take my socks off 'cause I knew my feet smelt and that so I waited all day Sunday and Monday morning to go to the day centre to get my clothes washed and have a shower and then go to the hospital in clean clothes. Because I waited I had to have my toe nail removed.* Man aged 25 Lambeth.

Many homeless people and project workers complained that doctors and other health professionals had been rude, unsympathetic or even abusive because they were homeless. Some people thought that health professionals assumed that all people sleeping rough had alcohol and drug addictions and that this affected attitudes towards them. In some cases people felt that they did not deserve treatment and that health professionals would blame the individual for his or her poor health.

> *A lot of doctors prejudge you, 'you're on the street, you're a waste of space' like. Basically they don't give a shit.* Man in his 50s, Gloucester.
>
> *It's called being depressed, not being a citizen, being a nobody without any rights...I never saw a doctor because I couldn't get past the receptionist...You end up getting demoralized, pack up your things and leave, or try another town.* Focus group, Manchester.

Some people sleeping rough felt that they would not receive sympathetic treatment, in many cases because of past experience, and this made them reluctant to approach health services unless they had to.

> *They don't want to examine you properly...it's like they don't want to come to close incase they catch something.* Man in his 20s, Gloucester.
>
> *I've got MS and epilepsy and it's very difficult to get help on the streets, and you get treated like the scum of the earth.* Woman aged 40, Nottingham.

Quality of care

As noted earlier, homeless people were likely to have multiple health problems, chronic and acute, and these were often complicated by mental health problems or drug and alcohol dependency. Although some respondents said that homeless people were difficult or expensive patients to treat, many GPs and other health professionals stressed that their health problems were not dissimilar to those of other marginalised groups of patients and no more complicated than, for example, many elderly patients. They were concerned, however, that people who were sleeping rough did not receive the same quality of care as other patients. There were a number of reasons for this including the use of temporary rather than permanent registration.

> *Just because you are homeless, it doesn't make you any more expensive to treat than anybody else, I mean anybody who gets a lymphoma or anybody who has MS or something.* RCGP representative.
>
> *Temporary registration means funding for three months. Many people have acute health needs, often due to lifestyle, they are going to get immediate treatment but other services, check ups, smears etc just won't kick in with temporary registration. Dr X. registers all his patients, but that means that people have come in and used up loads of resources and then gone again and he doesn't get any payment for them, so that is a disincentive.* Health Authority representative.
>
> *We don't like GPs registering anyone temporarily because we don't feel that they're actually getting the proper care, there's not the same requirement on the GP to immunise, do cervical smears...*GP Contracts Manager.

The disinclination of many people sleeping rough to go to a doctor was described above, and this sometimes meant that they put up with illness, pain and disability rather than see a GP.

This sometimes meant people sleeping rough presented late, putting off seeing a doctor until a problem became unbearable. When people sleeping rough did present very late, there was sometimes little that a GP could do.

Another major problem was trying to ensure continuity of care, this was not only an issue for patients but also for doctors who felt deskilled or demoralised when they could not provide a full service for their patients. Previous research has shown that people sleeping rough are often very geographically mobile, and a few respondents did describe moving around the country, most, however, tended to have moved quite short distances, for example within London, but this had taken them out of their previous GP's area. These movements meant that GPs working with people sleeping rough quite often only saw a patient once or twice.

A particular problem in providing continuity of care for GPs was the difficulty of trying to work without detailed medical records, which made all aspects of diagnosis and treatment more difficult. This was often coupled with a patient who perhaps had poor communication skills or who had little recollection of what other doctors had said. There were also many difficulties around compliance and appointment keeping, especially when people had to wait weeks or months for an appointment .

> *There is often a huge expectation about what will result from a consultation from homeless people because of the effort that it has taken to get there. Usually someone needs a whole series of consultations or contacts and that is very difficult for some homeless people to deal with. I don't think there is a problem of GPs not facing up to problems, I think it's that they get demoralised while trying to do so.* RCGP representative.

> *There are problems forming therapeutic relationships, they take a long time with initial consultation and then people disappear so follow up doesn't happen. Personality and mental health problems are often complex and confused by social problems, full registration of a patient, calling up records and spending time getting to know the patient and to build up a rapport can be very rewarding but with a temporary patient there is no reward and often no financial reward.* GP, Bristol.

> *I don't think homeless people have a particularly poor attendance record compared with many of the housed patients, maybe a bit more but I don't think it's terrible...in terms of hospital appointments it's much harder. If you say come back and see me here next week, by and large people will come back, but if you say wait for a letter in four weeks time to tell you about an appointment in six months time, it may be harder to turn up for that one.* GP, Lambeth.

Another factor which was thought to affect the quality of care patients received was GPs' suspicion that people sleeping rough would misuse prescriptions, without any medical records GPs had to rely on the patient's account of their history. As noted earlier some GPs simply refused to prescribe any drugs which might be misused.

> *You have to have a really high index of suspicion, because some of them are out to blag drugs off you....I think there are probably some genuine cases who don't get the level of pain relief that they may need, you won't prescribe because you know that you will be abused by an awful lot of others...that's the difficulty without any access to a history, records, it is very difficult to sort out the genuine need from those who are just trying it on* GP, Southampton..

Most respondents across all groups interviewed disliked the use of the health authority allocation procedure as they felt that GPs who were allocated patients were unlikely to treat them as well as they would other patients.

> *The last thing we want to do is to encourage patients to register with a doctor who doesn't really want to take them on, using the HA allocation procedure for example.* HAHP representative.

A number of respondents felt that people were simply grateful to have access to any service, whether it was of high quality or not. People sleeping rough had very low expectations of services and tended to think more about the attitude of medical staff toward them than the quality of care.

> *I think where there are issues around quality of care these are probably issues for the whole practice...but where GPs are trying to get people out of their hair then chances are that there might be problems with prescribing methadone without proper consultation work with other agencies...some of the GPs visiting hostels are not very good, but people value any medical input.* Health Authority representative.

> *There are issues around quality of care, there are GPs who will register anyone and give them what they want which might not be the best thing for the clients.* Health project worker.

Permanent registration and access to medical records were seen as extremely important, not only in ensuring continuity of care and appropriate treatment but in making the patient feel as though they 'belonged'. Although there was a evidence to suggest that people sleeping rough were unlikely to remain in an area for long this was not always the case. Some GPs spoke of patients who had been on their list for ten years and who had been homeless all that time. Most GPs and health workers who worked with people sleeping rough spoke of the importance of nurturing relationships, building trust, confidence and respect, which often took a long time.

> *We had a client, a rough sleeper, who hadn't had any medical treatment for 49 years and it took us six months to get him to go and see a doctor and another two months to get him to go to the hospital for treatment he needed. It's a long process and very intensive, you need to spend time and build a relationship, trust, with someone who wouldn't even tell us his second name, he's not on any benefits, he's not on anyone's list of anything, he is one of those invisible people.* Health advocacy worker, Manchester.

> *We try to register people permanently, then you can get their notes and try to do something. Ultimately we try to nurture relationships so that people will comply with treatment, you have to develop mutual trust and respect. So the idea that people won't comply which might put GPs off can be overcome. Getting people to follow treatment regimes or come for screening is more difficult but that comes with registering the patient, letting them know that you are their doctor and that you are not just saying 'I'll see you for this but I'm not really your doctor. You often see on temporary registration slips 'see own GP for such and such' but they haven't got their own GP, so if they need treatment they won't get it because they have only been seen on a temporary basis.* GP, Manchester.

Access to other health services

Seeing a dentist or chiropodist or getting access to mental health or drug and alcohol services could be more difficult than seeing a GP. People sleeping rough could also encounter problems when they used Accident and Emergency (A&E) services.

The response of A&E to people sleeping rough appeared to be variable. The same A&E was sometimes praised by some people sleeping rough but criticised by others in the same area. A common complaint was the length of waiting times in A&E, but this was generally seen as a simple fact of life in a busy A&E department rather than as something to do with homelessness. The main concerns that people sleeping rough and project workers had were that sometimes the receptionists, doctors or nurses had negative attitudes towards homeless people, particularly if they had a drug or alcohol related problem. There was also a feeling that A&E would sometimes 'patch up' someone sleeping rough and then discharge them without much thought about their continuing need for care.

Access to dentists varied. In both the London boroughs dental services targeted on homeless people were available and seemed to be both well used and accessible. These services were often associated with primary care outreach teams or medical centres for homeless people that provided a range of health services. In all the other areas access to NHS dentists was poor but this was attributed to a general shortage of NHS dental services. In Manchester and Bristol, however, people sleeping rough could, like any one else, make use of the services of the dental hospitals. Dental health was generally poor among people sleeping rough because of poor access to sanitation and other factors such as poor diet. People who were using oral methadone to deal with a heroin addiction often had severe dental problems but dentists were sometimes unable to treat them because it was dangerous to anaesthetise someone who was still dependent on drugs.

Opticians were sometimes available via targeted health services in London, but elsewhere access was often reliant on volunteer services and was poor. Access to chiropody services was also generally quite poor and almost exclusively dependent on infrequent volunteer or targeted services where it was available. This could be a serious problem for people sleeping rough, who quite often had severe problems with their feet.

As with their health more generally, their feet, dental health and eyesight did not seem to be a particular priority for people sleeping rough unless severe problems arose. The tolerance for ill health and reluctance to engage with services linked to low self-esteem that was a feature of their general approach to their health was again an important barrier to engaging with these services.

Drug and alcohol services were generally scarce and where they were available there was often a long waiting list. Respondents felt that the decision to come off drugs or alcohol was a difficult one for people sleeping rough and once they had taken that decision they generally wanted access to a service immediately. People sleeping rough talked about both the stress of homelessness and the difficulty in addressing reliance on drugs and alcohol while still homeless and awaiting drug or alcohol rehabilitation. They also talked about the ease of availability of drugs and peer pressure as factors that made it difficult to stop using without assistance.

A particular difficulty arose when people with a dependency also had mental health problems, in that relatively few drug and alcohol services would take on people with a diagnosed mental illness. Services specifically for people with a dual diagnosis were unusual, even in London.

The Homeless Mentally Ill Initiative had established targeted mental health services in London some years before the research and these outreach teams were still functioning in Westminister and Lambeth. Access was still sometimes problematic when someone had a dual diagnosis. Outside London, there were sometimes difficulties in getting mental health services for people sleeping rough, particularly in the more rural areas of the Forest of Dean and Gloucester. Some projects reported that it was more difficult to get access to mental health services for their users than it was to secure access to a GP. A number of the targeted primary health care projects had mental health services, such as Community Psychiatric Nurses and in some instances a link with a consultant, which gave their users more direct access to mental health services.

It was debatable whether those problems that existed in getting access to mental health services for people sleeping rough were related specifically to their homelessness. Most GPs and project workers talked instead about the general scarcity of mental health services rather than there being any particular barrier to people sleeping rough. The problems that have existed for some years with community mental health services across England are well documented and do not need to be restated here.

Mainstream or targeted services

The tension between providing targeted services and adapting the mainstream NHS has been noted in earlier research (Chapter One). The vast majority of respondents said that they favoured integration into mainstream services and believed that separate services were divisive. Registration with a GP was seen as essential if patients were to access all health services including secondary health care. However, there was a clear need to enable marginalised people sleeping rough to access primary health care and some form of targeted provision was thought necessary. The long term aim of targeted provision should be integration into mainstream health services in the view of most respondents.

As noted above, many homeless people lead chaotic lives and often lack the necessary skills or motivation to seek health care and almost everyone felt that on site services and outreach teams had an essential role in ensuring that people took an interest in their health and in providing a service which was more responsive to the needs of the most marginalised rough sleepers.

> *The health team used to visit once a week but we lost our nurse, it was a lot easier because you could bully residents and get them to pop in and see her when she was here. It is really difficult to get chaotic people to keep appointments, drop ins sound great but they are only there an hour or so one day a week or whatever.* Support worker, Bristol

> *I can't see how some of the issues with access can be resolved because it's not necessarily about getting GPs to register people, it's also about educating the homeless to access statutory services....when you position something alongside where they're getting a bed for the night or a free meal, or where they hang out during the day, they are more likely to see and think about their health needs. But if there isn't one in the hostel then they won't think 'I feel ill' and walk a mile down the road to the practice - assuming that they know where one is* GP Contracts Manager.

Accessing mainstream services was seen to be part of the process of resettlement, as people became more confident and able to cope with life generally then they would be able to access services. This confidence building and enabling was encouraged and developed particularly by advocacy workers but was also dependent on the treatment people received in doctors' surgeries.

> *We...encourage patients to come to the surgery with the idea that they would not be made to feel unwanted....That's the philosophy of the practice, fair play for all so I think they should not be told that the doctor is going to come to them. Also it gives them a certain independence in their decision making.* GP, Lambeth.

Another commonly held view among all respondents was that mainstream services should be more flexible and responsive to the needs of people who were sleeping rough, in some cases this benefited other patients, doctors and surgery staff.

> *We have a mixed appointment and drop in system....One beneficial effect of this is that I only do an average of one home visit a day...we are open all day more or less. Also, we can see more patients if we are not doing home visits.* GP, Nottingham.

> *There should be more walk in services for people, more access to health care but more variety of health care, provision on site....There is a need for specialist services when people are at crisis point but there is also a need to resettle people and help people move on and into mainstream services. That is part of the resettlement process, then they are more able to access services.*

> *There also has to be an outreach service for those who don't access services, there is a need to go out there and work with people.* SIGH representative.

> *I don't think there is a need for a separate service, the Big Issue* [in the North] *surgery is a general practice, education and awareness, increased flexibility is the way...I want services for my clients now like I'd want for myself. A good service that treats people well and is answerable to the client.* Resettlement team, Manchester.

Although most people agreed that there was a case for targeted provision and for all homelessness agencies to be more pro active in work with hard to reach individuals, questions and doubts arose around issues of choice and self-determination.

> *There are a lot of people who are not prepared to go to the doctor. I used to do a mobile surgery for about three years....the problem is that it is a bit like going into someone's lounge, going in and saying, 'wake up I'm a doctor do you need any help?' and they say piss off. It's not psychologically the right thing, there has to be the want or desire for something that makes them come to you.* GP, Westminster.

> *There are big questions about choice and quality of life and so on but in a civilized society it is not acceptable to see people so ill, so emaciated. We want to give people the choice to have a life, not to force them into a different lifestyle, but there are dangers in being too liberal. That could mean you leave people out there who are very vulnerable or a danger to someone else.* Resettlement and outreach team, Manchester.

> *I think you have to be flexible and accept that a combination of services is best. Not to impose white middle class views on everyone about what is best for them...People who are really desperately marginalised or alienated will never ever use general practice and there will always be people like that in society for whom we have to make some provision. Equally there are many others who could have used general practice if only people had been a bit more understanding.* RCGP representative.

Among homeless people there was some ambivalence, people felt there was a need for targeted services especially for people who habitually sleep rough and who do not access any services. Some people who had used targeted services, usually in London, thought the doctors there were more sympathetic and understanding than ordinary GPs and many said they preferred to use these services. In the other areas respondents felt that they should be able to register at an ordinary general practice and that they should be treated the same as any other patient.

> *They should have a doctor going out because if you can't get to them well, they'll die. Some people are incapable, pissed or drugged up so they need someone to take the responsibility for them.* Focus Group, Nottingham.

> *Should have services especially for us because we don't get treated well...But why should we have special services? Doctors should treat everyone the same.* Focus Group, Bristol.

> *People should be able to go to a normal GP but an outreach team would be a good idea, a doctor and nurses going out in a 'medivan', like a mobile library all equipped with medical gear...A service for people who are out on the streets and can't even get into a night shelter, people with pets....what they need is someone to go out to them.* Focus group, Nottingham.

Although the majority of people who had accessed GPs in ordinary practices complained either of feeling embarrassed, or about their treatment, some interviewees were very happy with the treatment they received. It was often easier for people to register with a general practice when they had an advocate.

> *I was going to a day centre and I saw the nurse there. One day she said 'don't you think you'd be better off getting your own doctor?' I said they don't want to know you if you are homeless. She said 'where do you want to go?' I told her and she writ me a letter and said 'you can register there'. The doctor never said 'why are you homeless, why are you living rough?' Treated your complaint, your condition. I was registered as a temporary patient here for two years then they said 'don't you think you'd be better signing full time. All my notes are there. All smashing, from the front desk to the doctors. Never felt that they looked down on you or looked at you as a piece of garbage. Even the doctors are brilliant, they say 'hello Eric, how are you doing?'* Man aged, 57, Lambeth.

Summary

The main finding of the interviews were that access to GPs and primary medical services for people sleeping rough was generally difficult and that interviewees across all groups felt that people sleeping rough did not receive the same quality of care as other patients. Most interviewees agreed that people sleeping rough should be integrated into mainstream health services but that there was a need for some targeted services for the more marginalised rough sleepers. These findings and their implications are discussed in the final chapter.

4 Conclusion

Introduction

This final chapter considers the implications of the research findings. The chapter begins with a brief discussion of the difficulties surrounding access to GPs before moving on to examine the most effective models of service provision. The chapter concludes with a consideration of the role that primary care can play in reducing the level of rough sleeping by two thirds by 2002.

The problem of access to GPs

The reasons for poor access

The evidence from the postal survey and the fieldwork did suggest that the longer someone had been sleeping rough, or perhaps more importantly, the more closely they resembled popular conceptions of a person sleeping rough, the more difficulty they encountered in accessing a GP. These difficulties in accessing GP services can be broadly described as:

- *Prejudice against and fear of people sleeping rough.* In some instances GPs and other medical professionals were reluctant to register or treat people sleeping rough because of fears about what their behaviour might be like. One of the more common anxieties was that people sleeping rough would be highly disruptive in the waiting room and that their behaviour would distress staff and other patients. There were also a few reports of people sleeping rough being mistreated by receptionists and some medical professionals.

- *Low self-esteem and depression among people sleeping rough.* Many people sleeping rough talked about their feelings of shame about their appearance and their situation. A fear of the attitudes that they might encounter if they tried to use a GP acted as a deterrent for some people sleeping rough. People sleeping rough, GPs and project workers referred to an acceptance of ill-health, adopting risky behaviour (such as drug use or unprotected sex with multiple partners) and a general failure to care for oneself, associated with poor self image and depression.

- *Drugs.* Drug dependency is far from being universal among people sleeping rough, despite popular beliefs, but it is much more common than among the general population (Gill *et al*, 1996). As well as being a risk to health, drug dependency formed a major barrier to many GPs and other health services. The concerns of GPs that people sleeping rough might try to 'blag' drugs from them were very real. This was a particular problem when medical professionals assumed that all people sleeping rough would seek drugs from them.

- *Financial and administrative factors.* Confusion about rights to permanent registration did exist among some people sleeping rough and some GPs. There were also a few concerns about GP payments when treating people sleeping rough from

> doctors. The extent to which confusion about registration, or GP payments, were barriers to treatment as opposed to rationalisations of a reluctance to treat people sleeping rough, was viewed as debatable by some respondents. The arrangement of appointments and the bureaucracy involved in using a GP was too much for some of the more chaotic and marginalised people sleeping rough.

Self image and perceptions of homelessness and access to GP surgeries

The results of the interviews created an impression of people sleeping rough who often had a very poor image of themselves and who were reluctant to go to the doctor in part because of being in a public situation, but also because of a fear about what sort of reception they would receive. Individuals who were sleeping rough were sometimes in a situation where they could not take any more of society's negative responses towards them and were often anxious about arriving at a GP surgery or some other medical service and being treated with contempt, which would further exacerbate the feelings of loneliness, low self esteem and depression that most people sleeping rough talked about. Drug use and alcohol dependency among some people sleeping rough reinforced a negative image of this group among some doctors. The administration of some practices could also mean that receptionists or bureaucracy acted as an effective, if sometimes unintentional, barrier against people sleeping rough.

Mutual apprehension about how the other party was going to behave permeated the views of people sleeping rough and GPs and created a barrier to services. People sleeping rough put off going to the doctor because of how they expected to be treated and some doctors and medical professionals sometimes refused to treat them because of anxieties about antisocial behaviour and drug dependency. These anxieties were not always groundless, some people sleeping rough were alcohol or drug dependent, abusive, difficult and had a very unpleasant appearance. Equally, some GPs, receptionists and other medical professionals did appear to be abusive or simply refuse to treat anyone who was homeless because of their view of homelessness and the people who experienced it.

Access to other health services

Similar issues affected access to other health services, although other factors were also sometimes important. Access to NHS dental services was described as difficult in most areas, but this was not seen as being related to rough sleeping but to what was perceived as a general scarcity of these services affecting the whole population. Some targeted services existed in the case study areas and access to a dentist, optician or chiropodist was not impossible for people sleeping rough in London, Southampton and some of the other areas. But in some areas access to these services seems to have been difficult because there was no targeted provision or easily accessible free or low cost services.

Dual diagnosis also seems to have been significant in restricting access to mental health services that would not take people with a drug or alcohol dependency. The extent of dual diagnosis among people sleeping rough is not really understood, but the evidence from the interviews and from previous research (Gill *et al*,1996) indicates that it is not uncommon. Working relationships between homelessness projects and mental health services were often described as difficult, although this finding needs to be balanced by noting that mental health professionals were not interviewed as part of the current research. Access to drug and alcohol services was poor. There were sometimes long waiting lists and many services were unwilling or unable to take people with a dual diagnosis. In some areas, access was so poor that there was a view that such services were essentially unavailable.

The geography of access to GP services

One of the original objectives of the research was to map areas of England in which access to GP services was particularly poor for people sleeping rough. Lessons could then be learned from the better performing areas and attention could be focussed on improving access in the poorly performing areas. The findings of the postal survey and the fieldwork revealed that while access was sometimes apparently worse in some areas than it was in others, it was of a generally poor standard throughout England.

Variations in access in the same area

While some variation existed between areas, this was less interesting than the finding that projects in areas with a rough sleeping problem quite often reported different levels of access to GP services. Projects in the same town, city and even London borough appeared to be experiencing very different levels of access to ordinary GP practices and to permanent registration.

The fieldwork suggested that ad hoc and informal arrangements were often very important in securing access to GP services. For example, a hostel might only have links to a GP because there happened to be a sympathetic GP in the area. Where more formal arrangements existed, they were quite often small in scale, with perhaps a few agencies and projects linking together, rather than there being a strategic plan or equivalent arrangements for the whole area. Southampton, in which the health authority had recently adopted a city-wide strategy which was based around a proposed PMS pilot scheme and involved housing agencies, social services and homeless services in planning, was to some extent an exception. Areas like Manchester and Westminster were characterised to a greater extent by a patchwork of services which, while not uncoordinated, had to some extent evolved separately from one another.

The findings of the postal survey suggested that informal arrangements and small scale links between individual projects and individual GPs were perhaps to some extent the norm across areas of England with a rough sleeping problem. It might also have been the case that liaison and coordination between existing homelessness services and primary care services was sometimes not all that it could have been in some areas. Such a situation might explain the variation in access reported by projects in the same area, as those projects with informal or small scale arrangements and agreements in place would enjoy good access while those lacking such arrangements or agreements would not.

Effective models of service provision

Three basic models exist for the provision of GP services to homeless people. The first is the provision of targeted services on a fixed site, via an outreach team, or through a combination of the two. The second is to provide workers, such as health visitors for homeless people, who act as a guide and an advocate to secure access to the mainstream NHS for their clients. The third is to make some adaptation to mainstream services to enable them to cope with people sleeping rough and homeless people as patients in a more effective way, an example would be the use of homelessness workers by a few A&E departments. The results of the fieldwork suggested advantages and disadvantages to all these models.

Targeted services

Targeted services were often seen as divisive, reinforcing the divide between people sleeping rough and the rest of society that was, in itself, an important cause of their poor access to ordinary GPs. These services also tended not to offer permanent registration, which meant there was no transfer of medical records which undermined the continuity and quality of care. They also often refused to prescribe drugs that might be sold on or used by someone who was dependent, which was in part related to not having their patients' medical records. This allowed the services to operate effectively and avoided the possibility that they would be overwhelmed by drug users. However, a GP and primary care service specifically for people sleeping rough and homeless people that could not prescribe for people with a drug dependency could ultimately be viewed as being somewhat illogical.

At the same time, targeted services were clearly the only service that some of the more marginalised people sleeping rough were ever likely to use. Further, there was a widespread view that some knowledge of homelessness and rough sleeping was needed to best treat and to respond to the needs of this population and to minimise the risk of abuse of prescriptions. Previous research has tended to have similar findings, also indicating that user satisfaction with services targeted on homeless people and people sleeping rough tends to be quite high. However, this research has also reported that such services often have restricted hours of opening and cannot provide the same level of service as a mainstream GP, an issue the fieldwork for the current research also uncovered. Previous research, like the current research, has also raised concerns about whether such services reinforce the segregation of homeless people (Varnam and Varnam, 1990; Bhugra *et al*, 1997).

Improving targeted services

There was clearly a need for access to medical records if at all possible, which could help overcome an understandable lack of trust from some GPs. There was also a need for better liaison with, and more availability of, drug and alcohol services in some areas.

Portable medical records could help overcome some of the problems reported by respondents. Experiments with portable records, which had been attempted in some of the case study areas, had met with mixed success. However, some sort of record system might help overcome some issues about the quality and continuity of care provided and also help establish sufficient trust between patient and doctor to allow targeted services to help treat people with drug dependencies. Some of the major targeted services might potentially cooperate in establishing a shared database of medical records for their users with remote access, if a system of portable medical records proved unworkable.

Advocacy and support to help people sleeping rough use the mainstream NHS

Services designed to encourage and enable people sleeping rough to use the mainstream NHS were generally seen as productive, but there were limitations to such an approach. The advantages are obvious, permanent registration means a transfer of medical records and continuity of care and it also provides access to secondary care via the GP. The disadvantages are that the structure of general practice does not suit some people sleeping rough and that some have a tendency to move around a great deal or at least to move from the area covered by one practice to an area covered by another, which may have some financial implications for the GPs concerned. Another issue is the question of scale, as such services are often very limited in scope, with perhaps a single member of staff covering a large area. Finally, there is also the question of a lack of support for GPs themselves, as although people sleeping rough often need some assistance to make contact with a GP and register, the GP may themselves need assistance in meeting the needs of people sleeping rough and coping with more marginalised and challenging members of the rough sleeping population.

As described in Chapter Three, senior interviewees often took the view that no one approach was suitable and that a mixed pattern of service provision, using both targeted services and making small adaptations to the mainstream was the best response. However, a few interviewees commented that even such a mixture of services was in itself inadequate and that a more holistic approach was needed.

Ways Forward: A holistic approach to rough sleeping

It is only through a reduction in the scale of rough sleeping that the health status of people who are currently sleeping rough can be improved. Access to GP services and health services could be improved, but that improvement is of limited benefit unless it is part of a coordinated response towards rough sleeping. Access to medical services is a prerequisite to effective resettlement for many people sleeping rough and will in some cases form the first step that someone can take in leaving the streets. A drug or alcohol dependent individual or someone with a severe mental illness cannot leave the streets, move into social housing and live a normal lifestyle without appropriate support and any attempt to resettle such an individual without appropriate services is likely to fail. Almost any person currently sleeping rough will need permanent registration with a GP, as well as access to suitable housing and support services if they are to be successfully resettled.

Equally, GP services and other medical services cannot help someone off the street by themselves. There is a role for the voluntary sector, social landlords and sometimes for social services as providers of community care or under their Children Act duties when a care leaver has ended up sleeping rough, as is quite often the case (Hutson and Liddiard, 1994). The evidence from research into resettlement is that unless the full range of a former rough sleeper's or homeless person's needs is addressed, there is a real possibility that they will return to homelessness (Dant and Deacon, 1989; Vincent *et al*, 1993 and 1995; Pleace, 1995). The social and economic marginalisation, alienation and poor health that characterises people sleeping rough all need to be addressed simultaneously if there is to be significant progress.

Such a coordinated response is not necessarily simple to orchestrate and deliver. While there is an apparent surplus of social rented housing in some areas, some elements of the stock have become effectively unuseable because of changes in the characteristics of the tenant population and a shortage of resources in the sector over the last 30 years. Health services are under constant pressure to deliver more and more services while the resources for the NHS will always be subject to constraint. People sleeping rough only represent a tiny fraction of the population for which health authorities are responsible and a decision to spend resources on people sleeping rough might mean that another larger group of the population perhaps do not get all the services that they might wish for. The voluntary sector working with people sleeping rough and homeless people is characterised, in large part, by its often precarious financial situation and hand to mouth existence. It is also characterised by competition between relatively small organisations for the resources that are available, by some degree of duplication and by often quite poor coordination (Pleace and Quilgars, 1996).

However, while it is important to acknowledge that these difficulties exist, they are not insurmountable. Better coordination and joint working need not be particularly expensive or difficult and some quite small steps might be taken to improve access to GPs and the links between GPs and other services. The first and most obvious point to make is that training could be introduced for GPs and receptionists to help them better understand the realities of rough sleeping and what people sleeping rough are actually like, which would help reduce some of the barriers to GP services. It is the understanding of the authors that Health Action for Homeless People is already working on training packs for receptionists and doctors along these lines.

Local cooperation and joint working could also be helpful here, for example a simple information sheet from all the homelessness services in an area could be given to GPs who could then pass it on to their patients. The role that a GP could play in helping address the non-medical needs of someone sleeping rough would have to be restricted to no more than perhaps giving them a leaflet or pamphlet about other services, because of the other pressures on their time. Such joint working and liaison is perhaps even more important for targeted primary care services, which have a specific remit to focus on people sleeping rough and homeless people and could play an important role in helping the more marginalised people sleeping rough get in contact with homelessness services.

Similarly, the results of the interviews suggested that not all people sleeping rough and project workers were aware of the targeted medical services for homeless people in their area. Training of project workers and perhaps some system of leaflets or pamphlets for people sleeping rough telling them where and how to access medical services and their rights and responsibilities might be productive. Such a system would have to be complemented by workers who could advocate for, or in some cases actually accompany, the more marginalised, less confident or perhaps sub-literate people sleeping rough.

Another possibly helpful development would be the introduction of resource directories for every area, models of which already exist in London and Bristol and other areas. Such resource directories should include contact details for all services for people sleeping rough and homeless people.

The research does suggest that more expenditure on drug and alcohol services for people sleeping rough may be necessary in some areas and that improvements in accessibility to services for people with a dual diagnosis is also important. It is important not to exaggerate the extent to which drugs and alcohol dependency are a problem among people sleeping rough, but at the same time, the need for these services does need to be recognised.

Reconsidering the role of resettlement services

Some consideration may need to be given to the existing structure and function of resettlement services for people sleeping rough and single homeless people. Originally, services tended to be orientated towards a form of intensive housing management, which meant that they focussed mainly on helping an individual run their own home and did not concern themselves with the health and general well being of an individual (Dant and Deacon, 1989). This model was soon replaced by services with more of a focus on advocacy, helping individuals form links with GPs, social services and other services and sometimes concerning themselves with helping people into employment or training and with establishing friendships as well (Pleace, 1995). Sometimes advocacy services are limited in that they are not designed to provide practical support or, like the original resettlement services, because the range of issues that workers are allowed to help with is restricted. Throughout the sector, resettlement services also tend to be a low cost service, with former rough sleepers and other former homeless people only getting a limited amount of contact with a worker and then only for a limited period of a few months or perhaps a year.

The need for a more holistic approach to rough sleeping, involving GP services and other primary care services working alongside a range of housing providers, social care providers and homelessness services might be met to some extent by better joint working between agencies. However, there may also be scope for reexamining the functions of resettlement services and considering, particularly with regard to habitual rough sleepers, whether there is a need for a more intensive and comprehensive service. A professional team for habitual rough sleepers might have resettlement workers who have training in mental health and drugs and alcohol, as well as in housing advice and tenancy support, for example, as well as formal links to the primary and secondary health care services that were most likely to be required. Social housing landlords would also have to be involved to ensure a supply of suitable and affordable housing. The ability to address most, if not absolutely all, of the needs of habitual rough sleepers would have to be coupled with an acceptance that such a service might need to give on-going support. Sometimes this support would be for years rather than months, although the eventual aim of the service would be to reintegrate people with mainstream society and mainstream services. Without comprehensive and relatively intensive services of this sort, it might be difficult to get some of the most marginalised and alienated people to leave the streets. Recent research among people sleeping rough found that some individuals using nightshelters reported being homeless for decades (Pleace, 1998a).

The impact of recent changes in the health service

At strategic level, there needs to be some consideration of the role that Primary Care Groups

(PCGs) will play in delivering GP services to people sleeping rough and homeless people. There were concerns among the interviewees that unless a PCG's area was one in which rough sleeping was a pronounced problem then the members might not take much of an interest in access to services for people sleeping rough. While there was unlikely to be much of a problem in inner city areas in which rough sleeping was likely to be part of a general concern about poor access of marginalised populations to GP services, in those areas with only a few people sleeping rough the issue might get ignored. Some interviewees thought that because there are only a few hundred people sleeping rough each night even in the major cities, that responsibility for service delivery to people sleeping rough, should continue to rest with the health authorities.

> *It all depends on the interests of the members and their experiences of homelessness. It is vital to ensure that homeless people are seen as part of the population they have a responsibility for and that there is some recognition of their needs...The homeless population in any area is not going to be that big, but most London PCGs will have that historical base of having worked with people who are homeless. In inner London you will probably have lots of interested people on the boards anyway.* HAHP representative.

Primary Medical Services (PMS) pilots also have an important potential in helping improve access to GP services for people sleeping rough. In Southampton the health authority had applied for PMS status for its existing GP, nursing and psychiatric service for people sleeping rough and homeless people. A PMS pilot could offer enhanced services to people sleeping rough and, as in the example of Southampton, be grounded in coordination and cooperation between the health authority, social services, social landlords and the voluntary sector working with people sleeping rough and homeless people. Due to the scale of rough sleeping in any given area, a single primary care service grounded in the ethos and practice of a multi-agency response to rough sleeping could often be sufficient, as it can work with the other agencies to help reintegrate people sleeping rough into society

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