

Homelessness and ill health

SUMMARY OF A REPORT OF A WORKING PARTY OF THE ROYAL COLLEGE OF PHYSICIANS

The Royal College of Physicians has a long tradition of concern for the factors which affect health as well as for the treatment of disease. This report continues that tradition by drawing attention to the relationships between health and homelessness. The number of people who are homeless has risen sharply over the past decade. Some become homeless because of ill health and most experience deterioration in their health as a result of homelessness. Many have difficulty in obtaining appropriate medical care. By gathering together a wide range of published data, this report aims to define the relationship between homelessness and health and makes recommendations to government, local authorities, family health service authorities and GP fundholders for the coordination and improvement of services for people who are homeless.

There are three main groups of homeless people. Only one group, comprising many families with children or pregnant women (described in this report as Group I), are *officially* recognised as homeless. In 1992 there were 169,966 of these statutorily recognised homeless households in Britain.

Rough sleepers and direct access hostel dwellers (described in this report as Group II) are *not* officially homeless and *not* included in official statistics. In the 1992 Census there were 2,827 rough sleepers and 19,417 hostel dwellers in Britain.

The third group comprises those who are sharing accommodation or are otherwise inadequately housed. As very little information exists about these people, this report concentrates on Groups I and II.

The types of housing that are available in Great Britain are: owner-occupied and private-rented, for both of which an adequate and reliable income is required; and local authority or housing association rented housing, together described as social-rented housing, where access is intended to be based on need rather than ability to pay.

Poor health and disability limit people's access to housing, because they often reduce employment opportunities and hence income, so home-ownership or private renting are out of reach. The social-rented sector has decreased considerably in size over the past few years, making access to it more difficult. The mechanisms intended to ensure that people in poor health have adequate housing (medical priority for rehousing) do not work effectively.

Homeless families (Group I) have been shown to experience more mental, physical and obstetric health problems than comparable housed groups. They make

greater use of hospital and community services. This is probably related not only to their health problems but also to the difficulties they have in gaining access to primary care. For many of them, a 'healthy lifestyle' is unattainable in crowded accommodation with inadequate cooking and recreational facilities.

Single homeless people (Group II) have a higher risk of death and disease than comparable housed people. Excess deaths are due mainly to suicide, accidents and violence, and alcohol-related and respiratory diseases. Single homeless people are prone to a wide spectrum of physical illnesses, involving all bodily systems. Among the specific conditions common in this group are tuberculosis, chronic obstructive airways disease (bronchitis), foot problems, infestations and epilepsy. The physical vulnerability of single homeless people, together with problems of compliance with treatment, pose special problems in relation to tuberculosis, where drug resistance may emerge with potential public health implications.

Single homeless people are more likely to have serious mental illness than the general population. Schizophrenia is the most commonly diagnosed disorder. The effects of mental illness, together with associated social and economic problems, can precipitate housing crises which the individuals concerned are unable to resolve and they thus become homeless. Community care programmes developed by health and social services do not take adequate account of housing need and so are not able to deal with these problems.

Various initiatives have been introduced in an attempt to improve health care for homeless people. On the whole, although valuable, they are small-scale and uncoordinated and have only a limited impact on these very considerable problems. Although the long-term goal is to provide homeless people with services that are integrated with those for the rest of the population, special arrangements are needed in the meantime for primary care, accident and emergency services, community care and discharge planning.

This report confirms the strong relationships between homelessness and health. It recommends that the Government, Local Authorities, the Housing Corporation and the NHS should, as a matter of urgency, develop a coordinated approach to the development of a housing and community care policy. This is seen as a prerequisite for progress in this field.

Since it is unlikely that there will be rapid, dramatic improvements in the underlying causes of homeless-

ness, there should be short-term arrangements to improve access to health care for homeless people.

In addition, future official statistics should include single homeless people (Group II); there should be regular monitoring of the health of homeless people; and current research on health and homelessness should be extended.

Detailed recommendations are given below.

RECOMMENDATIONS

To Government

The report draws particular attention to the different, and sometimes unintentionally conflicting policies of different agencies. Improvements could be achieved and resources more effectively deployed if there were better integration.

- The Government, Local Authorities, the Housing Corporation and the NHS should together undertake a wide-ranging review of housing and community care policies, addressing the opportunities for integration and the barriers to progress. The aim should be to develop a coordinated action plan which identifies and provides the organisational, management and resource requirements to allow the implementation and evaluation of a coherent joint policy. (*Recommendation 2 of the report.*)
- The statistics collected on homelessness by the Department of the Environment should be expanded to include rough sleepers and hostel dwellers (Group II homeless people), and such people should be officially recognised as homeless. (*Recommendation 1 of the report.*)
- The Department of Health should introduce systematic monitoring of the health of homeless people and their access to services.

This should include:

- principal and secondary health problems
- ethnic mix
- age and sex
- HIV infection, subject to informed consent and prescreening counselling
- tuberculosis
- GP registration
- hospital admissions
- type of homelessness
- accommodation on discharge

The results of such monitoring should be published as a regular report. (*Recommendation 7 of the report.*)

- The NHS Research and Development Directorate should take a lead in commissioning further research on the causes and consequences of all types of homelessness, building on earlier studies. (*Recommendation 8.*)
- The Government, through the proposed Regional Offices of the NHS Executive, should take steps to ensure that homeless people are not disadvantaged because of the financial implications of their care for GP fundholders. Although capitation mechanisms should take this into account, in the shorter term, arrangements should be considered, which could:
 - i organise the funding of special practices for homeless people in such a way that these practices would be allowed to administer their own budgets and hence compete with GP fundholders;
 - ii restructure deprivation payments to GPs by including a per capita payment which incorporates an amount based on the number of homeless people registered at the practice;
 - iii coordinate a nationwide service for handling the medical records of homeless people, thus ensuring that information is transferred smoothly between practices;
 - iv set national health targets relevant to the health needs of homeless people;
 - v coordinate a national strategy to provide better health care to homeless people. (*Recommendation 9 of the report.*)

Such a strategy would permit homeless people to choose where they wish to receive care either from a non-fundholding practice, a fundholding practice or a special practice.

To Health Authorities, Family Health Service Authorities and General Practice Fund Holders

The Report identifies the health problems of homeless people and their difficulties in gaining access to services and recommends that these difficulties should be specifically addressed as follows:

- Health commissioning authorities should assess the health and health care needs of members of homeless households and should commission services to meet these needs. (*Recommendation 4 of the report.*)
- Health Authorities and Family Health Service Authorities should ensure that members of homeless households placed in temporary accommodation have access to full registration with a local general practitioner. (*Recommendation 5 of the report.*)

Jointly to Local Authorities and Health Authorities

Many aspects of the care and support for homeless people require the joint action of local authorities and health authorities. Recommendations are as follows:

- Within the recommended joint policy (see Recommendation 2), the current medical prioritisation procedures should be reviewed and integrated with community care and housing need assessment procedures. The conferment of priority need status should not prevent the assessment of housing need in relation to health need. (*Recommendation 2*).
- Within the wide-ranging policy review (see Recommendation 2):
 - i Community care of severely mentally ill people requires full implementation of the Care Programme Approach and care management. Both should explicitly include adequate housing as an essential component. Community care should be seen as a combination of appropriate care and appropriate housing.
 - ii Community care plans drawn up by local authorities should specify the housing requirements of severely mentally ill people. Central Government should ensure that resources are available for capital developments (buildings and renovation), rehabilitation and support.
 - iii Direct access hostels should not be expected to provide care for severely mentally ill people. Health care commissioning authorities should ensure that a range of community and in-patient services are accessible to such people, complemented by an adequate supply of suitable housing. (*Recommendation 6*)

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