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HEALTH OVERVIEW AND SCRUTINY PANEL

Thursday, 20th March, 2014
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Stevens (Chair)
Councillor Claisse (Vice-Chair)
Councillor Cunio
Councillor Laming
Councillor Parnell
Councillor Spicer

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PUBLIC INFORMATION

Role of Health Overview Scrutiny Panel (Terms of Reference)

The Health Overview and Scrutiny Panel will have 6 scheduled meetings per year with additional meetings organised as required.

- To discharge all responsibilities of the Council for health overview and scrutiny, whether as a statutory duty or through the exercise of a power, including subject to formal guidance being issued from the Department of health, the referral of issues to the Secretary of State.
- To undertake the scrutiny of Social Care issues in the City unless they are forward plan items. In such circumstances members of the halth Overview and Scrutiny Panel will be invited to the relevant Overview and Scrutiny Management Committee meeting where they are discussed.
- To develop and agree the annual health and social care scrutiny work programme.
- To scrutinise the development and implementation of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy developed by the Health and Wellbeing Board.
- To respond to proposals and consultations from NHS bodies in respect of substantial variations in service provision and any other major health consultation exercises.
- Liaise with the Southampton LINk and its successor body "Healthwatch" and to respond to any matters brought to the attention of overview and scrutiny by the Southampton LINk and its successor body "Healthwatch"
- Provide a vehicle for the City Council's Overview & Scrutiny Management Committee to refer recommendations arising from panel enquiries relating to the City's health, care and well-being to Southampton's LINk and its successor body "Healthwatch" for further monitoring.
- To consider Councillor Calls for Action for health and social care matters.
- To provide the membership of any joint committee established to respond to formal consultations by an NHS body on an issue which impacts the residents of more than one overview and scrutiny committee area.

Public Representations

At the discretion of the Chair, members of the public may address the meeting about any report on the agenda for the meeting in which they have a relevant interest

Smoking policy – the Council operates a no-smoking policy in all civic buildings.

Mobile Telephones – please turn off your mobile telephone whilst in the meeting.

Dates of Meetings: Municipal Year 2013/14

2013	2014
23 May 2013	31 January 2014
18 July	20 March
19 September	2 April
21 November	17 April
	15 May

Council's Priorities:

- **Economic**: Promoting Southampton and attracting investment; raising ambitions and improving outcomes for children and young people.
- **Social**: Improving health and keeping people safe; helping individuals and communities to work together and help themselves.
- **Environmental**: Encouraging new house building and improving existing homes; making the city more attractive and sustainable
- **One Council:** Developing an engaged, skilled and motivated workforce; implementing better ways of working to manage reduced budgets and increased demand.

CONDUCT OF MEETING

Terms of Reference

Details above
The general role and terms of reference for the Overview and Scrutiny Management Committee, together with those for all Scrutiny Panels, are set out in Part 2 (Article 6) of the Council's Constitution, and their particular roles are set out in Part 4 (Overview and Scrutiny Procedure Rules of the Constitution.

Business to be discussed

Only those items listed on the attached agenda may be considered at this meeting.

Rules of Procedure

The meeting is governed by the Council Procedure Rules as set out in Part 4 of the Constitution.

Quorum

The minimum number of appointed Members required to be in attendance to hold the meeting is 3.

DISCLOSURE OF INTERESTS

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "Disclosable Pecuniary Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PECUNIARY INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:

(i) Any employment, office, trade, profession or vocation carried on for profit or gain.

(ii) Sponsorship:

Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.

(iv) Any beneficial interest in land which is within the area of Southampton.

(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.

(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.

(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

a) the total nominal value for the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or

b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class.

Other Interests

A Member must regard himself or herself as having an, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

Any body to which they have been appointed or nominated by Southampton City Council

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

Any body whose principal purpose includes the influence of public opinion or policy

Principles of Decision Making

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the "rationality" or "taking leave of your senses" principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, 'live now, pay later' and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

AGENDA

Agendas and papers are now available via the City Council's website

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Panel made in accordance with Council Procedure Rule 4.3.

2 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Democratic Support Officer.

3 DECLARATIONS OF SCRUTINY INTEREST

Members are invited to declare any prior participation in any decision taken by a Committee, Sub-Committee, or Panel of the Council on the agenda and being scrutinised at this meeting.

4 DECLARATION OF PARTY POLITICAL WHIP

Members are invited to declare the application of any party political whip on any matter on the agenda and being scrutinised at this meeting.

5 STATEMENT FROM THE CHAIR

6 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 20th February 2014 and to deal with any matters arising, attached.

7 INQUIRY MEETING 2: INQUIRY MEETING 2 - ACCOMMODATION AND SUPPORT SERVICES THROUGH THE VOLUNTARY SECTOR AND ACCESS TO AND DISCHARGE FROM HEALTH SERVICES

Report of the Assistant Chief Executive introducing the speakers that will address the Inquiry in relation to the provision of key services for single homeless people, attached.

Wednesday, 12 March 2014 HEAD OF LEGAL AND DEMOCRATIC SERVICES

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SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 20 FEBRUARY 2014

Present:	Councillors Stevens (Chair), Claisse (Vice-Chair), Cunio, Laming, Parnell and Spicer
Also in Attendance	Councillor Payne – Cabinet Member for Housing and Sustainability Councillor Shields – Cabinet Member for Health and Adult Social Care Councillor Bogle

43. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED: that the minutes for the Panel meeting on 23rd January 2014 be approved and signed as a correct record.

44. **INQUIRY INTO THE IMPACT OF HOUSING AND HOMELESSNESS ON THE HEALTH OF SINGLE PEOPLE: MEETING ONE - SETTING THE SCENE**

The Panel considered the report of the Assistant Chief Executive introducing the concepts and the speakers setting the context for the Inquiry.

The Panel received presentations from the South East Regional Manager of Homeless Link, the Council's Housing Needs Manager, the Commissioner for Supporting People and Adult Care Services, and a Consultant Nurse from Homeless Healthcare Team.

On hearing the presentation from Homeless Link the Panel noted:

- the key principles of the organisation;
- the organisations view of the current national context for homelessness and health detailing:
    - the current statistics, trends and numbers of homeless;
- how the Health Needs Audit tool was an important in identifying what was needed to address issues relating to health matters;
- the health inequality trends of the Homeless. It was noted that:
    - 80% of homeless people have more than one physical health need;
    - 70% have at least one mental health problem;
    - rough sleepers are more than 200 times more likely to have tuberculosis;
    - the average age of death for a homeless individual was between 43-47; and
    - 50-75% of rough sleepers have mental disorder such as anxiety, depression and psychosis.
- the wider costs to individuals, the National Health Service and society as a whole;
- barriers to the homeless accessing the right services including:
    - difficulties with registering for medical support;
    - a lack of integration of services to support individuals; and
    - the tendency for the homeless fall beneath treatment thresholds because their needs are too complex; and
- the Southampton perspective the Panel noted that;
    - Southampton's approach to homelessness was seen as a national good example;

- Southampton was one of the first areas to carry out the Homeless Health Audit;
- the City has a Homeless Health team - A multi-disciplinary primary care team providing care to homeless people in Southampton;
- the services available to homeless in Southampton including:
  - Southampton Street Intensive and Resettlement Service – including an in house needle exchange;
  - St James - a home for vulnerable older people with a history of homelessness; and
  - Two Saints - Introduction of Psychologically Informed Environments into all their hostels and
  - The Breathing Spaces Project.

The Panel received introductions to the Council's policy perspective on the provision of services to combat homelessness and improvement of health services from the Cabinet Members for Housing and Sustainability and Health and Adult Social Care.

The Panel also considered further evidence relating to the local situation from the City Council's Housing Needs Manager, the Commissioner for Supporting People and Adult Social Care Services and a Consultant Nurse from the Homeless Healthcare Team including:-

- an overview of the City's housing stock including the level of income required for 1 and 2 bedroom starter home compared with the median gross income within the City,
- the numbers of Households of the Council's waiting list and the high demand for one bedroom properties;
- that City's statutory obligations for certain types of individuals;
- the potential impact of welfare reform.
- statistics relating to:
  - homeless applications by priority need;
  - rough sleeping in Southampton; and
  - triggers causing rough sleeping in Southampton.
- measures taken to tackle rough sleeping in Southampton;
- the various levels of help that the supporting people services are able to supply;
- the emphasis on prevention and enablement for potential services users aiming to resolve issues before they declined any further;
- how the Homeless Health Care Team aims to support individuals;
- the health trends and concerns affecting by homelessness and how the local services were structured to tackle these.

RESOLVED that the presentations made by Homeless Link, the Council's Housing Needs Manager, the Commissioner for Supporting People and Adult Care Services, and a Consultant Nurse from Homeless Healthcare Team, be noted and the information provided be entered into the Inquiry's file of evidence.

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		INQUIRY MEETING 2 – ACCOMMODATION AND SUPPORT SERVICES THROUGH THE VOLUNTARY SECTOR AND ACCESS TO AND DISCHARGE FROM HEALTH SERVICES		
DATE OF DECISION:		20 FEBRUARY 2014		
REPORT OF:		ASSISTANT CHIEF EXECUTIVE		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Dorota Goble**	**Tel:**	**023 8083 3317**
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STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

This report provides details for the second meeting of the Health Overview and Scrutiny Panel (HOSP) Inquiry examining the impact of housing and homelessness on the health of single people.

The issues will be separated into two sections:

Part A will focus on homelessness accommodation and support services, offered by the voluntary sector. Services represented will include:

For adults:

- Society of Saint James - Guy Malcolm, Operations Director
- Two Saints - Jon Bramley, Business Development Manager

For young people:

- No Limits – Alison Ward, Project Manager
- Chapter 1 – Tina Hill, Service manager

PART B will focus on access to and discharge from health services.

Services represented will include:

- Homeless Healthcare Team - Pam Campbell, Consultant Nurse Homelessness and Health Inequalities, Solent Healthcare
- Substance misuse – Jackie Hall, SCC Integrated Commissioning Unit, Commissioner
- Mental Health Services – Dr Shanaya Rathod, Southern Health
- Adult safeguarding – John Callaway, SCC, Social Worker

RECOMMENDATIONS:

(i) The Panel is recommended to consider the information provided by presentations and use this, alongside the appendices, as evidence in the inquiry.

REASONS FOR REPORT RECOMMENDATIONS

1. To enable the Panel to consider the evidence in order to agree findings and recommendations at the end of the inquiry process.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. Not to proceed with inquiry. This option was rejected as the Panel have agreed to undertake the inquiry given the current high demand for single accommodation alongside the fact that single homeless people are less likely to be in priority need. It is widely known that homelessness, especially rough sleeping, has significant and negative consequences for an individual's health. Many studies have found strong correlations between homelessness and a multiplicity, and increased severity, of both physical and mental health conditions.

3. However, despite this increased morbidity, homeless people consistently miss out on the healthcare they need. As a result, health problems are left untreated and health deteriorates. When homeless people do access health services, they are likely to do so in an unplanned way (for example through accident and emergency) and to be in a state of chronic ill health. This results in longer stays in hospital and multiple readmissions, and has clear cost implications. The Inquiry aims to consider the impact and barriers to single homelessness people accessing healthcare and other services and make recommendations that aim to reduce blockages in the system and prevent future increasing demand on services, within existing cost constraints.

DETAIL (Including consultation carried out)

4. Following discussions with services some minor modification have been made to the Inquiry plan for the third meeting to focus on access to and ensuring long term accommodation, and the fourth meeting tackling complex health and other needs associated with homelessness. An amended Inquiry Plan is attached at Appendix 1.

5. The purpose of the Inquiry is to consider the impact of housing and homelessness on the health of single people, a significant number of whom have complex needs, and live unsettled and transient lifestyles, and to examine the difficulties that their everyday life presents to deliver a preventative and planned approach to improve their health and well being and access to a settled and decent home.

6. The second meeting will be split into two sections.

   Part A of the Inquiry aims to consider the issues and barriers for accommodation and support based service providers in the voluntary sector. Part B will consider access to and discharge from relevant health services.

PART A: ACCOMMODATION AND SUPPORT BASED SERVICE PROVIDERS IN THE VOLUNTARY SECTOR

7. **Society of St James** - Guy Malcolm, Operations Director, will highlight the services, issues and barriers that their clients experience. The Society of St James is a charity offering homeless and drug and alcohol dependency services in Southampton. An overview of their services and issues their clients experience is attached at Appendix 2. Further information on the services they offer is also available at www.ssj.org.uk

8. **Two Saints'** work in Southampton is with Single Homeless People. They have three main services, all of which work at the front end of the homelessness pathway. Jon Bramley, Business Development Manager, will talk about the services and issues for their single homeless clients. An overview of the Two Saints services and issues is attached at Appendix 3. Further information on the service Two Saints offer is also available at www.twosaints.org.uk

9. **No Limits** is an information and advice service for young people up to the age of 26. No Limits are a member of Youth Access. Youth Access is the national membership organisation for young people's information, advice, counselling and support services (YIACS). Alison Ward, Project Manager, will highlight the services and issues for young homeless people. An overview of No Limit services, client profile, case studies and key issues is attached at Appendix 4. Further information on No Limits services is available at www.nolimitshelp.org.uk

10. **Chapter 1 Young People's Supported Housing Service (Kingsley House)** provides supported housing to 16-25 year olds who have been homeless or at risk of homelessness. The service offers a range of accommodation to best suit the skills & circumstances of the individual. Tina Hill, Service Manager, will outline the services and issues for Chapter 1 clients. An overview of the Chapter 1 services is attached at Appendix 5. Further information on No Limits services is available at http://www.chapter1.org.uk/kingsley-house--southampton

PART B: ACCESS TO AND DISCHARGE FROM RELEVANT HEALTH SERVICES.

11. The **Homeless Healthcare Team** provide GP and health support from the Two Saints Cranbury Day Centre, along with outreach work at other provider services. Pam Campbell - Consultant Nurse Homelessness and Health Inequalities, Solent Healthcare, will give the panel more detailed information on the services and issues their clients present. An overview of the service and issues for the Homeless Healthcare Team are attached at Appendix 6.

12. Southampton's current **Substance Misuse Services** have been incrementally developed under the strategic direction of the Drug Action Team Partnership and the Tackling Alcohol Partnership since 2000. Alcohol services have recently been extended and improved via QIPP. Jackie Hall, SCC Integrated Commissioning Unit, Commissioner will outline the services and issues for clients linked to homelessness. An overview of the substance misuse services is attached at Appendix 7.

13. **Mental Health Services** are provided in Southampton by the Southern Health NHS Foundation Trust. Dr Shanaya Rathod, will give the panel an insight into the issues for mental health services and homelessness. An overview of the city's mental health services is attached at Appendix 8.

14. John Callaway, a **social worker** predominantly supporting vulnerable adults with complex alcohol needs will highlight a number of case studies that reflect some of the issues facing his clients. It is also intended that a strategic perspective is also given on the key issues for adult safeguarding – to be confirmed.

15. It is also planned that the panel will be have an overview of the council's children's safeguarding perspective - a representative from the children safeguarding team is still to be confirmed.

16. The Panel is invited to have a discussion on the overall model of provision for homelessness health from a practitioner's perspective with those giving evidence for access to health services and accommodation and support services provided by voluntary sector.

RESOURCE IMPLICATIONS

Capital/Revenue

17 None

Property/Other

18. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

19. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

20. None

POLICY FRAMEWORK IMPLICATIONS

21. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION

Appendices

1.	Inquiry Plan Version 3
2.	Overview of Society of St James
3.	Overview of the Two Saints
4.	Overview of No Limits
5.	Overview of the Chapter 1 Kingsley House
6.	Overview of Homeless Healthcare Team
7.	Overview of Substance misuse services
8.	Mental Health Services, southern Health

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	Yes/No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

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INQUIRY PROGRAMME (Amended March 2014)

Meeting 1: 20 February 2014
SETTING THE SCENE
National and local picture of homelessness
Single homelessness health needs and trends
Consider the health inequalities of homelessness compared to the local population and cost /impacts of demand on services
Outline of the model for homelessness prevention for adults and young people

To be invited:
Sarah Gorton, Homeless Link
Liz Slater, Housing Needs Manager
Matthew Waters, Commissioner for Supporting People and Adult Care Services
Pam Campbell, Homelessness Health team*
Cllr Payne, Cabinet Member for Housing and Sustainability
Cllr Shields, Cabinet Member for Health and Adult Social Care

Visits to be arranged prior to meeting*
Homeless Health Team
Street Homeless Prevention Team

Meeting 2: 20 March 2014
PART A: ACCESS TO AND DISCHARGE FROM HEALTH SERVICES
To be invited:
Homeless Health team, Pam Campbell
Substance Misuse Services, Colin McAlister
Mental Health services – Southern Health
Housing Coordinator, NHS Acute Care Support Team, Sean Smith?
Adult Safeguarding, John Callaway, Southampton Social Services

PART B: ACCOMMODATION BASED SERVICE PROVIDERS
Adults:
Society of St James*
Two Saints*

Young People
YMCA
Chapter 1*
No Limits*

Visits to be arranged prior to meeting*
Two Saints, Patrick House, Breathing Space, No Limits
GP Forum 12th March
Good practice examples – to be advised

Meeting 3: 2nd April 2014
ACCESS TO AND SUSTAINING LONG TERM ACCOMMODATION
To examine the barriers to remaining in long term accommodation, potential health risks of poor quality accommodation and availability of suitable accommodation.

To be invited:
Access to suitable long term accommodation
Overview of housing provision – Sherree Stanley
Regulatory Services – licensing and quality
Landlord's perspective
Probation Services

Sustaining long term accommodation
Developing life skills - Booth Centre & YMCA
Family Mosaic - Floating support
Welfare advice, social fund

Meeting 4: 17th April 2014
TACKLING COMPLEX HEALTH AND OTHER NEEDS ASSOCIATED WITH HOMELESSNESS
Issues and barriers for agencies experiencing frequent / specialist contact with single homeless people

To be invited:
UHS* TBC
GPs TBC
Ambulance Services?
Police?
JCP- Andrew Sherman,
EU Welcome, Dave Adcock - No recourse to public funds

Visits to be arranged prior to meeting*

Meeting 5: 15th May 2014
REVIEW OF THE EVIDENCE
Overview of the issues
What / where will services be in the next few years?
What is the strategy for this client group?

FIRST DRAFT OF RECOMMENDATIONS
Public Health
Housing Needs Manager
Supporting People Commissioner
CCG / ICU
Healthwatch
University?

A Report Concerning the Society's Southampton Homelessness Services

1. Our Clients

People who become homeless lack resources, not just financial but personal. Most don't have families and friends on whom they can call for positive, effective support, and most are inclined to act impulsively, lacking the skills or motivation to make – and then stick to – plans to secure their future wellbeing. So it is no surprise that many homeless people have grown up in unstable environments characterised by abuse, neglect, poverty and the involvement of social care and other statutory agencies. Like their parents, many have issues with alcohol and drugs, mental and physical health and/or offending behaviour. Many are vulnerable and some have personal care needs, physical or learning disabilities.

The homelessness sector in Southampton has got better and better at enabling clients to make sustainable progress so that they achieve independence and are no longer reliant on services. We have also got better at diverting clients away from supported residential services altogether, and rationing these services to ensure that we only provide supported housing – including hostels – to those that need it the most. This means that our client group is increasingly comprised of the most chaotic clients with the most complex needs, many having spent years in and out of prisons, psychiatric units, local authority care (as children) and social services. Many of our clients are regular users of A & E departments and psychiatric hospital inpatients or persistent ambulance callers. Many also spend a great deal of time behaving antisocially, in police custody or prisons.

2. Our Approach

The Society's Homelessness Services deliver housing-related support to clients. "Support" means that we empower and enable clients to do things for themselves (rather than doing it for them) whenever possible. "Housing-related" means that our work has a pragmatic focus on building the skills and networks that clients need to live independently and sustain independent accommodation, addressing the issues that stand in the way of such progress. Areas covered include: -

- Providing the basics (accommodation, usually utilities, sometimes food),
- Addressing alcohol and drug use,
- Stabilising mental and physical health,
- Debt management and maximising income, help with benefits and jobsearch,
- Finding meaningful constructive ways of spending time,
- Reducing offending and antisocial behaviour,
- Building links with other agencies, support services and families, to help make progress and sustain it after they leave our services.

We do not provide counselling or psychotherapy, but our approach is grounded in the motivational interviewing approach. This involves finding out what is important to each individual and using this as a starting point, helping the client to identify their goals and then dividing the path towards these goals into small, achievable steps. Each client has a keyworker (caseloads are around 6 to 9) responsible for working with the client to assess needs and risks and devise and review action plans.

A key challenge for our services is to develop trusting professional relationships with individuals who are very wary of authority; people involved in illegal activities who may have a great deal of negative experience in their dealing with social workers, teachers, police etc. The residential nature of our services helps to overcome this: unlike other agencies we do not rely on clients keeping appointments because we work where they live! We have also designed our service delivery around our clients by, for example, allowing clients to drink alcohol on the premises (rather than on the streets) and providing in-house needle exchange services, as a first step in engaging drug users with more therapeutic drug treatment services.

Another example of our pragmatic approach is encouraging clients to enter into "Managed Drinking Contracts", reducing the harm caused by alcohol use by agreeing a daily limit and restricting access to their personal money until they get used to a less destructive pattern of alcohol use.

Our role is to provide environments in which clients have as many opportunities as possible to make positive choices. For many of our clients, the motivation to change is triggered by something personal to them such as a health scare or the opportunity to have some contact with their estranged children. On such occasions we respond quickly and effectively – before the motivation fades – to support the client to change their lives for the better.

In addition to housing-related support we provide "intensive" housing management, funded by rents and service charges, including an out of hours security service that manages antisocial behaviour in services without 24-hour staff cover.

3. Our Services

The following Society of St James SP services are those most central to homelessness provision in Southampton[1]. Each contract was awarded by SCC following competitive tendering exercises: -

Southampton Street Intensive and Resettlement Homelessness Service	• 26-bed hostel (full board) with 24-hour staffing • 10-bed shared house/hostel without 24-hour staffing (St Theresa's House) • 12 supported flats at 2 locations	Funded from SP contract with associated rent.
Jordan House Intensive-Lifeskills and Resettlement Homelessness Service	• 26-flats, Millbrook Road East • 3 single and 2x2-bed flats at Denzil Avenue	Funded from SP contract with associated rent.
The Alcohol Service	• A 9-bed shared house with 7-day staff cover and meals provided. • Two 5-bed self-catering houses with daily staff support.	Funded from SP contract with associated rent and SCC Care Contract.[2]

[1] The Society manages several other SCC SP contracts including two mental health contracts.
[2] The Alcohol Service has a block domiciliary care contract because of the high number with personal care needs (e.g. incontinence). In other services, where appropriate, we will assist clients to access individual domiciliary care packages spot purchased by Social Care.

4. Needs and Outcomes

SP services are, in essence, preventative services: they have been described as "the fence at the top of the cliff – which means you don't need a fleet of ambulances at the bottom"[3]. In 2009 DCLG research commissioned by the Department of Communities and Local Government demonstrated that the £1.6 billion spent nationally on Supporting People resulted in a net saving of £3.4 billion[4].

When clients stay in our services their mental and physical health improves, substance use reduces, and there is a reduction in their use of expensive emergency services. Their antisocial and offending behaviours reduce, as do the associated costs of police, prisons, the criminal justice and offender management services. A significant proportion of clients make more sustained progress whilst being supported by our services, achieving a degree of independence and a more settled lifestyle that they manage to sustain after leaving our services.

92 clients moved on from the Society's homelessness services in 2013[5]. Of these, 73 (79%) moved on in a positive, planned way, 25 of whom (27%) moved into independent accommodation: -

92 clients	% with needs in this area	% of those with a need who made progress
Physical Health	61%	78%
Mental Health	50%	78%
Substance Misuse[6]	84%	61%
Manage Self Harm	26%	81%
Avoid harm from others	20%	94%

Of the 25 who moved on to independent accommodation	% still in the accommodation
After 2 months	96%
After 3 months	96%
After 6 months	85%
After 9 months	62%
After 12 months	58%

5. Future Challenges

- There is a general need for more move-on accommodation, particularly self-contained flats.
- Our clients are amongst those that are "furthest from the employment market" and as such most vulnerable to the stricter sanctions regime which can leave them without personal benefits for up to 3 years. We need to work more closely with Job Centre Plus to increase their understanding of how bet to help our clients make progress.
- We also need to find new ways of working with "revolving door" clients – those with the most complex needs, who make the least progress and are most costly to the public purse. Two such approaches are "Housing First" and "Making Every Adult Matter".[7]

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[3] Michael Patterson – Director, Support Solutions

[4] The research was carried out by Cap Gemini. It can be found at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/16136/1274439.pdf

[5] Most of these figures have been downloaded from the SP Client Record and Outcomes Office hosted by the University of St Andrews. Unfortunately these figures do not include the Alcohol Service as there was a technical problem in accessing information for this service.

[6] Heroin, crack or severely dependent alcohol use. Often all three.

[7] I will go into more detail on these on 20th March. If you can't wait, go to http://meam.org.uk/ and http://www.shp.org.uk/story/housing-first-provides-stability-chronically-homeless-people

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Homelessness and Health
Two Saints

APPENDIX 3

Two Saints' work in Southampton is with **Single Homeless People.** We have three main services, all of which work at the front end of the **homelessness pathway**.

1. Cranbury Avenue Day Centre

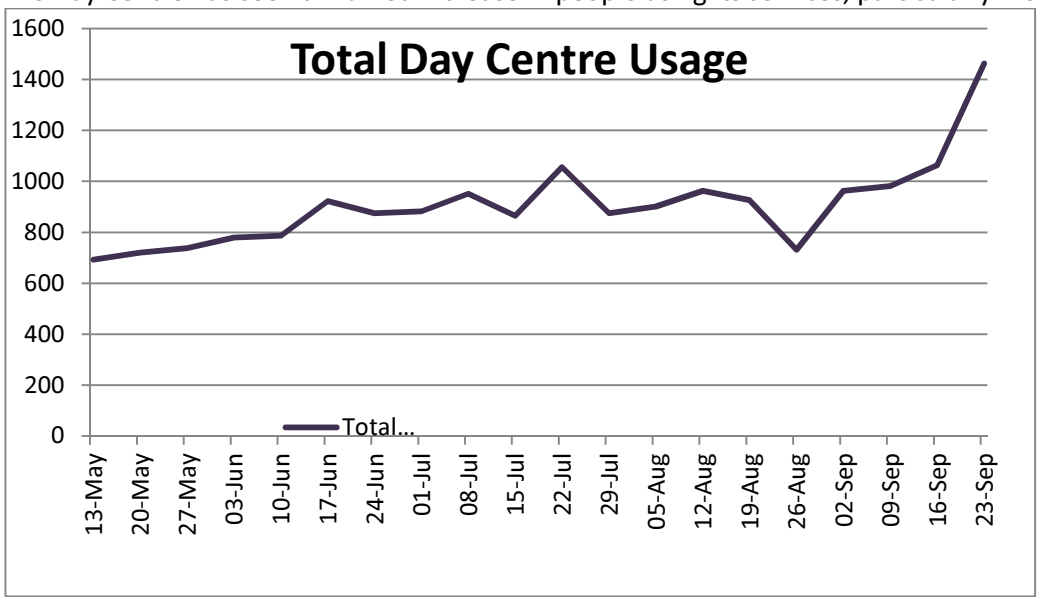
The Day Centre is an open-access drop in centre for anyone within the city. As such it is unusual in that it can offer support and advice to people with no recourse to public funds. These people cannot use other Supporting People services and so would otherwise be without any support. Within the Day Centre Two Saints offers a range of different services to clients:

- The Basic Needs Service – giving clients access to a hot shower, laundry, a hot meal and, importantly, somewhere safe to be during the day.
- The Accommodation Finder Service – supports clients to access housing from the private rented sector. We liaise with landlords to source suitable flats etc.
- The Benefits Advice and Skills Development Service – benefits advice, support with benefit applications, Jobsearch, IT skills, CV writing and related support. This is staffed whenever the Day Centre is open
- Real Lettings South (Private Sector Leasing Scheme) – Real Lettings takes flats from private landlords on long (e.g. 5 year) leases, and then lets them to people who would otherwise be homeless.

The Day Centre also acts as a hub within which clients can access other services:

- The Street Homeless Prevention Team – Southampton City Council (SCC)
- The Homeless Health Care Team – Solent NHS
- Floating Support service
- Other agencies, for example DWP or CAB, offer timetabled advice clinics

The Day Centre has seen a marked increase in people using its services, particularly more recently.



The Day Centre receives some general funding from Southampton City Council, as well as specific monies to fund work such as the Accommodation Finder. The shortfall between funding received and

actual running costs has, over recent years, been covered by fundraising and Two Saints' reserves. This is not sustainable in the long run and the situation will become worse as further SCC funding reductions take effect. It will be impossible to continue to offer the current level of service to clients.

2. Patrick House

Patrick House offers two services within the homelessness pathway.

a. Assessment Service

Around 20 rooms at any one time are occupied by clients whose needs are being assessed. We have a maximum of 4 weeks to complete this assessment, during which time it is necessary to gain their trust, complete a full Risk Assessment and Risk Management Plan, assess support needs and agree a Support Plan and make a referral to whichever support services are needed. These can include other homelessness services within the pathway and also specialist services like professional counselling, substance misuse or mental health. Referrals to homelessness services can include any service within the homelessness pathway.

b. Intensive Service

The other 36 rooms are given over to the Intensive Service. This supports clients to address the issues that have contributed to them becoming homeless. This may include ensuring that they make use of the specialist services mentioned above, or working directly with them to develop the attitudes, motivation and practical skills to allow them to succeed in their own, independent accommodation.

Support within Patrick House is funded by Southampton City Council. This funding is also supplemented by accommodation charges payable for the rooms.

3. Breathing Space – Hospital Discharge Service

Breathing Space is a new service to Southampton that fully opened in February. We work with the General Hospital to assess the housing and clinical needs of homeless people who have been admitted to hospital, so that they have somewhere suitable to live when they are discharged. If there is no suitable accommodation then we have a small (8-bed) building in Swaythling where clients can complete their recovery. This can include clients from other hostels within the pathway, as sometimes the hostel environment, particularly the influence of peers, can hamper recovery.

Breathing Space has very short term funding from the Department of Health, which will end in the next few months. Early indications are that the project is successful at:

- Helping homeless people to successfully recover
- Reducing readmissions to hospital
- Minimising unnecessary nights in hospital

We are looking at ways to secure the longer term future for Breathing Space. However the short funding period is unlikely to give enough time to accumulate enough evidence for the CCG. Another 6 months is likely to provide higher quality and more compelling data.

Health Issues faced by Homeless People

The most common issues that our clients face are:

- Alcohol issues - nausea/shakes/sweats/other withdrawal symptoms
- Addiction issues - withdrawal/sweats/ shakes
- Chronic and enduring mental health issues
- Chronic obstructive pulmonary disease (COPD) - chronic bronchitis, emphysema etc
- Deep vein thrombosis
- Hepatitis C
- HIV
- Gastric issues due to poor diet

Homelessness and Health
Two Saints

- Colds and Flu
- Gout/foot problems
- Depression/suicidal behaviours
- TB

As a response to these issues our staff will:

- Link into drug services – make referrals and sometimes accompany clients to initial appointments
- Support clients to access the walk in centre
- Liaison, informal conversations etc with the Homeless Healthcare Team. As they are based at the Day Centre we take clients across as well
- Issue warm clothing and sleeping bags
- Provide warm drinks and food
- Make referrals to the Street Homeless Prevention Team

Our clients, at a recent focus group and at regular updates and consultations, report that their health is not a priority for them. Clients' priorities are more basic; getting something to eat and somewhere safe to stay. This further divides up:

a) Where a client is looking for somewhere to stay, perhaps a hostel or a flat, this takes up a large amount of their time. Health appointments are seen as a distraction. Moreover clients will ignore or play down any ill health, as they may worry that this will become an issue that gets in the way of them securing accommodation.

b) Where a client is sleeping rough, either whilst waiting for accommodation, because they have no recourse to public funds or where they choose to do so rather than submitting to the rules inherent in hostel or other accommodation, they are only interested in securing somewhere safe to sleep for the night; illness is seen as irrelevant. For example one client said, "You get very fatalistic. If you wake up the next day, you wake up. If not, then there's nothing left to worry about anyway".

A Suggestion from Two Saints' frontline staff

It is best to engage homeless people with health services immediately when they mention a health issue. The Homeless Healthcare Team is an excellent service, but it operates as a GP Surgery, with appointments. Homeless people's lives are often chaotic, meaning that they do not plan well into even the near future, and so miss appointments. The effect of subsequent alcohol or drugs means that what earlier was a pressing health need can become less of a priority.

Staff suggested that having someone with nursing training, perhaps not a fully qualified nurse but with enough knowledge to operate a triage/sign posting service on site would be excellent. This would offer support to our clients without them having to make an appointment.

Homelessness and Health
Two Saints

HEALTH ISSUES FACED BY RESIDENTS OF PATRICK HOUSE (TWO SAINTS ASSESSMENT CENTRE):

There are many health issues faced by residents. This is an outline of the key issues.

Physical Health:

- Many residents have complications from alcohol misuse. These range from cirrhosis of the liver and alcohol related dementia to peripheral nerve damage and pancreatitis and chronic stomach problems. Some residents are subject to the End of Life programme as a result of this and there has been a move to include people within this provision who have alcohol related issues.
- As a result of alcohol issues residents can be at increased risk of falling and health issues can be further complicated as a result of injuries that occur. In general, homeless people are at a greater risk of injury and death from falls compared with the general population. Falling into roads and being hit by motor vehicles is an increased risk for homeless people.
- AS a result of general poor health homeless people are at increased risk of suffering from respiratory illnesses ranging from bronchitis to chronic obstructive pulmonary disease. Living on the streets or residing in very poor housing can exacerbate the effects of respiratory illnesses. Increased rates of smoking and not seeking medical intervention can increase the risks. We have had several residents who have been treated for tuberculosis.
- Residents suffering with epilepsy, if not medicated formally diagnosed, are at an increased risk of injuries caused by fitting and falling and can sometimes be dismissed as suffering from the effects of alcohol or alcohol withdrawal.
- The long term effects of diabetes can be more pronounced for homeless people if they are nor diagnosed at an early stage or if they do not take medication regularly and are not monitored by health care professionals regularly. Long term complication arising from diabetes can result in limb amputations, damaged eye sight and severe cardiac complications.
- Other residents suffer with a variety of skin disorders such as psoriasis and scabies. These can be exacerbated by general poor health and not engaging with health services.
- Residents who have problems with drug misuse can suffer with a range of physical health issues. Residents injecting drugs can suffer with deep vein thrombosis, which can be fatal or result in limb amputations or septicaemia. Sharing needles can result in homeless people contracting hepatitis and the HIV virus.
- Residents using class A drugs can be at risk of overdose, especially if they have not used for some time or if the drugs they use are contaminated or are particularly strong.

Mental Health:

- Homeless people will suffer with a range of mental disorders ranging from mild depression through to the major psychotic illnesses such as schizophrenia and bi-polar affective disorder.
- Mood disorders can be exacerbated by peoples' living circumstances, such as living on the streets and alienation from family and friends.
- All mental disorders can be exacerbated by substance misuse. Alcohol consumption will cause a mood disorder to deteriorate and some drugs will magnify psychotic symptoms. The onset of psychotic symptoms and deterioration in mood will often result in homeless people being less able to look after their physical health needs and render them less likely to seek medical intervention.
- Residents will often self medicate with alcohol and other substances which in turn put their physical health at risk. The issue of dual diagnosis is made more difficult to assess as a result of this and can result in a person not receiving a service from either the mental health or substance misuse services.

Homelessness and Health
Two Saints

Homelessness:

- Being homeless can make it difficult to register with a GP and consequently health issues are not addressed.
- Some homeless people have had poor experiences with health services and may have been dismissed as not deserving interventions.
- Being homeless can mean that it is not possible to receive post and people cannot receive letters for health appointments.
- Some homeless people may be unaware of where to seek help and as a result of substance misuse issues and mental health issues they may lack insight into health issues.
- Many homeless clients will have experienced complex trauma in their lives.{ resulting from abuse} and their behavioural issues can result in the pejorative diagnosis of Personality Disorder. They are often dismissed as not suffering from any treatable mental disorder and clients may then resort to substance misuse in order to help reduce their problems. Homeless people who are using substances will find it very difficult to access any form of psychological therapy.
- Living on the streets will very likely have an adverse effect on their health in general and health issues are sometimes only addressed when clients enter supported accommodation.

Suggestions:

- Increased outreach work to help homeless people engage with health services.
- Encouraging clients to attend walk in centres and surgeries such as Homeless Healthcare Team
- Training for A&E staff on health issues faced by homeless people
- Training for GPs in awareness of the difficulties homeless people have in accessing services.
- Introduction of a peripatetic health team going on outreach on the streets.
- Health education for clients in Day Centres
- Increased access to psychological therapies for homeless people.

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APPENDIX 4

Outline of services delivery

No Limits is an information and advice service for young people up to the age of 26. No Limits are a member of Youth Access. Youth Access is the national membership organisation for young people's information, advice, counselling and support services (YIACS). YIACS operate under the following core principles:

- Young people are central to the service and member agencies are committed to responding to their needs.
- Member agencies believe that young people have a right of access to quality information, advice and counselling services.
- The basis on which young people are able to make use of a service is made clear to each of them individually and a contract is agreed where appropriate.
- Member agencies of Youth Access aim to empower young people and treat them with respect based on an understanding of their individual culture and background.
- In all aspects of their work, member agencies of Youth Access aim to counter the oppression and discrimination faced by young people.
- Member agencies of Youth Access are working towards equality of access for all young people for whom their service is designed.
- Member agencies of Youth Access take all reasonable steps to ensure the safety and well being of young people and workers in an agency.
- Member agencies of Youth Access are committed to ensuring their workers are competent to perform the range and depth of duties offered by the agency and provide a framework for staff development that includes support, supervision and training.
- Member agencies of Youth Access are committed to establishing and maintaining procedures for monitoring and evaluating the service they provide.

No Limits has three drop-in centres across the city and also provides a drop-in service in 8 secondary schools and the 3 colleges. In addition to the drop-in there are a number of specialist support services proving one to one support on a range of issues including housing, tenancy support, substance use, sexual exploitation, young offenders, care leavers, young carers and LGBTT young people.

The support around housing includes mediation with families, referrals to supported housing and the local authority, floating support with tenancy maintenance and access to the private rented sector (A2T). There is also practical support such as use of a shower and laundry, clothes, food, sleeping bags etc. The support offered is always holistic and will consider mental and physical health, budgeting, benefit and debt advice, family, relationships and legal advice.

Client profile and health / housing needs & inequalities (can be supplemented with 1-2 case studies)

About a third of young people accessing No Limits have housing concerns (approx. 2000 a year) many also have a number of vulnerabilities, e.g. mental health, debt, offending history. Some are homeless due to a breakdown in family relationships, some have been in supported housing and been evicted, or have been evicted from the private rented sector, usually for rent arrears or anti-social behaviour. Some are housed but struggling with feelings of isolation, living on a low income or properties being in a poor condition. Welfare reform, particularly sanctions has increased these issues. Young people in receipt of housing benefit are only entitled to the LHA rate for a room in a shared house which can be difficult for some to manage. Landlords would often prefer not to house young people or people on benefits or those without a large deposit and references.

Case study

VJ first came to No Limits looking for housing advice as she was homeless. VJ had been sofa surfing for 3 months after being evicted from Housing association accommodation due to rent and council tax arrears. VJ had lived with her boyfriend. However the relationship turned abusive and violent involving drugs and alcohol. VJ's boyfriend has been convicted of Supplying Illegal substances. VJ is unemployed and not in education, training or employment. She wants to be a carer.

VJ successfully completed A2T (pre-tenancy training). VJ is now housed in the PRS in a shared house with 12 weeks housing support. She is applying for a course in Health and Social Care. VJ has started to address her debts. She is having counselling to address her levels of anxiety resulting from her relationship breakdown and period of homelessness.

Case study

17 year old living in the family home and struggling with a chaotic family life, Dad is disabled having suffered with arthritis and strokes, and Mum suffers with Crones disease and has left the family home as it was too stressful for her. The client has two brothers and a sister. All family members drink alcohol to excess on a regular basis. The client had been drinking virtually daily which resulted in risky sexual behaviour, inappropriate relationships and not attending college. The client was self-harming and had attempted suicide in the past. She was unable to sleep and feeling distressed.

The young person received support on the drop-in and through counselling over a twelve month period.

The client rarely drinks now and when she does it is not to excess and in a safe environment. She started attending college regularly and passed her hairdressing NVQ level 1, she is now studying for a level 2 NVQ. She has also recently got a job as a waitress. Relationships with her family have improved and she generally feels happier and more able to cope. She has had the same boyfriend for three months. She is not feeling distressed, is sleeping well and less anxious. She has remained in the family home which has prevented her from becoming homeless.

Key client solutions

- Early intervention to prevent homelessness where possible.
- A variety of options to suit the need of the individual.
- A holistic approach looking at all the needs of the individual not just their housing.
- Appropriate level of support which can be reviewed and last until there is no longer a need.

- Skilled and trained work force.
- Youth Information, Advice, Counselling and Support (YIACS) model of a drop-in backed up with specialist support.
- Emergency access into supported accommodation.

Main areas of concern

- Welfare reform, particularly sanctions.
- Difficult to find landlords willing to house young people.
- Lack of access to support with mental health/emotional wellbeing (No Limits have over 90 people on the waiting list for counselling)
- Rising debt and poor quality housing in the PRS resulting in health concerns like poor nutrition, anxiety, depression and self-harm.
- Local Housing Allowance is set very low meaning it is difficult to source good quality accommodation in the Private Rented Sector.

Potential solutions / changes that would make the most difference

- Local Housing Allowance rates to be higher.
- Young people to receive support when starting a tenancy to ensure they are registered with a GP and know where to get support to avoid inappropriate use of emergency services like the emergency department.
- Greater access to counselling, particularly for 19-15 year olds.
- Private rented access scheme to be part of the local authority response to homelessness. (Currently funded by national funding secured by No Limits.)

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APPENDIX 5

Chapter 1 Young People's Supported Housing Service (Kingsley House)

Profile.

This service provides supported housing to 16-25 year olds who have been homeless or at risk of homelessness. The service offers a range of accommodation to best suit the skills & circumstances of the individual. These comprise of hostel places, rooms in shared housing & studio flats, totalling 67 bed spaces. The service also manages 5 transition houses in the private rented sector with a further 26 bed spaces. Our aim is to promote healthy, well balanced independent living.

One of the primary roles of this service is to prevent the need for entry into adult services. Where we are successful the savings to local spending can be significant.

Overall we find that in terms of general healthcare the provision in the city for our client group is available & of good quality. At Kingsley House we have a good relationship with our local surgery and have examples of them going above & beyond to accommodate the needs of our tenants.

In general we find that access to providers offering specialist services such as mental health, substance misuse, sexual health, health trainer guidance, smoking cessation, dentistry, emotional support (inc. self harm, anger management) etc. are accessible, although there may be a waiting list.

Main Issues.

The main areas where we fail to find an appropriate co-ordinated response are with clients with more complex issues (see case study- Martin). This young man failed to 'fit' the criteria for mental health services as his psychoses are drug induced, and arguably self- inflicted. He also fails to 'fit' into drug programmes because his drug use is sporadic & variable in terms of substances used. The frustration for us as a service is that without specialist support this client won't be stabilised. His self harming is significant, disturbing & sometimes public. We have been unable to keep housing him because of his impact on staff & other tenants. He has been referred to an adult service, where the issues will continue if not worsen. Martin is not his real name, but I could give several real names for whom this story is accurate.

Another difficulty we have is getting the right support for those with a border-line learning disability, particularly when they also display high risk behaviours. The service is an unsafe environment for this group- they are often at risk of violence & exploitation from other clients. We have experienced sexual &, more regularly, financial abuse of these clients. In our safeguarding review of the past year- half of the 13 serious safeguarding logs we have been running involve a client with border line LD (half also care leavers, interestingly). If the client has been assessed to have an IQ score of 70 or less, a diagnosis of LD can be made & the client qualifies for specialist support. Ours sit at or just above 70, so do not qualify & come into mainstream provision. My team are trained to give tenancy support, as per our commission, and are not specialised to support these clients. EVERY client in this

group has failed to hold a healthy tenancy, even if this highly supported environment, and has been at higher risk of harm from being placed here.

Barriers.

The barriers for these groups of young people are that they don't fit into the criteria of services best placed to support them. Our service would have more success in housing these groups if additional specialist support was available where needed.

Another barrier is that my team are not specialists, and the service doesn't have the finance to pay for specialist staff. Our commission is tenancy support.

The complex, dual & poly-diagnosis clients will usually have been involved with services previously. As these services are so stretched- and the client may have missed many booked appointments- they, quite fairly, will insist that the client comes to them. It is our experience that this group is unable to commit to attending appointments. Even when we are resolved to take them, we have to find them first and usually their chaotic lifestyles have taken them elsewhere. We have no power to stop young people coming & going at will- nor would we want it.

A significant issue for us as a voluntary sector service is being taken seriously by, and achieve good engagement with, the statutory services our complex clients need support from. It is incredibly frustrating to work with the borderline LD clients, who may have been assessed as able to decision make- when the decisions they do make are dangerous & irresponsible. We know that we cannot keep these clients safe, nor will we prevent them from entering adult services.

For clients generally, limited income leads to lack of good diet. Many live on packets of noodles & microwave meals. The service does teach cooking, nutrition & budgeting skills, but young people rarely prioritise diet- and never consider future health issues as a result of poor diet now. At this service we do not provide meals.

Cannabis use is prevalent among our client group. Other drugs are used, but mostly the use is experimental & short lived. We have strict rules around cannabis use & work closely with the police, but cannabis use is 'normalised' within the family groups & communities around our clients, so they rarely take our messages seriously. Those with more serious drug use will always fail in their tenancies as they will not prioritise rent payment.

Successes.

There have been a couple of occasions where our commissioner has stepped in to open a pathway to the LD service for us and two clients have been placed into specialist LD housing. Neither client has come back into the service which would indicate successful placement.

Access to general health care is strong for our client group.

We are successful in promoting healthy independence with a large proportion of the young people we house- those without complex needs.

Solutions?

Widen the criteria for existing statutory services? This would potentially close the gaps that complex clients fall through, but with these services already stretched this could only impact the quality of provision unless more funding were made available.

Create new services for these groups? A very costly exercise.

Invest in more training for existing housing support services? I would suggest that the supported housing environment would no longer prove a suitable place for young people without these issues if services specialised.

Utilise current housing stock differently to create more specialist housing? This would prevent the more vulnerable, at risk clients from entering mainstream services, allowing these services to do what they were designed to do- tenancy support. With strong partnership work with the necessary providers it would be possible to create safer, appropriately supportive environments for these groups.

Stronger partnership work between existing providers? This is essential regardless of any other solution. The gap between voluntary & statutory services is still too wide. When a provider who spends hours each day observing behaviours from a client then reports issues to other services, this needs to be taken seriously and assessed.

Change the rules around ineligible service charges so that more complex clients can at least secure their housing while they are supported to address their issues? This may go some way to addressing the 'revolving door' issue of clients being evicted due to non-payment of rent, but having nowhere else to go. These clients will come back through the service again & again, accumulating debt and a history of evictions, making future secure housing difficult. These people *will* go into adult services because private landlords are understandably risk averse with this group.

Wider context.

Please see the attached report. This study was undertaken in 1997 but the conclusions ring true today. There are significantly higher instances of mental health issues & drug use among homeless young people as opposed to young people who are provided with a safe and consistent home life.

Young people not getting appropriate care & support can bring long term health issues into adulthood which will significantly impact the economy in the future.

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BrunnerRoutledge Taylor & Francis healthsciences

A comparison of homeless and domiciled young people

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Abstract

There is growing concern about the welfare of the substantial number of young people who are homeless in the UK. A sample of young people living in homeless hostels in Birmingham is compared with one derived from a private household survey carried out in the same city. Sociodemographic details along with information on mental health, substance use and service uptake were ascertained. The homeless sample were younger and more likely to be male than their domiciled counterparts. They had more often spent time in institutional child care and had worse educational records and lower levels of employment. Young people who were homeless had greater involvement with the police, more frequently used illicit drugs and reported worse physical and mental health than those in private households. They were equally likely to see a general practitioner and more often consulted for 'nerves' as well as having a higher rate of contact with mental health professionals. The bearing these findings have on how to tackle youth homelessness are discussed.

Introduction

The report of the national enquiry into preventing youth homelessness estimated that almost a quarter of a million young people became homeless in the UK during 1995 (Evans, 1996). The reasons proposed to explain this high level of youth homelessness have predominantly stressed structural antecedents and highlighted the need for better access to accommodation, improved opportunities for employment and enhanced social security benefits (Harvey, 1999). Shortcomings in these areas leave young people vulnerable to becoming homeless when they have to move out of their childhood homes (Smith *et al.*, 1998). However, while not denying their impact, it is difficult to ignore the reality that many young people exposed to these factors do not become homeless. This lends support to the argument that personal characteristics make a significant contribution to the risk profile for youth homelessness.

Smith & colleagues (1998) reported that two thirds of the young homeless people they interviewed came from 'disrupted' families and ended up homeless because of conflict with their parents, often in the context of abuse. For the remaining third, from 'non-disrupted' families, their own behaviour was most likely to be the trigger for them having to leave home. These results are echoed by Craig & Hodson (1998) who found that both childhood adversity (69%) and childhood conduct disorder (43%) were more prevalent

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in homeless compared to domiciled young people. They also identified significant associations between early adversity and later mental illness and between conduct disorder and subsequent substance misuse. High rates of both mental illness and substance misuse have been consistently reported in populations of young people who are homeless (Blaire & Wrate, 1997; Sleegers *et al.*, 1998). However, the pathways by which these and other individual factors mediate the experience of homelessness remain uncertain. The aim of the present study is to compare young people who are homeless with those living in private households in Birmingham, UK in order to explore the role of personal characteristics in youth homelessness. The findings should inform the debate about how best to help this disadvantaged section of the population (Evans, 1996).

Methods

Sample

A domiciled sample of people aged 16–25 years was obtained from a random sample of west Birmingham residents registered with a general practitioner (GP) drawn from a database held by the Family Health Service Authority. West Birmingham is consistently ranked in the top ten most deprived health districts in England (Smith *et al.*, 1996). The sample forms part of a wider study examining psychiatric morbidity rates and service utilisation in this catchment area (Commander *et al.*, 1997). Permission was sought from all GPs with potentially eligible patients to access their practice lists and to invite people to participate in the study. All the subjects identified were contacted by letter and subsequently approached for interview. The survey was completed between December 1994 and May 1995.

The homeless sample consists of people aged between 16–25 years drawn from homeless hostels in Birmingham accepting people within this age range. Twelve hostels were eligible to take part and of these 10 agreed to participate. Two hostels were specifically for men, six for women and two mixed gender. Four hostels confined themselves solely to people aged under 25 years. People in the hostels on a designated census day and all those subsequently using these facilities during the following 5 months were eligible for inclusion. The study took place between June and October 1997.

In both surveys subjects were interviewed in their accommodation by trained researchers. Each subject completed a written consent form prior to proceeding with a semi-structured interview. All completed interviews were reviewed by a senior member of the research team. A payment of £10 was made to each subject who participated.

Measures

The survey of the domiciled population in west Birmingham was completed before the homeless survey was conceived and limited the range of factors available for comparison. Where possible, identical items were included in the homeless survey. Sociodemographic details and information regarding the use of services were elicited.

Mental health was assessed using the UK version of the 5-item mental health dimension of the SF-36 (MHI-5; McCabe *et al.*, 1996). This instrument is short and easily administered. It consists of five questions rated on a six point scale from none to all of the time (item score 1–6); How much of the time during the past month have you (1) been a very nervous person? (2) felt down in the dumps that nothing could cheer you up? (3) felt calm and peaceful? (4) felt down hearted and low? (5) been a happy person? This

inventory gives a total score ranging from 5–30 and raw scores can be transformed onto a scale of 0–100, higher scores indicating better health. In addition, subjects were asked the question; Have you taken an overdose or attempted in any other way to deliberately self harm (DSH) in the past 6 months?

General health was examined using items from the UK version of the SF-36 (Jenkinson *et al.*, 1993). Two questions were asked; (1) In general would you say your health is: poor, fair, good, very good or excellent? (2) Compared to one year ago how would you rate your general health now: much worse, somewhat worse, about the same, somewhat better or much better? In addition, a question from the List of Threatening Experiences was utilised (Brugha *et al., 1985*); Have you suffered from a serious illness, injury or assault in the past 6 months?

Alcohol use was assessed by a general question asking whether the person drank alcohol and subsequently by the CAGE (King, 1985). The latter instrument requires the following four questions to be answered yes or no; (1) Have you felt that you ought to cut down on your drinking? (2) Have people annoyed you by criticising your drinking? (3) Have you felt bad or guilty about your drinking? (4) Have you had a drink first thing in the morning to steady your nerves or get rid of a hangover? The conventional threshold of two or more affirmative replies was used to distinguish a case from non-case. Drug use was assessed using the checklist criteria from SCID/DSM IIIR (Spitzer *et al.*, 1992) with the exception that 'heroin' and 'other opiates' were merged into one group.

Analyses

The characteristics of homeless and domiciled young people were compared. The data were analysed using SPSS (1993). Levels of significance were determined using χ^2 where appropriate. The *t*-test for independent samples and analysis of variance were used to compare the MHI-5 scores.

Results

Response

In the homeless sample, 70/119 (59%) young homeless people agreed to be interviewed. The response rate did not differ significantly for men (43/72, 60%) and women (27/47, 57%). In the domiciled sample 111/147 (76%) people who were contacted agreed to participate. The response rate did not differ significantly by gender (47/68, 69% men and 64/79, 81% women) but was greater overall for the domiciled than the homeless sample ($p<0.01$). Of those in the homeless sample, 36/70 (51%) had been homeless (defined as the time they were last resident in a private household for 6 months or more) for more than 6 months and 38/69 (55%) had a history of sleeping rough.

Comparison of homeless and domiciled young people

A higher proportion of the homeless sample were male and aged 16–17 years compared to the domiciled sample (see Table 1). The latter included a higher percentage of young people self-identified as Asian whereas the homeless sample included more people within the 'other' ethnic group. A similarly high proportion in both domiciled and homeless samples were born outside Birmingham. A quarter of the young people who were homeless compared with none of those in private households had spent time in institutional child care. They were also less likely to identify someone whom they 'felt particularly close to and could turn to and share their troubles'. Young homeless subjects had more often left full time education before the age of

Table 1: Sociodemographic details (%)

	Domiciled		Homeless		
	n	(%)	*n*	(%)	
Gender: Male	47/111	(42)	43/70	(61)	p=0.01
Age16–17 years	7/111	(6)	26/70	(37)	p<0.0001
Ethnicity					p=0.000
Asian	44/111	(40)	11/70	(16)	
Black	13/111	(12)	11/70	(16)	
White	50/111	(45)	36/70	(51)	
Other	4/111	(4)	12/70	(17)	
Born in Birmingham	76/111	(69)	40/70	(57)	*NS*
Time spent in local authority care	0/111	(0)	18/66	(27)	p<0.0001
Identify person they are close to	107/111	(96)	60/69	(87)	p=0.02
Left full time education < 16 yrs	12/111	(11)	23/69	(33)	p=0.0002
Any qualifications	79/111	(72)	33/68	(49)	p=0.002
Work in past week	54/111	(49)	5/67	(7)	p<0.0001

16 years, were less likely to have any qualifications and far less likely to be in work than their domiciled counterparts. They had also more often been charged by the police in the past six months (13/70 (19%) v. 3/111 (3%); p=0.0003).

Young people who were homeless were significantly more likely than their domiciled counterparts to have used illicit drugs during the previous 6 months (with the exception of ecstasy and solvents) as well as using two or more drugs and injecting (see Table 2). A higher proportion reported drinking alcohol although the level of problematic alcohol use, determined by the CAGE, did not differ significantly between the two groups. Homeless subjects had more often deliberately harmed themselves during the past 6 months and experienced a serious illness, injury or assault. They also reported worse general and mental health (see Table 2).

Although permanent registration with a GP was lower than for the domiciled sample (who were all necessarily registered), young people who were homeless had a similar level of contact with a GP in the previous 6 months and were more likely to have seen their GP for 'nerves' during this time (see Table 3). They also had greater involvement with mental health professionals both during their lifetime (including in-patient care) and in the past 6 months.

Discussion

Methodological issues

The definition of homelessness is fraught with difficulty (Sleegers *et al.*, 1998). The sample in this study is restricted to people using homeless hostels and is likely to reflect a marginalised group of young people who have exhausted other avenues of support. The hostels included represent those identified by key local agencies but other establishments, especially smaller privately run facilities, may have been omitted. The generalisability of the hostel sample to other sections of the homeless population including the 'hidden homeless' and people sleeping rough is uncertain. Also, in both surveys, but especially the homeless, the refusal rate was not inconsiderable and encourages cau-

Table 2: Health details (%)

	Domiciled		Homeless		
	n	(%)	*n*	(%)	
Drugs used in past 6 months					
Cannabis	16/111	(14)	36/66	(55)	$p<0.0001$
Amphetamines	5/111	(5)	10/66	(15)	$p=0.01$
Opiates	1/111	(1)	9/66	(14)	$p=0.0004$
Ecstasy	4/111	(4)	7/66	(11)	*NS*
Cocaine	0/111	(0)	6/66	(9)	$p=0.01$
Hallucinogens	3/111	(3)	3/66	(5)	$p=0.04$
Solvents	0/111	(0)	0/66	(0)	-
Any drug use	17/111	(15)	38/66	(58)	$p<0.0001$
Using two or more drugs	8/111	(7)	18/66	(27)	$p=0.0003$
Injecting drugs	0/111	(0)	6/66	(9)	$p=0.00$
Alcohol in past 6 mths	51/111	(46)	56/69	(81)	$p=0.0006$
CAGE caseness	4/92	(4)	8/65	(12)	*NS*
Deliberate self-harm in past 6 mths	1/111	(1)	8/70	(11)	$p=0.002$
Serious illness, injury or assault in the past 6 mths	12/111	(11)	34/70	(49)	$p<0.0001$
General health fair to poor	11/96	(11)	20/69	(29)	$p=0.004$
Health worse than 1yr ago	13/95	(14)	17/68	(25)	*NS*
	mean (SD)	*n*	mean (SD)	*n*	
MHI-5 transformed score *	72 (19)	95	61 (19)	65	$p<0.0001$

* Blaire & Wrate, 1997; mean 60, SD 19.

tion in interpreting our results. The conceptual problem defining mental illness represents a further hurdle to be overcome in undertaking research in this area. In contrast to Craig & Hodson (1998), no attempt was made to generate clinically meaningful diagnoses in this study. There are doubts about the performance of screening instruments developed in other populations. The homeless condition itself may lead to ratings that are not necessarily indicative of underlying pathology but may reflect demoralisation or unhappiness (Sleegers *et al.*, 1998). There is evidence to support the reliability and validity of the MHI-5 in homeless populations (Wood *et al.*, 1997). Less confidence can be placed in the CAGE (King, 1985) but comparative data from the domiciled sample dictated that this measure be used. Likewise in order to retain comparability, the checklist items for drug use in SCID (Spitzer *et al.*, 1992) were utilised even though it was not feasible to complete the full SCID substance use section in the homeless sample.

There are limitations to the use of a private household survey for comparison, especially as in this study it was not obtained with that purpose in mind. The young people in the west Birmingham sample were not asked if they had ever been homeless when this may have been the case for a substantial minority (Craig & Hodson, 1998). Also, had those living in private households become homeless they would not necessarily have been included in the homeless sample as many did not originate from the city. Likewise, almost half the homeless sample were born elsewhere. The distortions introduced into the analyses as a consequence are revealed in comparisons relating to ethnic group and

Table 3: Service use details (%)

	Domiciled		Homeless		
	n	(%)	*n*	(%)	
Permanent registration with GP	111/111	(100)	34/67	(51)	$p<0.0001$
Contact with a GP in last 6 months	85/111	(77)	44/69	(64)	NS
Seen GP for nerves in past 6 months	3/111	(3)	9/69	(13)	$p=0.007$
Ever been psychiatric in-patient	0/111	(0)	7/70	(10)	$p=0.0007$
Ever seen a mental health professional (*)	2/111	(2)	19/70	(27)	$p<0.0001$
Seen a mental health professional in the past 6 months	0/111	(0)	6/70	(9)	$p=0.002$

*= psychiatrist, psychologist or community psychiatric nurse

place of birth. The stark finding that almost half the young people who were homeless identified their ethnic group as 'non-white' is masked by the substantial proportion of people from ethnic minorities living in west Birmingham (14% black and 23% Asian, 1991 Census). When contrasted with the population of Birmingham as a whole (21% 'non-white', 1991 Census) it becomes transparent that young people from ethnic minorities are probably over represented in the homeless population. The greater likelihood of their being brought up in deprived areas with prominent overcrowding and high unemployment as well as their exposure to racism and discrimination have been tentatively proposed as reasons for this disparity (Julienne, 1998). More certainty can be attached to evidence regarding the unacceptability of much existing homeless provision to ethnic minorities and credence given to demands that specific attention be paid to interventions to tackle homelessness in this group (Davies & Lyle, 1996, Julienne, 1998). The similarly high proportion of homeless and domiciled young people who were born outside the city conceals the considerable mobility of the homeless sample almost half of whom did not originate from Birmingham. This too is important for service development as it suggests that strategies targeted on the city alone are likely to have only a partial impact unless combined with measures to address the problem countrywide.

Key findings

The homeless sample included a larger proportion of very young people, aged 16–17 years, than those living in private households. This may be an inevitable consequence of the fact that as they get older young people tend to exit homeless settings. It is also likely to reflect a period of high risk for becoming homeless. A breakdown in the relationship with one or both parents is the precipitant of homelessness in over two thirds of cases (Craig & Hodson, 1998, Smith *et al.*, 1998) and around a third of young homeless people have spent time in institutional child care settings (as compared to none of our domiciled sample). The development of family mediation services (Randall & Brown, 1999) and improvements in leaving care services (DoH, 1999) link into these early experiences and have been identified as offering potentially valuable contributions to preventing youth homelessness (Bruegel & Smith, 1999). Both antecedents are likely to result in lower levels of support being available to young people as they attempt the transition to adult life. Our finding that almost nine out of 10 young people who were homeless could

identify someone they could turn to for support was more optimistic than the 64% reported in a survey in Edinburgh (Blaire & Wrate, 1997). However, many of these relationships are likely to be with young people in similar circumstances (Randall & Brown, 1999). Such contacts may hinder moves away from homelessness as young people are understandably reluctant to disrupt fragile social networks. Loneliness has been repeatedly identified as a key factor undermining attempts at resettlement (Fitzpatrick *et al.*, 2000). Services are likely to be more effective if they intervene promptly when young people first become homeless and so avoid them drifting away from their local area and established friendships (Fitzpatrick, 1999). Young people who were homeless were far more likely than their residentially stable counterparts to have left school before the age of 16 years and were less likely to possess any qualifications. This is consistent with reports from previous UK studies (Blaire &Wrate, 1997; Craig & Hodson, 1998) and is corroborated by Breugel & Smith (1998) finding that over half the homeless young people in their sample had been excluded from school. Along with early aversive experiences at home, poor educational attainment provides a marker for people at high risk of becoming homeless (Craig & Hodson, 1998; Breugel & Smith, 1998) and should draw attention to the need for additional support, not least in school. Their weak academic performance also helps explain why less than one in 10 young homeless people were in work and underlines the importance of schemes to facilitate access to training and meaningful occupation (SEU, 1998).

The present study reinforces concerns regarding the well being of young people who are homeless (Blaire &Wrate, 1997; Craig & Hodson, 1998). When compared to the domiciled group, the homeless sample experienced worse general health including a greater likelihood of having suffered a serious illness, injury or assault within the previous six months. They scored lower on the MHI-5, had more commonly deliberately self harmed and reported more extensive illicit drug use, including polydrug use and injecting. Young people who were homeless were also more likely than their residentially stable counterparts to have been charged with an offence by the police during the previous 6 months. This may be at least partly accounted for by higher rates of conduct disorder (Craig & Hodson, 1998). It is not possible to unravel the temporal order of events in a cross sectional survey but Craig & Hodson (1998) found that mental health problems (mental illness, substance misuse and conduct disorder) predated the onset of homelessness in the majority of cases. This strengthens the argument for the early identification of those at risk and for prompt intervention to avert any corrosive impact on home life and schooling and subsequently support networks and employment. But what about the requirements of those young people who are presently homeless? Overall contact with GPs was comparable with our domiciled sample and consultations for 'nerves' higher in the young people who were homeless. The latter were also more likely to have had contact with a mental health professional and a significant minority had been in a psychiatric hospital. These findings contradict suggestions that young homeless people have difficulty negotiating their way around an unco-ordinated care system (Evans, 1996). The obstacle appears to be with the services provided rather than simply to do with access. The quality of services available to homeless people has often been poor and the attitude of service providers frequently negative (Fisher & Collins, 1993). Where dedicated and enthusiastic specialist psychiatric services have

been initiated they have proven unattractive to young people perhaps sensitive to the disparaging images associated with mental disorder (Blaire & Wrate, 1997). Agencies concerned with young people who are homeless should consider training their own staff to be better able to tackle common mental health problems and either develop 'in-house' services or close ties with other providers targeting young people in order to offer more specialist psychotherapeutic interventions (Commander *et al.*, 1998).

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Notes

This information is based on domiciled and homeless young people aged 16-25 like KH.

- This study was written in 2002 based on young homeless people. Evidence has come from 1995-1998. This shows a comparison of how much services have or have not changed between then and now.
- Although this has been sampled through West Birmingham it still gives a good representation on young people and mental health.
- Table 1: talks about age, ethnicity and gender. This gives statistics of those with mental health who were domiciled and homeless. This is a comparison of health between the two groups and how great the difference is or is not.
- Table 2: illustrates the health details of those who are domiciled or homeless and also gives statistical information. This table is based on those who consume have consumed. (like *Martin*)
- Table 3: Shows the type of contact or how frequent the contact is with the health services.

This shows that access to health services was not great in 1995-1998. Now in 2014 access for those with mental health and who are domiciled or homeless access to health services is not that much better.

Chapter 1 Case Study

Martin is a 21 year old male in supported hostel accommodation. He previously had lived in a more independent self contained flat. When he was originally assessed for housing Martin had few support needs. It was known that he had a previous drug addiction to an amphetamine but he hadn't used in the last month before the assessment date. He had also previously taken MDMA and smoked cannabis. In these circumstances Martin had not had professional support to stop his addiction; he had done this by himself with nothing but willpower. In his initial assessment, Martin disclosed that he used to self harm and had only on one occasion entered hospital for treatment of wounds. He had also disclosed trying to commit suicide by overdosing on sleeping medication on two different occasions. Martin had previous connections with the local mental health team and had been diagnosed with having a Borderline Personality Disorder and had been prescribed two different forms of medication one of which was an anti-psychotic drug and the other an anti-depressant.

Martin had previously coped in the self contained flat until he felt unable. At his first review he felt that he had not managed to budget well and had mostly spent his benefit money on drugs, amphetamines again. This lead him to neglect buying food and topping up his electricity and gas meters. Martin was often found sat in the dark with no electricity, heating or food. He was still taking medication for his mental health needs. The second review showed little to no improvement; Martin still struggled with budgeting for food and utilities and would spend his money mostly on drugs. Martin was no longer involved with the local community mental health team, so had not been taking his regular prescription. He disclosed that he was still regularly taking amphetamines, and was open to discussions of making contact with local drug services to help him with his addiction. When he lived in the self-contained flat he was in contact with an Early Intervention in Psychosis (EIP) team worker due to his drug use leading to drug induced psychosis. This psychosis had worsened and he eventually was admitted to stay in the local mental health unit. The stay lasted nearly a month, Martin's well being had improved greatly. He had a discussion with his worker within the project and his EIP worker and agreed to move into the more intensive support unit of the hostel accommodation.

About a month after moving into the hostel accommodation Martin showed signs of further deterioration and had been abusing his medication prescribed for his mental health and psychosis. He had asked a member of staff to look into entering a detox facility due to the effects of taking drugs. Martin often presented to staff in the reception area of the building stating that he had thought about self-harming, and a want to take morphine. He was receptive with having conversations with staff. There was an occasion where Martin presented with psychotic symptoms as previous, but this time they were more serious and worrying as he was threatening to self harm or possibly attempt suicide and had also made threats of harming other people. Emergency services were contacted and he was admitted to hospital and then admitted onto the mental health unit, but he was not sectioned. When Martin had left the unit and returned to the hostel, it was decided by management that due to the risks posed by Martin not only to himself but also to the other young people around him, that the project was no longer prepared to house him. A referral was made to adult services and he is to move on to accommodation provided by adult services.

Being in a hostel situation and in supported housing had a major effect of Martin's health and well-being as well as his stability in maintaining a tenancy. The housing and how it affected him mentally lead to an increase of drug use, meaning that he often had little to no money to feed himself and maintain utilities in his flat. Martin's drug use eventually lead to drug induced psychosis which affected his current mental health needs. This then lead to a further breakdown in his housing situation.

APPENDIX 6

HOMELESS HEALTHCARE TEAM

1. Aims and objectives

Solent NHS Trust holds a contract with NHS England to provide primary care provision to homeless people in Southampton. The service is provided by Solent NHS Trust. The contract has been in place since 2000 but the team itself has been in existence since 1992. In 2001 the provision was formally extended to include refugees and asylum seekers. This specialist, multi-disciplinary team provides care both to individual homeless people and families across Southampton. The team fulfils an important function by addressing health inequalities in the city and has a strong public health focus.

2. Target Group

The service is provided to homeless people across the city of Southampton. The description "homeless" encompasses people living in:

- hostels or night shelters,
- bed and breakfast,
- supported accommodation for those with mental health or substance misuse problems,
- refuge houses for women fleeing domestic violence,
- approved premises for offenders,
- bedsits or private rented accommodation without security of tenure,
- mobile homes, caravans or cars;
- as well as people with no accommodation who are residing on the streets.

In addition the team provides care to asylum seekers or migrants from abroad who find themselves without support.

Over the years of operation the team has expanded its work to meet the needs of new groups who are marginalised and who experience problems accessing health care. The team seeks to uncover and meet new areas of need within Southampton in a bid to address health inequalities.

3. Services provided

The Homeless Healthcare Team seeks to provide equity of provision for homeless people whilst recognising that a separate service is needed because many people are unable or unwilling to access mainstream provision despite having extremely complex needs.

3.1 Comprehensive new patient check for all patients prior to seeing GP which includes the following:

- Basic physical observations – height, weight, blood pressure
- Current health including completion of template for any long-term conditions
- Recent medication
- AUDIT-C questionnaire for alcohol use. Education and referral on.

- Fibrosis markers if appropriate (to determine the likelihood of liver damage)
- Drug misuse – sharing of works, risks. Education and referral on.
- Blood borne virus screening incl. pre-test counselling for HIV, vaccination for Hep B if appropriate
- MMR vaccination if appropriate
- Smoking cessation advice
- Quantiferon Test for TB and referral if active or latent disease is suspected
- Urine test
- Liaison with past providers (including prisons) to determine recent medication etc.

The new patient check takes between 30-60 minutes.

3.2 GP Provision

There are currently 3 sessional GPs employed by the Team who provide 6 sessions. There is 1 GP session per day. GPs provide both booked appointments and drop-in consultations. Appointments are booked for 15 minutes but in reality some consultations take much longer. GPs are very aware of the danger of compounding problems by prescribing additional drugs which may be misused. The GPs work very closely with the Nurse Prescribers within the team.

3.3 Long term conditions

Patients are offered time to discuss the management of their long-term conditions on an opportunistic basis. Patients rarely attend for planned appointments for this. Team members sometimes need to be creative in how they can support people. Support workers can provide assistance in ensuring patients attend secondary care appointments and screening tests.

3.4 Sexual health services

- Pregnancy testing
- Screening
- Discussion of contraceptive options
- Implanon insertion

3.5 Screening and Vaccination

The team conducts screening at each new patient check and thereafter on an opportunistic basis. Screening provided includes:

- TB Screening – following NICE guidance
- Blood borne virus screening – Hepatitis and HIV
- Screening for liver disease (Fibrosis Markers)

Vaccinations provided include Flu and Pneumococcal, MMR to complete course, Hepatitis B and any others required.

3.6 Asylum seekers and refugees – including people with no recourse to public funds
Victims of Human Trafficking

The Team is often the first to become aware of asylum seekers or refugees living in the City. From a public health perspective it is crucial that appropriate health screening is provided, for example TB screening. The Homeless Healthcare Team aims to provide this and then clients are registered with local GPs if they are permanently housed. The team has also secured a small fund to ensure that essential medication is available to patients with no recourse to public funds on the basis that prevention is cheaper than costly hospital admissions.

Recently the Medaille Trust, a voluntary charity, set up a number of house for victims of sex trafficking. The Homeless Healthcare Team is providing initial screening for these clients. Of those first screened 50% had positive quantiferon tests (meaning there is a strong suspicion they have latent Tuberculosis).

3.7 Ante-natal services

The team provides basic ante-natal care and also seeks to facilitate access to a midwife. This is not always easy because often the women have had experience of having babies removed at birth and therefore seek to hide their pregnancy and/or do not wish to engage with healthcare services. The Health Visitors provide care to women in temporary accommodation and support to new mothers.

3.8 Gypsies and Travellers on illegal sites

The Team drew up this work in conjunction with Southampton City Council. Members of the Team (usually a Nurse Practitioner and Health Visitor) attend illegal sites to provide health assessments and urgent care prior to the people being evicted.

3.9 Mental Health Service

Many people who are homeless have mental health issues. The team includes three part-time Community Mental Health Nurses (two whole-time equivalents) and an Associate Practitioner. The Community Mental Health Nurses are employed by Southern Health but their salaries are paid for by the Homeless Healthcare Team. They are based with the Team in the Two Saints Day Centre and they work jointly with other members of the team. They offer assessment, treatment (in the form of regular depot medication and CBT interventions) and support to clients with mental illness. They also offer advice to other members of the team about the most appropriate service.

The Associate Practitioner supports clients with day to day living, for example resettlement, budgeting, healthy lifestyles, management of long-term conditions including substance misuse and accessing healthcare.

The Community Mental Health Nurses and Associate Practitioner provide a service to any homeless person within Southampton, rather than only those registered with the Team for PMS services.

The team has been successful in ensuring that a practitioner from the IAPT (Improving Access to Psychological Therapies) team provides a face to face clinic on a weekly basis at the Day Centre ensuring equitable access for homeless people who often do not have adequate telephone or on-line access.

3.10 Health Visiting Service

The Health Visiting Team supports families and pregnant women who are homeless in Southampton. This includes families from the surrounding area such as Eastleigh and the New Forest who are placed in temporary accommodation in Southampton but who do not wish to re-register with a GP. Children are not allowed in the Day Centre where the Homeless Healthcare Team is based and therefore families are not able to register with the Team but are supported to register with local GP surgeries. The Homeless Healthcare Team health visitors remain involved until the family is settled.

Many of the clients they work with have suffered from domestic violence and some of the children have suffered physical, emotional or sexual abuse. Many of their families are on the Child Protection Register and they work closely with the Safeguarding Team and Social Services.

A Family Support Worker provides assistance with resettlement, obtaining sufficient food, access to schooling and childcare, registration with a GP and accessing healthcare.

The Health Visiting team works with asylum seeker and refuge families as well as families resident in the trafficking houses run by the Medialle Trust.

3.11 Complementary Therapies

A recent development has been the provision of Acupuncture and Hopi Ear Candling. These are provided by the Associate Practitioner with the aim of reducing anxiety and assisting clients in managing their substance misuse. A trained Osteopath also provides a weekly session on a voluntary basis.

3.12 Facilitation of access to other services

A podiatrist does a morning session once every six weeks at the Team base. This can be accessed by anyone who is homeless rather than just those who are registered. The Team also has a weekly session from an Improving Access to Psychological Therapies

practitioner. Staff also facilitate access to dental care. It has always been an important aspect of the work of the Homeless Healthcare Team to advocate for patients to ensure they have access to appropriate care. This has involved the presentation of patients to the Vulnerable Adult Board to ensure adequate care is provided. This level of advocacy on behalf of the most vulnerable and marginalised patients has impacted on many healthcare services over the past 20 years forcing managers and commissioners to consider how their service manages the needs of those with health inequalities.

3.13 Enhanced Services

The Homeless Healthcare Team aims to participate in all relevant enhanced services. This is the despite the fact that there is no specific remuneration involved. This is in order to ensure that patients registered with the Team are in no way disadvantaged.

3.14 Other work of note

GSF
The team has an active GSF register and are at the forefront of this work locally. The provision is palliative care for homeless people is a challenging are but one which the team strive to champion. End-stage liver disease is an area of particular interest.

Teaching and Advice
The Team provides a considerable amount of teaching for the health community and act as experts for the purposes of information on homelessness, asylum seekers, substance misuse, etc.

MAPPAs
The team attends Multi-Agency Public Protection meetings for clients registered with the Team. These seek to minimise the risk to the public.
Performance Indicators and the Faculty of Medicine

The Homeless Healthcare Team Lead GP and Nurse Consultant are members of the College of Medicine's Faculty of Homeless and Inclusion Health. This is a nationwide faculty bringing together experts in these fields. The Faculty have produced some standards for commissioners and service providers which we are seeking to work towards. There is a link here: http://issuu.com/collegeofmedicine/docs/homeless_health_standards

The Homeless Healthcare Team is striving to meet the standards set out in this document.

"London Pathway" research

Members of the team are currently involved in the very early stages of a research project which would seek to determine if having a Homeless Healthcare Team nurse visiting and assessing homeless patients in the local acute hospital and overseeing discharge arrangements would provide better health outcomes and reduce re-admissions.

Service user involvement

The Team strives to obtain the views of service users and runs focus groups every 2-3 years in locations accessible to homeless people. This is recognised as the best way to obtain reliable opinions in a way that seeks to be supportive of the users themselves. The views are discussed within the Team and used to inform service development. The need for pre-bookable appointments came from focus groups. The Health Visiting team are seeking to develop similar focus groups in the refuge houses.

Participation and Leadership in the areas of homelessness and asylum seekers /refugees

Team members participate in a wide variety of forums and meetings aiming to ensure that the focus is on the patients and their health outcomes. Links to accommodation providers, and the City Council as commissioners are extremely important. There is also significant input in areas of substance misuse (particularly drug related deaths) and domestic violence. Wherever possible a joined up approach is sought in the best interests of homeless people.

4. Locations of service

The Homeless Healthcare Team is based in a voluntary owned Day Centre for homeless people. This is a location which provides easy access for homeless people. It also means they can get all their basic needs met in one single location (the Two Saints charity provides food, clothing, washing facilities, accommodation and benefits support).

Over the past 20 years the Homeless Healthcare Team has provided GP and/or Nurse sessions in a number of different voluntary settings. These are reviewed as appropriate in terms of the numbers of clients seen and whether they would or could attend to be seen at the Day Centre.

At present a Nurse Practitioner visits Patrick House (the largest hostel in the city and assessment centre) twice a week to register new patients and to provide care to existing patients. In addition one of our GPs provides a weekly session there on a Wednesday morning. There is a fully equipped medical room at the hostel.

The Nurses visit other hostels as necessary to provide care, which may be on an on-going basis depending on the health needs of individual patients.

The Community Mental Health Nurses and Associate Practitioner also regularly visit Patrick House and a number of other hostels.

The Health Visitors and Family Support Worker visit the Emergency Accommodation at Millbrook Road East, all the Women's Refuge Houses (for women escaping domestic violence) and the Medialle Houses (for victims of trafficking) on a weekly basis.

5. Performance Indicators

The team participates in the Quality and Outcomes Framework, although some disease areas have very few patients on them. Mental health, Asthma and COPD, Diabetes and Epilepsy are significant disease areas. The management of long-term conditions is challenging because it is often exacerbated by substance misuse and/or mental health conditions as well as by the poor social conditions in which patients reside.

The issue of having specific performance indicators has been addressed in the past but never reached fruition. Pertinent areas have been screening for blood borne viruses, substance misuse, management of liver disease (particularly end stage) and Tuberculosis screening. This is why the team has focussed on the Faculty of Medicine's standards.

Client profile and health / housing needs & inequalities

Age range	Male	Female	Total
18-24	58	13	71
25-34	149	26	175
35-44	121	15	136
45-54	87	9	96
55-64	35	4	39
65-74	6	0	6
75+	0	0	0
Total	456	67	523

Health needs

Substance misuse (alcohol &/or drugs which impacts daily life) - 326
Mental health (schizophrenia, bi-polar and psychoses only) – 47
Depression – 98

Clients with no recourse to public funds and those who are unable to access hostel provision are present particular challenges in terms of providing healthcare.

Key client solutions

Vigorous outreach
Liaison with acute trust & identification of frequent attendees
Suitable accommodation, particularly post-hospital admission
Joint working with professionals from other agencies, voluntary & statutory

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APPENDIX 7

SUBSTANCE MISUSE

Southampton's current Substance Misuse Services have been incrementally developed under the strategic direction of the Drug Action Team Partnership and the Tackling Alcohol Partnership since 2000. Alcohol services have recently been extended and improved via QIPP.
The majority of services are currently commissioned and coordinated by SCC/ ICU in partnership with CCG with funding transferred from Public Health and the Police and Crime Commissioner.
A new Integrated Drug and Alcohol Substance Misuse Service is currently out to tender and should be in place by the end of July 2014.

Current Services :

ALCOHOL

Southampton Alcohol Brief Inventions and Counselling Service, run by CRI, is the first point of contact for anyone concerned with their or someone else's alcohol use whether mild to moderate dependence, binge drinking, severe dependence or with complex needs e.g. mental health, child protection, vulnerable adult.
All service users requiring medical interventions such as community or residential detoxification or residential rehab will be referred on to the New Road Centre.

The New Road Centre
Provides support for more dependant and complex clients they receive referrals from SABICS, Social Services and other specialist substance misuse and mental health services
The services at The New Road Centre are provided by Southern Health NHS Foundation Trust

Alcohol Specialist Nurse Service
A specialist team working in Southampton General Hospital (UHST) receiving referrals and proactively identifying problematic drinkers attending hospital offering support and onward referrals

Alcohol Day Detox Service (Solent Healthcare)
Taking referrals from SABICS, New Road Centre and ASNS **only**, ADDS provides medically supported alcohol detoxification in the community

Community Wrap Around
Providing and coordinating a wide variety of support and peer support in the community for people concerned by their alcohol use.
Community Wrap Around Services are provided by The Society of St James

DRUGS

The Bridge is open six days a week and is the **first point of contact** for people who want help with drugs in Southampton. The Bridge offers advice and information, harm reduction, one to one and group work and referral to other services or agencies. The Bridge also provides access to Southern Health NHS Foundation Trust's care coordination and the rapid prescribing service for people who need substitute prescribing for heroin and some other drugs.

The Drug Intervention Programme (DIP) provides a similar range of services to The Bridge but is specifically for people who use drugs and who are involved with criminal justice agencies.
The DIP also provides drug treatment for a person who's Court Order includes Probation supervised **Drug Rehabilitation Requirement (DRR).**

SHARP (**Southampton Harm Reduction Partnership**) is based at The Bridge and has two components
Assertive Outreach Service ~ providing outreach to engage groups that are underrepresented or may need additional support to enter treatment and with service users who are struggling to remain in treatment and to re-engage with those who have dropped out.

Harm Reduction ~ As well as the provision of sterile injecting equipment (needle exchange services) **SHARP** provides advice, information and care to reduce the harm of taking drugs including safe injecting techniques, alternatives to injecting, wound care, BBV testing and inoculations, health checks and referral to further treatment services.
The service also offers a specialist needle exchange service for steroid users.
SHARP also works with a number of pharmacies and hostels in the City to offer Needle Exchange and Harm Reduction Services

YOUNG PEOPLE

DASH Youth Drug and Alcohol Project offering confidential support and advice for drug, alcohol or solvent problems to anyone under 19 years who lives in Southampton

FAMILY and CARER
Parent Support Link
A support service for anyone concerned by someone else's alcohol or drug use

Drugs

Recent adult prevalence rates of Opiate and/ or Crack users are estimated to be **1,707**

Alcohol

Increasing risk	**Higher risk**
21 units to 50 units for a man	Men who regularly drink over 50 units per week
14 units to 35 units for a woman.	Women who regularly drink over 35 units per week.
31,519	**10,413**
40,249	**12,701**

Size of the problem

32% of new presentations to drug services (YTD Q3 2013/14) report a housing problem

NFA - urgent housing	10%	35
Housing problem	22%	72
No Housing problem	68%	220

16% of new presentations to alcohol services (YTD Q3 2013/14) report a housing problem

NFA - urgent housing	1%	3
Housing problem	16%	50
No Housing problem	81%	244

A snapshot from the Street Homeless Prevention Team (SCC)

Street Homeless Prevention Team engagement

Outreach Q3 2013/14

Total number of individuals engaged **41**

Class A drug users **18** (45%)

Hostel referral Sessions (Feb 2014)

Total seen **78**

Number with "drug issues more serious that cannabis"**20** (26%)

Dual Diagnosis Snapshot

Snap shot view of Homelessness Services Drug Use (Dec 13)

HOMELESSNESS SERVICES RESPONSES	**PATRICK HOUSE**	**SOTON ST.**	**JORDAN HOUSE**	**BOOTH CENTRE**	**IN TOUCH FS**	**TOTALS**
Service user has a dual diagnosis of mental health and alcohol/substance use	24	7	18	13	15	**77**

Issues

Recovery

Risk of relapse is raised if suitable, stable accommodation is not available to a person in recovery
People discharged from prison with no suitable, stable accommodation
Substance Misuse as a factor in risk of eviction

- Support initiatives to increase abstinent and supported accommodation for people with a history of substance use
    - IOM houses
    - Alcohol Accommodation Tender
- Substance Misuse Awareness training
- Floating support for those at risk of losing tenancy

Overdose

Historic significant incidence of overdose and “near miss events” in hostel accommodation

- Continued support of access to Naloxone and associated training
- Continued effective joint working between Substance Misuse Services and services for people at risk of or currently Homeless

Blood Borne Virus

The sharing of contaminated injecting equipment presents a significant risk of BBV infection. The burden of undiagnosed Hepatitis C, in particular, presents significant health costs.

- Develop interventions to encourage hostel residents to access testing and treatment for BBV
- Support initiatives to provide harm reduction equipment, advice and information, across our services for people engaging with homeless services.

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Southern Health NHS
NHS Foundation Trust

Southampton Health Overview and Scrutiny Panel
Homelessness Inquiry

Report from Southern Health NHS Foundation Trust
10 March 2014

Homelessness and mental health in Southampton

Overview

Mental health problems and homelessness are intrinsically linked. Mental ill-health can cause homelessness, and be a result of homelessness.

National and local data shows homeless people are more likely to be experiencing mental health problems compared to the housed population. Evidence also suggests homeless people are more likely to access acute health services for their mental and physical health. It is estimated that 60-70% of homeless people have some form of mental health problem, including depression, psychosis, and self-harming behaviour. In many cases these illnesses are undiagnosed.

Histories of childhood abuse, alcohol and substance misuse, relationship breakdowns, periods in prison, and bereavements are common experiences amongst people using homelessness services. All are risk factors in the development of mental health problems.

Between 10 – 50% of homeless people using mental health services have some form of dual-diagnosis (more than one condition requiring treatment).

How we work with homeless people and services in Southampton

Our mental health teams work closely with the numerous homelessness organisations and services in Southampton. This includes the Homeless Health team, the Street Homeless Prevention Team, the Floating Support Service, the Society of St James and Two Saints services. We also provide substance misuse services which have close links with homelessness services in the city.

The most common referral route for homeless people in Southampton is through homelessness services or through acute/urgent care services where homeless people present more regularly compared to the housed population. Homelessness services generally have good awareness about mental health but are typically not specially trained.

As soon as a person is referred into our services, we will aim to produce a care plan which will include plans for suitable accommodation if this is identified as an issue. From this point we will link with other services to identify a housing solution that is appropriate for the individual's mental health needs. Finding suitable housing for people with severe and enduring mental health problems is not just about finding a 'roof over their heads'. We are extremely reluctant to discharge people from our services onto the street or into environments where their mental health may deteriorate, and work hard to prevent this.

Although our clinicians regularly link with homelessness services and support people with accommodation challenges, we also have a dedicated housing coordinator (Sean Smith) who is focussed on securing appropriate accommodation for service users (especially with complex housing issues) to reduce situations where a service user is ready to move on but there is no suitable accommodation available. Sean has spent a decade building relationships and networks in Southampton and also trains other staff so they are better able to help people access suitable accommodation.

Southampton has a Mental Health Accommodation Panel (MHAP), chaired by the CCG mental health commissioner, where all decisions about supported accommodation for mental health service users are made.

Strengths of the current system

On the whole we have very strong and proactive relationships with the various homelessness services in the city. In our experience, Southampton has a higher level of

homelessness service provision compared to the rest of Hampshire.

The MHAP is effective at finding suitable supported accommodation in the city, and there are rarely issues with these placements once identified.

Finding hostel accommodation for people over 25 is quick and straightforward. Street Homeless Prevention Team are always extremely helpful and prepared to attend meetings to discuss accommodation issues. The housing providers themselves have the final say but as long as clients arrive with a move-on plan, full risk assessment and support from the community mental health team then they are usually satisfied. However, it should be remembered that hostels are rarely the most appropriate environment for people with mental health problems.

Challenges facing the current system

There is currently a waiting list of around 18,000 people for social housing. Of this number, 7,200 are waiting for single occupancy housing, for which there is typically a seven-year wait. Single occupancy housing solutions are suitable for a large number of people currently using our services and would enable many people to move on and become more independent.

In the past six months, there has been an increase in the number of young people (under 35) with accommodation issues admitted to acute psychiatric units. Usually, these issues prolong their stay in hospital due to the additional time required to find a solution. This is more expensive for the health economy and can be harmful to an individual's recovery.

There are a number of factors influencing this:

1) Under 35s unable to claim more than single room rate for housing benefit in private accommodation (see below)

2) Street Homeless Prevention Team prevent U25's into the hostel system unless absolutely necessary (as it is rarely the most appropriate solution)

3) Young Person's housing services in Southampton struggle to manage clients with high level of mental health need

4) General lack of social housing

The housing benefit reforms have imposed some challenges on our work to support people with housing needs. People under 35 can only claim for single room rates, which currently amounts to just £63.42 /week. In many cases this is not sufficient to cover the costs of rent in the city which is preventing many people moving on from supported accommodation. It also makes it difficult to find accommodation for people who need to live away from disruptive environments where they are currently living. There are exemptions to this rule, for example people who have spent the last three months in a hostel. We would argue that people who have been living in supported accommodation should be exempt too, as many of these people are ready to move on to regular accommodation but could not do so on £63.42 / week.

There is no specific housing provider for people with a dual-diagnosis (which is more common amongst homeless people). This could be a combination of mental health problems, or a mental health problem and substance misuse problem, for example.

Potential solutions and 'spend to save' schemes

Key to improving the current situation is to ensure there are no blockages in the flow of people through services, so they can move on from high-cost/more restrictive services to low-cost/more independent living arrangements as soon as is appropriate. This is better for the people we serve, and will be more cost effective in terms of resources across the whole system. The ultimate aim should always be to support people to manage their own tenancy and be as independent as possible.

Making the best use of current resources: This includes the right training for staff (both in mental health and housing), as well as ensuring our buildings and services are being used appropriately.

Increase in availability of single occupancy social housing: It is more cost-effective to help people move on more quickly to such housing, with appropriate floating support / community mental health input as required, compared to lengthy placements in supported accommodation or inpatient mental health services.

Closer working with local private landlords: For example the establishment of a Landlord's Forum, could prove beneficial in breaking down stigma towards mental illness and providing reassurance about the support available to landlords if they are struggling with a tenant.

Additional Information *(see also separate documents enclosed with this report)*

Snapshot of mental health service users currently in homelessness services (obtained on 10 March 2014)

Patrick House: Currently have 57 residents, four of which have a mental health care coordinator (this means they are known to our services and are receiving treatment, and that they have a care plan in place).

Southampton Street Intensive and resettlement service: Currently have 26 residents, of which 6 have a mental health care coordinator.

Snapshot of mental health service users currently in homelessness services (data for January 2014)

In January, 32% of people using homeless services in Southampton disclosed that they had a mental health problem. Of this, 8% said they had a severe and enduring mental health problem.

Note: these snapshots only give an impression of the number of people who are known to mental health services. It does not take into account undiagnosed mental health problems, or people who are receiving treatment from substance misuse services who also have a mental illness (dual diagnosis).

Homeless young people and mental health

We always try to avoid placing a young person (under 25) in adult homelessness services. This is because the environment is rarely suitable for younger people. For example, around 75% of people at Patrick House are heroin users and there is an increased likelihood that younger people could be targeted / manipulated by adults in these environments.

We can evidence at least three cases where Young Person's Services have refused to take a client based upon their risk. However these individuals do not necessarily need support from a specific mental health supported accommodation and would benefit more from intensive life skills support and a more boundaried approach from a young person's scheme. The outcomes for these three referrals have been that one ended up having to be accommodated in mental health supported housing, another ended up being taken into Patrick House, and the third remains an in-patient.

The service user who remains as an inpatient reported that the "rejection" of being turned down by the Young Persons generic housing project had an adverse effect on her confidence and her mental health, and she has been quite difficult to manage since then, continuing to self-harm. The self-harming behaviour is of course not a direct consequence of the housing situation, but it does mean that in the eyes of any housing provider, particularly one that is set up for young people and focussed on recovery and swift move-on, she is going to be difficult to manage.

Even when a client is deemed as appropriate for the Young Persons service, there can be delays. A referral form is submitted, considered by the weekly Young Persons Panel, then there will be an interview, and more risk assessments to complete before move-in. A waiting time of around three weeks seems to be the average – even in cases where we have identified the placement and completed all required paperwork within three days of admission to acute in-patient care. Sometimes it is quicker to move someone (often inappropriately) into a mental health scheme as a temporary step-down measure, whilst the correct service can be accessed.

We have also worked with two clients this past year who are still being looked after by the Care Leavers service. Because this service will use any accommodation available in order to prevent street homelessness, by the time they have been admitted to hospital, many 'bridges have been burned' after chaotic periods living in B&Bs, hotels, or in one case a private self-contained flat funded by the care team, which was entirely inappropriate for a young man of 18 who had not lived independently before.

Housing / homelessness services outside Southampton

Generally, there is less generic housing available in Hampshire compared to Southampton. In our experience it is more difficult to house homeless people in Hampshire.

For example, there are no hostels in the whole New Forest/Totton/Waterside area.

Southampton benefits from the Supporting People contract and strong networks of support services which are less developed in Hampshire.

There is also a lack of self-contained supported accommodation options outside Southampton (e.g. long term social housing with floating support input).

Anecdotal experiences / case studies from outside Southampton:

These examples highlight the complexity and highly individual nature of the support that we aim to provide, in partnership with other agencies. There is no 'one size fits all' approach and every person requires support that is tailored to their specific needs:

"I have worked with one young lady with a diagnosis of emotional instability with risk to self, homeless and alcohol misuse. I worked with her, the Trinity Centre and housing services, and she responded well to emotional coping skills work and psychoeducation, she was then found accommodation and successfully discharged from the team."

"I have assessed a gentleman who was urgently referred and presenting with hypomanic behaviour, though this turned out to be drug induced. However further liaison with housing providers and the police highlighted he was known to MAPPA (Multi-Agency Public Protection Arrangements) and they were out of contact with him, the police were updated and MAPPA team facilitated a longitudinal assessment of his difficulties. He had a long history of contacts with forensic services, sporadic engagement with various mental health services. He was allocated a care co-ordinator who investigated his history further, had assessments with consultant psychiatrist, we were unable to find him housing, but this was due to his history of risk to other vulnerable adults, inappropriate behaviours, assaultative behaviours, potential risk to children and an anti-social behaviour order. He was discharged from mental health services and his management was overseen by the MAPPA team. He was banned from the Trinity Centre due to his behaviour whilst attending there."

"I worked with another gentleman who was referred urgently with psychotic symptoms. I had to work closely with the Trinity Centre for this, he had been homeless for many years, and led an itinerant lifestyle. He was eventually admitted, and agreed to be housed but a referral to housing panel was turned down due to lack of local connections, he subsequently left the area. This was, I have to say, unfortunate as he was an unwell and vulnerable young man, that services around the country had struggled to keep in one place long enough to treat."

"I worked with a young man who had emotional instability, forensic history and substance misuse. He was unable to engage on an emotional level and requested discharge as he found simply talking too overwhelming, however he was housed, but then lost his accommodation, and was found further housing via Elderfield. The Trinity Centre continues to work with him, as do Homer, but he is no longer open to our services.

"We had another man who had had some contact with the Trinity Centre and the mental health team, who was detained and in PICU (psychiatric intensive care) for some time. He refused any accommodation, and was eventually discharged homeless, however he changed his mind very quickly, and was discussed with housing homeless officer and found accommodation very quickly (within a week) and provided with bed and breakfast via the Trinity Centre meanwhile."

"We supported a couple who were made homeless, via private landlords. They were placed in bed and breakfast until accommodation could be found for them, which happened within three weeks."

"I have a chap who is currently homeless and vulnerable following a relationship breakdown. He has autistic traits, and chronic anxiety / depressive disorder. He was accommodated on a crash bed at Dene court which was not appropriate for his mental health and has been particularly vulnerable from others whilst there. He has been on crash for nine weeks now whilst we wait for suitable accommodation to become available. This is having an impact on his mental health. I have liaised with housing and the well-being centre are supporting him in the meantime."

"There is a lack of placements willing to consider people who have been evicted for challenging behaviour. It is then difficult to treat people therapeutically until they are housed and difficult to get them housed until they are treated. They also tend to leave the area frequently, I have had a few who have turned up for assessment but then left the area."

"The lack of local connection is a particular issue, I understand the rationale but was disappointed when the young, psychotic, itinerant man was turned down, when he had been in and out of the area for years, and appeared not to have a local connection anywhere."

"Together have been very helpful in enabling people to maintain their tenancy, and understand the rationale of having to abide by certain rules, manage practical issues and provide support with budgeting, shopping, etc. We have done a lot of work with them, and refer a lot of patients their way, in an attempt to avoid eviction, and as a way of moving on from supported accommodation. It would be particularly helpful if they could get involved with those that are homeless and in need of support. The Trinity Centre are helpful with this group, but are also bound by the needs of running the centre. they have a project running there, which involves co-ordinating care for those discharged from hospital with no fixed abode, to help find them accommodation."

About Southern Health NHS Foundation Trust

Southern Health provides mental health, physical health, learning disability and social care services in Hampshire. In Southampton we provide mental health services for working age adults as well as older people (including dementia care). We focus on supporting people in the community and promoting independence and the ability to live a life beyond illness.

We operate Antelope House, an acute psychiatric hospital in the city centre, as well as community mental health services and a specialist eating disorder service. We provide some of the city's substance misuse services. We also run the Recovery College, which takes an educational approach self-management of mental health problems and is free for people using our services.

Our focus on recovery and independence extends to supporting people with accommodation problems, in that we always aim to find solutions that are the least restrictive and enable people to self-manage as much of their lives as they can.

Our services in Southampton are commissioned (funded) by the Southampton City Clinical Commissioning Group.

For more information about us, please visit our website or get in touch:

www.southernhealth.nhs.uk
communications@southernhealth.nhs.uk
023 8087 4106

SOUTHAMPTON HOMELESS REFERRAL FLOWCHART

Client is NFA hospital in-patient. Correct referral procedure for accommodation will fall into one of five groups shown below.

Client requires specific mental health supported accommodation with ongoing support for their mental health needs.

Care co-ordinator/mental health/social work professional refer to Funding/Accommodation Panel via **Community Management Team** on **02380821227**. Suitability for panel can be discussed with Community Management Team or **Housing Co-Ordinator**.

Client on Local Authority (SCC) housing list, has sufficient points, and is appropriate to manage a tenancy and live independently

Inform SCC of situation immediately (medical points may be added if applicable), present to homelessness if necessary and actively bid on properties.

Client requires young persons (under 25) or women's refuge type accommodation (eg fleeing domestic violence)

Client referred or can self refer to **YMCA** or **Chapter 1 Housing**, **Kingsley House** (YP) or **to Southampton Women's Aid**, respectively

Client appropriate for a hostel or generic homeless accommodation. Can self present or be referred by staff.

Client presents on MON, WEDS or FRI to **Two Saints Day Centre 9am-11am**. Ward/appropriate individual fills out Basic Needs Assessment form and faxes to Street Homeless Prevention Team on fax number 02380832343. **STREET HOMELESS TEAM NEED THIS FORM TO PROCEED, WILL NOT CONSIDER PLACEMENT WITHOUT ONE.**

Client requires private accommodation without support

Encourage client to seek via letting agents/newspapers. Present to **SCC Homelessness** and contact **Housing Advice**. Check with **Housing Co-Ordinator** if any local availability. After following these steps, client to go via **Street Homeless Team** route.

Please note that in any of the above three circumstances a referral to the Street Homeless Team may be applicable whilst they are waiting for more appropriate accommodation.

Client is referred to **PATRICK HOUSE**, which is now the starting point, and the assessment centre in terms of street homeless provision in Southampton. Staff there will assess each individual within 4 weeks and endeavour to help them move on, as soon as possible, into the various move-on options and associated provision within the City which I have listed below. There is a longer term (6 month) intensive area of the hostel for longer stay, difficult to place clients

Society of St James and **Stonham** have some generic projects which will take people from a variety of backgrounds. The referral would be directly to Stonham or SSJ Housing Management

INTENSIVE LIFESKILLS PLUS – the **Salvation Army Booth Centre** 24 hr hostel. **Jordan House** which has cover until 8pm, and **Denzil Avenue – Stonham** flats managed with intensive SSJ support. 6 month maximum stay as a rule

INTENSIVE SUPPORT: These projects can handle more entrenched, difficult or dual diagnosis clients. **10 Southampton Street** hostel and the **Intensive Support Area of Patrick House**. 6 months maximum stay.

PRIVATE SECTOR: Private accommodation may be appropriate. Day Centre have a **Private Accommodation Worker** to help facilitate this. Based at the **Two Saints Day Centre** in **Cranbury Avenue**. Tel **02380227933.**

USEFUL TELEPHONE NUMBERS

Street Homeless Prevention Team: **023 8083 2343**
Fax: 023 8083 2343
Two Saints Day Centre: **023 8022 7933**
Homelessness Unit, SCC: **023 8083 3278**
Housing Advice SCC: **023 8083 2254**
YMCA Southampton: **023 8022 1202**
Chapter 1 Housing Kingsley House: **023 8055 0131**
Southampton Womens Aid: **023 8033 8881**
Society Of St James: **023 8063 4596**
Stonham Southampton: **023 8042 5350**
Patrick House: **023 8078 1721**
Booth Centre: **023 8033 0797**
10 Southampton Street: **023 8022 3479**
Community Management Team: **023 8082 1227**
Housing Co-Ordinator: **023 8082 1239**
Specialist Assessment Team SCC: 80833578
Accommodation Panel Forms obtained by contacting the Community Management Team or Housing Co-Ordinator.

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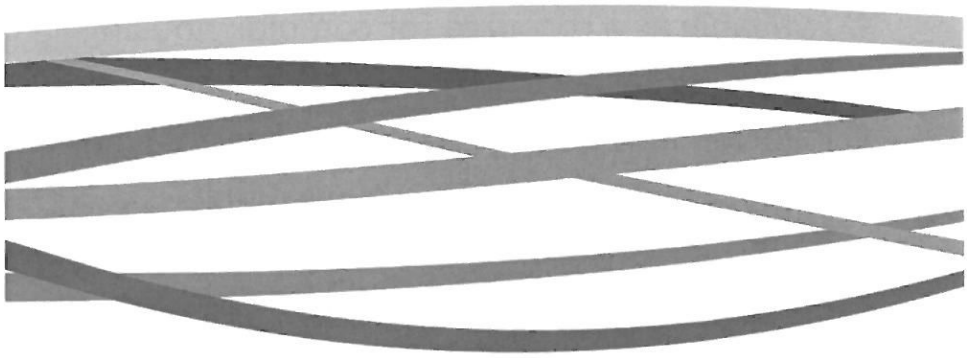
Housing Options In Southampton



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A presentation by Sean Smith, Housing Co-Ordinator, Acute Care Support Team

- A training presentation to give professionals a guide to what accommodation is available in the City, and how to access it

November 2013

Southern Health NHS
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My role as Housing Co-Ordinator

- Specialist housing worker for Southern Health Trust
- Available as a resource for complex housing issues
- Involved in reducing the number of delayed transfers of care where accommodation is an issue

Southern Health NHS
NHS Foundation Trust

What this training aims to achieve

- To show what supported accommodation is available to Mental Health Service Users, and how it is accessed
- To explain the Homelessness Pathway for any homeless individuals in the City and how to access services
- To give a detailed look at the Southampton City Council Homebid register and how the Specialist Assessment Team work
- To answer any questions professionals may have relating to how they can help resolve the housing issues of their service users

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Accommodation List

- Handout provided separately
- Shows all accommodation with a brief description of each, number of beds and support set-up
- All properties on the list are accessed via the Mental Health Accommodation Panel

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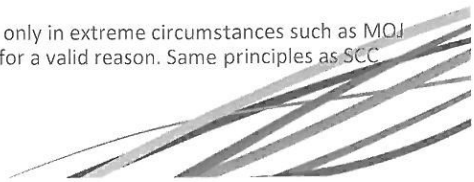
Aims of Supported Accommodation

- To help support service users in a stable community environment to move towards more independent accommodation
- To provide support around a variety of different areas, including managing mental health, budgeting, social integration, cooking, shopping and accessing services
- Must be based upon client need. Always look at the least restrictive option
- Must be a clear move-on plan in place for any referral to ANY supported housing – even the longer term schemes. Even if the move on is not realistic at the time of referral.
- Any referral needs to be backed up by a thorough and comprehensive referral forms. No point leaving anything out! Always give worst outcomes and risk information – it helps the providers to formulate their own risk plans
- Clients must be referred by a Community Treatment Team, AAT, AOT, EIP, TQ21 or Homeless Healthcare professional
- Out of area referrals will be considered but only in extreme circumstances such as MOJ clients or those that cannot live elsewhere for a valid reason. Same principles as SCC housing



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Natalie House

- Stonham-run 24hr registered care home for mental health service users
- Commissioned by Southampton City Council & Southern Health
- Southampton-only resource
- Aim to move clients on within 1 year
- Move-on extremely important
- Any dual diagnosis clients must be engaged with appropriate substance misuse services to address issues

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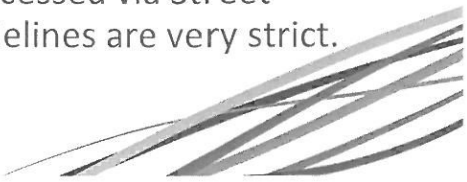
Homeless Flowchart

- Handout supplied separately
- Explains pathway through services for homeless service users or indeed anyone needing to access generic services in the City
- All homelessness services are provided, like the Mental Health schemes, via Supporting People. Homeless services are accessed via Street Homeless Team and guidelines are very strict.



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Street Homeless Prevention Team

- In place within Supporting People structure to gatekeep referrals into homelessness services
- Will establish "Local Connection" and eligibility to access SP homeless resources
- Can help divert people and relocate to appropriate area where no Local Connection is established in Southampton
- SHPT will carry out an assessment to assess the need and vulnerability and make appropriate referrals to supported accommodation or to the private rented worker. This is done at 3 hostel referral sessions held at the Two Saints Day Centre at 30 Cranbury Avenue on Monday Wednesday and Friday from 09.30am to 11am.
- As part of the SP contract anyone being evicted for SP generic supported accommodation will inform SHPT of clients who are at risk of becoming homeless. SHPT will then mediate and look at solutions and alternative accommodation.

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NHS Foundation Trust

- SHPT conduct 2 early morning out reach sessions to find street homeless people and signpost to services
- SHPT will carry a case load of street homeless clients and those at risk of losing accommodation.
- HMP prisons and hospital discharge team will make referral to SHPT to clients leaving hospital and prison who will be NFA on release
- SHPT attend MAPPA meetings and multi agency meanings for complete and challenged clients
- SHPT work with EU welcome see migrant workers who are homeless at the Two Saints Day centre on a Tuesday from 10 am to 12 am
- SHPT has a part time worker who works long term with entrenched homeless clients to support them in independent accommodation.
- SHPT work closely with UKBA with dealing with immigration offenders and supporting the process of removal

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Hostel Accommodation and Considerations

- Patrick House and the other hostels are potentially very challenging environments for mental health clients. They provide robust 24hr support but feature a mixture of service users with a number of social problems
- SHPT will try and avoid wherever necessary placing under 25's into hostels due to vulnerability and the fact we have an existing age-appropriate Young Persons service
- Support in hostels not necessarily geared towards Mental Health so providers will need to feel adequately supported when a referral is made. Information sharing where necessary, good follow up and crisis plans are key
- Remember that all hostels are commissioned to help move people on and that is their ultimate aim. They are not long-term services nor will move-on be neglected – it will be part of each individual support plan

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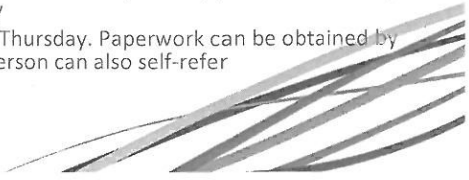
Young Persons Services

- For young people under the age of 25
- Two main projects – YMCA and Kingsley House
- Project house difficult clients from variety of backgrounds and emotive situations – care leavers, young offenders, "runaways"
- Engagement is extremely important. All young people need to engage with keyworker sessions and aim of stay is focused on move on
- YP services can provide tenancy training, initiate engagement with agencies like No Limits and City Limits, get young people involved in vocational opportunities, education, volunteering, accessing support
- Environment in schemes can be "lively" – as there are lots of young people living in close proximity
- Projects will take Mental Health service users but adequate support and follow-up and joint working between services is key
- Young Persons Panel sit every week on a Thursday. Paperwork can be obtained by contacting projects directly. The young person can also self-refer



Southampton City Council Housing
This section compiled with help from

Specialist Assessment Team
Housing Allocations

- Social housing – the reality
- The Lettings Policy
- Priority housing – the process
- No priority decisions and further reviews
- What priority?
- What is urgent?
- Exception to Policy
- Housing options – the alternatives
- Older person's accommodation – 50+, 60+ and extra-care

The reality:

- **18 000** The number of people currently waiting for social housing
- **7 200** waiting for 1 bed property (40%)

  Last year 446 1 bed properties were advertised (6%)

  5 to 7 year wait for a one bed property

  2 to 4 year wait for 2 bed flat/maisonette or up to 6 for a house

  2 to 5 year wait for 3 bed flat/maisonette – up to 7 for a house

  7+ years for a larger flat/maisonette/house

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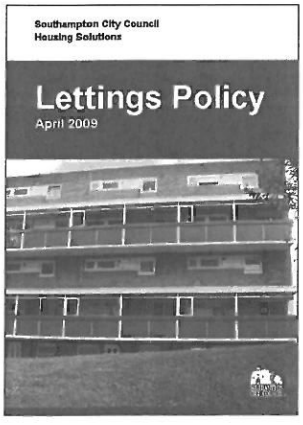
The Lettings Policy

- All decisions are made in line with the information provided in this policy
- A copy can be found on the council website:

www.southampton.gov.uk/living/housing/housingpolicies



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The process:

- HS1 (housing/transfer application form) – section 8
- Additional Priority form
- Further information required?

  HS4(health and support need assessment form)

  contact: doctor/specialist/other professionals
- Home visit
- 'Call-in' – interview at Civic Centre

'No priority' decisions

Decision will not be reviewed unless there is a significant change in the applicant's circumstances, since the original assessment, which causes their housing to have a significant impact upon their health/welfare

Applicants will not normally be given reasonable preference on medical /welfare grounds for the following conditions:

- Alcohol abuse
- Bedwetting (enuresis)
- Damp property/No central heating
- Diabetes without complications
- Drug abuse
- Dyslexia
- Depression caused solely by living conditions
- Epilepsy controllable with medication
- Gastric/duodenal ulcers
- Glandular fever
- Glue ear/grommets/middle ear infections
- Growing pains
- Harassment/Neighbour difficulties
- Hay fever
- Hernia/Haemorrhoids
- Obesity/overweight
- Pregnancy
- Recurrent upper respiratory problems (coughs/colds) and Bronchitis
- Sexually transmitted infection except AIDS
- Single parenthood
- Skin problems
- Temporary illness e.g. recovering from surgery
- Temporary orthopaedic difficulties eg. broken limb
- Varicose veins

All cases will be referred to the Specialist Assessment Team for their consideration.

What priority?

Requirement :

Main points:

- Assessed medical/welfare/social need to move **30**
- Living in at least 1 of the defined unsatisfactory housing conditions **30**
- Homeless **30**

Additional points:

- Applicants with a proven link to Southampton **30**
- Applicants with insufficient financial resources to meet their own housing needs **30**
- Existing city council tenants **25**
- Second household member with medical/welfare need to move **5**
- Living in 2 or more of the defined unsatisfactory housing conditions **5**

- **Exceptional points:**
- *Under occupying city council tenants **200**
- Management transfers (4 month period only) SCC tenants **150**
- Short-term points (4 month period only) (e.g. urgent medical/welfare grounds, homeless in temporary accommodation) **100**
- People with assessed social need to move to a particular area where otherwise hardship would result **30**
- Waiting time - points per month **1**

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What is Urgent?

- 100 points
- Exceptional circumstances
- Case discussed with and agreed by the District Medical Officer (independent medical adviser)

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Exception to policy

Applicants requesting an extra bedroom on medical grounds

Only granted if evidence proves that this is needed for:

- 24 hour care needs - assessed, and funded
- lack of space for medical equipment storage (not motor scooter)*
- partner requires breathing apparatus at night*
- younger sibling in danger if sharing a room*

***Discretion only. NB Bedroom tax would apply in these cases.**

Direct Lets

- Adapted property/mobility flats
- Require OT report
- Work with the housing OT to find the best match

Housing Options – the alternatives:

- Overcrowding – ways of alleviating the situation:
  partitions
  changing rooms
  moving furniture
- Private renting
- Shared ownership
- Sheltered housing

Sheltered Accommodation

- Sheltered Accommodation in Southampton is split into three categories:
  - Housing for the over 50 's
  - 60 Plus
  - Extra Care

Housing for the over 50's

- Accommodation is for residents who are over the age of 50
- No scheme based warden but floating support is available only for those over 60
- Pull cords in every flat
- No communal rooms
- There are also a number of 55+ schemes. These are mainly Housing Association schemes.

60 Plus Accommodation

- Accommodation for those over the age of 60
- Broken down into Scheme based support and floating support.
- Pull cords available
- Communal areas
- Some have facilities such as guest rooms and laundry

Extra Care

- Extra Care is accommodation for those over the age of 60 who wish to live independently whilst having access to a range of facilities.
- Some schemes have guest rooms, hairdressers and restaurants.
- Care agency based in the schemes and sleep-in staff for emergencies.
- Cannot cater for night time needs at present.

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