THE HEALTH NEEDS OF ROUGH SLEEPERS IN HOUNSLOW

1. INTRODUCTION
People who sleep rough\(^a\) experience severe health inequalities, with an average life expectancy 30 years shorter than the rest of the population.\(^1\) They often suffer tri-morbidity – the combination of physical health needs, mental health needs, and substance misuse.\(^2\) Furthermore, poor health can be both a cause and an outcome of sleeping rough.\(^3\) Rough sleepers experience significant barriers in accessing services to support their health, and do not use primary (GP) care when it is needed, leading to significantly greater secondary care (hospital) usage and costs, and greater long term costs to local authorities.\(^4\)

2. PROFILE OF HOUNSLOW’S ROUGH SLEEPERS
The annual count of rough sleepers in Hounslow has grown year-on-year. There were 106 people seen sleeping rough in Hounslow during 2012/13, 78% (83) of whom were new to the streets. This is a significant increase from 2009/10, when there were 24 rough sleepers seen in the borough. Based on the 2012/13 count, Hounslow has the 16\(^{th}\) highest number of rough sleepers, out of 34 areas in London (33 boroughs and Heathrow). There is an average of 4 new rough sleepers in Hounslow every week.

The sections below describe the profile and health needs of a sample of 36 entrenched rough sleepers in Hounslow – people who have been on the streets (whether consistently or intermittently) for a long period of time. As of September 2013, the ‘core group’ of entrenched rough sleepers has grown to 44 people, with many more on the streets throughout the year. The profile and health needs described here do not include those of 8 Polish rough sleepers in Hounslow; due to language barriers it has not been possible to assess these.

| Median age | 51 years |
| Age range | 21-78 years |
| Proportion of males | 92% |
| Nationalities | British and Irish 67%<br>Eastern European 19%<br>South Asian 11% |
| Median time spent sleeping rough | 2 years |
| Range in time spent sleeping rough | 3 months – 34 years |
| Engagement with support services | Yes, always 54%<br>Yes, sporadically 23%<br>No 23% |

LBH’s Rough Sleepers Coordinator believes that the lack of engagement of some clients is due to longstanding mental illness (often below the threshold for intervention) and a mistrust of services.

3. HEALTH NEEDS
The table on the following page outlines some of the health needs of the sample of Hounslow’s entrenched rough sleepers.

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\(^a\) Rough sleepers are those people who stay on the streets or other insecure locations (e.g. parks, night buses, doorways, sofa-surfing or squats), not those provided with temporary accommodation by a local authority, as this second group is not considered to have substantially different health needs to the rest of the population.\(^2\) Rough sleepers tend to be single males, though there are women and couples who sleep rough.
### Physical health needs

| Proportion with known physical health needs | 31% |
| Range of known physical health needs | lower limb ulcers, tuberculosis (TB), head injury, HIV, deep vein thrombosis (DVT), incontinence, ulcers |

### Mental health needs

| Proportion with known mental health needs | 72%; incl. at least 16% known to be demented |
| Range of known mental health needs | chronic self neglect, self harm, depression, anxiety, personality disorder, psychosis, schizophrenia, paranoia, Korsakoff’s syndrome, dementia |

### Substance misuse

| Proportion with known substance misuse | 42% |
| Substances | Predominantly chronic alcoholism; but some heroin and other drug use. |

These health problems may underestimate the true extent of need, as many health problems are not obvious and therefore not reported. For example, a national audit of 700 rough sleepers found that 82% had a physical health need, 72% had a mental health need, 75% drank alcohol (20% harmfully), and 52% used illegal drugs (see Annex 1).

As poor health is known to reinforce sleeping rough, these needs must be addressed in order to support these people with both their health and wider housing and social needs.

### 4. HEALTH SERVICE USE

It is difficult to quantify health service use amongst rough sleepers, as it is not always known when an admission or A&E attendance has occurred. We know that since March 2013, 21 of the sample of 36 entrenched rough sleepers in Hounslow (58%) have had at least one admission to hospital (9 were admitted under the Mental Health Act due to self neglect).

Hospital use data on rough sleepers are not readily available, but ‘No Fixed Abode’ (NFA) can be used as an approximation. In 2012/13, there were 286 A&E attendances by NFA patients at WMUH, and 30 people were admitted. NFA patients require significant health resource input; a group of 13 NFA patients had a total of 37 outpatient appointments in one year. Of the 30 NFA persons who were admitted in 2013/14, 86.7% (26) were discharged to NFA (i.e. referral to the Local Authority’s Housing Department and paying their taxi fare to the Civic Centre). During the same year, 10 NFA persons were admitted to Lakeside Mental Health Unit (14 admissions in total). Since 2011, there have been fewer than five patients treated for tuberculosis who were known to be single homeless persons sleeping rough.

An Inner North West London audit of rough sleepers looked at health service use amongst this group and associated costs. If the same proportion of rough sleepers in Hounslow used hospital services in a similar pattern to those in inner NW London, we could expect costs to the local health economy of approximately £107,000 each year – excluding associated costs in Housing, Police and Ambulance services (see Annex 1 for details).

The system of referring discharged NFA patients to the Local Authority’s Housing Department and paying their taxi fare is not adequately supporting Hounslow’s rough sleepers; of 42 referrals made to Housing via hospital discharge in 2012/13, just 6 were accepted as being owed a housing duty, 10 people did not present at all, and outcomes for the others (n=26) are unknown.
Annex 1: Health of rough sleepers – Inner North West London and national comparisons

Data are not routinely collected on the health of rough sleepers, but audits of 700 rough sleepers from across England\(^6\) and of 933 rough sleepers from the Inner North West London tri-borough area (Hammersmith and Fulham, Kensington and Chelsea, and Westminster)\(^7\) can provide a picture of the needs of Hounslow’s rough sleepers.

A. Poor health outcomes

- Rough sleepers have a life expectancy approximately 30 years less than the rest of the population.\(^1\) Many rough sleepers die from treatable conditions, including respiratory disease, trauma, substance misuse, HIV, and liver and gastro-intestinal diseases.\(^7\)
- The most common health needs of rough sleepers are physical ill-health, complex mental health needs, and drug and/or alcohol misuse – in combination known as ‘tri-morbidity’.\(^8\)
- A national audit of 700 rough sleepers found that:\(^6\)
  - 82% of clients reported at least one physical health need (commonly joint/muscular problems, dental needs, respiratory problems, and sight problems); and 56% said that they had a long-term physical health need, compared to an estimated 29% in the general population. One-fifth of rough sleepers said that they found it difficult to manage their health problem.
  - 72% of clients reported one or more mental health needs (almost 2.5 times greater than the general population), and 44% of those reported self-medicating with drugs or alcohol. 35% or those with a mental health needs said that they needed more support for their mental health.
  - 77% of clients smoke; 75% drank alcohol (20% harmfully – more than 4 times per week); and 52% used illegal drugs (mostly cannabis, but many with heroin, crack / cocaine, methadone, and a small number with amphetamines).
- Ill-health is a cause and a consequence of rough sleeping. It is thought that two-thirds of chronic health needs amongst rough sleepers pre-exist before the person becomes homeless (and may be part of the cause of the transition to homelessness), but health problems will be worsened by being homeless.

B. Health service use

**PRIMARY CARE**

- Rough sleepers are less likely to access primary care services than the rest of the population; just 27% of rough sleepers in inner NW London are registered with a GP.\(^7\)
- A national audit of rough sleepers found that of those registered with a GP practice, 80% saw a GP within the last 6 months, but despite this, used secondary care service disproportionately more than the general population.\(^6\)

**SECONDARY CARE\(^7\)**

- In inner NW London, 538 of 933 rough sleepers (58%) were tracked as using secondary healthcare services over a 30-month period from January 2010 to June 2012 – though the others may have used secondary care but not recorded as doing so due to using alternate names. The rough sleepers who used hospital services attended A&E an average of 7 times each (seven times more than the general population), had 10 outpatient appointments each, and had 3 inpatient admissions each. This equated to a cost of approximately £4,350 per rough sleeper over 30 months.
If the same proportion of rough sleepers in Hounslow used secondary care services in a similar pattern to those in inner NW London, we would expect costs to the local health economy of approximately £107,000 each year.

- The highest number of outpatient attendances amongst rough sleepers in inner NW London were for mental illness (1,163 attendances over 30 months); trauma and orthopaedics (321 attendances), ophthalmology (213 attendances), and hepatology (204 attendances).

- Rough sleepers in inner NW London experienced a high rate of emergency admissions (which are four times as costly) rather than elective admissions, compared to the general population for whom the opposite is true. Rough sleepers had a rate of 163 emergency admissions per 1,000 population, compared to 47 per 1,000 in the general population.

- Over a 30-month period, the most common diagnoses amongst rough sleepers in inner NW London admitted to hospital were: mental and behavioural disorders (including substance misuse; 159 admissions), injury and poisoning (136 admissions), unclassified signs and symptoms (104 admissions), and digestive diseases (96 admissions).

- Length of stay amongst rough sleepers in inner NW London was more than double that of the general population (5.8 days compared to 2.8 days).

C. Barriers to improving health

- Nationally, 9% of rough sleepers said that they had been refused access to services such as a GP or dentist, with reasons including 'unsuitable behaviour', or lacking ID or proof of address (which are often not able to be produced by rough sleepers).

- Nationally, just over one-quarter (27%) of rough sleepers admitted to hospital said that they had help with their housing situation prior to discharge.

Qualitative findings from inner NW London found common barriers to rough sleepers accessing healthcare included: experience of stigma, fear of clinical settings, trouble communicating, not understanding the system, being refused access, not wanting to seek help, poor coordination between services (for dealing with tri-morbidity), and early or inappropriate discharge. Full findings are available below and on the following page.
Barriers to accessing healthcare as reported by rough sleepers

**Not seeking help for health needs**
- Neglecting health as a form of self-harm
- Health not seen as a priority
- Not accepting diagnosis e.g. some people with a personality disorder

**Communication and understanding of the system**
- Difficulty communicating health needs
- Poor engagement and communication skills
- Lack of understanding of the system

**Stigma**
- Experience of stigma and discrimination from health professionals
- Gender discrimination

**Fear**
- Fear and denial of ill-health
- Fear of officials and clinical settings

**Negative perceptions and experiences**
- A belief from healthcare workers that the rough sleeper can't be treated (especially amongst people with personality disorders)
- Previous negative experiences of healthcare
- Negative perceptions of health services
- Embarrassment and low self esteem

Issues with discharge

The qualitative research identified hospital discharge as a significant problem for rough sleepers
- Early discharge before the patient felt their health needs had been met
- Discharge without housing needs being addressed
- Failure to communicate effectively with the relevant agencies prior to/ upon discharge
- Discharged without clothing or transport.

References