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Homeless People's Access to Medical, Care and Support Services

A Review of the Literature

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

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1. Introduction

The Welsh Assembly Government commisioned the University of Salford to carry out this review to inform its approach to the provision of medical, care and support services to homeless people in Wales. The National Homelessness Strategy recognises the importance of research in this area, and gave a commitment to reviewing the research evidence on the reasons for poor access to and take up by homeless people of medical, care and support services and to highlight ways in which this might be improved.

This review focused primarily on material relating to the United Kingdom, but also takes account of literature in English from other countries.

The report is in several parts. First, the legislative and policy background to homelessness is given with specific reference made to medical, care and support. Second, literature on the health requirements of homeless people is explored along with examples of how access and take up of medical care services has been improved. The penultimate section considers the support needs (including housing related) of homeless people and uses examples to demonstrate how access and take up of services might be improved. Finally, a series of conclusions and recommendations, to inform service planning, and provision have been provided, and an annotated bibliography gives more details of selected studies.

2. Legislative and Policy Background

Legislative Background

However it is defined, homelessness is a substantial problem in Wales. In 2001-02, Welsh local authorities received 13,949 homelessness applications from eligible households, of which 38% (5,333) were found to be unintentionally homeless and in priority need. These statistics do not, of course, record people who are not assessed under the statutory procedure.

Recently, the Homelessness Act 2002 has been passed. This Act *'not only strengthens the safety net for homeless people but also heralds a new era, which moves the focus of policy decisively away from crisis intervention towards prevention and a more strategic approach'* (Hilditch, 2002). In terms of strengthening the safety net, the Act restores the duty of local authorities to ensure that unintentionally homeless households in priority need have access to settled accommodation (e.g. a suitable offer of council, housing association or private rented accommodation). In Wales, the Homeless Persons (Priority Need) (Wales) Order 2001 already extended the definition of priority need to include all homeless people below the age of eighteen, as well as categories now added by the 2002 Act such as people leaving the armed forces or prison.

In terms of a new preventative and strategic approach, the Act requires local authorities in England and Wales to carry out a fundamental review of homelessness in their areas and agree a comprehensive multi-agency strategy, tackling the root causes of homelessness and developing policies for preventing homelessness. In view of the growing amount of research evidence indicating strong links between health and social care problems and the incidence of homelessness, this change of policy emphasis could be argued to be timely and of major importance.

Research related to government policy on homelessness

Research evidence on the nature and causes of homelessness in the UK over the years has revealed a fairly consistent and persistent pattern. The largest and most comprehensive study of statutory homelessness ever conducted was undertaken in nine local authority areas between 1992 and 1995 and commissioned by the then Department of the Environment (O'Callaghan et al., 1996). Almost 2,500 homelessness applications were recorded and their outcomes were monitored over a two-year period, with the homeless applicants being interviewed twice in the course of the study. Most applicants were found to be young, poor and with multiple needs. Their homelessness was usually the consequence of a number of problems, which occurred either simultaneously or sequentially. The typical situation was that of a combination of changes in family structures or relationships (e.g. related to life-cycle transitions) with difficulties in accessing suitable affordable accommodation. For example, a young person on the threshold of establishing an independent home falls out with his or her parents, leaves home, but lacks the resources to find their own settled accommodation. One common pattern of causation is therefore one of family disputes and lack of suitable housing for low-income households.

Studies of people sleeping rough have tended to confirm this general picture, although the homeless people involved are mostly not the same as those presenting as homeless to local authorities. Anderson et al. (1993), for example, in a survey of single homeless people who were sleeping rough or living in bed and breakfast hotels or hostels, found that less than two fifths had applied to the local council as homeless in the previous twelve months. The causes of single (non-priority) homelessness also appear to be more specific. Anderson (1993), among others, has pointed out that the increase in single homelessness in the UK since 1988 was associated with the impact of long-term unemployment, reductions in income support, cuts in housing benefit, and the continuing exclusion of single people from the social housing system in the face of increasing numbers of one-person households. Anderson et al. (1993) found that the vast majority of single homeless were male, especially in older age groups, and white. As with the statutorily homeless, however, the main reasons for their homelessness were their low income, difficulties in accessing suitable accommodation, and problems relating to families and relationships. Significant additional factors associated with single homelessness were those of leaving social services care (a children's home or foster care) or leaving an institution such as a long-stay hospital, prison or armed forces. The incidence of health problems was found to be particularly high among those sleeping rough.

Since 1990, the United Kingdom Government's Rough Sleepers Initiative (RSI) has aimed to put an end to rough sleeping, initially in London, and later in other large cities in England, but this policy has never been extended to Wales. More recently the Welsh Assembly Government has adopted the policy to eliminate the need for rough sleeping in Wales. Independent evaluation has suggested that it was reasonably successful in reducing the numbers of people sleeping rough in central London (Randall and Brown, 1993, 1995, 1996). Critics of the RSI, however, pointed to its reactive and piecemeal character:

'Despite the practical value of additional resources for single homeless people, the programme continued to focus on limited geographical areas and to address only the visible problem of street homelessness while ignoring the wider needs of single homeless people. The Rough Sleepers Initiative represents a responsive, fragmentary approach to mitigating the most severe consequences of single homelessness. Were the government and local housing providers to implement preventative, inclusive housing policies, which recognised the legitimate needs of low-income single people for fair access to social housing, there would be no requirement for special initiatives'. (Anderson, 1999)

This conclusion has clear implications for developing appropriate policies for meeting the needs of homeless people in Wales. The English experience of dealing with rough sleeping shows the limitations of treating it as a purely housing problem, without addressing wider needs of health, care, and support. Louise Casey, the head of the United Kingdom Government's Rough Sleepers' Unit, admitted that:

'Previous initiatives focussed too much on a 'bricks and mortar' solution, providing accommodation without enough focus on the underlying problems of drug or alcohol addiction, and mental health problems. There was not

enough emphasis on sustaining tenancies and helping people to rebuild their lives away from the street. Far too many people were caught in the revolving door of hostel bed, boredom, loneliness and a return to the streets. Prevention was not seriously on the agenda and, as a result, rough sleeping was failing to be tackled at source. The well-trodden pathways to the street from prison, the armed services or care were not being blocked.' (Casey, 2001: 10)

A review of research into single homelessness from 1990 to 1999, for the Joseph Rowntree Foundation found that policies designed to reduce single homelessness were being introduced without a real understanding of its causes or the needs of those affected (Fitzpatrick et al., 2000). Their main points of criticism were:

- *'Although the individual 'risk factors' and 'triggers' associated with homelessness are now well understood, the social and economic factors driving homelessness are not – for example, labour market trends and family restructuring;*
- *The emphasis on rough sleeping has diverted attention away from other forms of homelessness such as living in bed and breakfast hotels or staying 'care of' other households (so-called 'hidden' homelessness;*
- *There has not been enough research into the needs of single homeless drug users or into the health needs of single homeless people generally*;
- *There is widespread acceptance of the importance of strategic, multi-agency working in meeting single homeless people's needs but in practice significant difficulties have been experienced in establishing inter-agency cooperation*
- *Very little is known about homeless people's friendship networks, even though this is a key area of concern within resettlement work*
- *The cost effectiveness of most types of initiatives is not known'*

In England, increasing emphasis is being placed on the role played by front-line staff, including outreach workers, in helping homeless people with health problems. For example, the Homelessness Training Unit, funded by the RSU and managed by the START team at the South London and Maudsley NHS Trust, delivers a national training programme to front-line staff working with homeless people with mental health problems. Also, six Tenancy Sustainment Teams in central London now support former rough sleepers within their new homes. These teams include specialist youth, substance misuse, mental health and employment workers. Seventeen areas across the country have now adopted the tenancy sustainment approach.

Fitzpatrick et al. (2000) found far less published research and other information on homelessness in Wales than in England or Scotland. As Mullan (2001) points out, the only large-scale studies of single homeless people in the UK have been conducted in England. Mullan argues, however, that much research is being done in Wales at a local level, focused on needs assessment or service evaluation in particular areas. The quality of this research, though, is hard to gauge, since it consists largely of routine information gathering (e.g. numbers of rough sleepers, visits to advice centres, numbers rehoused, numbers using hostels and emergency shelters, etc), with little evaluation of particular services, such as advice, support,

and employment schemes. Still, Mullan (2001: 8) is able to conclude that the main gaps in service provision for homeless people in Wales are general direct access/emergency accommodation and supported emergency accommodation for people with substance misuse problems and high support needs. Mullan also states that the provision of resettlement support for homeless people in Wales remains generally inadequate.

Mullan (2001: 27) provides a review of selected literature on homelessness, which makes a number of other relevant points, including:

- *'Existing research focuses largely on urban areas, where there are the largest concentrations of homeless households. This work may not translate directly to rural areas.*
- *There is a lack of research that rigorously examines the relationships between patterns of homelessness and social and economic processes, e.g. between homelessness and urban growth and decline*
- *There is a lack of research into what happens before and after an episode of homelessness, and examine the differences between those who make one-off and recurrent homeless applications*
- *There is a lack of information about the effectiveness of certain types of homelessness prevention, e.g. family mediation.'*

Government policy today

In February 2002, the Government published a Good Practice Handbook to help local authorities in England develop their strategies under the Homelessness Act 2002 (Randall and Brown, 2002). Most of the guidance in this handbook applies equally to Wales. The handbook identifies the key stages in creating a strategy as consultation, needs assessment, an audit of services and resources, and a programme for planning and implementing the strategy. The handbook stresses the importance of consulting not only all the agencies providing services to homeless people in the area but also homeless people themselves. It identifies barriers to joint working and how to overcome them. It places preventive activities and services at the centre of homelessness strategies, in particular: identifying people at risk of homelessness, providing advice and information, resettlement and tenancy sustainment, multi-service agencies and day centres, and community action to reduce the risk of homelessness (e.g. tackling crimes such as repeated burglaries, violence from outside the home and drug-related crime, as well as racial harassment and neighbour disputes).

In March 2002, the Government published a major report into tackling homelessness (DTLR, 2002), which complements much of the material in the Homelessness Strategies Good Practice Handbook. The report notes that tackling the complex personal problems of homeless people has been limited to those who are sleeping rough in England, and this approach, adopted by the Rough Sleepers Unit, needs to be extended to all homeless people (DTLR, 2002: 17). The report points out that, although we know about the immediate triggers of homelessness, and even about the wider structural causes of homelessness:

'Overall, we know relatively little about the personal, social and economic circumstances of homeless families and other vulnerable people

accepted by local authorities for housing. [e.g. compared with what we now know about people sleeping rough]'

'We do know that people moving in and out of 'institutions' are vulnerable to homelessness. People leaving prisons, hospitals, psychiatric placements, as well as young people leaving care, are vulnerable to social exclusion, which can lead to homelessness.' (DTLR, 2002: 12)

In April 2003, the Welsh Assembly Government published a National Homelessness Strategy, which takes up many of these concerns (see http://www.housing.wales.gov.uk/index.asp?task=content&a=j1). This strategy points out that in Wales:

'There has been no systematic monitoring of people who sleep rough, or the much larger numbers of people who may have shelter but have no secure home of their own and are not in "priority need", often called the 'hidden homeless'.
(Welsh Assembly Government, 2003: 8)

As proof of its commitment to tackling homelessness it has increased its funding for this from £650,000 in 1999 to £4.7 million in 2003/4. It also expects local homelessness strategies to link closely with other strategies and initiatives, such as Supporting People, Communities First, Young People's Partnerships, Community Legal Services Partnerships, and plans related to health, education, and other services (ibid: 11).

Government publications, both in England and Wales, recognise the frequently complex health, care and support needs of homeless people. For example:

'People who are homeless, or at risk of it, often suffer from physical or mental ill health. In addition, they may also be addicted to drugs, solvents, volatile substances or alcohol. Their needs are often complex, exacerbated by their lack of housing, and cannot be dealt with in isolation.'(DTLR, 2002: 25)

This English report goes on to describe some of the health needs of homeless people and to discuss how these might best be met. For example:

'Any person, whether homeless or otherwise, is eligible to register with a GP. However, in practice, there are many barriers to this happening, both within the doctor's surgery and from misconceptions about services by homeless people themselves. Currently, for many homeless people, health issues may only become a priority at a time of crisis. Accident and Emergency departments often then provide the easiest route into the health system. This is costly for both the health service and for an individual's long-term health.

One practical way of getting mainstream health care to disadvantaged groups in England is through Personal Medical Service (PMS) pilots. For homeless people these pilots enable GPs to provide the time and space to address all of their needs, from physical and mental health problems to drug and alcohol addictions. (In Wales some funds are available through the health and social care flexibility grant programme). Similarly, local development schemes, administered by the Primary Care Trusts, or Local Health Boards in Wales, can offer financial support to GPs who provide services for homeless people.

It is particularly important that homeless families with children placed in temporary accommodation, especially in Bed and Breakfast

hotels, have regular health checks. Babies and young children must receive follow up visits from community midwives and health visitors. Good practice includes multi-agency teams, which notify primary health services, organise health visits and monitor arrangements. The statutory code of guidance expects local authority housing staff to refer homeless families and children to the appropriate community health service.

Other methods of taking health care to homeless people include GPs running services in hostels and day centres, or providing surgeries where no appointment is necessary. These can be very successful in targeting help and advice at people who would otherwise overlook health concerns.

Drug addictions, in particular, are responsible for making people's lives more chaotic and unstable. Tackling substance misuse can help prevent homelessness and is an important step in stabilising those who may have already lost their home. Agencies that work with rough sleepers report that drug use is increasing rapidly and are concerned that these addictions lead to other issues relating to crime, anti-social behaviour and ill-health.

Treatment services will therefore need to be flexible in the services that they provide if national targets on treating drug misuse [in any of the countries of the UK] are to be met. Experience of the Rough Sleepers Unit has shown that detoxification and rehabilitation facilities need to be available, as well as harm minimisation, if entrenched and complex addictions are to be tackled.

Existing services must also remove barriers that prevent homeless people from accessing the help they need. Homeless people are often unable to qualify for treatment as their chaotic lifestyles mean that they miss appointments or have moved on before they reach the front of the waiting list.

In Wales, Drug and Alcohol Action Teams, which are now subsumed under the community safety partnerships,– have responsibility to plan and commission services for all people including those from hard to reach groups. Local authorities homelessness services and voluntary sector providers should work with local specialist drug and alcohol teams to ensure that the needs of homeless people are taken into account and appropriate services are commissioned.

At the sharp end of health and addictions are the many homeless people who have multiple needs, or a dual diagnosis. These complex and interwoven issues often prevent vulnerable people from accessing health care, drug detoxification and housing support. Local service providers will need to work in partnership to support people with multiple needs so that their problems are not examined in isolation, otherwise people will continue to fall between gaps in service provision. Homelessness strategies will provide a framework for agencies to examine how they can provide a seamless service for homeless people, which does not exclude anyone. Around the country there are good examples of how this can be achieved, ranging from guidance on how to assess an individual's needs, to the provision of supported accommodation units with access to health care and life skills training.' (DTLR, 2002: 25-6)

In Wales, the National Homelessness Strategy (2003: 22) emphasises individual needs assessments as *'the foundation of work to tackle homelessness and to ensure that vulnerable people are able to maintain their tenancies'*. These assessments *'will link vulnerable people to "Supporting People" or other voluntary or statutory services'*. Some projects previously funded under s180 of the Housing Act 1996 will now fall into Supporting People Revenue Grant, which will be payable to all projects where an element of support is being provided. The strategy also commits the Assembly

Government to supporting the development of outreach work that enables homeless people to maintain communication with services, such as mailbox and telephone points (ibid: 23). On health needs, the strategy recognises that: *'Homeless people are particularly vulnerable to problems with mental health, skin, musculo-skeletal, respiratory and arthritic conditions. There is also a high prevalence of drug and alcohol problems, which may need specific health services'* (ibid: 25), and: *'The Assembly Government has already identified the problems experienced by homeless people in gaining access to health services'* (ibid: 25), for example:

'The lack of a stable address, or any address at all, can result in homeless people losing contact with primary health services, and they can experience difficulty in being accepted onto a GP's list. Other secondary services and dental and optical care may not be accessed due to the mismatch between homeless people's lifestyles and structures for accessing services.' (Welsh Assembly Government, 2003: 26)

The Strategy goes on to note that:

'There are some examples of good practice in this area, particularly where nurse-practitioners have been given dedicated time to work with homeless people in a multi-agency setting[…] However, a more systematic focus is required so that homeless people are always able to access primary health care designed to deal with their needs and circumstances, and which can link them into other specialist health services as required.' (Welsh Assembly Government, 2003: 26)

The Assembly Government has already addressed the needs of homeless people through the National Service Forum for Mental Health, and further proposes to commit itself to the following actions:

- *'Issue guidance on Health, Social Care and Well-Being Plans, requiring Local Health Boards specifically to address the health needs of homeless people*
- *Promote and fund good practice initiatives for developing accessible front-line services for homeless people*
- *Take account of the importance of planned discharge to appropriate housing in the guidance it issues to health services on the arrangements for discharging patients.' (Welsh Assembly Government, 2003: 26)*

On ex-prisoners, the Strategy notes a significant correlation between homelessness and re-offending, and makes a number of commitments, including the promotion of protocols between prison, probation and housing services to cover resettlement planning, and ensuring the availability of appropriate accommodation based support services through the inclusion of probation services in Supporting People planning frameworks (Welsh Assembly Government, 2003: 26-7).

On substance misuse, the Assembly Government already has a Substance Misuse Strategy, which sets out its priorities for planning and delivery of services. It is currently undertaking a review, which aims to scope the availability of, and access to, substance misuse treatment and rehabilitation services in Wales, to ensure that all homeless people can secure access to substance misuse treatment services. (Welsh Assembly Government, 2003: 29)

3. Health and Homelessness

The health problems of homeless people

Pleace and Quilgars (1997: 149) reported that:

'The extensive literature on health and homelessness in the United Kingdom and the rest of the industrialised world tells us a very similar story. Homelessness is very bad for your health, especially if you are someone who spends time sleeping on the street. A street homeless person in New York, Japan or London is much more likely than the general population of those countries to catch tuberculosis (Concato and Rom, 1994; Yamanaka et al., 1994; Citron et al., 1995). *'If one is homeless in an advanced industrialised nation, there is also a much higher chance that one will have a mental health problem than members of the general population* '(Craig and Timms, 1992; Cohen and Thompson, 1992; Geddes et al., 1994).

The Royal College of Physicians (1994) criticised the standard of some studies of health and homelessness. They pointed to an absence of any comparison between the health of homeless people and other sections of the population with similar characteristics. The bias of some research, which made statements about the prevalence of health problems among all homeless people by looking only at the health of homeless people who used health services, was also noted. An exception to this criticism was Victor (1992), who compared the health of homeless people in temporary accommodation across several London boroughs with that of the housed population and found that the high prevalence of acute illness and longstanding limiting illness was very similar in the housed and homeless populations.

Bines (1994) undertook the first major study of the health of homeless people in the UK that appears to be immune from these criticisms. The study makes valid comparisons between the health of single homeless people and that of the general population (a representative sample of the 'general population' was taken from the 1st wave of the British Household Panel Survey), and clearly shows the significantly worse health status of those sleeping rough. Most specific health problems were found to be two to three times higher among single homeless people. Mental health problems in particular were found to be eight times as high among residents of hostels and bed and breakfast accommodation, and eleven times as high among those sleeping rough, as among the general population.

In general: *'Well documented research has conclusively demonstrated a close association between social disadvantage [such as homelessness] and health impairment … high levels of mental health problems and physical health disorders have been found'* (Wrate and Blair, 1999: 93-94). In addition, Wrate and McLoughlin (1997: 61) have drawn attention to:

'The circularity of problems featuring in the vicissitudes of the troubled lives of the single homeless… between drug use, sleeping problems, feeling unsafe, and peer group choice offering some support and protection but simultaneously exposing young people to violence and more drugs. Poor quality accommodation compounds these problems.'

Bines (1997: 138) has pointed out that: *'There has been considerable research into the mental health of single homeless people, much of which has highlighted the prevalence of*

mental illness among them (Timms and Fry, 1989; Marshall, 1989).' Examples of such research internationally include: Gill et al. (1996) (Britain); Schnabel (1992) (Netherlands); Cohen (2001) (Los Angeles, US); Poirier et al. (2000) (Canada); MosherAshley et al. (2000) (Massachusetts, US); Vazquez and Munoz (2001) (Madrid, Spain); Becker and Kunstmann (2001) (Germany); Halldin et al. (2001) (Sweden); Lee et al. (2000) (Guyana); Herman et al. (1998) (Long Island, US); McCabe et al. (1998) (Birmingham), Reid and Klee (1999) (Greater Manchester), Wrate and McLoughlin (1997) (Edinburgh).

As Bines (1994) noted, the incidence of health problems, especially mental health problems, while being generally higher among the homeless than the rest of the population, is even higher among those sleeping rough. Craig et al. (1996) estimated that 62% of young homeless people in London had mental health problems, compared with a quarter of the general population. Gill et al. (1996) found that two thirds of young homeless people had a psychiatric disorder. In Hammersley and Pearl's (1996) study, 59% of young homeless people reported mental health problems. Reid and Klee (1999) found that 82% of homeless people using illicit substances reported psychological health problems. More recently, Lilley (2000) has reported that between 30% and 50% of people sleeping rough suffer from mental health problems, and Cauce et al. (2000) have diagnosed two thirds of their sample of young homeless people as having one or more psychiatric disorders. Other studies have shown that homeless children score higher than average for mental health problems (Cumella et al., 1998; Vostanis et al., 1996).

Other health needs of homeless people specifically considered by researchers are those relating to food or diet (Dachner and Tarasuk, 2002), substance misuse (Carlen, 1996; Craig et al., 1996; Hammersley and Pearl, 1996; Flemen, 1997; Johnson et al., 1997; Klee and Reid, 1998; Reid and Klee, 1999; Adamczuk, 2000; Fountain and Howes, 2002), pregnancy and childbirth (Hanna, 2001; Wenzel et al., 2001a; Stein et al., 2000), domestic violence (Vostanis et al., 2001), HIV/AIDS (Clatts and Davis, 1999), brain injury (Smith, 2001), the effects of imprisonment (Petersilia, 2001), and long-term institutionalisation (Simard, 2000). Conditions that are problematic for health and are directly attributable to homelessness itself have been listed as: *'Exposure to the cold and wet, unhygienic living conditions and associated exposure to infectious diseases, increased accident risk, interrupted sleep cycles, and an unbalanced diet* '(Victor, 1996).

The precise nature of the relationship between homelessness and mental health has not always been clear from the research conducted. Pleace and Quilgars (1997: 152) make the point that:

'In the mid-1980s, research appeared that argued that the rise in street homelessness was caused by the closure of state mental hospitals. Homeless people were increasing in number because people with a mental health problem were being discharged from long-stay hospitals, could not cope and ended up on skid row (Basuk, 1984). More recently, research began to appear that disputed this, arguing that becoming a street homeless person in the United States drove individuals who were previously healthy into developing a mental health problem (Winkleby and White, 1992; Cohen and Thompson, 1992). Both these arguments, which are meant to contradict each

other, are probably at least partially right. The relationship between the extent to which becoming homeless causes health status to deteriorate and the extent to which people may become homeless because they have poor health status is not properly understood…. More sophisticated analyses of single homelessness (Dant and Deacon, 1989; Vincent et al., 1995; Caton, 1990) hint at a potential role for mental health problems in increasing the risk of homelessness, because the socio-economic forces that cause homelessness seem to affect the most vulnerable groups within society disproportionately.'

Nassor and Brugger (2000) found that two fifths of homeless people who had fled physical violence in their parental home had depression or anxiety, compared with less than one fifth of those who became homeless for other reasons. In the USA, North et al. (1998) (cited in Stevens, 2002: 15) showed that the early onset of depression predicted more chronic homelessness. In a study of the psychiatric morbidity of 590 young offenders in England and Wales, Lader et al. (2000) found that 61% of males reported running away from home and 46% having been homeless. This study concluded that the chances of having a personality disorder were more than twice as high for those who had run away compared with those who had never run away. Overall, Bines (1997: 140) concluded that: *'homelessness in itself may not cause mental health problems but it may be related to, or a consequence of, a stressful previous life event which may in turn exacerbate, or eventually trigger, mental health problems.'* What this means in practice has been summarised by Craig et al. (1996) as follows:

'In comparison to the domiciled population, the homeless young people in our study were more likely to be unemployed, in receipt of state benefit, 'topping-up' benefits through unofficial temporary/part-time work, through begging and petty crime. They were significantly less likely to have been successful at school and less likely to be involved in or considering further education (including youth training schemes). Their childhoods were characterised by multiple breakdowns in care arrangements, high levels of domestic violence and extremes of parental indifference, inconsistent supervision, and physical and sexual abuse that far outstripped that seen in their domiciled contemporaries.'

These observations are broadly in line with those of the majority of American studies of young homeless people.'

A recently published review of the literature on the mental health needs of homeless young people makes a number of further relevant points:

'Risk taking behaviour: Self-neglect may result from a combination of practical barriers and the manifestation of mental health problems. Self-harming is thought to be relatively common among young homeless people [see, for example, Grenier, 1996] and suicide is the biggest single cause of death among the street homeless' [Grenier, 1996]. [Rohde et al. (2001) suggest that young female homeless people and homeless people over the age of 18 may be at 'particularly high risk' of suicide.] 'There is a relatively high prevalence of sexual risk behaviour among the young homeless population [unprotected sex, sex under the influence of substances and circumstances where sex is used in exchange for money or drugs' (Wrate and Blair, 1999)] [The risks associated with such behaviour include sexually transmitted infections, unplanned pregnancy and potential for abuse or exploitation.]. Substance use also has a significant effect on security of domicile. Criminal activity can be an inevitable and unavoidable consequence of lengthy periods of insecure domicile. It is preferable to see this

risk taking behaviour as something that can be treated, rather than as a dimension of some people's lives that may be to some extent deliberately chosen.

Vulnerability: Young people understand the dangers of street living and harbour associated fears. Young homeless people are more likely to be the victims of crime rather than the perpetrators' [from the 1996 Inquiry into Preventing Youth Homelessness in England, cited in Nassor and Brugger, 2000].

Social exclusion: While 'street children' are the most visible section of the young homeless population, they comprise the smallest. Many more young people with insecure domicile have high levels of need. Homelessness degrades job opportunities, impedes the acquisition of social capital '[superficial contacts, shallow attachments and lack of confidants are often features of homelessness' (Craig et al., 1996)], undermines the young person's sense of identity and exposes young people to a wide range of dangers and stressors. (Stevens, 2002: 3)

Stevens (2002: 17) argues for caution in seeing a link between mental health problems and substance abuse:

'Co-morbidity between mental health problems and substance abuse is high, but this issue should be treated cautiously. For example, 'use' might be considered something that is of a similar prevalence throughout the adolescent population and not necessarily of a problematic nature. Rates of substance use disorders have been reported as being broadly similar to those in the housed population, 'except where occurring conjointly with mental illness', where there is also a suggestion that 'use' may be more frequent (Craig et al., 1996). While co-morbidity was identified in three studies between mental health problems and substance 'dependency', importantly this did not hold for substance use'. (Wrate and Blair, 1999)

Stevens (2002) also makes a number of relevant points about diagnosing mental illness in homeless young people:

'Accuracy of diagnoses: Mental health issues may be less easily diagnosed than physical health issues by both clinician and patient, especially when there are complex presentations. Diagnostic procedures in adolescence are fraught with difficulties, in that the line between disorders requiring a clinical response and the troubles many children experience during 'ordinary' growing up is a fine one. The behaviour of homeless people may be construed as indicative of mental health problems when it may in fact be adaptive behaviour '(Lilley, 2000; Snow et al., 1988, cited in Fisher and Collins, 1993). *'It is important to avoid unnecessarily pathologising the problem.'* (Stevens, 2002: 21, 30)

Mullan (2001: 36) cites further evidence that people who have both mental health problems and substance 'dependency' fail to obtain help from either mental health or drug rehabilitation services because mental health services generally do not accept people with substance misuse problems, while addiction services generally refuse those with severe mental health problems (citing Connelly and Crown, 1994; Gill et al., 1996).

The most recent comprehensive research into the needs of single homeless people was carried out in London by Crane and Warnes (2001). This research confirmed the findings of previous studies concerning the high levels of mental illness and substance misuse among people sleeping rough (67% of men and 71% of women), especially young people. The research also drew attention to the under-representation of women with mental health and substance misuse problems in the resettlement population, implying that they

were most likely to remain stuck in hostels or on the street.

The health needs of specific 'groups' of homeless people

Much of the research on homelessness has had a specific focus, principally delineated by age. But there has also been a geographical aspect, inasmuch as the focus has been on specific cities or towns. As a result of this variation in focus, the findings and recommendations have tended to be either what is necessary to meet the needs of a specific age group, or how services need to be improved to meet the needs of a local population. This could be taken to suggest that the findings and recommendations differ and, therefore, service design might need to differ. This conclusion, however, is not generally drawn in the literature. Rather, the general emphasis has been on core aspects of support transcending age or location, which may need to be augmented with specialist input for different 'groups'.

Young people, particularly those who have left, or are leaving care, have received close attention in the literature (for example: Fleming, 2000; McCabe et al., 1998; Smith et al., 1998). This is justified because of the high incidence of care leavers in the homeless population (see below). Crane and Warnes (2001a) have considered the needs of older people, whereas Ensign and Panke (2002) look at the needs of 'female adolescent youth'. Geographical studies tend to take a holistic perspective by looking at the needs of homeless people in that specific location (for example Ahmed and Steele, 2002; Jones and Higate, 1999; Reid and Klee, 1999).

Studies of older homeless people have been less common, and those that specifically examine the health needs of older homeless people are particularly rare (for example, see Hawes, 1997, but contrast Iqbal, 1998). Crane and Warnes (2000), however, found that, for many older homeless people who had been evicted from their homes, mental health problems were a contributory factor. It is likely that physical health problems will also figure more frequently and more seriously among older homeless people (Iqbal, 1998). A recent newspaper report stated: *'as they get older and frailer, street life exacerbates all the physical and mental ailments associated with ageing'* and: *'Everyone agrees that specialist outreach work is the only way to get through to this group: it requires concentrated, long-term effort – but does eventually pay off'* (Holmström, 2002).

Other categories of homeless people who have been the subject of study include, for example, lesbian, gay and bisexual people (Dunne et al., 2002), young children (Torquati and Gamble, 2001; Buckner et al., 1999; Burton et al., 1998; Vostanis, 1999), teenage mothers (Hanna, 2001), adolescent females (Ensign and Panke, 2002), care-leavers (Collins, 2001), and black and minority ethnic people (Julienne, 1998; Small and Hinton, 1999; for a review of the literature on black and minority ethnic homelessness, see Somerville et al., 2002). Tessler et al. (2001) report that males are more likely than females to cite mental health problems as a reason for being homeless.

One of the most striking and well-known findings is the high proportion of single homeless people who have been in care – at 30% of the total of young single homeless (Richardson and Joughin, 2000), with 20% of care-leavers experiencing some form of homelessness within two

years of leaving care (Biehal et al., 1995). A history of being in care was clearly related to the incidence of health problems:

'43% of homeless young people [using Centrepoint in London] who had experienced being looked after by a local authority had health problems compared to 23% of those who had not been in care. 32% of those who had been looked after by a local authority suffered from depression/anxiety compared to 18% of those who had never been in care.' (Nassor and Brugger, 2000)

It is generally agreed that young people from minority ethnic groups, at least in London and other large cities in England, are more likely to become homeless than their white peers (Craig and Hodson, 2000), but less likely to sleep on the streets, as they tend to find accommodation with relatives and friends (Davies et al., 1996). The situation, however, is complex and fluid (Somerville et al., 2002), and there is evidence that rough sleeping is increasing among black and minority ethnic groups (Carter, 1998). One group that may be currently falling through the safety net is that of Unaccompanied Asylum Seeking Children, 'because no-one wants to take responsibility and so there are children being neglected and abused as a result' (Stevens, 2002: 18). Refugees and asylum seekers are more isolated and disadvantaged and likely to have distinct health needs (Woodhead, 2000).

Evidence on rough sleepers in particular underlines the major and growing importance of drug problems among this group (Adamczuk, 1992; Grenier, 1996; Flemen, 1997; Fountain and Howes, 2002). The Scottish Executive (2001) has emphasised the physical health problems associated with drug misuse, such as abscesses from injecting sites, Hepatitis B and C, and HIV status. A survey published by CRASH earlier this year of users of Rolling Shelters in London from April 2000 to November 2001 found that the number of rough sleepers expressing a need for help with drug abuse problems more than doubled over this period, from 15% to 37% (CRASH, 2002).

Available research throughout the world therefore indicates overwhelmingly that there is a link between homelessness and poor health. The nature of this link, however, is complex. The general consensus is that homelessness can be a consequence of poor health, for example, as a result of an impairment making it difficult to manage one's housing (for example, a mental health problem), but it can also (particularly in the case of rough sleeping) be a cause of ill health. Distinguishing between a consequence and a cause, particularly in relation to mental health, has proved to be very difficult. In many, perhaps most, cases, the link between homelessness and poor health is not direct but mediated, through family relationships (e.g. divorce, family break-up), unemployment, substance misuse, etc. The patterns of mediation here can be almost impossible to identify and disentangle. Partly related to the wide variety of mediations involved, the health needs of homeless people are also extremely varied and not fully understood. Research has tended to focus more on young people and on specific geographical areas. There is widespread agreement on the need for preventative services and support services, but there is a lack of specificity concerning the form that is best for such services to take in relation to different types of health need.

mproving the Provision of Medical Care

It is identified above that the health of homeless people is significantly poorer than that of the general population. It has also been shown that current government policies focusing on homelessness have identified that improving access to medical care and support must be a key component in strategies designed for homeless people. However, there is no specific guidance on how access to medical care and support should be achieved. An instance of this is the Welsh Assembly Government's 'NHS Wales, Guidance on the establishment of Local Health Boards in Wales' (2003) in which there is information on the 'Health, Social Care and Well-Being Strategy' (s9:1). This offers a framework within which services should be developed but the responsibility for the precise design of 'local strategies' is in the hands of Local Health Boards and Local Authorities, along with stakeholders and service users. The remainder of this section will, therefore, concentrate on literature which features research on homelessness and the issues confronting service providers and homeless people in improving access to, and the use of, medical care and support.

Whilst the literature reflects the complex lives of homeless people and the challenges facing service providers, two broad aspects can be identified. These are *barriers* facing homeless people needing to access medical care and support and *strategies* to enable homeless people to access medical care and support. Consequently, the discussion will be organised under these two headings.

Barriers to access to medical care and support

The increased prevalence of mental illness allied to alcohol and substance misuse amongst homeless people has already been highlighted. This continues to be a feature in research on the provision of medical care and support. Indeed, it pervades the literature. This is not restricted to professional definitions: as George et al.'s (1991) census of single homeless people in Sheffield found, *'there was a high prevalence of self reported mental illness'* (ibid: 1389). The incidence of mental illness and its association with alcohol and substance misuse is identified either as a rationale supporting the unwillingness of GPs to register homeless people (Wood et al., 1997) or as a stereotyping of homeless people by medical staff (Black et al. 1991; Lester, 2002). This, in turn can create an assumption amongst staff in support environments (for example hostels) that they are ill equipped to meet the needs of homeless people and, therefore, require specialised training (McCabe et al., 1998).

A consequence of this view is that medical staff are perceived by homeless people themselves as having a negative attitude towards them. Homeless people have been found, therefore, to be reluctant to approach primary care practices or accident and emergency departments. Shiner and Leddington (1991) found that 'only 16%' (ibid: 22) of the homeless people they surveyed were in a position to access a GP by 'the official route' (ibid: 22). They also identified that negative attitudes towards homeless people by front line staff created an additional deterrent for homeless people. They concluded:

'The negative attitudes of some GPs' receptionists and members of the public are deterrents even when access is guaranteed by registration.' (1991:22)

Support staff in McCabe et al.'s (1998) study expressed strong views about the negative response received from local GP practices in Birmingham. They found that

they had to be selective when a young homeless person whom they were supporting needed medical attention. The staff had established which GPs would treat users of the hostels and would not send a service user to a GP whom they had found to be reluctant to provide treatment, or whom they had found to be negative. Indeed they stated they had 'a list of "friendly" GPs who we send people on to.' (ibid: 10)

Accessing medical care and support is further complicated for homeless people by the fragmented nature of welfare services (Crane and Warnes, 2001a), which impose bureaucratic structures on homeless people, notably those with problems associated with mental illness and the misuse of alcohol and/or substances. For example, homeless people find appointments difficult to keep and frequently fail to adhere to treatment regimes (Bunce, 2000). Kneale and Kennedy (2002) suggest that there can be several complicating features:

'Homeless drug users can be excluded from hostels and supported accommodation projects, or may not know what services exist. They may feel too embarrassed or ashamed to seek help, or be reluctant to approach professionals because they are afraid of arrest or anxious about children being taken into care.' (2002:197)

Whilst these concerns exist amongst homeless people there is evidence to suggest that they do access medical care, but that it tends to be when illness or medical conditions are advanced. Consequently, there can be additional complications because of secondary conditions, which make treatment harder (Crane and Warnes, 2001). In many instances, homeless people go to hospital A and E departments (Black et al., 1991; Little and Wilson, 1996). Holohan (2000) in a study conducted in Dublin found that, along with higher levels of alcohol and substance misuse, referrals to an A and E department were inappropriate. They should, more appropriately, have been dealt with by a GP. However, he found that homeless patients had a low possession of medical cards. Those who did have a card had an increased record of attendance at a GP surgery in the previous six months. So, although being registered with a GP they still attended an A and E department. This would tend to support the view that A and E departments are attractive to homeless people because no appointment is necessary. However, Little and Watson (1996) found that A and E departments were not liked by homeless people because of the attitude of staff and the public, as identified above, and because of long waiting times. Little and Watson (1996) also found that 'only 42.1%' (ibid: 417) were aware of mobile clinics and other community based primary care provision, where their treatment could have been more appropriately dealt with.

Some studies have focused on issues relating specifically to certain medical conditions. Because of its high prevalence mental health is one of these. Notwithstanding, separating issues related to mental health alone is problematic due to its high prevalence in the homeless population overall. Studies in the USA (Marshall et al., 1995; Morse et al., 1992; Rosenheck et al., 1998; Rosenheck and Dennis, 2001) have featured different 'treatment' approaches and programmes aimed at improving the mental health of homeless people. The general conclusion is that, whilst there may be variation in the outcomes of different approaches,

homeless people who receive treatment generally experience positive outcomes in their mental health.

Tuberculosis is a specific feature of research because *'there is a greater incidence of TB among homeless people than the general population'* (Rayner 2000:871). Coursey Bailey et al. (1993), Kumar et al. (1995) and Rayner (2000) consider the prevalence of TB and strategies for its treatment amongst homeless people. The issues, it is concluded, for the treatment of homeless people, comprise two aspects. Firstly the condition is often well advanced among homeless people because of their late referral for treatment. Consequently, the condition is more virulent and likely to be passed to others living in close proximity. As most of the homeless people featured in the research used hostels or night shelters the opportunity for the disease to be passed on were high. The second aspect is the treatment of the disease once it has been diagnosed. Because of the transient nature of homeless people's lives continuing treatment is problematic. Furthermore, as treatment frequently requires hospitalisation homeless people are reluctant to be admitted and will tend to discharge themselves before treatment has been completed. The research considers ways of solving this. One option discussed by Rayner (2000) is the giving of incentives for attending and completing treatment. However, although clear conclusions are elusive, the consensus is that improvements need to be made. One of these identified by Rayner (2000) is the need for information to be passed between health care providers. The issue of information and 'joined up services' is one that will feature later when strategies to improve services are discussed. Suffice it to say, at this point, that an underlying theme in much of the research is the absence of coordination and the fragmented nature of the provision of medical care and support.

Although the point has been made that addressing the medical care and support needs of homeless people on the basis of singular health states is not conducive to improving services in general, it is worth noting two specific pieces of research that did focus on specific aspects of medical provision.

1) Hwang and Bugeja's (2000) research into diabetes management. No comparable work appears to have been conducted in the UK but the experience of homeless people with diabetes in Toronto should serve to illustrate how this group face particular difficulties. Firstly they encountered problems with maintaining a diet suitable for someone with diabetes. Secondly there was the issue of managing insulin injections. In the case of the former it was felt that shelters did not offer an appropriate diet from which people with diabetes could choose. In the case of the latter the logistics of storing insulin at an appropriate temperature and finding a location that enabled the safe injection of insulin was extremely difficult. The solution to this, Hwang and Bugeja (2000) suggest, would be to improve dietary options and provide secure refrigeration in shelters; along with the provision of a private place wherein those with diabetes could safely and hygienically inject their insulin. Additionally haemoglobin levels could be monitored and advice given by qualified medical staff on a periodic basis, to fit in with the life patterns of homeless people.

2) Kippen's (1998) research on the provision of a community dental health service in Glasgow. He concluded that formalised service provision deters

homeless people from accessing treatment (as identified above). Kippen's review of the service found that homeless people had significantly worse dental health than the general population. This was exacerbated by life-style and co-existing medical conditions. Consequently, homeless patients frequently needed to be referred for further treatment, in some instance dental surgery. However, unlike the pattern exhibited in other research the homeless patients did attend for follow up. This, he concludes, is probably because of the less formal nature of dental care and other bureaucratic procedures encountered elsewhere. Additionally, although the quality of the surroundings within which the mobile dental treatment unit was located (a basement in a homeless people's shelter) were considered to be inadequate and inappropriate, Kippen believed the success of the service was largely due to it being taken into the community and made available during the hours when the shelter was being used by homeless people.

In summary the barriers to homeless people needing to access medical care and support have been identified as being:

1) Formal bureaucratic procedures and inflexible services that do not match the needs of homeless people.
2) Negative attitudes towards homeless people by front line staff and members of the public and a fear of losing anonymity.
3) Ignorance of existing community based services.
4) A reluctance on the part of some GP practices to treat homeless people.

It is evident that there are barriers to homeless people readily accessing medical care and support. Some are perceptions, others are structural. Whichever is the case, if homeless people are to have their medical and health needs met, they need to know that medical care and support is there for them and is available without prejudice. However, whilst barriers do exist there are a number of examples that illustrate how these can be overcome. Positive strategies and good practice will form the focus for the next section.

The research clearly identifies that where services are provided in a flexible manner and are sympathetic to the circumstances of homeless people, they are effective. This was best achieved by either locating services in places that homeless people are known to frequent (hostels, night shelters, drop-in centres) or by providing a mobile facility that would also locate on a relevant site. In addition successful services adopted open and visible policies in relation to consultations.

Gillis and Singer (1997) refer to a project which had a team comprising two nursing practitioners, a part-time social worker and an outreach worker *'who was formerly homeless'*. (ibid: 31) If necessary they could consult a physician by phone. 70% of people using the service did not have an appointment and *'clients were served depending on the acuity of need rather than what time of day they arrived'*. (ibid: 32) Morrow et al. (1992) point to a slightly different approach whereby access to medical services is part of an alliance with a community project providing a range of services, such as hot meals, counselling, housing advice and job guidance. Crane and Warnes (2001a) highlight flexibility: *'The drop-in clinic was particularly valuable, for its unarranged appointment suited the residents [of the Lancefield Street hostel].'* Crane and Warnes (2001b) also extol the value of outreach strategies, which *'reach out to*

isolated people and provide services that are easily accessible'. (ibid: 441)

Kumar et al. (1995) see the benefit of flexible provision in the treatment of TB. They suggest that *'follow up and treatment'* should be *'improved by involving outreach community workers...'* (ibid: 633) Use of dental care was also increased, with Kippen (1998) arguing that *'more flexible dental services would be better suited to the homeless population'* (ibid: 789). This he concluded from an evaluation of the three-hour programme evening dental surgeries that took place in the community.

So, where services are integrated with existing provision for homeless people and are provided on a flexible basis, they appear to be more successful. However, a cautionary note needs to be sounded. The majority of the research has been conducted in established community projects or services, such as hostels and night shelters. It is evident that those homeless people access medical care and support but identifying those homeless people who do not access such services is problematic. It was shown earlier that defining and identifying the population of homeless people is fraught with difficulties so assumptions need to be made about those who are predominantly 'rough sleepers' and 'transient'. One assumption is that that group may well use A and E departments for treatment. As Little and Watson's (1996) study showed, of those homeless people using A and E 63.9% were unaware of community-based services. How homeless people are made aware of community-based services will now be discussed.

Attitudes present a particularly difficult set of issues. It is relatively straightforward to include training about homelessness in professional education programmes. Equally, in-service awareness training can be implemented for existing staff, particularly those working in the front-line of service delivery. Public attitudes are less open to change with:

'the single homeless person subject to the constraints imposed upon them by a society that appears to have little commitment to ease their plight.' (Bunce 2000:45)

This suggests that public attitudes will be harder to affect. Indeed, given the negative portrayal of homeless people it would take a programme of public education of a significant nature to shift attitudes. That said, there are steps that can be taken.

Commenting on developments in the provision of primary health care for homeless people, Lester et al. (2002) argue that:

'New services would need to be guided by the views of service users underpinned by training, for example, to dispel the persistent barrier-inducing myths of mobility and registration regulations... '(ibid: 91)

Lester et al. (2002) are highlighting the need for service users to be involved as a means of allaying preconceptions. This would go some way to enabling homeless people to 'see a doctor who understands what it's like to be homeless' (Shiner and Leddington 1991:23). In addition, training would help:

'Health care providers to recognise and appreciate the lifestyle, beliefs, and adaptive attitudes of homeless youth, rather than labelling them as deviant.' (Ensign and Panke 2002:166)

Whilst the involvement of service users has been stated as desirable, caution should be exercised lest it is assumed that they will tell other professionals what one set of 'homelessness aware' professionals feel their colleagues should know. One consideration is the lifestyle of homeless people. Some homeless people live in 'Hopelessness, also described as learned helplessness', Vance (1994:1378) states in relation to a study into older homeless men. Homeless people should not be viewed as a homogeneous group. They are, as mentioned above, extremely diverse. Consequently, involving service users in raising awareness requires experienced and skilled facilitation and funding to equip homeless service users to deal with the disparity in power they will be confronted with.

It cannot be assumed either, that service users will have the same perspective as professionals. As Kneale and Kennedy's (2002) study identified:

'Although the service users' views of good practice could be divided into the same five categories as the service providers' views, their prioritising of these categories was rather different.' (ibid: 201)

Indeed one interesting difference was that service users placed housing support at the top of their rankings, whereas staff placed *'having non-judgmental staff'* at the top of theirs. It might be concluded that, at least in the case of young homeless people, if they get a good quality of service, they are less concerned about the attitudes of the people who provide it. Whilst this appears to contradict earlier statements, it may be that, because the staff who were providing the support did have positive attitudes towards the service users, it did not appear to be a significant issue for them.

Fear of losing their anonymity was considered by some homeless people to be a factor in their not accessing medical care and support. Given the general level of mistrust expressed in much of the research the fear of losing anonymity is probably best resolved by homeless people believing that they can trust the professionals they consult. It would, however, need to be clear that anonymity is not the same as confidentiality, and whilst professionals should be able to guarantee confidentiality, they cannot allow themselves to collude in illegal actions. Health and social care workers do, therefore, need to be clear about their own professional boundaries and ensure that when they establish relationships with service users, the service users are equally clear about the parameters of the worker's role.

Perhaps surprisingly there was an absence of research on how homeless people become aware of medical care and support. Given that most 'outreach' services are located in physical establishments it can be assumed that those people who use them learn of the service from others on the premises. It can be implied that they may pass this on to other homeless people they converse with. However, this would appear to be a somewhat haphazard way of disseminating information so there is scope for specific research focusing on the issue of publicising services to homeless people on the margins of society.

The literature offers few strategies for tackling the reluctance of many GPs to register or treat homeless people. Whilst the literature reviewed above clearly identifies this reluctance there is an implicit compliance with the status quo. This comes across in the form of an almost imperceptible implication that GPs are

morally obliged to treat all and if they do not choose to act morally then attitudes need to change. Strategies to tackle attitudes would, therefore, address the evidence in the literature that the prevailing attitude amongst GPs is negative towards homeless people. However, two strategies do emerge, aside from general awareness building.

Firstly there is the concept of 'incentives'. Wood et al. (1997) concluded that:

'The study has highlighted a need for government to consider providing incentives to GPs to register homeless people without resulting in adverse effects on their contract targets.' (ibid: 292)

Crane and Warnes (2001a) go a stage further and suggest that recruitment should be a focus:

'The recruitment of GPs and other health care staff to work with marginalized client groups should be encouraged through incentives, training and realistic target setting...' (ibid: 275)

A different model, but also relying on additional resources is suggested by Lester et al. (2002):

'A better model might be inclusive service provision that combines specialised and mainstream primary care services.' (ibid: 91)

This they see as a 'crisis' model whereby the immediate critical needs of a homeless person are dealt with by the specialist team and then the homeless patient is enabled to register permanently with a mainstream practice.

It would appear, on the basis of the above, that if homeless people are to get the primary medical care to which they are entitled then GPs will need to be persuaded by 'incentives'. That said, it is unlikely that homeless people would be concerned about the nature of motivation lay behind their treatment, as long as they received a non-prejudicial service that met their needs.

On the basis of the above, it can be concluded that evidence on good practice and strategies to improve access appears to be adequate to guide policy making, at least at the macro level. There is, however, one remaining aspect to consider. That is, how will services be co-ordinated at a local level and who should be given the responsibility?

There is a body of evidence contained in the literature to suggest that the voluntary sector is best placed to do this. Crane and Warnes (2001b), for example, point out that as a consequence of central government funding policies voluntary organisations have *'become the leading providers of services to the single homeless.'* (ibid: 442) Fleming's (2000) study on the work of three voluntary sector projects for young homeless people concludes that the capacity for voluntary sector organisations to work in flexible and innovative ways means that their services can respond more flexibly than statutory social services, to the needs of homeless young people.

There is also a consensus in the literature that multi-disciplinary, multi-professional and multi-agency work, done in a co-ordinated and collaborative way, produces the best outcomes. As the voluntary sector has less investment in professional status and is less embedded in inflexible patterns of service provision there is scope to consider how that expertise and those qualities can be used in the future provision of services.

4. Care and Support and Homelessness

Social support needs of homeless people

Social support can be defined broadly to include:

- The provision and giving of information on a range of topics. e.g. welfare benefits, housing and sources of help and support
- Advocacy and counselling.
- Training, for example in life skills.
- Mentoring and individual support.

Mullan (2001: 39) reports that: *'Research has shown that a lack of support services, being unprepared to move on, poverty, isolation, lack of access to alternative housing options, not being receptive to support, drug or alcohol addiction and/or mental health problems can lead to tenancy breakdown. All of these barriers can be tackled through adequate provision of resettlement services and community care support, but provision remains inadequate.'*

As one would expect, a number of studies find that a homeless person's success in accessing a range of services is associated with the level of social support they have (for example, Lam and Rosenheck, 1999 – for people with serious mental illness). Alternatively, the level of social support available to a homeless person can moderate the impact of homelessness upon them, possibly reducing the urgency of their need for formal assistance (Buckner et al., 1999). Some studies suggest that access to certain services, such as birth control (Wenzel et al., 2001b) and housing (Robinson, 1998), may be more difficult for those whose health problems are more severe. School-based services can be beneficial for the health of young people who are homeless or at risk of homelessness (Nabors et al., 2001). With regard to the issue of discharge from psychiatric hospital, Craig and Timms (1992) suggest that what is important in giving rise to homelessness is not the circumstances surrounding the discharge itself but the provision of adequate long-term care in the community. Bines (1994) found that a high proportion of homeless people who had stayed in a psychiatric hospital had been in another institution during some time in their lives – in particular, in prison or a remand centre (a quarter of people in hostels and bed and breakfast accommodation and six out of ten people sleeping rough). Bines (1997: 141) concluded that: *'These findings suggest that many single homeless people are trapped in a "revolving door" of homelessness, crime and mental illness.'*

In general, the chaotic living of many homeless people creates an obvious need for forms of flexible, floating support, but such support is generally lacking (Fitzpatrick, 2000). Safe houses and street projects can reach and help young runaways but these are limited (and maybe increasingly so, as three of England's four voluntary sector refuges for runaway children that accept under 16s were recently closed due to lack of funds – Rickford, 2001, and there are no such refuges in Wales), and there is a need for a network of provision across the UK (Barter et al., 1996). The most positive outcomes are associated with maintaining contact with trusted staff at a secure base (Craig et al., 1996), and allowing a development of greater independence while providing support when necessary (Pleace and Quilgars, 1999). Mullan (2001: 42) comments that: *'Research has found that*

[floating support] schemes have been successful at providing housing and resettlement support to encourage independent living skills, but the range of services provided were less successful in meeting emotional needs and providing support to help people overcome isolation, loneliness and boredom. Floating support services have been found to be much cheaper to run than hostels etc but evidence on their long term effectiveness remains limited.'

Stevens (2002) provides a useful summary of homeless young people's need for social support:

'Despite housing long being identified as a pre-requisite for good health' (Lilley, 2000), *'a roof is not always the whole solution and can actually serve to exacerbate underlying problems'* (Fitzpatrick, 2000). *'Staying with friends and partners is not always a safe alternative to the street as violence, abuse, and victimisation may occur there'* (Barter et al., 1996). *'Loss of tenancies, further homelessness or use of insecure housing will not be avoided unless financial and emotional security are addressed'* (Coles, 2000). *'Ongoing social support from both lay and professional sources also has proven benefits in reducing psychiatric morbidity. Without this support, young people are likely to become more isolated and vulnerable to distress' (Mind, 2000). 'Research shows, however, that they can often find they are pushed from one service to another without receiving adequate help'* (Shelter, 2000). (Stevens, 2002: 23, 31, 42)

Pleace et al. (2000) have pointed out that day centres and drop-ins have an important role to play in providing targeted health services on site or enabling users to access mainstream NHS services (cited in Mullan, 2001: 37). Mullan (2001: 41) states that there are over 250 day centres for homeless people in the UK: *'Typically they comprise an "open-door" building based facility, and offer a wide variety of services such as support, advice, practical help, facilities, food and somewhere warm to shelter and socialise. Many have adopted proactive approaches beyond the provision of food and shelter to providing medical services and advice. They serve a valuable role in bringing marginalized homeless, particularly older single homeless, who tend to be chronically homeless, fiercely independent and quite streetwise, into contact with services.'* Mullan (2001: 40, citing Dant and Deacon, 1989, and Vincent et al., 1993, 1995) reports that: *'Studies of resettlement have shown that having something to do and a purpose to each day is fundamental to the successful rehousing of former rough sleepers.'*

The quality of support services for homeless people

A need for support has therefore been highlighted in the literature as a principal means of preventing, resolving, or ameliorating homelessness and its effects.

A substantial number of studies of homelessness and health consider the services provided for homeless people, typically with a view to assessing the effectiveness of such services. The most common such studies examine clinical interventions (mainly by psychiatrists) to address the mental health problems of homeless people (Schnabel, 1992; Poirier et al., 2000; Denoncourt et al., 2000; Thibaudeau and Fortier, 2000). Others consider the roles played by professionals such as occupational therapists (Tryssenaar et al., 2000) and health visitors (Walters, 1999). Most studies conclude that mental health agencies have a positive effect on the social circumstances of people with mental health problems, for example, by enhancing their placement options (MosherAshley et al., 2000) and improving their quality of life more generally (Poirier

et al., 2000). Gale and Holling (2001) argue that mental health action is 'most effective when it intervenes at a number of different life-stages, at a number of different times and at a number of different levels'. When an actual health problem presents, the earlier the intervention takes place, the more beneficial it is likely to be and the less severe the problem is likely to become (Young Minds, 1998). However, there are problems associated with the stigma attached to a diagnosis of mental illness, leading to increased difficulties in accessing secure accommodation and 'hidden discrimination' within the health care service (McCabe et al., 1998).

Pleace and Quilgars (1997: 153) argue that: *'The main impact, the unique impact, of homelessness on health in the United Kingdom is that it restricts or even prevents access to health services.'* For example, Bines (1994) found that less than a third of single homeless people with mental health problems were actually receiving treatment for their condition. Studies in London (Hinton 1992, 1994) have demonstrated low levels of registration with GPs (60% of rough sleepers compared with 98-99% of the general population). Pleace and Quilgars (1996) found that it was often difficult for people sleeping rough to get access to GPs, especially if they had a drug or alcohol dependency. Mullan (2001: 36, citing Pleace, 1995; Pleace et al., 2000; and Hinton, 1994) states that *'research has found evidence of prejudice against, suspicion of and some reluctance to work with homeless people among health professionals'*. Within hospitals in London in particular, the attitudes of staff towards homeless people and service provision for homeless people have sometimes been criticised. There is some evidence that single homeless people can be kept waiting longer than other patients, that treatment received can be cursory and that follow-up and discharge arrangements are often inadequate (Martin et al., 1992; Hinton, 1994; Pleace and Quilgars, 1996). One comparative study looking at the inpatient admission of homeless and housed children found that homeless children admitted into one London hospital had generally less severe illness than the housed children, but decisions to admit were taken because social factors (namely homelessness) were thought to undermine the chance of recovery if the children were not admitted (Lissauer et al., 1993).

Crane and Warnes (2001) found that existing services had arisen either in response to a perception of need by individuals or organisations, or as part of broad government programmes (such as the RSI), but never as part of an overall strategic plan. The distribution of services was noted as being ad hoc, with nearly two-thirds of facilities (day centres and first stage hostels) being in five contiguous inner London boroughs, while twelve London boroughs had none. Day centres in particular were identified as being the least structured of the homelessness services, and their role and whom they should be helping were the least well defined.

A number of issues emerge from the research that point to failings in support services. Reid and Klee (1999) identify young homeless people's fear of being stigmatised as a barrier to approaching services provided by voluntary organisations. Pleace (http://www.jrf.org.uk/knowledge/findings/housing/h153.asp) concluded that the 'non-housing' needs of homeless people were not being addressed. Smith et al. (1998) found that the support young

homeless people received from their families has a strong socio-economic influence with young people from families living on local authority housing estates being disproportionately represented in the homeless people in their sample. Jones and Higate (1999) established that if a strategy for homelessness was not in place then services were less effective. Crane and Warnes (2001b) pointed to a structural weakness in service provision by highlighting a recurrent theme:

'None of the generalist welfare agencies have a duty to seek out those who do not present. As a result, single homeless people fall between the housing, health and social services and amass exceptional unmet needs.' (ibid: 436)

The different agencies charged with meeting the needs of homeless people are guilty, research suggests, of not working together so that 'Often, different agencies could make matters worse by providing conflicting information.' (Reid and Klee 1999:22)

Learning about support services is also an issue for homeless people. There is little indication in the literature that agencies promote or publicise their services. Information is gleaned predominantly by homeless people sharing their knowledge, so those who have been homeless for some time acquire knowledge of support and where it can be obtained. Ahmed and Steele (2002) found that this did not help families who became homeless, or those who were not 'roofless' as they did not frequent hostels, shelters, or drop-in facilities.

On the basis of the above it is evident that support services suffer from:

1. A lack of coordination.
2. Inflexible approaches, which do not respond to the needs of all homeless people.
3. Limited awareness amongst homeless people.
4. A poor record of taking their services to the people who need them.
5. An absence of strategic plans designed to address homelessness.
6. An image that induces a fear of stigmatisation amongst many homeless people.

The above has highlighted deficiencies as identified in the literature. This, however, should not be taken to imply that the literature is overwhelmingly negative. Indeed, the literature features recommendations for delivering support services, which evidences unanimity about how services can be provided. This is in contrast to the fragmentation currently found in service provision.

The quality of housing-related support services

In general, it could be argued that:

'The provision of stable accommodation should have two principal effects on the health of homeless people; firstly, to improve their health status because of the reduced risk of illnesses associated with street or hostel living; and secondly, to improve access to health care by removing the barriers imposed by having no fixed abode.' (Connelly and Crown, 1994)

A number of studies have considered the relationship between health and living in forms of temporary accommodation such as hostels and bed and breakfast hotels. Hutson (1999: 210) notes that concerns

about the health implications of living in such accommodation were first raised by health visitors. There were reports of the poor health records of children and mothers in the cramped conditions (Drennan and Stearn, 1986) and of high levels of infections among children using shared washing facilities. High rates of accidents to children and delayed developmental progress were also of concern. In hostels, there were reports of frequent violent behaviour, drunkenness and drug dealing (Hutson and Liddiard, 1994; Pleace, 1995). Pleace (1995) suggests that, although major incidents may occur months apart, these are remembered and become often-told stories. Such stories, when combined with the constant noise and verbal abuse of hostels, can make them threatening places in which to live. In all-women's hostels, the violence tends to come from outside, with male partners breaking in or threatening staff as they leave. Pleace (1995: 26) comments:

'When individuals in distress did not direct violence at either themselves or other people in the hostel, it was quite frequently the case that they would smash fixtures and fittings.'

Other studies, of hostels with an older, more stable resident population, have found them to be more comfortable environments, with greater satisfaction among residents (Duncan et al., 1983; Garside et al., 1990; Thomas and Niner, 1989; Kemp and Rhodes, 1994; Dix, 1995). In her review of the literature in this area, however, Hutson (1999: 222) concluded that:

'A predominant theme which runs through all the accounts presented here is of the dangers of temporary accommodation. These dangers, particularly acute in hostels, come from the shared aspect of living and fears of mixing with others who are not known. These dangers can continue in shared accommodation even when conditions are much improved.'

Styron et al. (2000) concluded that problems of ill health among homeless people living in temporary accommodation were related more to the quality of the sheltered environment provided than to any other factor. Allgood et al. (1997) found that length of stay in temporary accommodation was most strongly related to factors such as ill health on entry into such accommodation, recent release from an institution, homelessness precipitated by a family crisis, and the age of the homeless person.

Mullan (2001: 37) points out that: *'although there is a disproportionate prevalence of mental health problems and chemical dependencies among rough sleepers many direct access hostels specifically exclude those with chemical dependencies or other support needs'*. Adamczuk (2000, cited in Adamczuk, 2001: 24) notes, however, that there is little direct evidence that hostels have any limiting effect on drug abuse. Although there is considerable variation in the prevalence of illicit drug use from one type of hostel to another, this appears to be a function of access arrangements and client group type rather than behaviour intervention or hostel entry criteria (Clark, 2000). Craig et al. (1998) found that drug abuse and dependency actually increased with the length of time spent in a hostel. Adamczuk (2001: 26) also notes:

'Positive health campaigns have not yet begun to penetrate the hostel sector. Evidence presented indicates that substance use has intensified in recent years for young men and young women in residence. The picture outside the hostel is much bleaker and it is incumbent on the

voluntary agencies to maximise their influence to reduce substance abuse. Essentially the task involves multi-agency working across the continuum of support including social care, health education and training to reinforce the message.'

The findings of CRASH (2002) reinforce the observations of Crane and Warnes (2001) that services are neither effective in helping mentally ill female rough sleepers nor are young homeless women with mental health and/or substance misuse problems being resettled in any numbers. During the 20 months covered by the survey, 1,251 individuals used the shelters, all of whom had been referred by the Contact and Assessment Team. 827 (47%) of them had been sleeping rough for at least two years, and 48% of them moved off the street, primarily into hostels. However, there is a lack of affordable, supported accommodation to which hostel residents can move, and the majority do need high levels of support to be able to sustain a successful independent tenancy.

Despite all the problems with temporary accommodation described above, research has shown the continuing need for direct-access accommodation and challenges the assumption that self-contained accommodation or smaller hostel settings should always be seen as more appropriate than large hostels (Vincent et al., 1995, cited in Mullan, 2001: 39).

In terms of access to services of all kinds, therefore, research shows that homelessness acts as a major handicap. Health services, social services, daycare services, housing services, hostels and so on all tend to be organised in ways that make it more difficult for homeless people to access them compared with people who are housed. In general, service provision is organised unstrategically and on an ad hoc basis, and different services catering for homeless people are not coordinated with one another. Service providers are often not aware of the needs of homeless people, and homeless people are often unaware of the existence of relevant services or how to contact them. Some research has shown that some forms of service provision for homeless people, such as hostels and bed and breakfast hotels, can themselves be bad for the health and safety of homeless people – e.g. because of the spread of infectious diseases, the threat of violence, and the temptation of illicit drugs.

Strategies for improving support services for homeless people

Having outlined failings in services, it might be suggested that improving services is a straightforward matter of correcting those failings. That would, however, run the risk of over-simplifying the issue and miss a crucial element that has been found to be crucial in the successful design of services, namely, the views of service users. Lindsey (2000) argued, following her study with homeless mothers, that *'Clients are experts on their own lives,'* (ibid: 67) Consequently, to design services which ignore those 'expert' views is to risk failure. Indeed, much of the literature featured in this section is based on research studies that have elicited the views of homeless service users, thereby giving the conclusions validity.

On this basis it is possible to identify two key elements that will be necessary if support services are to be effective: flexibility and coordination. McCabe et al. (1998) established that:

'Young people felt it was important that resettlement services could offer a range of options in support after leaving hostels/supported accommodation.'(ibid: 17)

This is a theme reinforced by Fleming's (2000) study, in which she identified five 'strands' of support: ongoing contact; practical support; time and support to develop social and life skills; advocacy; and groupwork. (ibid: 54)

A number of strategies for achieving the above are identified in the literature. One suggestion by Ahmed and Steele (2002) is a 'half-way house' where life-skills and 'a degree of support' could be provided. (sect. 3.9) A strategy to meet the needs of young people leaving care is reported by Valios (2000). She extols the qualities of a partnership between Wakefield Council and Barnardo's, which has created a 'leaving care scheme' that offers many of the above elements in a flexible way. Jones and Higate (1999) found that *'The majority of service users were in favour of the provision of day services for people in housing need.'* (ibid: 43) Reid and Klee's (1999) Greater Manchester study found that 'street work' was highly effective in providing support and bringing services to the attention of homeless people 'sleeping rough'.

On foyers, Mullan (2001: 38) reports that, *'while supporters argue that their value lies in their holistic approach to addressing young people's housing and employment needs, their value has yet to be established and their continued expansion carries far from unanimous support. However, evaluators have been positive, finding them to be successful in assisting more disadvantaged young people to compete for existing employment and housing opportunities'*.

The above points to a range of options relating to the delivery of services. For example, in terms of housing, Mullan (2001: 39) states that: *'Overall, there needs to be a range of accommodation options: emergency shelters, direct-access hostels – small and medium-sized; small HMOs, bedsits, general "second-stage" supported housing, and "second-stage" supported housing for "vulnerable" homeless; finally, long-term housing to reflect the needs and budgets of family and single homeless'*.

The provision of a range of housing and other options, however, does not intrinsically address the endemic problem highlighted throughout this review, namely, the fragmented and uncoordinated nature of services. Much of the literature points to the need for services to be co-ordinated (Ahmed and Steele, 2002; Jones and Higate, 1999; Reid and Klee, 1999; Sainsbury and Oldman, 2002). However, whilst this extols the benefits of 'joined up services', it does not offer a strategy for achieving them.

Bunnin et al. (1992) identified that there were a vast range of agencies providing services in London, making it extremely difficult to develop a capital wide strategy. They did, nevertheless, point out that local strategies were effective and this might point to a way forward in a national context. Crane and Warnes (2001b), whilst not specifically suggesting the coordination of services, offer some guidance:

'Clear referral pathways also need to be established between voluntary organisations and statutory health, social service and mental health providers.' (ibid: 442-3)

One example of a co-ordinated inter-agency response to the needs of homeless

young people is the Scottish Office's 'One Door' initiative (Hunter et al., 2001, cited in Mullan, 2001: 43). Informal partnerships among the homelessness agencies resulted in a number of practical developments, including the production of practical assessment tools for use by a range of agencies. Most young people interviewed a year after first receiving support from the initiative reported positive personal changes and had found stable accommodation.

So the literature highlights a number of different ways of providing flexible and coordinated services for homeless people, related to the wide variety of needs identified in earlier sections of this report. Flexibility is probably more important, in the sense that services need to be tailored to the needs of individual homeless people, and the literature also suggests that coordination can be most efficiently and effectively achieved through clear local strategies.

5. Conclusion and recommendations

This review of research literature in the area of homeless people and their access to medical, care and support services has identified a number of issues. These are:

1. Homeless people are a heterogeneous group of people with diverse and complex needs.
2. As a definition homelessness includes people living in a variety of different circumstances. Some may be 'rough sleepers', others may be living in bed and breakfast accommodation. Consequently homelessness should not be taken to mean 'roofless'.
3. The medical care and support needs of homeless people are compounded by their lifestyle.
4. Many homeless people have complex co-existing medical conditions, often exacerbated by mental illness allied to alcohol and/or drug misuse. The nature of these medical conditions is many and varied, e.g. depression, anxiety, psychoses, tuberculosis, diabetes, cardiovascular conditions, other respiratory conditions, and tooth decay.
5. Mainstream medical, care and support services do not meet the needs of homeless people generally, i.e. inappropriate, inflexible and insensitive services; negative attitudes of staff and public towards homeless people; homeless people's lack of awareness of such services (inadequacy of outreach services); discrimination by some service providers, e.g. GPs; lack of clear and effective local strategies.
6. Some client groups are much less likely than others to have their needs met, e.g. black and minority ethnic groups, ex-offenders, substance misusers, asylum seekers, single people generally, and particularly those with more chaotic lifestyles and those with severe mental health problems.

This review has identified a number of conditions that need to be satisfied in order for homeless people to have effective access to medical, care and support services:

1. Services need to be flexible in terms of:

a. the time of day the service is provided

b. open appointment systems

2. Services should be provided in a location frequented by homeless people e.g. hostels, night shelters, drop-in centres, or mobile units driven to appropriate locations.
3. Front-line staff and practitioners should be non-judgmental and have an understanding of the circumstances of homeless people.
4. Services need to be co-ordinated to provide a coherent response to the needs of homeless people.
5. Service planning should ensure that the views of service users are listened to and are allowed to influence service design.
6. Additional funds need to be made available to:

a. Provide incentives to practitioners to work with homeless people.

b. Ensure that services can be provided at unconventional times.

c. Provide the appropriate equipment to enable services to be taken in to the community.

d. Provide for adequate and appropriate evaluation of services.

7. Strategies need to be developed, particularly at local level, to ensure the efficient and effective co-ordination of the different services involved.

The review has shown that there is no blueprint for a successful service. It has, nevertheless, provided evidence concerning a range of options that could be pursued. This evidence demonstrates key elements that will need to be present in any service designed to meet the medical, care and support needs of homeless people in Wales.

Bibliography

Adamczuk, H. (2000) *Drug Abuse, Cigarette Smoking and Alcohol Use among Young Homeless People*. Birmingham: University of Central England/Drugscope.

This research was based on two samples of the 16-18 year old population, targeted at hostels and day care establishments in Birmingham and Newcastle. 83% of respondents in Newcastle, and 62% in Birmingham, reported using at least one illicit drug in the past year. Drugs used in Newcastle included cannabis resin (79%), amphetamine (62%), ecstasy (41%), cannabis leaf (40%), magic mushrooms (33%), LSD (30%), cocaine powder (27%), solvents (21%), tranquillisers (14%) and heroin (10%). In Birmingham, drug use was of cannabis resin (42%), amphetamine (20%), ecstasy (22%), cannabis leaf (40%), magic mushrooms (12%), LSD (12%), cocaine powder (8%), solvents (11%), tranquillisers (4%), but heroin (22%). The research sheds light on the personal circumstances associated with youth homelessness. For example, it found that their first homeless episode was often closely tied to the arrangements and relationship with a principal carer, with contacts involving a degree of tension and the relationship characterised by conflict. Young people frequently talked about parents having a new partner or separation or divorce, and consequent problems related to step parents etc. For homeless people, the general experience of childhood care was not one of a continuous single arrangement. Discontinuities of care tended to have negative effects on young people.

Allgood, S., Moore, M. and Warren, R.S. (1997) 'The duration of sheltered homelessness in a small city', *Journal of Housing Economics* 6: 60-80.

This study analyses the factors that influence the length of stay in shelters for the homeless, using administrative data from a large regional shelter. A variety of individual-specific characteristics is found that increase the length of stay: the presence of a medical condition, recent release from an institution, a family crisis, age, and gender. The study finds no evidence that either a history of drug abuse or mental illness has a statistically significant effect on the rate of exit from the shelter.

Baylies, C., Law, I. and Mercer, G. (1994) *The Nature of Care in a Multi-Racial Community: Summary report of an investigation of the support for black ethnic minority persons after discharge from psychiatric hospitals in Bradford and Leeds*. Research Working Paper 8. Leeds: School of Sociology and Social Policy, University of Leeds/JRF.

Survey of 101 BME people discharged from psychiatric hospitals in Bradford and Leeds, and 62 carers. African-Caribbeans were approximately twice as likely to be in psychiatric hospitals as other BME groups. Found many of them poorly prepared for return to the community, with widespread experience of poverty, unemployment, racial harassment and social isolation. Many were dissatisfied with their housing, had little awareness of after-care services, or considered services and advice to be inappropriate to their needs. The most frequently mentioned housing problems were major structural defects, overcrowding, difficulty in paying rent or mortgage, and racial harassment. The worst housing problems were experienced by young, single African-Caribbeans who had been in insecure private

accommodation before their admission, lost their homes while in hospital, and became homeless after discharge. No users or carers in the study considered that their views had ever been taken into account in community care planning or practice.

Bines, W. (1994) *The Health of Homeless People*. York: Centre for Housing Policy, University of York.

This survey involved structured interviews with three different samples of single homeless people – 1,346 people living in hostels and bed and breakfast accommodation and 507 people sleeping rough using day centres and soup runs. The third sample was taken from the first wave of the British Household Panel Survey, as representative of the general population. The survey illustrated the considerably worse health of single homeless people compared with the general population. Single homeless people were not only more likely to have health problems but they were also more likely to have more than one health problem. More than a third of people in hostels and BandBs, and well over half the people sleeping rough, reported more than one health problem compared with a quarter of the general population. Standardised morbidity rates, controlling for age and gender, revealed that most individual health problems were two or three times higher among single homeless people compared with the general population, with chronic chest conditions or breathing problems being twice as high among people in hostels and BandBs and three times as high among people sleeping rough, skin complaints being twice as high among people using day centres and three times as high among people using soup runs, musculoskeletal problems being twice as high among people sleeping rough, visual impairment being three times as high among people sleeping rough, digestive problems being twice as high among people in hostels and BandBs and at least twice as high among people sleeping rough, frequent headaches being at least twice as high among people in hostels and BandBs and at least three times as high among people sleeping rough, and mental health problems being eight times as high among people in hostels and BandBs and eleven times as high among people sleeping rough. A high proportion of single homeless people who reported mental health problems also reported heavy drinking – a third of those in hostels and BandBs and almost half of those sleeping rough, compared with 10% of the general population. Almost a half of hostel and BandB residents, and seven out of ten people sleeping rough, had been in at least one form of institution, including a children's home, psychiatric hospital, alcohol or drug unit, prison and a young offenders' institution.

Buckner, J.C., Bassuk, E.L., Weinreb, L.F. and Brooks, M.G. (1999) 'Homelessness and its relation to the mental health and behavior of low-income school-age children', *Developmental Psychology* 35, 1: 246-257.

The participants in this study were 80 homeless and 148 never homeless children, who had recently been exposed to various severe stressors. Housing status was associated with internalising problem behaviours but not with externalising behaviours. Among homeless youths, internalising behaviour problems showed a positive but curvilinear relationship with number of weeks having lived in a shelter. Housing status was not associated with self-reported depression and anxiety.

Carter, S. (1998) *Hidden Crisis: A study of black and minority ethnic homelessness in London*. London: Frontline Housing Advice.

Analysed homelessness data compiled by DETR, Housing Services Agency and Homeless Network, and conducted survey of BME homeless people through homelessness agencies. 50 agencies participated, generating 1138 respondents. Found that BME groups made up 45.1% of statutory homeless households in London. Rates of homelessness for African/Caribbeans were 4.4 times those for whites. Also, 41.3% of those who said they had slept rough were from BME groups. In addition, asylum seekers were emerging as a significant group of homeless; this was largely hidden so far, but was likely to become more visible in the absence of adequate accommodation and support.

Cauce, A., Paradise, M., Ginzler, J., Embry, L., Morgan, J., Yvette, L. and Theofelis, J. (2000) 'The characteristics and mental health of homeless adolescents: age and gender differences', *Journal of Emotional and Behavioural Disorders* 8, 4: 230-239.

This was a study of a sample of 364 homeless young people. Using DSM-III-R criteria, two thirds of the sample were diagnosed as having one or more psychiatric disorders.

Chevannes, M., Dooher, J., Maurimootoo, A.M. and Tait, T. (1998) *A Study to Consider the Accommodation, Support and Care Needs of Individuals with Mental Health Problems from the African Caribbean Community in the City of Leicester and County.* Leicester: Mary Seacole Research Centre, De Montfort University/Housing Corporation/Advance Housing and Support/Foundation Housing Association.

This study used semi-structured interviews with potential service users, carers and staff, using a combination of individual interviews and focus groups. Respondents were contacted following consultation with the Responsible Medical Officer, with permission being obtained as necessary from the key worker/primary nurse and from the carer. A total of ten service users were interviewed individually, and 17 participated in focus groups.

The researchers found strong feelings among clients about the inadequacy of the range of care, treatment and therapy opportunities for African Caribbean people suffering mental ill-health, and the lack of choice of accommodation on discharge from hospital. Carers complained that accommodation was not provided on a sufficiently long-term basis, for example six-month tenancies, and felt that statutory services lacked awareness of African Caribbean agencies and how to access them. Professionals felt that housing workers needed more support in their role, particularly mental health training and guidance and client advocacy. Most participants expressed support for culturally specific supported accommodation, on a short, medium and long-term basis, and respite accommodation for clients and carers.

Collins, M.E. (2001) 'Transition to adulthood for vulnerable youths: a review of research and implications for policy', *Social Service Review* 75, 2: 271-291.

Adolescents aging out of the child welfare system are particularly vulnerable to poor health, under-education, unemployment and homelessness, and have been under-researched. This article reviews what is known about these young people and the impact of independent living programming on youth outcomes. It also examines research on life transition, resilience, and social support. The findings underscore the importance of continued family and community support to foster individual development, even after young people leave home. The article identifies broader ideas for helping vulnerable youths transition successfully.

Craig, T.K.J., Hodson, S., Woodward, S. and Richardson, S. (1996) *Off to a Bad Start: A longitudinal study of homeless young people in London*. London: The Mental Health Foundation.

This was a study of homeless people aged 16-21 living in the London Connection and Berwick Street hostels. The focus of the research was on the measurement of psychological disorder but included separate drug abuse and drug dependency categories. The researchers reported both higher rates of mental illness, and of co-morbidity of substance dependency and mental illness, among homeless people than in the general population. In 45% of cases showing a mental illness there was also regular abuse of one or more substances of addiction. 40% of the sample were characterised by substance abuse or dependency (defined as used every day for at least two weeks in the past year), compared with 24% of a non-homeless control group. One third of the sample reported attempting suicide. Two thirds of the respondents (107 people) were re-interviewed after a year, when it was found that the proportion judged to have a dependency was the same but the pattern of dependency had changed, with lower alcohol dependency and higher multiple drug dependency. Other data from the research suggest that time spent in homeless projects could be a factor in the deterioration of the drug abuse and dependency status for the most vulnerable young people. Interestingly also, 40% of the re-interviewed females (16 out of 40) had at least one confirmed pregnancy, all of which were unplanned.

Crane, M. and Warnes, A.M. (2000) 'Evictions and prolonged homelessness', *Housing Studies* 15, 5: 757-773.

The evidence for this study is from 45 single homeless people (among 313 in a succession of ethnographic studies) who reported that eviction made a contribution to their homelessness. Using preceding states and events as criteria, a taxonomy of these once-evicted older homeless people is proposed. For most, eviction followed a protracted failure to meet their financial obligations or to keep their property in good condition, and for many, mental health problems or exceptionally low competence in basic domestic skills were contributory factors. The experiences of the group strongly suggest that homelessness can be prevented if support is provided to vulnerable people as difficulties mount. Six risk factors for eviction are re-identified.

Crane, M. and Warnes, T. (2001) *Single Homeless People in London*. London: Thames Reach Bondway.

This research looked at homeless people on the street, in hostels, in day centres and at the point of resettlement. Data were provided on 4,465 rough sleepers, 3,295 hostel residents, 2,300 resettled people, and 1,187 day centre users. The research found that rough sleepers were generally more needy than homeless people in other settings, with 67% of men and 71% of women having mental health or substance misuse problems. Hostel residents displayed an extreme diversity of needs and cultural backgrounds, with (for example) 55% of Irish men being aged over 50, while 68% of Black British or Black Caribbean women were under 30. Young rough sleepers had a much higher prevalence of substance misuse problems than young people in other settings and a low rate of resettlement. Women sleeping rough were twice as likely to have mental health and substance misuse problems as women hostel residents and resettled clients. The researchers suggest that this indicates services are not effectively helping some mentally ill female rough sleepers and that young homeless women with mental health and substance misuse problems, women of all ages with drug problems and older mentally ill women in hostels are all under-represented in the resettlement population and are therefore most likely to remain stuck in hostels or on the street.

Frontline workers who contributed views to the research emphasised the need for services for people with drink, drug and mental health problems (and for those 'multiple needs' clients with two or more of these problems), for people with histories of violence, sex offenders and care leavers. There were strong views about the paucity of specialist addiction and mental health services to meet needs.

The researchers also noted that the approach to homelessness taken by the media and Parliament is broad brush, ill informed, impressionistic and anecdotal. The vast majority of stories, references and parliamentary contributions are heavily biased towards rough sleepers (40% of all references), young people (24%), and drug-related issues. Very little mention is made of day centres, multiple need clients or minority ethnic homeless people (who constitute 35% of hostel residents in London). Older homeless people figure in less than 2% of references.

Davies, J. and Lyle S. with Deacon, A., Julienne, L. and Kay, H. (1996) *Discounted Voices: Homelessness amongst Young Black and Minority Ethnic People in England*. Sociology and Social Policy Research Paper 15. Leeds: University of Leeds/FBHO/CHAR.

There were three stages to this research: (1) a review of existing data; (2) 126 interviews with homeless young people from four ethnic groups, in three regions, contacted through agencies such as housing associations and advice centres, and through outreach work using community contacts; also, discussions with groups of young people and a postal survey of agencies in the three regions; (3) interviews with staff and residents at three case study hostels, identified by young people in stage (2) as good examples.

Causes of homelessness were found to be much the same for young people in all ethnic groups in the three regions (namely, family breakdown), but their experience of homelessness was different, especially in terms of the type of housing provision made available to them. The needs of BME groups were not well recognised by statutory and voluntary services, and young BME people would prefer to live in hostels staffed by people from their own communities, but such accommodation is very scarce.

Dunne, G.A., Prendergast, S. and Telford, D. (2002) ' Young, gay, homeless and invisible: a growing population?' *Culture, Health and Sexuality* 4, 1: 103-116.

This paper describes the experiences of a hitherto invisible and possibly increasing population in England, namely young homeless lesbian, gay and bisexual people. It draws on preliminary findings from research into transitions for young lesbian, gay and bisexual people that took homelessness as one theoretically informed focus. The paper explores two main questions. Firstly, how far and in what ways does sexuality play a role in a housing crisis? Secondly, why have the experiences of young people who may be questioning their sexuality been neglected in service provision and in the mainstream literature on leaving home and homelessness? Qualitative and quantitative evidence is brought together to suggest that a sizeable proportion of young homeless people may be lesbian, gay and bisexual, and that issues of sexuality have had an important bearing on their circumstances. At a time when it may be easier than before for a person to come out at a younger age, the risks associated with constructing identity and lifestyles against the norm should not be underestimated. Accounts of sexuality that ignore wider material circumstances do so at their peril.

Flemen, K. (1997) *Smoke and Whispers: Drugs and Youth Homelessness in Central London*. London: Turning Point.

This study used data from 696 outreach contacts at the London Project, of whom 613 were drug users. 348 (50%) of the sample reported using one drug (alcohol, cannabis, cocaine, heroin, or other illicit substance), and 265 (38%) used two or more drugs. 130 (19%) injected. Preferred drugs were cannabis (44%), heroin (17%), cocaine (12%), and alcohol (8%). The sample was broadly representative of hostel, day centre and street homelessness. Heroin use among rough sleepers was reported at 34%, twice the level of hostel residents at 17%.

Fountain, J. and Howes, S. (2002) *Home and Dry?* London: Crisis.

This study interviewed 389 homeless people in London who had slept rough for at least six nights in the last six months. Although drug users were not targeted for the study, it was found that, in the previous month, two thirds had used cannabis and alcohol, and nearly half had used heroin or crack; around a third had used benzodiazepines and the same proportion had used opiates other than heroin; a quarter had used cocaine powder, amphetamine and/or ecstasy. Of the 372 respondents using a substance in the previous month, 32% said that heroin was their preferred substance, and 70% of heroin users took it on a near daily

basis, as did 53% of alcohol users and 46% of crack users. Polydrug use was also common, with 38% using both crack and heroin in the previous month. According to the DSM-IV and ICD-10 method, 84% of substance users scored as dependent upon their main substance, with just over a third as heroin-dependent (all of those citing heroin as their main substance) and a quarter as alcohol-dependent. The use of drugs increased with length of homelessness, with 39% of those who had been homeless for two years using heroin in the last month, and 49% of those who had been homeless for ten years or more.

Garvie, D. (2001) *Far From Home: The Housing of Asylum Seekers in Private Rented Accommodation*. London: Shelter.

This research investigated the housing conditions of those seeking asylum in the UK. A total of 154 dwellings were inspected by local EHOs in five local authority areas, 60% of which were houses in multiple occupation (HMOs). 17% were found to be unfit for human habitation, and 86% of the HMOs were unfit for the number of actual or intended occupants. Asylum seeker households in over 80% of HMOs were exposed to unacceptable risks of fire. Bedsits and shared houses were particularly inadequate. 30% of homes failed to meet the needs of the asylum seekers living there, because of location (far from amenities or in areas with hostile local populations) or because of unacceptable conditions for children (for example, living in one room with their families).

Gill, B., Melzer, H., Hinds, K. and Pettigrew, M. (1996) *Surveys of Psychiatric Morbidity Report 7: Psychiatric morbidity among homeless people*. London: Office of National Statistics.

This was a sample survey taken in 1994 of homeless adults in Britain under the age of 65. The scope of the questionnaire included an assessment of psychiatric disorder and social data. For 16-21 year olds, 67% were found to have a psychiatric disorder, 55% a conduct disorder, and 30% had experienced major depressive episodes. The study supported the thesis that high levels of drug use were the result of self-medication by depressed subjects.

Hammersley, R. and Pearl, S. (1996) 'Drug use and other problems of residents in projects for the young, single homeless', *Health and Social Care in the Community* 4, 4: 193-199.

This study involved interviews with 100 young, single homeless people aged 16-30 in Glasgow. It used both a client self-assessment and a normative psychiatric assessment framework (employing the Severity of Dependency Scale). The self-interpretation approach produced a figure for opiate use at 44%. In addition 50% of the sample had used an opiate on at least one occasion. Findings from the standard interview schedules were less dramatic, but still indicated high clinical severity, with 49% found to be dependent upon at least one substance (alcohol, benzodiazepine, an opiate, or another substance), and 59% reporting mental health problems (stress, anxiety, or depression). Rates of hospital admission and attempted suicide were significantly higher in this sample than in the general population of Glasgow.

Hanna, B. (2001) 'Adolescent parenthood: a costly mistake or a search for love?' *Reproductive Health Matters* 9, 17: 101-107.

This paper reports on a study using an ethnographic approach that explored the mothering experiences of five sole-supporting Australian teenage mothers who had a child over six months of age. Early childbearing is often a response to adverse social conditions such as poverty or homelessness and is not uncommonly chosen by teenage girls from socially deprived backgrounds. Educational and employment opportunities may be limited, whilst motherhood may provide a purpose in life when few other options are possible. Young women who make this choice need comprehensive services to support them in the parenting role, including appropriate health care, welfare and housing benefits, and support in dealing with parenting, a role which they may greatly desire but are not automatically well prepared for.

Herman, D.B., Susser, E.S., Jandorf, L., Lavelle, J. and Bromet, E.J. (1998) 'Homelessness among individuals with psychotic disorders hospitalised for the first time: findings from the Suffolk County Mental Health Project', *American Journal of Psychiatry* 155, 1: 109-113.

This reports on the occurrence of homelessness in a quasi-representative sample of persons newly hospitalised with psychotic disorders. It also compares rates of homelessness in different diagnostic groups and among groups with differing symptom profiles. Data came from 237 first admission patients hospitalised at ten of the twelve in-patient facilities in eastern Long Island. Consensus diagnoses were derived from multiple sources of information; homelessness histories were based on subject self-reports. 15% of the patients had experienced at least one episode of homelessness before or within 24 months of their first psychiatric hospitalisation. The high rate of homelessness observed must be viewed with profound concern by clinicians, consumers, and policy makers alike.

Julienne, L. (1998) 'Homelessness and young single people from Black and minority ethnic communities', *Youth and Policy* 59 (Spring): 23-37.

This article seeks to demonstrate that both Asian and African Caribbean young people have to endure racism, racial discrimination and racist stereotyping which is preventing them from accessing services that many young single white people take for granted. Also assesses the extent to which black single young people are represented within specific categories of need, including care leavers, refugees and asylum seekers, ex-prisoners and people suffering from mental health problems and how membership of these categories contributes to black youth homelessness.

Klee, H. and Reid, P. (1998) 'Drugs and youth homelessness: reducing the risk', *Drugs: Education, Prevention and Policy* 5, 3: 269-280.

The increase in youth homelessness in the UK and internationally is a cause for public concern. Perhaps an association with drug misuse is one of the most serious social consequences of this trend, threatening the health of many young people with long lasting

effects. The family history and current privations of the lives of 200 young, homeless drug users were studied in depth to reveal the nature and range of coping responses to the hazards they face. A major way of coping was through self-medication with drugs. The young and newly homeless, if not using drugs already, were likely to be absorbed into a drug-oriented community. If they were using drugs recreationally, then their involvement was likely to increase. Older, long term users were using more drugs and using them more frequently.

Lam, J.A. and Rosenheck, R. (1999) 'Social support and service use among homeless persons with serious mental illness', *International Journal of Social Psychiatry* 45, 1: 13-28.

It has been widely hypothesized that persons with greater social support use fewer services, although previous studies have shown variable results. This study examines the relationship between levels of social support and formal service use among clients entering 18 community treatment programmes for homeless persons with serious mental illness as part of the ACCESS demonstration project of the US Center for Mental Health Services. Baseline and follow-up data on 1,828 clients entering the ACCESS programme were used to evaluate the relationship between individual client socio-demographic and clinical characteristics, seven measures of social support, and levels of formal service use in this population. Three measures of social support were positively related to the use of outpatient medical services and one each to the use of substance abuse services and the total days of service use. Six out of seven measures of social support were positively related to the receipt of multiple services. It appears that social support is most strongly associated with improved access to an array of different services – a very important need among this population.

Law, I., Davies, J., Lyle, S. and Deacon, A. (1999) 'Racism, ethnicity and youth homelessness', in Spiers, F. (ed), *Housing and Social Exclusion*. London: Jessica Kingsley Publishers: 141-161.

The research involved group discussions in West Midlands, East Midlands and West Yorkshire, with the participation of 53 African-Caribbeans, 46 Pakistanis, 8 Indians, and 5 Bangladeshis. Respondents were contacted through relevant agencies (typically housing associations and advice centres) and outreach work using community contacts.

Causes of homelessness were found to be similar for white, African-Caribbean and Asian young people, the most common cause being family breakdown. A third of African-Caribbeans had been in a children's home. All respondents expressed a preference for black-run hostels.

Lee, J.A.B., Odie-Ali, S. and Botsko, M. (2000) 'The invisible visibles: a study of the needs of the homeless and mentally ill in Guyana', *International Social Work* 43, 2: 163-178.

Focusing on the heavily populated coastal area of Guyana, this study is the result of an international social work collaboration. Many of the respondents have coexisting mental and substance abuse disorders. Living on the street is associated with serious physical health problems and violent victimization. Loss of family support precipitates homelessness for respondents, who summarize their needs as a home, a meal and a job.

MosherAshley, P.M., Henrikson, N. and French, E. (2000) 'Meeting the needs of the mentally ill homeless in Massachusetts-based emergency shelters', *Journal of Social Distress and the Homeless* 9, 1: 1-18.

A state-wide survey of emergency shelters for homeless people was conducted in Massachusetts to determine the prevalence of serious mental illness among residents and the extent to which they received psychiatric services. An average prevalence rate of 22%, ranging from 1% to 70%, was reported despite the fact that 87% of the shelters restricted admission of those exhibiting severe behavioural problems. Nearly three quarters of the shelters reported providing some mental health services as part of their programme, and 80% had established ties with professional mental health agencies. Linkages with these mental health agencies greatly enhanced placement options for mentally ill persons. When queried on the most pressing community-based service needed for the homeless mentally ill, nearly two thirds of the shelters reported a need for additional housing alternatives.

Nabors, L., Proescher, E. and DeSilva, M. (2001) 'School-based mental health prevention activities for homeless and at-risk youth', *Child and Youth Care Forum* 30, 1: 3-18.

Schools are an optimal setting for providing prevention services. This article describes the implementation of and results from the Empowerment Zone (EZ) project, which involved providing mental health and health prevention services to children during small group and classroom activities. The EZ Project was incorporated into character education activities for a summer school programme designed to improve reading and maths skills for at risk elementary school age youth. The character education programme is a key component in the Baltimore City schools where character traits, such as honesty, are taught through small group and classroom activities. Teachers were trained to implement mental health prevention activities; they also reported on the quality and utility of the programme. Parents also had opportunities to participate in classes, which focused on teaching discipline techniques and discussing ways to improve parent-child relationships and foster children's socio-emotional development. Results were positive.

Poirier, H., Bonin, J.P., Lesage, A. and Reinharz, D. (2000) 'Assessment of quality of life and needs of homeless mentally ill people: perceptions of an outreach team', *Santé Mentale au Québec* xxv, 2: 195-215.

This project studies how the members of an outreach team from the CLSC des Faubourgs perceive the impact of their clinical intervention with homeless people suffering severe mental illness. A convenience sample (n=52) was selected within the team's clientele. The clientele's needs were evaluated with the Camberwell Assessment of Needs. Quality of life was measured twice with the Wisconsin Quality of Life Questionnaire. The project shows that clinical intervention is associated with an improvement in quality of life of severely mentally ill homeless people and this despite the existence of numerous other needs that are not met. The study suggests the work done by the outreach team touches the clinical aspects and is associated with the improvement of social problems of severely mentally ill homeless people.

Reid, P. and Klee, H. (1999) 'Young homeless people and services provision', *Health and Social Care in the Community* 7, 1: 17-24.

This study involved semi-structured interviews with 200 users of illicit substances in the Greater Manchester area, who were all living in temporary accommodation (squats, hostels, bed and breakfast hotels, short term stays with friends, etc). 82% reported psychological health problems. Over half (101) were not seeking any medical help but were using street drugs for depression. 71% of the sample reported self-medication without recourse to medical or counselling support. Cannabis was the drug most commonly used in the past six months (97.5%), followed by alcohol (86.5%), amphetamines (57.5%), LSD (49%), heroin (46%), crack cocaine (36.5%) and cocaine powder (15%).

Robinson, D. (1998) 'Health selection in the housing system: access to council housing for homeless people with health problems', *Housing Studies* 13, 1: 23-41.

Drawing on qualitative data concerning the experiences of a sample of single homeless people with health problems, this study illustrates that people with health problems are struggling to re-enter the housing system despite, in theory, having priority among people eligible for council housing.

Rowe, M., Kloos, B., Chinman, M., Davidson, L. and Cross, A.B. (2001) 'Homelessness, mental illness and citizenship', *Social Policy and Administration* 35, 1: 14-31.

Assertive mental health outreach to homeless persons, which operates under the premise that mental illness must be understood and treated within the individual's social and economic environment points towards the goals of community membership and citizenship. This article argues that the concept of citizenship is a useful framework for approaching these goals. It reviews the principles of assertive mental health outreach and relevant aspects of contemporary citizenship theory; presents a case example of outreach leading to a 'citizenship project'; and discusses the potential benefits and pitfalls of a citizenship framework, including strategies and recommendations for programme administrators, researchers, and policy makers.

Smith, P. (2001) 'Banging heads together', *Health Service Journal* 17.5.01: 12-13.

Management of brain-injury patients is falling far short of what is needed. This article reports on a push for change and looks at recommendations made by the Commons health select committee following its inquiry into the problem. According to committee members, lack of appropriate care is resulting in very real human tragedies, from family break-up, divorce to homelessness and even prison – because underlying emotional and physical problems facing a brain-injured patient too often go unrecognised.

Stein, J.A., Lu, M.C. and Gelberg, L. (2000) 'Severity of homelessness and adverse birth outcomes', *Health Psychology* 19, 6: 524-534.

This study involved interviewing 237 homeless pregnant women in 78 shelters and meal programmes in Los Angeles in 1997. It was hypothesised that they would report worse birth outcomes than national norms, that African Americans would report the worst outcomes because of their greater risk in the general population, and that homelessness severity would independently predict poorer outcomes beyond its associations with other adverse conditions. Other predictors included reproductive history, behavioural and health-related variables, psychological trauma and distress, ethnicity, and income. African Americans and Hispanics indeed reported worse outcomes than are found nationally, and African Americans reported the worst outcomes.

Steele, A. (1997) *Young, Drifting and Black: A report on the findings and recommendations of a study into young black homelessness for Nottingham City Council*. Nottingham: Nottingham City Council.

A wide range of agencies in Nottingham providing services to BME homeless young people aged 16-35 were approached and asked to promote the study among this group. Where an agency provided accommodation for BME people, they were asked to facilitate interviewer access to relevant addresses. Where an agency provided advice rather than accommodation, they were asked to distribute self-completion questionnaires to the young BME people. Interviewers were also asked to interview any other young BME people whom they knew to be homeless. 191 interviews were achieved, but excluding those not known to agencies or to interviewers. Semi-structured interviews were also held with twelve representatives of organisations providing services to homeless young BME people.

The research found that nearly three-quarters of respondents were unaware of the housing options available for young people in Nottingham, especially in terms of type of accommodation, though most of them had contacted the City Council Housing Department to find accommodation. Thirty respondents had slept rough, mainly men below the age of 21, and African/Caribbeans represented the largest group of rough sleepers. The most common way for young people to find out about individual services was through friends and family. Seven out of ten respondents wanted immediate permanent accommodation, and hardly any of them preferred to share accommodation. Respondents and providers both cited relationship breakdown, particularly with parents, as the main cause of their homelessness, and providers believed that the most vulnerable homeless young BME people were those leaving care, prison or mental health institutions. Providers also felt that the clients perceived many of the services available as unwelcoming, and some of the accommodation available as inappropriate, especially hostels.

Styron, T.H., JanoffBulman, R. and Davidson, L. (2000) ' "Please ask me how I am": experiences of family homelessness in the context of single mothers' lives', *Journal of Social Distress and the Homeless* 9, 2: 143-165.

The goal of this study was to examine the experience of family homelessness through interviews with formerly homeless mothers about their lives before and after leaving the shelter system. In-depth interviews with 24 formerly homeless single mothers in New York City were conducted and subsequently analysed employing a qualitative-narrative approach. Major themes that emerged from the women's life stories are elucidated: poverty, neglect, abuse, troubled interpersonal relationships, and mental health concerns. Surprisingly, a majority of women spoke of their experience in the shelter system in positive terms. This and other findings are discussed in the context of the women's life experiences and support services provided by the New York City shelter system. Social policy issues and recommendations for future research and programme development are presented.

Tessler, R., Rosenheck, R. and Gamache, G. (2001) 'Gender differences in self-reported reasons for homelessness', *Journal of Social Distress and the Homeless* 10, 3: 243-254.

This examined the relative frequency of eleven different reasons homeless males and females cite for being homeless. Males were more likely to cite loss of a job, discharge from an institution, mental health problems and alcohol or drug problems. Women were more likely to cite eviction, interpersonal conflict, and someone no longer able or willing to help. Self-reported reasons for being homeless are also related to age, marital status, race, and being a veteran. As expected, they are also linked to receptiveness to treatment. Gender differences in reasons for homelessness may require different approaches to building helping relationships with homeless men and women.

Tryssenaar, J., Wilkinson, S. and Bailey, C. (2000) 'Homelessness, mental health and occupational therapy', *Santé Mentale au Québec* xxv, 2: 109-131.

Persons who are homeless with a mental illness constitute a significant portion of the homeless population. They have a myriad of occupational performance problems and are further compromised by systemic and political issues. There is growing evidence that occupational therapy can make a contribution to the health and quality of life of this marginalized, under served population. This paper describes the process and challenges providing occupational therapy services to persons who are homeless with mental health problems, addictions, and serious mental illnesses using the Canadian Model of Occupational Performance. There is a goodness of fit between the values and beliefs of the occupational therapy profession and the needs and occupational performance issues of persons who are homeless. Through helping people to develop meaningful occupations and gain control of their lives, people may be able to make permanent and positive changes in their lives. Within this dynamic is a great deal of potential learning and growth for human beings regardless if they are providers or recipients of service.

Vostanis, P., Tischler, V., Cumella, S. and Bellerby, T. (2001) 'Mental health problems and social supports among homeless mothers and children victims of domestic and community violence', *International Journal of Social Psychiatry* 47, 4: 30-40.

This article reports on the prevalence of mental health problems in homeless parents and children who have experienced domestic and neighbourhood violence and their access to social support networks. Three groups of families who had become homeless were compared: those experiencing domestic violence (48 with 75 children), victims of neighbourhood violence (14 with 29 children), and those who became homeless for other reasons (31 with 54 children). The research found that levels of psychiatric morbidity were high in the group experiencing domestic violence (35.7% in children and 21.9% in mothers) and higher still in those who were victims of neighbourhood violence (52.2% in children and 50% in mothers). Levels of social support were found to be an important factor, particularly in relation to professional support and support from other family members, as they predicted both child and maternal psychopathology. The article concludes that mental health interventions for victims of domestic and neighbourhood violence should be integrated with community programmes of social reintegration. Mental health professionals should work in close collaboration with Housing Departments, Social Services, Education and the Police.

Wenzel, S.L., Leake, B.D., Andersen, R.M. and Gelberg, L. (2001a) 'Homeless women's gynaecological symptoms and use of medical care', *Journal of Health Care for the Poor and Underserved* 12, 3: 323-341.

This study documents and explains gynaecological symptoms and conditions and use of medical care in a probability sample of 974 reproductive-age (15-44) homeless women. Two thirds of women reported symptoms during the previous year; 71% of those received medical care. Pregnancy, drug dependence, more episodes of homelessness, and general physical health symptoms were positively associated with a number of gynaecological symptoms. Gynaecological symptoms, younger age, better perceived health, and insurance coverage were positively associated with medical care; women reporting recent drug use and rape received less care. Findings support the importance of medical care and other treatment and support services for homeless women, including expanded care during pregnancy and substance abuse treatment. Health insurance coverage and an interruption in the cycle of homelessness also appear vital to women's health.

Wenzel, S.L., Leake, B.D., Andersen, R.M. and Gelberg, L. (2001b) 'Utilization of birth control services among homeless women', *American Behavioral Scientist* 45, 1: 14-34.

This study involved interviews with 974 homeless women in shelters and meal programmes in Los Angeles County. Multivariate logistic regression analysis revealed that among those women who wanted birth control services during the previous year, using these services was associated with fewer perceived barriers to health care, having a regular source of care, consistent use of contraception, and lower odds of alcohol dependence.

Wrate, R.M. and McLoughlin, P. (eds) (1997) ***Feeling Bad: The Troubled Lives and Health of Single Young Homeless People***. Edinburgh: Primary Care Services, Lothian Health Board.

This study assessed the mental and physical health of 143 homeless 16-21 year olds in Edinburgh, who were sleeping rough or at a night shelter or 'hidden' homeless. About a third were living in hostels and the rest in a continuum of homeless settings. It was found that 46 of the respondents had used cannabis in the last month, 28 had used amphetamine, 20 ecstasy, and 3 methadone. The findings on drug use were different from those in other studies, in that heroin use was not specifically reported. The study examined the relationship between drug use and a series of psychological factors assessed by international schedules and semi-structured interviews. Psychiatric disorders presented by the sample included past depressive episodes (33%), suicide attempts (28%), major depressive episodes (10%) and schizophrenia (3%). The researchers concluded that the co-occurrence of depressive illness and drug use could be explained both in terms of inappropriate coping strategies, with depressed subjects using substances to self-medicate, and in terms of substance abuse acting as a catalyst for mental illness in vulnerable people.

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