Extent, Nature, and Causes of Homelessness in Glasgow

A NEEDS ASSESSMENT

David Morrison
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1. Key issues from this needs assessment.

1.1 **This report** describes Glasgow's homeless population, including their demographics, various measures of their health, accommodation and social needs. The aim is to provide a basis for rational planning and evaluation of homeless services. It is hoped that the needs assessment of homelessness presented in this report will be the principal one used by Homelessness Partnership agencies.

1.2 **Prevention of homelessness** is a fundamental goal of all agencies in the Homelessness Partnership. Prevention of homelessness can be tackled at three stages. Primary prevention involves efforts to avoid vulnerable people becoming homeless. Secondary prevention involves enabling homeless people to successfully live in settled accommodation. And tertiary prevention involves attenuating the worst impacts of homelessness when it does occur. Arguably it is easier to engage with those who have presented as homeless than it is to identify people at risk of homelessness dispersed throughout the community.

1.3 **Current demands on the homeless services** are that nearly 12 000 presentations are made by just under 8 000 Main Applicants (see page 16) every year in Glasgow. This estimate does not include those who are homeless and do not present to Council services and is 23% higher than the figure reported by the Homelessness Taskforce. It does not appear to have increased over several years, however. Until new services reduce new and repeat homeless presentations, homeless services should anticipate serving this size of population.

1.4 **Repeat homeless** presentations are an indication of the unresolved problems of homeless people. 40% of people who present to the Council as homeless re-present. About half of them (20% of all presentations) re-present in successive years (see page 33), without successfully resolving their reasons for homelessness. Men (see page 35), younger people (see page 34), and those with some particular reasons for homelessness (see page 36) are at much increased risk of re-presenting as homeless. It may be more efficient to target resources, where possible, on these groups, for whom current services are evidently not successful. The potential impact on individuals' lives, and on the burden of homelessness more generally, would be greater. The corollary of these figures is that 60% or more of all Council homeless presentations appear to successfully resolve their homelessness without re-presenting.

1.5 **Young people** are least well served by hostel accommodation and tend to leave within a few weeks only to re-present (see page 30). High suicide rates in hostels (see page 50), injecting drug use and particularly sharing of injecting equipment, manifest themselves as blood borne viruses (see page 51) as well as criminal behaviour and prostitution. Hazardous alcohol use (see page 53) affects both younger and older homeless people.

1.6 **Rough sleeping.** A key area of success in the Homeless Strategy will be to eliminate the need for rough sleeping (see page 41). This requires meeting a variety of needs identified by rough sleepers (see page 38) in addition to providing suitable new alternative accommodation. The particular differences and advantages of new accommodation will need to be advertised and promoted to rough sleepers.

1.7 **Homelessness is generated from all areas of Glasgow** (see page 28) and homeless accommodation is provided throughout Glasgow (see Appendix 2, page 65). Over half of Glasgow City Council's homeless accommodation is outwith the city centre and this proportion will progressively increase as large hostels are closed. Support services should be allocated based on an understanding of current **demographics** and anticipate rather than react to shifts in the homeless population.

1.8 **Employment and training.** It seems reasonable to propose that employment and training are important contributors to successfully resettling homeless people and sustaining them in settled accommodation (see Table 20, page 40). The benefits trap, in which individuals are worse off if they obtain employment, training or education, presents a significant obstacle in this area. More information needs to be collected on employment and training needs of those presenting as homeless to Partnership agencies.

1.9 **People leaving institutions.** The associations between local authority care as a child (see page 53), leaving prison and leaving the armed forces (see page 32 and page 36) indicate potentially useful organisations to target education, information and support services to prevent homelessness.

1.10 **Alcohol use.** Excessive alcohol use by homeless people has been recognised for a long time. It manifests itself in admissions to hospital either directly as a result of alcohol or because of injuries associated with intoxication (see page 43). Deaths due to alcohol are also more common in homeless people (see page 49). Tuberculosis (see page 51) is associated with chronic alcohol use, poor nutrition, and homeless circumstances. In a year, about 6000 homeless presentations to Glasgow City Council are likely to be by people with hazardous drinking patterns, of whom about 2000 are new to homelessness (see page 53).

1.11 **Homeless families.** Preventing homelessness in families should be a particular priority (see page 25). There is good evidence to indicate that family disruption, interruption in schooling, and other impacts of homelessness, have life-long detrimental effects on people's lives. There is evidence that cycles of family homelessness occur. Children in homeless families are a particular priority. Nearly 3500 children are part of over two thousand homeless applications made each year. The number of all homeless household members is usually not reported.

1.12 **Decommissioning of the Council's homeless hostels.** Evidence provided in this report indicates that young people are worst served by homeless hostels and that re-provisioning should be a priority for this group. Current hostel dwellers identify several key components to alternatives to the existing large hostels (see page 59), including smaller units for people with particular problems, adequate support and an aim to ultimately resettle residents.

1.13 **Sex.** The majority of identifiable homeless people in Glasgow are men (see page 23). This is partly because men tend to re-present almost three times more often than women (see page 35).

1.14 **Domestic violence.** 6% of people presenting as homeless report that they are fleeing domestic violence (see page 32) most of whom are women. It seems likely that the true figure is higher than this because the stigma attached to reporting domestic violence leads to under-reporting.

1.15 **Ethnicity.** The great majority of homeless people in Glasgow are white (see page 24) and come from Glasgow itself (see page 27).

1.16 **Causes of homelessness.** The reasons that people become homeless are complex and varied and most reasons focus on the last event or circumstances before homelessness (see page 32). More valid and comprehensive information will be collected in the new Integrated Assessment. However, this report indicates that a cluster of behavioural problems and circumstances, suggesting a highly external locus of control and lack of personal empowerment, are features in repeat homelessness. Associations with alcohol and drug dependence may be as much self-administered responses to this lack of personal empowerment rather than causes of homelessness. One-off circumstances, such as fleeing emergencies, usually result in one-off homelessness. A philosophy of homeless services should therefore be to present practical ways in which individuals can demonstrably gain greater control over their circumstances. There may be scope for cognitive-behavioural interventions to achieve this.

1.17 **Exclusions** from accommodation are commonly cited as reasons for homelessness (see page 40). Among RSI clients, over half reported that their own violent or damaging behaviour had resulted in being banned from accommodation. In some cases people may wrongly believe that they have been excluded from accommodation. Providing stable accommodation for those with "complex needs" (a term often used to describe violent, threatening or anti-social behaviour) is likely to require smaller units that specialise in particular problems (see page 59). In particular, these would not mix drug users and individuals with alcohol dependence.

1.18 **Homelessness and health.** The high prevalence of injecting drug use and its sequelae (including blood borne viruses), alcohol dependence, and mental illness, is evident in self-reported information (see page 39), hospital admission data (see page 43), death records (see page 49), and a one-off survey (see page 53).

1.19 **Services to improve the health of the homeless.** This report indicates that improvements in the health of the homeless population in Glasgow might be best achieved through:

1.19.1 **The primary, secondary, and tertiary prevention of homelessness itself** using a range of housing, social work, educational, employment and health services.

1.19.2 **Initiatives to provide a comprehensive evidence-based response** to the major health problems of the homeless population (for example, see page 57). These initiatives should have specific, measurable, and achievable targets.

1.19.3 **Dissemination of homeless services.** Most investment in homeless health services has been concentrated around the city centre, while an increasing majority of homeless, and potentially homeless, people live elsewhere. This will increase the existing geographical mismatch between needs and services. A systematic dissemination of homeless services, providing both specialist and enhanced mainstream services, should be delivered.

Needs-based response

Throughout this report, summaries of the information are followed by suggestions on how a needs-based response might be made. These are classified into

ⓘ - information needs - highlighting areas where better information is required

Ⓟ - processes- indicating where current practices might be modified to improve the service

✓ - service needs - suggesting how new services might be provided to meet needs

2. Aims

The purpose of this needs assessment is to provide a public health perspective on homeless people in Glasgow that will form the basis for rational planning and organization of services, indicate where important data are missing, and suggest ways in which services should monitor and evaluate their activity to identify the most effective interventions. Although principally intended to inform Glasgow City Council's Strategy for the Prevention and Alleviation of Homelessness, it is expected that Greater Glasgow NHS Board's health services will also reflect the needs identified in this report in accordance with recommendations in Health and Homelessness Guidance[1].

3. Objectives

The aims of this report have been met through the following objectives:

1. To provide a profile of the homeless population in Glasgow in terms of their location, health and social needs, and temporal characteristics
2. To describe, using a variety of types of data, the health of homeless people in Glasgow
3. To describe the major services for homeless people
4. To indicate the main features of an appropriate needs-based response for homeless people in Glasgow

4. A brief history of homelessness in Glasgow

The picture of homelessness in Glasgow has been formed from several major factors.

Vagrancy has been a feature of human societies since records began[2]. There has also been a long history of common lodging houses and working men's hostels in Glasgow[3]. Accommodation in them slowly declined from a peak of over 13 000 beds after the First World War. This was due both to the loss of men's lives in the War and a large programme to build more local authority housing to improve the wellbeing of the population. After the Second World War a decline in the need for cheap hotels for itinerant manual labourers and rising unemployment meant that large city centre hostels increasingly became repositories for the unemployed and rootless. Although the older common lodging houses and working men's hostels were replaced in the early 1970s with new buildings, their function continued as accommodation for people who had no real home.

Continuing rises in unemployment in the 1980s, coupled with the introduction of heroin to Glasgow in the mid-1980s, were associated with further increases in homelessness and particularly a shift to younger people with injecting drug habits.

In 2002, Glasgow City Council provides about half of the city-centre based homeless accommodation plus temporary flats around the city. Voluntary service accommodation, mainly provided by Christian charities, plus some private provision, accounts for the remainder. More recent broader definitions of homelessness (see *Who are they? page 15*) now also include a range of individuals who were not previously defined as living in homeless circumstances.

5. Political and policy context

The modern movement to improve homelessness began at the end of 1966, when Shelter held its first meeting in the crypt of St Martin-in-the-Fields Church in London and Ken Loach's film *Cathy Come Home* was screened on television, generating considerable public debate.

The first Act of Parliament, the Housing (Homeless Persons) Act, which for the first time gave limited rights to homeless people seeking local authority accommodation, was passed in 1977. It obliged housing departments to provide permanent accommodation to homeless people in priority need and who were unintentionally homeless. A series of Acts followed but the most far-reaching of these was the Housing (Scotland) Act 2001, which extended the obligations of local authorities towards homeless people. These included a requirement of local authorities to produce homeless strategies by March 2003.

Shelter Scotland's efforts to encourage the new Scottish Parliament to set up a Homelessness Taskforce were successful, and a series of research reviews and reports has been published since 2001.

Health and Homelessness Guidance[1], published by the Scottish Executive's Department of Health in 2001, required all Scottish Health Boards to produce homeless action plans that were based on needs assessment of their homeless populations.

In addition to legislation and guidance that specifically applies to the homeless, there have been many other relevant policies in Scotland, particularly concerning employment, children and young people, education and social exclusion.

6. Definition of needs

The central argument in this report is that any understanding of need† is only meaningful if applied to a valid profile of the homeless population in Glasgow.

The emphasis in the early sections of this report is in describing the characteristics of homelessness as accurately as current information allows. It is generally true that too little information exists on the health, well-being and needs of homeless people and throughout this report information needs are indicated by the symbol ⓘ.

† See Appendix 1 (page 63) for a description of them

7. Profile of the homeless population in Glasgow

7.1. Sources of data and data quality

The principal sources of data used to describe the characteristics of the homeless population are from Glasgow City Council's Integrated Housing Management System (IHMS, also known as ESSO*) and the Rough Sleepers' Initiatives (RSI). Details of all individuals who present to the Council's housing offices are recorded on the IHMS. Where an individual is homeless, this is recorded along with particular questions that form a homelessness assessment. The IHMS constitutes an exceptionally comprehensive and accessible database on homeless and housing and compares favourably with systems in other UK and European cities. However, it suffers from some limitations, namely:

- It is based on counting Main Applicants making a homeless presentation. A Main Applicant is the principle adult applying for homeless accommodation to Glasgow City Council. It sometimes, but not always, includes partners but it does not include dependent children. A continuous period of homelessness may involve rough sleeping, presentation to the Council, a stay in a hostel, a further presentation to the Council and so on. Thus repeated presentations do not necessarily equate to repeat homelessness.
- Duplication of records and therefore over counting of homeless presentations. The integration of different information systems in 1999 resulted in duplication of records on the IHMS. More recent data, however, are likely to be more valid.
- The system is continuously updated and therefore repeated analyses are subject to small changes in, for example, the total number of those who are rehoused. Where possible, data have been analysed for the financial year 1st April 2001 to 31st March 2002 for this report. Where questions were not collected continuously over this period, alternative recent samples have been analysed.
- As with any recording system, it is subject to human errors in entering, retrieving and analysing data. Some caution should therefore always be used in making over-precise assumptions based on IHMS data.

The Rough Sleepers' Initiatives in Glasgow comprise 12 projects, ranging from accommodation to outreach street working, which first began operating in Glasgow in 1998.

RSI data are recorded on all clients who use their services although details are often built-up over a series of consultations. The main information fields of the RSI monitoring form are provided in Appendix 5, page 76. Of 1316 individuals seen by RSI projects, 81% (1061) were homeless and 37% (484) were sleeping rough. The available data do not always distinguish between characteristics of these groups but further analysis of the data may subsequently be available.

Summary point: data on homeless

- Glasgow City Council's Integrated Housing Management System (aka ESSO) and the Rough Sleepers' Initiative data are the principle sources of information on homelessness in Glasgow
- Data are limited by being based on presentations made by Main Applicants, rather than being based on individuals.

* ESSO – Estate Services Systems Operation

Needs-based response

ⓘ Ⓟ A new field, case closure, should be added to the IHMS, in accordance with Homelessness Taskforce recommendations[6]. This will allow repeat presentations and repeat episodes of homelessness to be differentiated.

7.2. Who are they?

Local authorities define homeless people using these legislative criteria:

- without any accommodation in which they can live with their families
- who cannot gain access to their accommodation or would risk domestic violence by living there
- whose accommodation is "unreasonable"; or is overcrowded and a danger to health
- whose usual accommodation is a caravan or boat and they have nowhere to park it

but the Homelessness Taskforce[4] also includes the following groups, whether or not they are covered by the legislation:

- roofless: those persons without shelter of any kind, including people sleeping rough, victims of fire and flood, and newly-arrived immigrants
- houseless: those persons living in emergency and temporary accommodation provided for homeless people
- households residing in accommodation which is unsuitable as long-stay accommodation because they have nowhere else to stay
- those persons staying in institutions only because they have nowhere else to stay
- insecure accommodation: those persons in accommodation that is insecure in reality rather than simply, or necessarily, held on an impermanent tenure
- involuntary sharing of housing in unreasonable circumstances: those persons who are involuntarily sharing accommodation with another household on a long-term basis in housing circumstances deemed to be unreasonable

It is worth referring to these definitions for two reasons. The first is to recognise the breadth of circumstances that are considered to be homeless. And the second is that information is much more readily available on people who present to the Council and are legally defined as homeless. Descriptions of the homeless population tend to be skewed towards the identifiable homeless, leaving a group sometimes called the "hidden homeless."

As the emphasis in homeless services shifts towards primary prevention (preventing homelessness in the first place) as well as secondary prevention (alleviating it once it has occurred), new systems will be needed to identify, for example, those at risk of losing their tenancies, those in institutions and others. It seems probable that people who are most in need of preventive interventions are least likely to present to services that might help them.

Any profile of the homeless population needs at least to describe them in terms of age, sex and family composition. It is also important to understand the complex and heterogeneous reasons that people become homeless and their expressed and felt needs if services are likely to be more appropriately provided.

Summary point: Defining homelessness

- Homelessness embraces a wide range of personal circumstances.
- Many homeless people remain hidden from readily-available statistics.
- Many sources of information (e.g. in the NHS) do not comprehensively identify homeless people according to the broad Homeless Taskforce criteria.

Needs-based response

ⓘ Ⓟ The Integrated Housing Management System should record and recall homeless records for individuals, rather than only Main Applicants and applications. This would reduce duplication of information gathering from homeless people and encourage services to be person- rather than service-centred.

Ⓟ Protocols to identify homeless individuals using the Homelessness Taskforce definitions are required for the NHS, voluntary organisations etc.

Ⓟ Wider dissemination of the definitions of homelessness may help to destigmatise homeless people, who are often still regarded as being rough sleepers only.

ⓘ Ⓟ The Common Monitoring data from the Rough Sleepers' Initiatives should be considered when establishing minimum datasets for other homeless agencies, e.g. in the NHS, private and voluntary sectors.

7.3. How many homeless people are there?

While it is not readily possible to account for many of the groups of homeless people categorised above, much information is available from Glasgow City Council's Integrated Housing Management System (IHMS) and some broad statements can be made about private and voluntary accommodation.

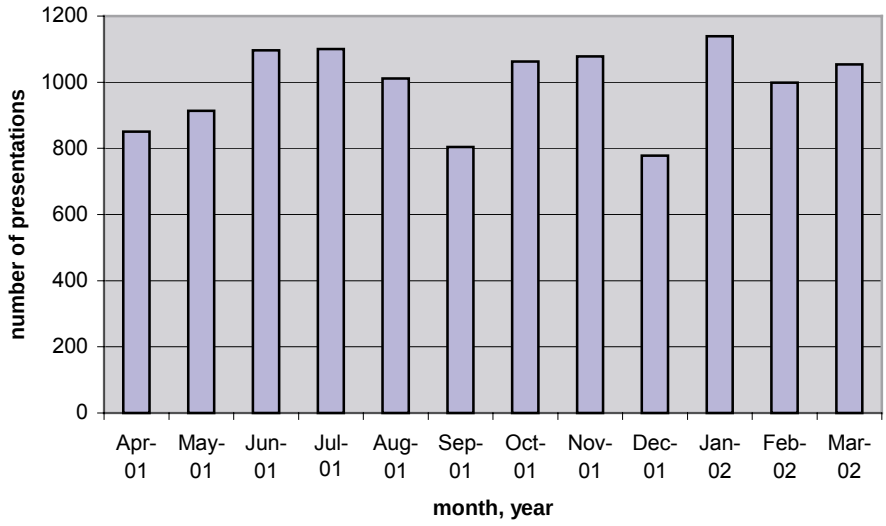
At any one time, at least 4000 people in Glasgow are likely to be homeless. This figure is derived from the number of beds provided for homeless people (see *7.4 Where are they?*) plus an arbitrary allowance for rough sleepers and other undetermined groups.
In terms of homeless presentations to the Council

- About 11889‡ homeless applications are made to GCC every year.
- This total figure is made up by about 7690 different people (Main Applicants).
- Many applicants also have partners or children, so that a total of about 11500 homeless individuals are in need of housing and support by Glasgow City Council each year.
- The majority of individuals present as homeless only once but a minority make repeated presentations (see *7.13 Repeat homeless presentations*).

The most reliable figures on homeless presentations, gathered over the last financial year, do not suggest that there is any consistent seasonal pattern associated with homeless presentations to the Council - **Figure 1**.

‡ In 2001-02, 13226 applications were made by 8258 Main Applicants. 1337 were cancelled without the process being completed, leaving 11889 applications made by 7690 Main Applicants.

Figure 1 Number of homeless presentations to GCC per month, April 2001-March 2002.



Beyond Rough Sleepers' Initiative data, no satisfactory information is readily available to describe the demographics of homeless populations in most other circumstances.

Summary point: How many homeless people are there?

- About 4000 people are homeless in Glasgow at any one time.
- Nearly 12 000 homeless applications are made by 8000 Main Applicants each year to Glasgow City Council.
- There is no seasonal variation in homeless presentations.
- There is insufficient information on the numbers of homeless people using private and voluntary services.
- A minimum of 484 people slept rough in Glasgow in 2001-02; no reliable data are available to say how many people this omits. (see *7.4.4. Others - the "hidden homeless"*)

Needs-based response

Ⓟ Regular (e.g. monthly) reporting of homeless presentations, repeat presentations and rough sleeping is required to monitor progress in tackling homelessness.
ⓘ Ⓟ The IHMS question on rough sleeping should be refined so that a more reliable count of numbers of homeless people presenting to the Council who have been homeless in any given time period can be obtained.

7.4. Where are they?

There are four broad groups of provision in Glasgow:

Glasgow City Council's large homeless hostels
Glasgow City Council's flats for homeless people
Private and voluntary accommodation
Others - the "hidden homeless"

A list of Council, private and voluntary accommodation (but not flats) is shown in Appendix 2.

7.4.1. Glasgow City Council's large hostels

Council hostel accommodation comprises about 1000 bed spaces in large city-centre based hostels (see also Table 3). Norman Street hostel is likely to close in early 2003 and Clyde Place opened in June 2002 as an assessment centre. A programme to close all large Council hostels in favour of smaller alternatives is planned for the next 5 years.

7.4.2. Glasgow City Council's flats for homeless people

The Council provides about 1300 flats, of which:

- 1010 are temporary furnished flats, nominally provided for 8-10 weeks but typically occupied for 3-6 months whilst permanent accommodation is arranged
- 117 supported flats for under-25 year olds, widely distributed throughout the city, allocated through young people
  - who apply for housing at area offices
  - who move on from care placements
  - who move on from homeless accommodation
- 146 flats supported by Assessment and Resettlement Officers which are more widely distributed throughout the City compared to hostels - see Appendix 2

There will be a progressive increase in numbers of dispersed flats for homeless people as large city centre hostels close.

7.4.3. Private and voluntary accommodation (from GCC Social Work Services' Purchased Services Review)

There are about 1000 beds for homeless people provided in a variety of locations by the private and voluntary sector (see Appendix 2, page 65). These vary from large hostels (such as the Bellgrove Hotel, Hope House and Kingston Halls) to 5-10 bedded facilities (such those provided by the Glasgow Simon Community).

Social Work Services currently purchase 11 dedicated services, which have been recently reviewed. Most purchased homelessness services have been delivered exclusively by the voluntary sector. The scope, range and capacity of provision within this sector have increased significantly over the past 25-30 years.

- **Talbot Association** has developed a range of services including registered and unregistered social care units, emergency temporary accommodation and tenancies with support.
- **Glasgow Simon Community** has developed registered and unregistered social care units, tenancy support schemes, a soup kitchen service, street outreach team, resettlement teams, and training schemes. Glasgow City Council granted funding in the early 1990s to establish paid core staffing and administrative support arrangements although the principle of volunteer support remains strong.
- **The Church of Scotland** has provided accommodation for homeless adults in the east end of the city since 1979, first as a night shelter then as a registered social care provision. The unit was relocated within the east end in 1995. Services for more severely disabled people are limited.
- **Wayside Centre** was established in the 1930s to provide support to homeless men in the city centre. The Day Centre was opened in 1982 through Urban Aid.

- **Social Work Services** also include Duty, Rough Sleepers, Court Diversion and Prisons Outreach, Women's Service, Hostels Outreach and Home Support. The residential and supported accommodation services include both registered and unregistered facilities. Capacity ranges from small-scale provision for 6 persons to the largest-scale unit in the purchased homelessness sector of 40 places. The unregistered day service provides a range of service interventions to as many as 94 service users on a direct access basis in any single day. Other services including outreach work and tenancy support are also available within the day service. The residential service providers included in the review, the respective status, capacity and category of each unit are as follows:

Table 1 Residential services for homeless people purchased by GCC Social Work department. UR, unregistered; R, registered

Provider	Unit	Status	Capacity	Category
Talbot Association	Belmont Street	UR	23	Alcohol related problems
	Buchanan Lodge	R	40	Alcohol related problems + other support needs
	Hill Street	R	20	Alcohol related problems + other support needs
	Riverside	R	12	Mental Health support needs
Glasgow Simon Community	Castlemilk House	R	6	Alcohol related problems; male-only
	Dennistoun House	R	6	Multiple Support Needs; female-only
	Maryhill House	R	7	Multiple Support Needs; female-only
	Tollcross House	UR	10	Alcohol
Church of Scotland	Kirkhaven	R	14	Multiple support needs
Turning Point	Midway Homes	UR	25	Mental health support needs
Total	**10 units**		**163**	

The nature of provision across each of the homelessness residential services varies. In some, the approach is to offer longer-term accommodation for individuals who have alcohol problems and a range of other support needs. The service aim is to promote safe drinking levels, however, a significant number in each unit continue to drink, some heavily. Individuals who wish to reduce or cease drinking will be supported to do so. Two of Talbot Association's units adopt this service model, Buchanan Lodge and Hill Street. For many of the residents within both of these services, the establishments are regarded as a 'home for life'.

Historically, Glasgow Simon Community's Maryhill House has responded to the needs of older homeless women who continue to drink. This too has come to be regarded as longer-term provision for the older residents. However, as the age profile of the resident group has begun to change recently, this will inevitably impact on the throughput of the unit with the potential to reduce the length of the residential placement to one of medium term.

GSC's Castlemilk House is a small-scale unit for homeless men that adopts an abstinence model and assist individuals to develop the skills to move towards sustaining their own tenancies in the future. The organisation's Tollcross Project is also a male-only service where the objective is to provide a supportive environment to assist individuals to identify and address their needs in ways that enable them to move on to more independent living arrangements. The GSC service, Dennistoun House, offers medium term accommodation to women with multiple needs and the aim here also is to enable individuals to move to more independent forms of housing provision. Talbot Association's Belmont Street facility is a residential unit that aims to provide an alcohol free environment and offer individuals the opportunity of working towards achieving their own tenancy.

Access to any of the above residential or supported accommodation services requires completion of a full community care assessment and care plan in respect of all individuals referred to these services. This is carried out by social work staff from the Homeless Persons Team, the 9 Area Service Teams and Hospital and Prison services and authorised by the relevant Senior Social Worker.

Admission is agreed, subject to budget availability, once a determination is made in the community care assessment that an individual has care/support needs that can only be met through admission to one of the registered or non-registered purchased homelessness services. The initial post-admission review arrangement is the responsibility of the Senior Social Worker and Care Manager however responsibility to arrange subsequent reviews is the Provider's responsibility.

A common/shared assessment tool is in development in Glasgow for application within all partner agencies with regard to the needs of individuals who are homeless. The tool adopts a 'tiered' approach to assessment and the different levels of assessment intervention are basic, comprehensive and specialist assessment. The primary aim of the common tool is to produce better outcomes for individuals with quicker access to targeted service provision. It is expected that this will be fully operational by 2003.

The only purchased day service, the Wayside Centre, currently has daily attendance figures of up to 94 individuals on a direct-access basis. A significant majority of daily service users within the Wayside Service are rough sleepers, whilst others live in hostel or other homelessness provision or are at risk of becoming homeless. Support is also available to a number of people who have previously experienced periods of homelessness and who have now secured their own tenancy. This service aims to assist individuals to sustain their tenancy.

There is no requirement for a community care assessment to be carried out to access any of the services provided by the Wayside Centre, either day provision or the outreach service to the commercial hostel provision, court service or tenancy support.

7.4.4. Others - the "hidden homeless"

There are no readily available figures for most of these groups, including travelling people, those at risk of losing their accommodation, staying with friends, and others. The Rough Sleeper's Initiative reported that between 1st April 2001 and 31st March 2002, 1316 clients were seen, of whom 730 had a history of rough sleeping and 484 were sleeping rough at the time of referral. It is not possible to say how much in excess of 484 individuals slept rough in Glasgow between April 2001 and March 2002.

Summary point: the geography of homelessness in Glasgow

- About half of the homeless population lives in or near the city centre in large hostels and half lives in widely dispersed accommodation including Council temporary flats.
- A further significant shift of homeless people towards dispersed non-central accommodation will occur over the next 5 years.
- At least 484 individuals slept rough in Glasgow between April 2001 and March 2002.

Needs-based response

✓ Resources for homeless people should be approximately divided so that half are based around city centre provision and half are more widely disseminated.

✓ Loss of economies of scale in community provision means that it is probable that more than half of all homeless resources should be community-based at present.

Ⓟ ✓ A progressive move to increase community-based homeless resources while reducing city centre-based ones should be planned rather than reactively organised as Council and charitable hostels close.

7.5. Age

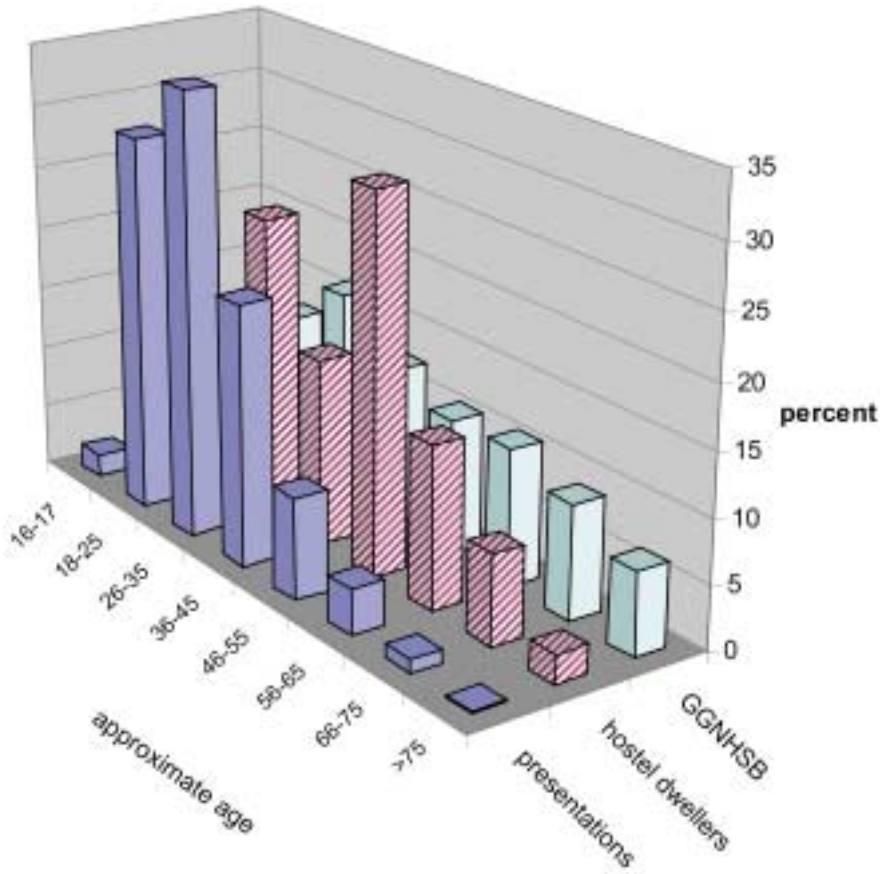
Homeless people in Glasgow are young - **Table 2**. Two thirds (66%) of those making homeless presentations are under 35 years old; a third (32%) are less than 25 years old. Only 13% are over 45 years old. Users of Rough Sleepers' Initiatives have a similar age profile. A small but significant number of under-18 year olds (231) make homeless presentations to Glasgow City Council in a year. Table 2 also shows the age-profile of all those presenting as homeless to the Council, including partners and dependent children. 1 in 5 of all homeless people who require housing is under 16.

Table 2 Age and sex of Main Applicants presenting as homeless, age of all people presenting as homeless (including dependent children and partners), April 2001-March 2002. Excludes cancelled applications & those where age not available.

age	Sex - Main Applicants				All
	Male	Female	sex not recorded	total	
<16	11 (0.1%)	14 (0.1%)		25 (0.2%)	3 384 (20.4%)
16-17	96 (0.8%)	120 (1.0%)		216 (1.8%)	487 (2.9%)
18-25	2 176 (18.3%)	1 340 (11.3%)	9 (0.1%)	3 525 (29.7%)	4 067 (24.6%)
26-35	2 941 (24.8%)	1 158 (9.8%)	11 (0.1%)	4 112 (34.6%)	4 401 (26.6%)
36-45	1 689 (14.2%)	759 (6.4%)	15 (0.1%)	2 463 (20.7%)	2 605 (15.7%)
46-55	701 (5.9%)	260 (2.2%)	4 (<0.1%)	965 (8.1%)	1 000 (6.0%)
56-65	331 (2.8%)	88 (0.7%)	1 (<0.1%)	420 (3.5%)	441 (2.7%)
66-75	91 (0.8%)	36 (0.3%)		127 (1.1%)	138 (0.8%)
>75	15 (0.1%)	8 (0.1%)		23 (0.2%)	28 (0.2%)
TOTAL	**8 051**	**3 783**	**40**	**11 876 (100.0%)**	**16 551 (100.0%)**

Figure 2 compares the age profile of homeless presentations to the Council, people in Council hostels, and the Health Board population. Two thirds of Council hostel dwellers are over 35 years old. Figure 2 also shows the relatively small number of homeless people who live into older age compared to the rest of the Glasgow population.

Figure 2 Homeless presentations (April 2001-March 2002), hostel dwellers (June 2002), and mid-year estimates of GGNHSB area (2000), by age.



The hostel dwellers' age profile is similar in most of the large all-male hostels (James Duncan House, Robertson House and Peter McCann House - Table 3). The James McLean project is solely for young homeless people and Merken House is a resettlement project for older men. Inglefield Street hostel is the only all-female hostel and has a younger than average population. Norman Street hostel is a mixed sex emergency hostel and has a younger than average population. It is anticipated that the new assessment hostel at Clyde Place will also have a younger group of residents because of its emphasis on early interventions and prevention of homelessness.

Table 3 Age distributions in GCC hostels, June 2002.

Hostel	% in age group				Total population
	18-25	26-40	41-65	>65	
James Duncan House	7.3	40.8	38.2	13.6	224
Robertson House	12.1	41.9	37.2	8.8	252
Peter McCann House	9.6	42.4	36.7	11.4	254
James McLean	100	0	0	0	12
Inglefield Street*	26.5	36.8	27.9	8.8	75
Merken House	0	0	56.3	43.8	16
Norman Street	17.2	43.1	32.8	6.9	48
All GCC hostels	**12.9**	**39.6**	**36.2**	**11.3**	**885**

*female only

Summary point: the age of homeless people

- The homeless population is largely much younger than the rest of the population.
- Hostel dwellers have an age-distribution that is more typical of the general population but fewer people live into old age.
- Homelessness has a lasting impact on the course of individuals' lives, beginning early in their lives.

Needs-based response

ⓘ a longer-term outcome of improved homeless services should be an increase in life expectancy of this population.

ⓘ the IHMS generally represents Main Applicants, not the partners and children of homeless people. In representing the true population of those who present at Council housing offices as homeless, statistics should routinely describe all applicants as well as Main Applicants (see Table 2, page 21)

Ⓟ ✓ The needs of homeless people will vary by age. A fifth of presentations are children. The potential years of healthy, independent living, employment, education and training, family life etc that are lost are very great. It should be the aim of services to identify each of these needs and engage homeless people where possible. Those who are older and have been in the homeless system for longer are likely to require systematic de-institutionalisation to prepare them for independent living.

7.6. Sex

The majority of homeless people in Glasgow are men - **Table 4** (see also Table 2, above). This observation may be biased because women and families use alternatives to statutory services, such as the 58 Women's Aid flats, although they may be legally or otherwise defined as homeless. However, it seems more likely that any bias in reporting male homelessness among single people is eliminated when families are included.[5] Table 4 also shows that by comparison the adult population in Glasgow has a slightly higher proportion of women than men over all.

Table 4 Sex distributions in Glasgow City Council, Rough Sleepers' Initiatives, Glasgow City Council hostels, and Greater Glasgow NHS Board mid-year population estimate from 2000.

Population	male	female
GCC presentations	68%	32%
RSI	73%	27%
GCC hostels	88%	12%
GGNHSB 2000	47%	53%

Much of the difference between the number of men and women presenting as homeless is made up of a much higher number of repeat presentations in men compared to women (see *7.13 Repeat homeless presentations*, page 33).

Summary point: homelessness in the sexes

- About two thirds of homeless people in Glasgow are male.
- It seems unlikely that this is purely an artefact, although more women may be hidden from statistics because they use non-statutory alternatives to homeless accommodation and services.
- There is less of a difference in the numbers of men and women who first become homeless but men tend to re-present much more.

Needs-based response

ⓘ It is not clear why men are poorer at resolving homelessness once it has occurred. Explanations that suggest that women have better social networks would be expected to affect initial presentation rates equally. There is a strong case for a research project to identify the reasons that men and women become homeless and re-present.

ⓘ The number of men who live in homeless hostels is particularly high compared to women. This may be partly because lack of hostel accommodation for women has obliged them to seek alternatives or be a further reflection of men's relatively poorer ability to resolve their homelessness.

Ⓟ ✓ It seems appropriate that communal homeless accommodation should remain separated for the sexes. The prevalence of domestic violence and sexual abuse indicates vulnerable populations. An exception to this must be made where accommodation for couples is provided.

7.7. Ethnicity

Data from 2001-2002 Rough Sleepers' Initiatives in Glasgow show that 99% of clients for whom details on ethnicity are available (over 95% of clients) are white.

A similar picture is found in presentations to Glasgow City Council although missing data in nearly a third of cases could mean that estimates are skewed, especially for smaller ethnic minorities. 97% of presentations are by white people, 2% are by British Asians, and 0.6% by British Black people - see Table 5.

Table 5 Ethnicity of all homeless presentations to Glasgow City Council, April 2001-March 2002

Ethnicity	Number	%	% known
Asian, Asian Scot/British: Bangladeshi	3	0.0%	0.0%
Asian, Asian Scot/British: Chinese	5	0.0%	0.1%
Asian, Asian Scot/British: Indian	38	0.3%	0.5%
Asian, Asian Scot/British: other	29	0.2%	0.3%
Asian, Asian Scot/British: Pakistani	32	0.3%	0.4%
Black, Black Scot/Black British: African	35	0.3%	0.4%
Black, Black Scot/Black British: other	10	0.1%	0.1%
Mixed	4	0.0%	0.0%
Not known	3495	29.4%	X
Other	92	0.8%	1.1%
Refused	1	0.0%	0.0%
White: Irish	14	0.1%	0.2%
White: other	31	0.3%	0.4%
White: other British	78	0.7%	0.9%
White: Scottish	8019	67.5%	95.6%
TOTAL	**11886**	**100.0%**	**100.0%**

Summary point: ethnicity

- Information on ethnicity is unavailable on nearly a third of presentations to the Council.
- Where data are available, both Rough Sleepers' Initiatives and Council data suggest that at least 97% of homeless people are white British people.

Needs-based response

ⓘ Greater efforts should be made to record ethnicity on all homeless presentations to the Council.
ⓘ No data are available to suggest whether there is a need for interpreting services or other specialist services for ethnic minorities who are homeless
ⓘ Ⓟ Further analysis of existing IHMS data would be possible to identify, for example, whether reasons for homelessness, re-presentation or other variables vary by ethnic group

7.8. Homeless families and household types

Homelessness in families is particularly important for several reasons. By definition, it affects several individuals. The impacts of disrupted education, poverty and any local support, such as friends and family, may have serious consequences for the rest of a child's life. And while the evidence to support the view that homeless children are more likely to become homeless adults and propagate a cycle of homelessness is restricted to one study[6], there is stronger evidence that cycles of deprivation and young teenage pregnancy occur within families.

The Hamish Allan Centre (HAC) is the largest single receiving centre overall for homeless people. Data in **Table 6** indicate homeless housing lists and it is important to note that a much greater number of individuals present to the Hamish Allan Centre; when they are referred to a neighbourhood office, their records change to the neighbourhood office. Just over half (52%, 6154/11900) of all homeless housing list applicants are on the Hamish Allan Centre list. Of this group, 92% are single people, 25% are single and under 25, and 59% are single and between 25 and 65 years old.

2178 (18.3%, 2178/11900) of all homeless applications had dependent children. Of this group, the majority (84%, 1833/2178) were by single parents - Table 6.

Table 6 Homeless housing lists, Glasgow City Council, by household type, 1st April 2001-31st March 2002. SP, single person; PaS, single parent; C, couple. Note that initial presentations to the Hamish Allan Centre may be transferred to non-HAC waiting lists thereafter.

	PaS≥25	PaS<25	SP18-24	SP25-65	SP>65	SP<18	C w/child	C no child	Other	TOTAL
HAC	208	73	1519	3611	80	464	70	75	52	6154
	(3%)	(1%)	(25%)	(59%)	(1%)	(8%)	(1%)	(1%)	(1%)	(100%)
Non-HAC	1173	379	937	2498	111	113	275	122	139	5746
	(20%)	(7%)	(16%)	(43%)	(2%)	(2%)	(5%)	(2%)	(2%)	(100%)
TOTAL	1381	452	2456	6109	191	577	345	197	191	11900
	12%	4%	21%	51%	2%	5%	3%	2%	2%	100%

Of families with children, the majority have one or two children - Table 7.

Table 7 Number of applications with number of dependent children. April 2001-March 2002.

No. dependent children	No. applications
1	1 074 (9.0%)
2	599 (5.0%)
3	250 (2.1%)
4	89 (<0.1%)
5	24 (<0.1%)
6	10 (<0.1%)
7	2 (<0.1%)
8	1 (<0.1%)
none	9838 (82.8%)
TOTAL	**11 887 (100.0%)**

All homeless families who present to GCC housing services are given accommodation and referred to the Homeless Families Unit, an NHS team based at the Hamish Allan Centre. Families are referred to neighbourhood housing offices as soon as possible, if they have not presented through a neighbourhood office in the first place. A Health Visitor is allocated to each family to make an initial assessment, including whether the family is engaged with existing community health and social services. Referrals to the Homeless Families Unit in May, June and July 2002 were 77, 67 and 88 respectively.

In addition to these families, 972 applicants reported having access/custody to a child living apart in 2001-2. A further 212 applications by 197 individuals were made that year in which a client was pregnant. The mean and median ages for these clients were 25 and 23 years respectively. This suggests that there is not a significant problem of teenage women becoming pregnant to obtain a house through homeless services.

The Homeless Families Unit identify the following key issues in their patients:

- educational disruption of homelessness
- lack of parenting skills
- drug use and its social sequelae
- diagnosing and treating physical and mental illness
- difficulties engaging general community health, local authority and voluntary services

Maintaining as stable school education as possible is crucial because it provides a constant feature in children's lives and because better educational attainment gives them greater opportunities as adults. Two critical factors influencing educational interruption have been identified: absence of rigorous attempts to rehouse homeless families close to their previous accommodation (providing they are not fleeing the area) and bureaucratic obstacles to getting bus passes so that rehoused children can travel to school. Children who disappear from a school role may be pursued using the City Test, which checks whether the child has been re-registered at another school within Glasgow. It may be the case that a child has not been re-registered with another school but is known to the Council's homeless or housing services and thus an additional check could be made.

A new service at the Homeless Families Unit will aim to enable parents to develop improved parenting skills. Providing day care alone does not help parents play with their children nor teach them communication and personal skills. There is also scope for further input into parenting skills through lessons learned from the Starting Well child health demonstration project in Glasgow.

Adults in homeless families, as with single homeless people, have many health, addictions and social problems. Engaging them with mainstream community-based services is an important need, because homeless families are disseminated widely throughout the city. There is scope for LHCCs and area-based social work and housing teams to provide support and training for staff so that the added work of caring for homeless families does not fall to a few interested individuals.

Summary point: families

- Homelessness in families is a particular priority for services.
- 1 in 6 homeless applicants have dependent children, totalling over 2000 family applications per year.
- It is not clear to what extent homeless families who present to neighbourhood offices are not entered onto homeless lists, further increasing the size of the homeless families population.

Needs-based response

ⓘ Ⓟ Clarification is needed about whether all homeless families are referred to the Homeless Families Unit

Ⓟ The Homeless Strategy, and the work of the Homeless Partnership, require to ensure that a comprehensive service to support homeless families is provided in both community and city-centre based settings. All members of the Homeless Partnership have a responsibility to stop cycles of homelessness within families.

ⓘ Ⓟ Where a child is de-registered from a Glasgow school, in addition to a City Test, the IHMS should always be searched to determine if the child is known to services provided by other parts of the Council.

ⓘ Ⓟ ✓ An important measure of the success of homeless services should be the proportion of homeless families with school-age children who are successfully registered and attend school.

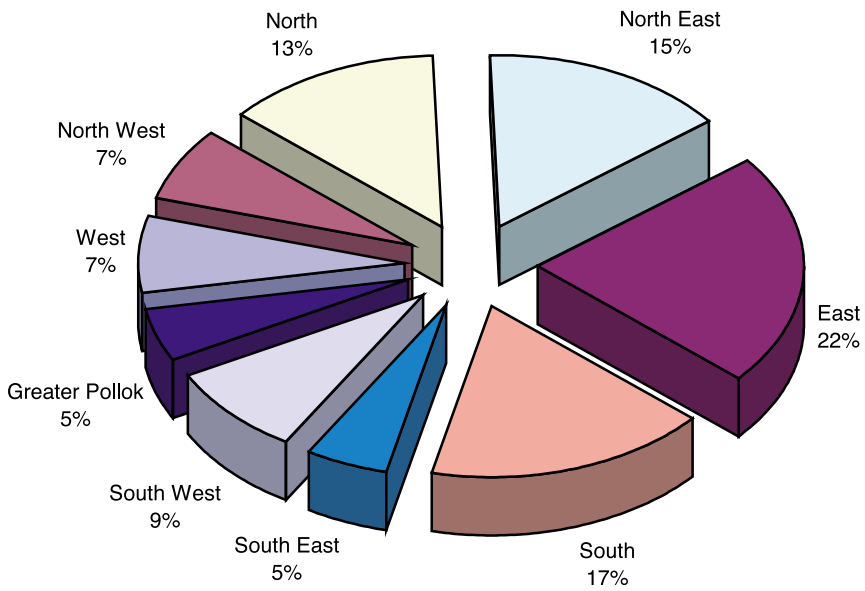
Ⓟ Unless a family with school age children is fleeing an area, they should preferably be rehoused in the same area.

Ⓟ ✓ The Starting Well demonstration project in Glasgow indicates ways in which effective support can be given to families of infants and children in deprived circumstances. Its potential to either inform or provide services for homeless families should be pursued by the Homeless Partnership.

7.9. Where do they come from?

Figure 3 indicates where people who present as homeless provide as a last or current address by Social Work geographical area teams (see Appendix 2), where codes can be given. Reliable data only became available in June 2002. The areas generating most homeless presentations are the East, North East and South, which account for over half of all presentations; however, all areas contribute to the homeless population. About 90% of presentations to Glasgow City Council come from Glasgow. Influx from other areas is not a major contributor to the homeless population.

Figure 3 Homeless presentations to GCC, June-November 2002 inclusive, by Social Work Area Team covering the client's last address.



Social Work area teams are not all the same size. Table 8 shows the number of presentations from each area over a 6-month period, with the rate per 1000 population. The average presentation rates across Glasgow is 19.3 per thousand adults, and the last column of Table 8 shows how much higher or lower each area is relative to this average. This shows that the East generates the greatest number of homeless applications per head of population while the North West generates the smallest number.

Table 8 Homeless presentations' current or last address, by Social Work Area Team. June-November 2002 inclusive, with estimated yearly rates. Does not include presentations where a SWAT could not be allocated.

Area team	Presentations	Per thousand population per year (est.)	% above or below average (est.)
West	329 (7.3%)	12.0	-38%
North West	303 (6.8%)	7.5	-61%
North	585 (13.0%)	22.3	+15%
East	989 (22.0%)	33.6	+74%
North East	672 (15.0%)	29.4	+52%
South West	395 (8.8%)	17.6	-9%
Greater Pollok	221 (4.9%)	11.8	-39%
South East	225 (5.0%)	17.0	-12%
South	767 (17.1%)	24.5	+27%
TOTAL	**4486**	**19.3**	**0%**

Summary point: geographical origins of homelessness

- All areas of Glasgow generate homeless people.
- The social work areas of the East, North East and South together generate over half of all homeless presentations.
- The primary prevention of homelessness, particularly in terms of employment, education, resolving family disputes and so on, is therefore a responsibility of agencies throughout the city.

Needs-based response

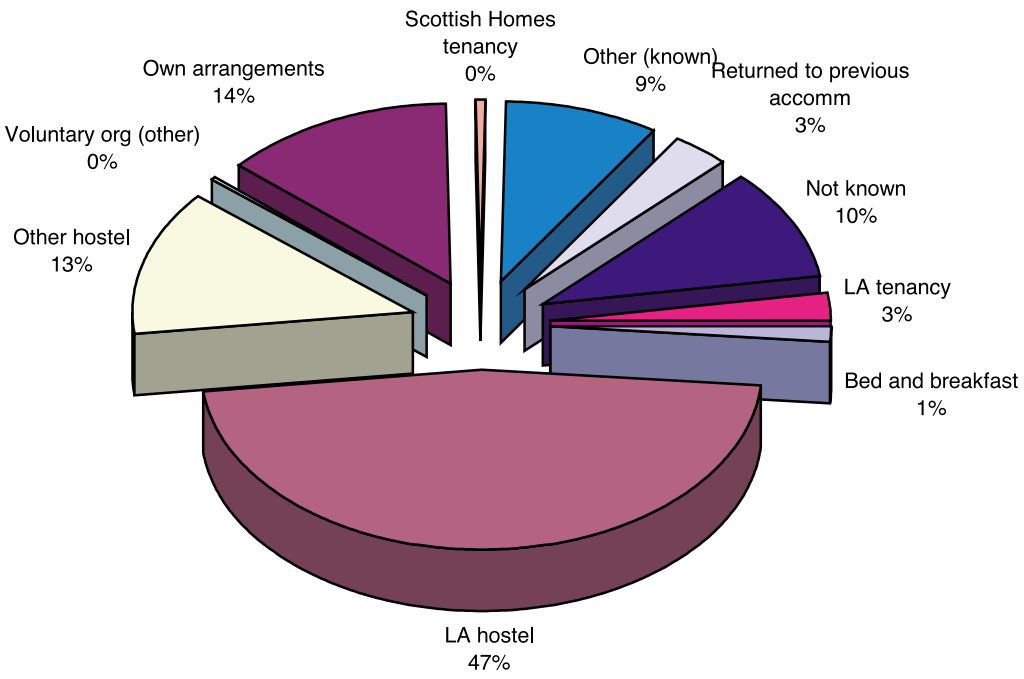
ⓘ The Social Work Area Team covering the area from which a person presents should be routinely recorded on the IHMS.

Ⓟ ✓ The size of the presenting population in each SWAT should guide the allocation of community-based resources, particularly those for the prevention of homelessness.

7.10. Where do they go?

Figure 4 shows that nearly half of homeless people who present to the Council are accommodated in GCC hostels, 1 in 6 make their own arrangements and about 1 in 8 are accommodated in other hostels. Very few - between 1/2 and 1 per cent - are accommodated in Bed and Breakfasts.

Figure 4 Placement decisions made by GCC housing offices for homeless people.



where <1%, pie shows 0%

Summary point: destination of homeless people after Council presentation

- Nearly half of all homeless presentations are accommodated in Council hostels.
- It is unclear where many people go who are classified as making their own arrangements, or not known.
- Those who return to their previous address may still be homeless.

Needs-based response

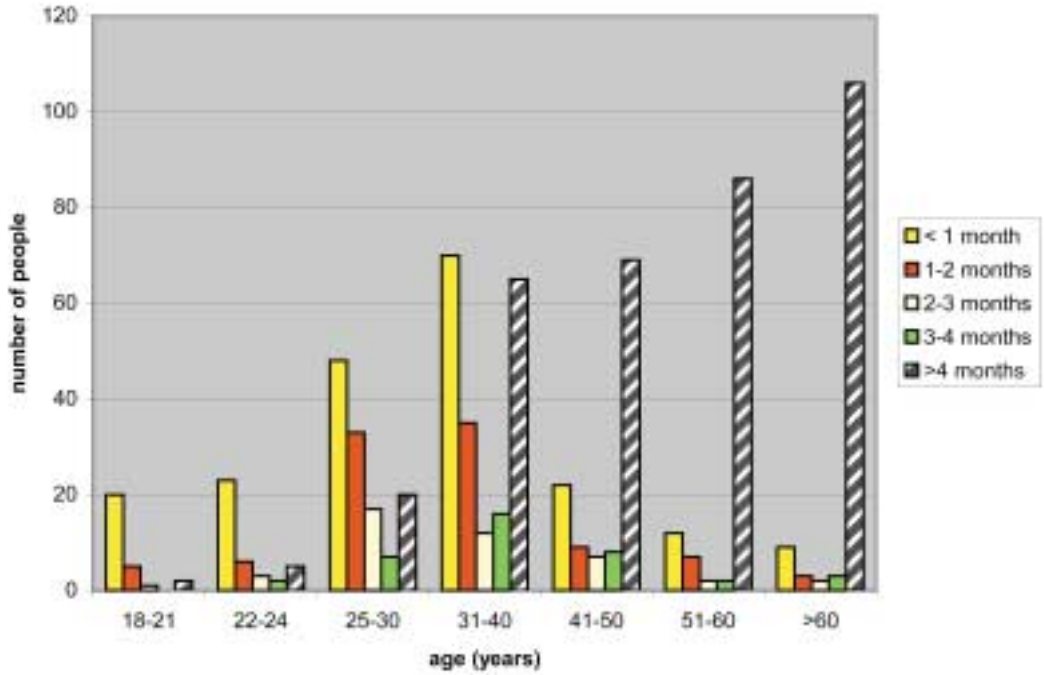
ⓘ A more comprehensive account is needed of where people who present as homeless go. In particular, "made own arrangements," and, "not known," may suggest continuing unresolved homelessness and are the recorded outcome in a quarter of all presentations

Ⓟ ✓ The size of the homeless population in any given SWAT (see also locations in page 28) should guide the allocation of resources for the prevention of homelessness.

7.11. How long do they stay in hostels?

There is a striking dichotomy between lengths of stay in hostels between younger and older residents - Figure 5. The majority of residents under 30 remain in hostels for only a few weeks, while above 40 residents usually have lengths of stay of over 4 months. It appears that the older group may remain in hostels for several years or decades. The implications for service provision is that the ability to engage with a client may be limited in younger groups, whereas there is potential to develop a longer-term therapeutic relationship with the older group. Given that two thirds of Council hostel dwellers are over 35 years old, a general pattern emerges of an older, more stable group.

Figure 5 Lengths of stay (months) in GCC hostels, by age. June 2002.



Summary point: lengths of stay in hostels

- Hostels work least well for younger residents, who are likely to remain for only a few weeks.
- Older residents appear to find some stability within hostels, with long lengths of stay.
- Longer lengths of stay allow greater engagement with health, social work, employment and other support services.

Needs-based response

Ⓟ ✓ The priority for providing alternatives to hostels should be for younger residents and younger presenting homeless people because hostels fail this group particularly badly, and younger individuals have the greatest number of years of life to benefit.
ⓘ Ⓟ A measure of the success of new accommodation services will be that they extend lengths of stay in younger residents.
Ⓟ ✓ Longer lengths of stay should be accompanied with systematic provision of a range of appropriate services for younger homeless people, including medical, psychiatric and addiction services, training and employment support, social work interventions, and any voluntary or private support services.

7.12. Why are people homeless?

Research from the Joseph Rowntree Foundation and CRASH (the Construction and Property Industry Charity for the Single Homeless)[55] summarised 200 research reports on single homelessness and came to the following conclusions:

- **Major economic and social forces** likely to affect the level of homelessness include shortages of suitable or affordable housing, availability of jobs, levels of poverty and social security, and trends in relationship breakdown and family re-structuring. However, there has been little rigorous research to show how national trends affect patterns of single homelessness at a local level.
- **Individual factors** linked to an increased risk of homelessness include low income, unemployment, sexual or physical abuse, family breakdown, school exclusion, poor mental health, drug and alcohol misuse, service in the armed forces and experience of local authority care or prison.
- **Events** most likely to 'trigger' homelessness among high-risk individuals include leaving the family home after arguments, relationship breakdown, eviction, bereavement, a sudden deterioration in mental health or increase in drug / alcohol abuse, leaving care, release from prison or discharge from the armed forces.

Table 9 shows the reasons given for being homeless by people who presented to GCC housing services. The answers are often about the accommodation circumstances that were left rather than underlying psychological or social determinants of homelessness. There is some duplication in categories but the most common reason (about a third of all) given among those who gave an answer was leaving parents or friends. 15% left a partner (whether violence was reported or not), 13% left a hostel or lodging house, and 12% left prison.

Table 9 Reasons for homelessness in presentations to GCC, April 2001 - March 2002.

Reason given	Number
friends/family not willing/able to accommodate	3775 (31.8%)
lost accommodation in lodging house/hostel	1551 (13.0%)
other	1550 (13.0%)
discharge from prison	1453 (12.2%)
separated from partner – non-violent	1025 (8.6%)
separated from partner - violent	711 (6.0%)
not available	265 (2.2%)
gave up secure accommodation	211 (1.8%)
left temporary accommodation	168 (1.4%)
action by landlord	154 (1.3%)
discharged from hospital	150 (1.3%)
emergency(fire, flood, storm, etc.)	124 (1.0%)
fleeing non-domestic violence	112 (0.9%)
arrears	111 (0.9%)
loss of tenancy - other	102 (0.9%)
harassment-other	93 (0.8%)
mortgage default	64 (0.5%)
court order-other	59 (0.5%)
expiry of short assured tenancy	45 (0.4%)
violent/abusive dispute with family	43 (0.4%)
racial harassment	32 (0.3%)
not reasonable to continue to occupy	26 (0.2%)
antisocial behaviour	24 (0.2%)
loss of service tenancy incl. armed forces	14 (0.1%)
overcrowding	13 (0.1%)
evicted from Women's Aid accommodation	5 (<0.1%)
house condition(e.g. order from envl. health)	5 (<0.1%)
youngster affected by domestic violence	2 (<0.1%)
TOTAL	**11887 (100.0%)**

Summary point: reasons for homelessness

- Data on reasons for homelessness tend to be circumstantial rather than indicating underlying reasons.
- About a third of all people who present as homeless simply say that their friends or family shall no longer accommodate them.
- Loss of hostel accommodation, discharge from prison, and separation from a partner are also common reasons for homeless presentation.

Needs-based response

Ⓟ ⓘ ✓ Further information on the events and decisions that resulted in homelessness is needed. It may be useful for this information to be gathered in a research project but the Integrated Assessment might be able to add more searching questions on reasons for homelessness.

7.13. Repeat homeless presentations

Re-presentation as homeless, particularly within a few months, might be regarded as evidence of the failure of homeless services to adequately address an individual's problems. How often does this happen? In a given year, most people (76%) present only once - **Table 10**.

Table 10 Number and percent of individuals making numbers of applications, 1st April 2001-31st March 2002.

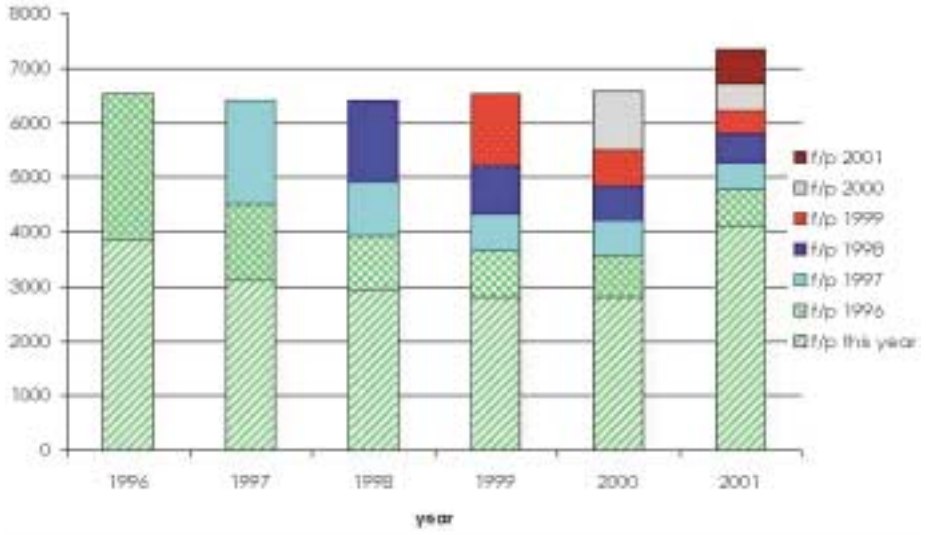
Applications/year	Number	%
1	5831	75.8
2	983	12.8
3	362	4.7
4	184	2.4
5-10	303	4
11-19	27	0.3
Total	**7690**	**100.0**

Figure 6 shows the number of individuals who made their first identifiable homeless presentation to Glasgow City Council each year (green hatched area). Those who first presented in a given year and re-presented as homeless (whether in the same or subsequent years) are shown in another year-specific colour.

Each column totals around 6500 individuals. The actual total number of individuals who present is higher than this, because it excludes individuals who first presented before 1996. For example, in 1996, 7805 individuals presented as homeless, although the bar in Figure 6 includes only the 6535 who first presented in that year.

In 1996, 3867 (59.2%) people presented for the first time and did not re-present that year. The remaining 2668 (40.8%) re-presented at least once within that year. The cohort of individuals who first presented in 1996 can be followed as the chequered lime-coloured bar. 1401 (21.4%) of them re-presented in 1997 and 984 (15.1%) re-presented in 1998.

Figure 6 Number of individuals making first and repeat homeless presentations to Glasgow City Council, 1996-2001. f/p=first presentation since 1992



Tables 11, 12 and 13 show the odds ratios of re-presenting with 95% confidence intervals.

Odds ratios describe the number of times more (or less) people with different characteristics are likely to re-present. One characteristic is chosen as the comparison and its odds ratio is always 1.

With smaller samples (for example, break in community care order) there is much more uncertainty in making generalisations from these data. 95% confidence intervals are statistical measures of the likely range within which the true figure lies. Where indicated with an asterisk, the results are statistically significant and are likely to indicate a difference that is not just due to chance alone.

Table 11 shows that, compared to over-34 year olds, 18-24 year olds are 1.3 times, or 30% more likely, to re-present. 25-34 year-olds are 1.7 times, or 70% more likely, to re-present.

Table 11. Odds of re-presenting as homeless, by age, 1999-2002.

Age (years)	odds ratio
18-24	1.3* (1.2-1.4)
25-34	1.7* (1.6-1.7)
>34	1.0

* significant at 95% level

Table 12 shows that, compared to women, men are 2.6 times, or 160% more likely, to re-present within the 3-year period.

Table 12 Odds of re-presenting as homeless, by sex, 1999-2002.

sex	odds ratio
male	2.6* (2.5-2.7)
female	1.0

* significant at 95% level

Data on reasons for homelessness are only available in about two-thirds of all presentations. Table 13 shows reasons for being homeless and associated likelihood of re-presenting[§]. The commonest reason given for being homeless is that friends or family will no longer accommodate an individual. Compared to this group, for example, those who report that their behaviour has led to homelessness are nearly 9 times more likely to re-present, those discharged from hospital (which may include psychiatric hospitals) are over 3 times more likely to re-present, and those who have lost their accommodation at a lodging house or hostel are at least 4 times more likely to re-present.

Conversely, those who are homeless as a result of an emergency are less than half as likely to re-present, and those who have separated from a partner are a fifth as likely to re-present. These make some intuitive sense, in that such events are more likely to be single rather than recurring events.

§ The proportions of people giving different reasons for homelessness is slightly different from those in Table 9 partly because of over-counting errors, which were less of a problem in more recent years.

Table 13 Odds of re-presenting compared to "friends or family won't accommodate," by reason given for being homeless, 1999-2002. 95% confidence intervals in brackets.

Reason for homelessness	number	Odds of re-presenting
behaviour	137 (0.2%)	8.8 (3.9-20.0)*
no fixed abode	2637 (4.5%)	6.7 (5.7-8.0)*
loss of hostel/lodging house accomm	2294 (3.9%)	4.4 (3.8-5.1)*
not available	19105 (32.6%)	4.1 (3.8-4.3)*
discharged from hospital	617 (1.1%)	3.5 (2.7-4.5)*
financial	68 (0.1%)	3.0 (1.5-6.4)*
evicted from GCC tenancy	74 (0.1%)	2.1 (1.1-3.9)*
evicted from HA	23 (0.0%)	1.9 (0.7-5.7)
left temporary accommodation	597 (1.0%)	1.5 (1.2-1.8)*
discharge from prison	3180 (5.4%)	1.4 (1.3-1.5)*
evicted from private tenancy	180 (0.3%)	1.3 (0.9-1.9)
gave up secure accommodation	902 (1.5%)	1.1 (0.9-1.3)
advice, not homeless	884 (1.5%)	1.1 (1.0-1.3)
family, friends won't accommodate	13868 (23.6%)	1.0
fleeing violence	2338 (4.0%)	0.9 (0.8-1.0)
break in community care	3 (0.0%)	0.8 (0.1-8.9)
other	3373 (5.7%)	0.6 (0.5-0.6)*
evicted, Women's Aid	24 (0.0%)	0.5 (0.2-1.1)
court order- rent arrears	49 (0.1%)	0.4 (0.2-0.7)*
overcrowding	47 (0.1%)	0.4 (0.2-0.6)*
emergency (fire, flood, storm, etc.)	451 (0.8%)	0.4 (0.4-0.5)*
refugee/asylum seeker	155 (0.3%)	0.4 (0.3-0.6)*
harassment - other	254 (0.4%)	0.3 (0.2-0.4)*
evicted from Scottish Homes tenancy	5 (0.0%)	0.3 (0.0-1.6)
loss of other social tenancy	92 (0.2%)	0.2 (0.1-0.3)*
loss of service tenancy	28 (0.0%)	0.2 (0.1-0.4)*
court order -other	125 (0.2%)	0.2 (0.1-0.3)*
youngster affected by domestic violence	7 (0.0%)	0.2 (0.0-0.8)*
action by landlord	516 (0.9%)	0.2 (0.1-0.2)*
split with partner	5494 (9.4%)	0.2 (0.2-0.2)*
house condition	8 (0.0%)	0.2 (0.1-1.0)
loss of LA tenancy - all reasons	64 (0.1%)	0.2 (0.1-0.4)*
loss of private sector tenancy	445 (0.8%)	0.1 (0.1-0.1)*
expiry of short assured tenancy	201 (0.3%)	0.1 (0.1-0.2)*
mortgage default	303 (0.5%)	0.1 (0.1-0.1)*
harassment - racial	120 (0.2%)	0.1 (0.1-0.2)*
TOTAL	**58668 (100%)**	

more likely

less likely

* significant at 95% level

Summary point: repeat homelessness

- Re-presentation as homeless is a key marker for failure to resolve the underlying reasons for homelessness.
- The majority of homeless individuals present once and appear to resolve their homelessness successfully.
- Over 20% of people present in subsequent years, falling into a pattern of chronic repetition.
- Being male and under 35 increase the risk of repeat homelessness.
- A cluster of reasons given for homelessness - antisocial behaviour, loss of hostel accommodation and others - suggest particular chaotic behaviour that remains unresolved.

Needs-based response

Ⓟ ⓘ ✓ Reduction in re-presentation as homeless should be a key indicator of the success of homeless services.

ⓘ Individuals vary in their risks of re-presenting. The effectiveness of any future services to resolve repeat homelessness should be judged on the background risk of clients.

✓ Discharge from hospital, prison, or homelessness due to financial reasons also increase the likelihood of re-presentation. These suggest that specific initiatives for these groups are required.

8. Information on needs

This section brings together information on needs gathered by Council housing officers, Rough Sleepers' Initiatives and an expert (normative) view based on a review of published literature.

8.1. Categories of Priority Need - GCC

Consideration of priority need is given to all people who present as homeless. About 80% of homeless presentations are deemed to be in priority need. The commonest priority needs are shown in Table 14. Alcohol and drugs problems affect about a third of all 1000 homeless presentations to the Council every month. 5% of presentations are deemed to be vulnerable because of mental illness.

Table 14 Categories of priority need on presentation to GCC housing services. Results from January-August 2002 inclusive. (Average number of presentations per month ~ 1000).

Category of Priority Need	Applicants	%Total
Vulnerable – drink/drug problem	2448	30.4 %
Not in priority need	1703	21.1 %
Household with dependent children	1008	12.5 %
Vulnerable – special reasons	533	6.6 %
Vulnerable – mental illness	438	5.4 %
Vulnerable - youth	370	4.6 %
Fleeing domestic violence/abuse	237	2.9 %
Fleeing non-domestic violence	234	2.9 %
Discharged from institution (e.g. prison)	226	2.8 %
Young person 16-17 yrs old	223	2.8 %
Household member pregnant	121	1.5 %
Vulnerable – medical condition	116	1.4 %
Vulnerable – physical disability	115	1.4 %
Vulnerable – old age	107	1.3 %
Lost contact/withdrew/resolved before offer	49	0.6 %
Asylum seeker/refugee	43	0.5 %
Vulnerable – learning disability	38	0.5 %
Emergency (fire/flood/storm)	29	0.4 %
Young person not categorised	18	0.2 %
Fleeing racial harassment	3	0.0 %
Total:	**8059**	**100.0 %**

8.2. Needs identified by RSI

Homeless people who present to the Council and to Rough Sleepers' Initiatives have almost identical age and sex profiles. Tables 15-20 indicate some of the principal findings from RSI projects in Glasgow. Tables 16-20 compare characteristics of rough sleepers with non-rough sleepers. An individual could give more than one answer, so total percentages may exceed 100%.

About 1 in 5 rough sleepers say that sleeping rough is their own decision, although 1 in 10 say they were asked to leave their last accommodation by family or friends, and a similar number say they were evicted from a Council hostel or their relationship broke down. One in 13 say that being released from prison, breakdown of a relationship, or drug use has resulted in them sleeping rough (see **Table 15**).

Table 15 Factors contributing to sleeping rough. RSI monitoring data, April 2001 - March 2002. Rough sleepers only (n=484).

Factors contributing to sleeping rough	RS
User decision	87 (18.0%)
Asked to leave (family/friends)	48 (10.0%)
Eviction - Council hostel	41 (8.5%)
Release from prison	38 (7.9%)
Relationship breakdown	37 (7.6%)
Drug use	35 (7.2%)

Table 16 indicates that drug use is a common problem for both rough sleepers and non-rough sleepers. Intravenous drug use, physical health and alcohol problems are reported in a third to a quarter of both groups. One in five reports family issues and mental health problems. Not surprisingly, the immediate physical needs of a sleeping bag or blanket, concerns over safety, and getting clothing are reported much more frequently by rough sleepers. What is perhaps more surprising is that non-rough sleepers report loneliness and isolation almost twice as commonly as rough sleepers.

Table 16 Problems identified by rough sleepers (n=484) and non-rough sleepers (n=832) in Glasgow, April 2001 - March 2002.

Problem	RS	Non-RS
Drug problem	233 (48.1%)	339 (40.7%)
IV problem	160 (33.1%)	224 (26.9%)
Physical health	142 (29.3%)	206 (24.8%)
Alcohol problem	138 (28.5%)	221 (26.6%)
Family issues	98 (20.2%)	201 (24.2%)
Mental health	100 (20.1%)	180 (21.6%)
Need sleeping bag / blanket	94 (19.4%)	7 (1.0%)
Safety	80 (16.5%)	90 (10.8%)
Relationship breakdown	45 (9.3%)	78 (9.4%)
Money problems	44 (9.1%)	81 (9.7%)
Drugs and Alcohol Problem	44 (9.1%)	62 (7.5%)
Accessing methadone prescriptions	43 (8.9%)	84 (10.1%)
Getting clothing	43 (8.9%)	32 (3.8%)
Loneliness/isolation	40 (8.3%)	119 (14.3%)

Table 17 shows that tenancy support needs are similar in rough sleepers and non-rough sleepers, although the former report drugs support more frequently. It is interesting to note that non-rough sleepers feel they need advice and information, practical support and support with money more often than rough sleepers. This may reflect that they are at a stage of planning a more settled and stable future or may indicate that those who want to access information and support are less likely to sleep rough in the first place.

Table 17 Tenancy support needs. RSI monitoring data, April 2001 - March 2002. Rough sleepers (n=484) and non-Rough sleepers (n=832) shown.

Tenancy support needs	RS	Non-RS
Support with drugs	153 (31.6%)	191 (23.0%)
Someone to discuss issues with	136 (28.1%)	220 (26.4%)
Advice / information	135 (27.9%)	330 (39.7%)
Practical support	123 (25.4%)	286 (34.4%)
Support with drinking	84 (17.4%)	147 (17.7%)
Support with mental health	60 (12.4%)	99 (11.9%)
Support with money	49 (10.0%)	124 (14.9%)

Nearly 4 in 10 rough sleepers have been banned from accommodation, compared to about 1 in 10 non-rough sleepers. **Table 18** indicates that of all those banned from accommodation, their own violent behaviour is the commonest reason, accounting for up to half of all bans. 1 in 6 have been banned due to drug use. Alcohol use, damage to property, and Council hostel eviction are commoner in non-rough sleepers. Although they comprise a relatively small proportion of all bans, it is notable that mental health is seen as a reason for accommodation bans in up to 1 in 20 cases.

Table 18 Reasons for accommodation bans. RSI monitoring data, April 2001 - March 2002. Rough sleepers banned (n=178) and non-Rough sleepers banned (n=99) shown.

Reasons for accommodation ban	RS	Non-RS
Own violent behaviour	74 (41.6%)	50 (50.5%)
Drug use	31 (17.4%)	17 (17.2%)
Rent arrears	26 (14.6%)	12 (12.1%)
Alcohol use	19 (10.7%)	21 (21.2%)
Damage to property	8 (4.5%)	8 (8.1%)
Eviction – Council hostel	5 (2.8%)	4 (4.0%)
Mental health	4 (2.2%)	5 (5.1%)

Table 19 confirms previous findings that homeless people are less likely to be registered with, and even less likely to use, a GP. Only 4 in 10 rough sleepers report being registered with a GP, but more importantly only 3 in 10 use their GP. The provision of a new PMS-funded GP practice for homeless people in Glasgow, and the work of the Homeless Physical Health Team, will be expected to lead to improvements in both of these indices through late 2002 and 2003.

Table 19 GP access. RSI monitoring data, April 2001 - March 2002. Rough sleepers (N=484) and non-Rough sleepers (N=832) shown.

GP access	RS	Non-RS
GP registered	206 (42.6%)	500 (60.1%)
Use GP	131 (27.1%)	367 (44.1%)

About a third of RSI clients had no income - **Table 20**. A third had been employed at some time in the past and this proportion was similar in both rough sleepers and other homeless people.

Table 20 Income and employment. RSI monitoring data, April 2001 - March 2002. Rough sleepers (N=484) and non-Rough sleepers (N=832) shown.

Income/employment	RS only	Non-RS
Income source	289 (59.7%)	589 (70.8%)
On benefits	144 (29.8%)	724 (87.0%)
Ever been employed	136 (28.1%)	255 (30.6%)
Seeking employment	53 (11.0%)	87 (10.5%)

Summary point: needs in Rough Sleepers' Initiative clients

- A variety of reasons for rough sleeping are given. Eviction from a Council hostel, release from prison and drug use together account for nearly a quarter of reasons given for rough sleeping and may be amenable to changes in service provision.
- RSI clients identify drugs problems, physical illness, alcohol problems, family issues and mental illness as the commonest problems they have.
- Their tenancy support needs reflect these problems and suggest there are opportunities to provide more information and advice.
- Less than half of rough sleepers, and only just over half of non-rough sleepers report being registered with a GP: but only two-thirds of these people actually use their GP.
- Around a third of RSI clients do not report having any income.

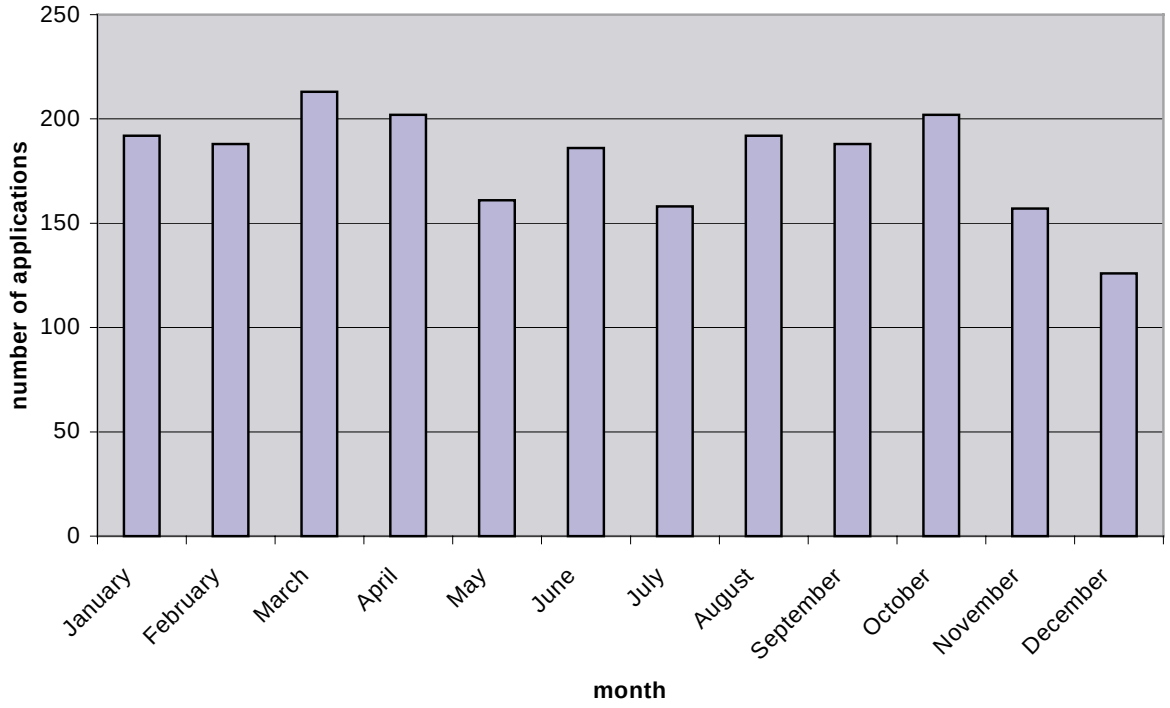
Needs-based response

Ⓟ ✓ In order to stop individuals choosing rough sleeping, attractive alternatives are required plus information and promotion of them.
Ⓟ ✓ RSI data support the need, identified in other sources of data, for a continued expansion of addictions, physical and mental health services.
Ⓟ ✓ Advice and information services, particularly on drugs, health and financial advice, are felt to be needed by RSI clients.
Ⓟ ✓ Services to ensure that the third of RSI clients who have no source of income receive any due benefits etc.

8.3. Rough sleeping identified by Glasgow City Council

About 1 in 6 homeless presentations to GCC say that they have slept rough in the past 3 months. Data became available in 2002 only - see **Figure 7** - and do not indicate any clear trend between warmer and colder months or over time.

Figure 7 Number of monthly presentations reporting that any applicant slept rough in the past 3 months, January-December 2002 inclusive



Summary point: rough sleeping

- Every month, about 175 homeless presentations report having slept rough in the past 3 months. There is no seasonal trend or downward trend through 2002.
- Arguably there are sufficient beds provided by Glasgow City Council to accommodate all rough sleepers; however they are regarded as being less attractive than rough sleeping.

Needs-based response

Ⓟ Current hostels can be made less unattractive by systematic changes such as separation of the most chaotic drug users from more stable ones, progressive reductions in the size of existing hostels, and addressing the needs identified by Rough Sleepers (see *8.2 Needs identified by RSI*)

Ⓟ ✓ Better, more attractive, alternatives (see *14.3 Reprovisioning*) to hostels are needed to reduce rough sleeping.

Ⓟ ✓ New accommodation and services require to be advertised and promoted so that potential rough sleepers are aware of the alternatives. Such information needs to extend to school pupils, servicemen and women, and prisoners.

8.4. Alcohol and drug problems in non-Council hostel dwellers

Social Work Services have estimated the prevalence of alcohol and drug problems in voluntary and private homeless accommodation - Table 21.

Table 21 Residential Services for homeless people purchased by GCC Social Work department. Note: R = Registered and UR = unregistered provision

Name	No of places	No full year admissions	A Estimated % (n) with primary drug problems	B Estimated % (n) with primary alcohol problems	Total A + B
Talbot Kingston UR	67	422	95% under 30's (207)	95% over 30's (194)	401
Talbot McTaggart UR	52	2	Nil	100% (52)	52
Talbot Govanhill UR	15	38	95% (36)	Nil	36
Talbot Buchanan R	40	21	90% (36)	Nil	36
Talbot Hill St R	20	1	5% (1)	80% (16)	17
Talbot Riverside R	12	9	U/k	U/k	
Simon Castlemilk R	6	16	16% (3)	21% (3)	6
Simon Dennistoun R	5	11	30% (3)	4% (0)	3
Simon Maryhill R	6	8	3% (1)	21% (2)	3
Simon Govanhill UR	15	94	30% (28)	43% (41)	69
Simon Tollcross UR	10	20	20% (4)	19% (4)	8
Salvation Army (Hope) UR	99				
Salvation Army (ECS) UR	52				
Salvation Army (OS) UR	40				
Church of Scotland Kirkhaven R	14	20	Nil	71% (14)	14
Total	453	662	319	326	645

9. Homeless hospital inpatient admissions in Glasgow

Scottish Morbidity Records for acute general hospital and psychiatric inpatient admissions (SMR1 and SMR4 respectively) from 1st April 1999 to 31st March 2001 were obtained from Greater Glasgow NHS Board's Information Services. Patients were identified by three criteria: having an address with a postcode that is specific to one of the large homeless hostels in Glasgow (Council, private or voluntary), an address coded as a temporary address, or as no fixed abode. It is important to recognize that, aside from postcode-specific hostel admissions, accurate information on homeless status is not routinely collected in hospitals and this paper gives a general picture only of hospital use by homeless people. In particular, rough sleepers, people living in overcrowded or unsuitable accommodation, or those at risk of losing their tenancies may not be identified.

9.1. SMR returns

In 1999-2000 there were 1814 inpatient admissions by homeless people and in 2000-2001 there were 1711. 2097 (59.5%) admissions were from postcode-specific hostel addresses, 843 (23.9%) from temporary accommodation, 583 (16.5%) with no fixed abode, and 2 admissions from learning disability accommodation. The mean (average) age was 49 years and ages were nearly normally distributed so the median age was 46 years.

9.2. Main diagnostic groups

Table 22 shows the major categories of diagnoses in 1999-2000 and 2000-01. International Classification of Diseases, 10th revision (ICD-10) codes are shown for reference. The commonest reasons for hospital admissions were injuries and poisonings (1 in 5 of all homeless admissions), mental and behavioural disorders (1 in 6 of all homeless admissions), symptoms and signs (1 in 8 of all homeless admissions), and circulatory diseases (1 in 9 of all homeless admissions).

Injury, poisoning and certain other consequences of external causes (S00-T98)
- largest diagnostic group (21%)
- head injuries (from superficial wounds to fractures) within this group comprise 10% of all homeless hospital admissions
- poisoning accounts for 4% of all homeless admissions

Mental and behavioural disorders (F00-F99)
- second largest diagnostic group (15% of all homeless admissions)
- mental and behavioural disorders due to psychoactive substance use (which include those due to alcohol)
- 7% of all homeless admissions were mental and behavioural disorders due to the use of alcohol
- schizophrenia, schizotypal and delusional disorder together make up 4% of admissions

Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)
- third largest diagnostic group (12%)
- symptoms and signs involving the circulatory and respiratory systems (including high blood pressure and chest pain) are the largest subgroup (5% of all acute homeless admissions)

Diseases of the circulatory system (I00-I99)
- 11% of all homeless admissions
- phlebitis and thrombophlebitis comprise 4% of all homeless admissions - likely to represent infections contracted from injecting drug use
- ischaemic and pulmonary heart disease were the second largest subgroup (2.5% of all homeless admissions)

Diseases of the digestive system (K00-K93)

- 9% of all homeless admissions
- largest subgroups were diseases of the oesophagus, gastritis and duodenitis which together comprise about 2% of all homeless admissions
- liver diseases, principally alcoholic liver disease, comprise 1.4% of all admissions

Diseases of the skin and subcutaneous tissue (L00-L99)

- 6% of all homeless admissions,
- 81% of this group is cellulitis, skin abscesses and other skin infections that were likely to be a consequence of injecting drug use

Diseases of the respiratory system (J00-J99)

- 6% of all homeless admissions
- chronic lower respiratory diseases (bronchitis, emphysema et cetera) comprise about 2.5% of all admissions

Other notable conditions

There were 15 cases of respiratory tuberculosis and 6 admissions for acute hepatitis B.

Table 22. Inpatient hospital admissions by homeless people in Glasgow, by diagnosis and year.

Main diagnosis	1999/00	2000/01	Total
Injury, poisoning and certain other consequences of external causes	341	386	727 (20.6%)
Mental and behavioural disorders	291	251	542 (15.4%)
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	279	231	420 (11.9%)
Diseases of the circulatory system	218	165	383 (10.9%)
Diseases of the digestive system	166	149	315 (8.9%)
Diseases of the skin and subcutaneous tissue	70	136	206 (5.8%)
Diseases of the respiratory system	123	90	213 (6.0%)
Disease of the musculoskeletal system and connective tissue	62	68	130 (3.7%)
Neoplasms	65	59	124 (3.5%)
Disease of the genitourinary system	57	32	89 (2.5%)
Diseases of the nervous system	40	30	70 (2.0%)
Factors influencing health status and contact with health services	29	33	62 (1.8%)
Certain infectious and parasitic diseases	30	36	66 (1.7%)
Endocrine, nutritional and metabolic diseases	15	16	31 (0.9%)
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	7	15	22 (0.6%)
Diseases of the eye and adnexa	12	8	20 (0.6%)
Pregnancy, childbirth and the puerperium	7	3	10 (0.3%)
Other congenital malformations		1	1 (<0.1%)
Conditions originating in perinatal period	1		1 (<0.1%)
TOTAL	**1814**	**1711**	**3525 (100%)**

9.3. Admission type

Over 70% of identifiable homeless admissions are non-injury emergencies - Table 23. Over 4% (146) of all admissions were self-injuries.

Table 23 Types of admission to hospital by homeless people in Glasgow, 1999-2001.

Admission type	Number (percent)
Emergency non-injury	1770 (50.8%)
Emergency - other injury	466 (13.4%)
Planned transfer	416 (11.9%)
Routine elective	251 (7.2%)
Urgent admission, no detail	235 (6.7%)
Emergency – self-inflicted	146 (4.2%)
Emergency (other, including transfer)	50 (1.4%)
Emergency admission – no detail	79 (2.3%)
Routine admission, no detail	39 (1.1%)
Emergency home accident	20 (0.6%)
Emergency - RTA	12 (0.3%)
Emergency not known	3 (0.1%)
TOTAL	**3488**

9.4. Discharge type

A relatively high proportion (12%) of homeless people discharge themselves against medical advice (irregular discharges). Table 24 shows the proportion of different kinds of discharges in common diagnostic groups among hostel dwellers and people with no fixed abode. It is possible that some of these irregular discharges were precipitated by inability of patients to receive heroin or methadone (particularly among drug-related conditions such as cellulitis and phlebitis). One reason for introducing Glasgow Drug Problem Service's (GDPS) liaison nurses in 2002 was that by providing hospitals with information on patients' methadone prescriptions these irregular discharges would be reduced.

Table 24 Type of discharge in homeless hospital admissions, 1999-2001. Hostel and no fixed abode admissions only shown, n=2684. Percent of each diagnostic group shown.

diagnosis	discharge type			total
	irregular	regular	died	
Head injuries	42 (13.0%)	279 (86.6%)	1 (0.3%)	322
Mental and behavioural disorders due to use of alcohol	26 (14.9%)	148 (85.1%)	0	174
Cellulitis and phlebitis (all)	51 (20.6%)	195 (78.6%)	2 (0.8%)	248
Others	195 (10.5%)	1688 (87.0%)	57 (3.3%)	1940
ALL	**314 (11.7%)**	**2310 (86.1%)**	**60 (2.2%)**	**2684**

9.5. GP registration

A high proportion of homeless admissions (91%, 3214) were recorded as having a GP. This figure is about 35% higher than expected from Rough Sleepers' Initiative findings in Glasgow over a similar period (see Table 19, page 40). This may suggest that the rate of GP registration among the wider homeless population is higher than usually reported, or may be an artefact because of over-reporting of GP registration on the Community Health Index. It may nevertheless be the case that despite being registered with a GP, individuals are unable to access the service.

9.6. Lengths of stay

Lengths of hospital stay give a better indication than numbers of admissions of the health service resources required. Over two years, 33 958 bed-days - the equivalent of having nearly 93 inpatient beds fully occupied each year - were identified as being used by homeless people**.

Lengths of stay vary by specialty and by whether an admission is an emergency or planned (elective). Accident and Emergency has an average length of stay of just over 1 day, and Psychiatry of Old Age an average stay of 179 days - see Table 25.

Table 25 Twelve largest specialties receiving homeless hospital admissions in Glasgow, 1999-2001. Continuous inpatient stays over 2 years excluded.

Speciality	Number (%)	Average LOS* (days)	Total LOS* (days)
General medicine	1525 (43.3%)	4.5	6848
General surgery (excl. vascular)	408 (11.7%)	2.5	1015
General psychiatry	365 (10.4%)	106.9	39029
Accident and Emergency	324 (9.3%)	1.2	390
Orthopaedics	186 (5.3%)	5.9	1097
Urology	92 (2.6%)	4.7	434
Gastroenterology	76 (2.2%)	5.6	425
Geriatric medicine	52 (1.5%)	23.4	1219
Communicable diseases	48 (1.4%)	11.2	535
Psychiatry of old age	26 (0.7%)	179.1	4657
Vascular surgery	13 (0.4%)	9.9	129
Oral surgery	7 (0.2%)	3.7	26
Other	365 (10.5%)		
TOTAL	**3487 (100.0%)**		

* excludes continuous hospital stays of over 2 years

9.7. Specialties

Table 25 shows the twelve largest specialties receiving homeless people and largely reflects the major diagnoses shown in Table 22. General medicine receives two fifths of admissions, including wound infections, alcohol-related admissions, poisoning and a proportion of signs and symptoms (particularly chest pain). General surgery and A&E will receive head injuries (except in the South, where orthopaedics takes them) and general surgery will receive some symptoms and signs, such as abdominal pain.

9.8. Hospitals

Glasgow Royal Infirmary receives over two fifths of all homeless hospital admissions and the Southern General Hospital just over a fifth (Table 26). This is likely to directly reflect the large hostel population in the centre and east of Glasgow city, but may fail to account for admissions from the large number of temporary furnished flats for homeless people, which are more widely dispersed throughout the city.

** This figure excludes data where individual lengths of stay are longer than 2 years because of continuous hospital stay that started before 1999.

Table 26 Inpatient episodes for homeless people in Glasgow, 1999-2001.

Hospital	Number (%)
GRI	1339 (42.6%)
Stobhill	128 (3.6%)
Victoria Infirmary	265 (7.5%)
Western Infirmary	495 (14.0%)
Southern General Hospital	729 (20.7%)
Parkhead Hospital	122 (3.5%)
Gartnavel Royal Hospital	110 (3.1%)
Leverndale Hospital	108 (3.1%)
Other	229 (6.5%)
TOTAL	**3525 (100.0%)**

9.9. Comparison with the Scottish population

It is not possible to calculate accurate standardised admission (or, more correctly, discharge) ratios to compare the homeless population with other groups, because the size, age and sex constitution of the homeless population is not known with sufficient accuracy. However, a broad comparison can be made with the Scottish population.

In a year, a population of 100 000 people in Scotland would be expected to generate 24 088 general hospital discharges[7] - that is, not including psychiatric admissions or obstetrics. If person-specific discharge rates were the same in the homeless population, the 3083 general discharges in the two years between 1999 and 2001 would be expected to be generated by a homeless population of 6399 adults. Given that it is estimated that at least 7690 people are homeless in Glasgow every year, it can be said that this does not suggest that the homeless population has a higher admission rate than the general population. However, missing data may make this an underestimate of the true use of hospital care by homeless people.

In terms of the diagnostic casemix, homeless people present an unusual profile. Differences in the 5 commonest reasons for hospital admission in Scotland are significant in all cases for the homeless population (see Table 27). The largest differences are in having over twice the proportion of all admissions for injury and poisoning and about a quarter the proportion of admissions for cancer (malignant neoplasms) and heart disease. These differences cannot simply be explained by the younger age profile of homeless people, because hostel dwellers have a very similar age profile to the general population. The explanation is likely to be that these figures reflect differences in the distribution of overall needs rather than absolute differences in disease-specific admission rates.

Table 27 Comparison of common reasons for hospital admission between Glasgow homeless and Scottish population. Percent of all hospital admissions (excluding obstetrics and psychiatry) in Scotland, 1999, and in Glasgow homeless 1999-2001. (95% confidence interval shown in brackets).

Diagnosis	ICD-10	Scotland	Glasgow homeless
Disease of the digestive system	K00-K93	14.1%	8.9% (8.0-9.8%)
Malignant neoplasms	C00-C97	11.0%	2.6% (2.0-3.2%)
Symptoms, signs & abnormal clinical findings…	R00-R99	10.7%	11.9% (10.8-13.0%)
Injury, poisoning & certain other consequences…	S00-T98	8.7%	20.6% (19.2-22.0%)
Heart disease	I00-I52	7.7%	2.0% (1.5-2.5%)

9.10. Summary and hospital data

Summary point: hospital admissions by homeless people

- In 1999-2000 there were 3525 hospital inpatient admissions by homeless people
- There is no evidence that homeless people in Glasgow were admitted to hospital more often than the general population. If this is true and not solely an artefact of the incompleteness of the data, then it seems likely that it represents an under utilization of hospital care by a population with a high level of morbidity and health care needs.
- The commonest reason for admission is injury and poisoning, which comprise 2.5 times the proportion of all admissions compared to the general Scottish population.
- Symptoms and signs, and diseases associated with injecting drug use are also prominent.
- A relatively high proportion of homeless people discharge themselves from hospital against medical advice.
- Glasgow Royal Infirmary and the Southern General Hospital together receive about two thirds of all homeless admissions, although all of the receiving Glasgow hospitals contribute to the acute care of homeless people.
- If new services to improve the health of homeless people (new PMS practice, Homeless Physical Health Team, Homeless Addiction Team, Homeless Mental Health Service) are effective, a number of changes might be seen in future hospital data. The overall rate of admissions may rise if those in need are more successful in obtaining appropriate hospital care. However, some diagnoses, such as injuries, poisonings, and diseases associated with alcohol excess and injecting drug use, would be expected to fall if preventive services and primary care become more effective. It may be that the symptoms and signs group represents minor or self-resolving illness that might otherwise have presented to a GP, and that better provision of primary care will reduce the excess of these admissions. Discharges against medical advice might also be expected to fall as a result of GDPS liaison nurses' work. As large city centre hostels close, there may be modest reductions in the proportion of homeless people treated at Glasgow Royal Infirmary in favour of other Glasgow hospitals.

Needs-based response

ⓘ consistent definitions for homelessness need to be used by the NHS if a complete picture of homeless health service use is to be created (see *7.2 Who are they?*)

ⓘ it seems very likely that GP registration rates among the homeless are greatly over-estimated in hospital data; it is not clear how this affects assumptions about continuity of primary care after discharge

ⓘ there are many gaps in information about the needs of homeless people, including the size and scale of nutritional deficiencies, and physical and mental disabilities.

Ⓟ ✓ improvements in specialist homeless health services should affect the use of hospital services, although changes require careful interpretation (see above)

Ⓟ ✓ improvements in continuity of care between specialist homeless services and hospital services should reduce discharges against medical advice

Ⓟ ✓ a broad range of acute and chronic illnesses exists among the homeless population; GGNHSB protocols and practises for these conditions should extend to homeless people.

10. Deaths in homeless people

Total deaths in the large-hostel population in 1999, 2000 and 2001 were 69, 76 and 52 respectively - **Table 28**. Data for 2001 are provisional, and the lower number of deaths is likely to be an artefact of incomplete death record returns.

Several causes of death are recorded on a death record - the main cause of death itself and several predisposing factors. Broad categorizations have been created to describe the main causes of death in Table 28. Alcohol and heart disease were each cited as a main part of the cause of death in at least 1 in 5 deaths; cancers accounted for about 1 in 6 deaths; drugs were cited in at least 1 in 8 cases; and suicide or undetermined cause of death was named in at least 4% of deaths.

To understand whether there are more deaths than expected, it is necessary to compare them to the expected deaths in a Scottish population with the same age and sex distribution. At the time of writing, important data on the exact age and sex throughput of hostels were not available. In 1999, one would have expected 12 deaths in the hostel population if age-specific death rates were the same as the Scottish population. There were 56 deaths. The crude mortality ratio in 1999 was therefore 478 (95% CI 353-604), or nearly five times higher than the general population. Although caution should be used in interpreting this figure, because the turnover of the hostel population increases the actual size of the population from which the data come, they do suggest that deaths are significantly higher in the hostel population compared to the rest of the population.

Table 28 Deaths in homeless hostel dwellers, 1999-2001. 2001 data are provisional

Cause	1999	2000	2001
Drugs, opiates	8 (11.6%)	12 (15.8%)	12 (23.1%)
Alcohol	22 (31.9%)	14 (18.4%)	17 (32.7%)
Suicide & undetermined	5 (7.2%)	3 (3.9%)	3 (5.8%)
Heart disease	14 (20.3%)	15 (19.7%)	3 (5.8%)
Cancers	11 (15.9%)	12 (15.8%)	5 (9.6%)
Other	9 (13.0%)	20 (26.3%)	12 (23.1%)
TOTAL	**69**	**76**	**52**

It is useful to see the age distribution of these deaths so that appropriate preventive measures might be targeted most effectively. Table 29 shows the number of deaths at different ages for 4 common causes of death in homeless people. The majority of alcohol-related deaths and heart disease occur between 40 and 64, while those caused by drugs peak between 30 and 34 years. The small numbers of suicides makes valid generalisations difficult, but it is of concern that over half of the 11 suicides occurred before the age of 40.

Table 29 Ages of death, by cause, among homeless hostel dwellers in Glasgow, 1999-2001 (provisional). V = 1 death.

	Cause of death			
age	**alcohol**	**drugs**	**heart disease**	**suicide**
15-19				V
20-24		VV		
25-29	V	VVVVVVVV		V
30-34		VVVVVVVVVVVVV		VV
35-39	V	VVVV		VV
40-44	VVVVVVV	V	VVV	
45-49	VVVVVVVV	VVV	VVVV	V
50-54	VVVVVVVVVV		VVVV	VVV
55-59	VVVVVVVV		VVV	V
60-64	VVVVVVVVVV	V	VVV	
65-69	VVVVV		VVVVVVVV	
70-74	VVV		VVVV	
>74			V	
TOTAL	**52**	**32**	**30**	**11**

Summary point: deaths in homeless people

- Insufficient data are available to account for all deaths in homeless people in Glasgow; only deaths among hostel dwellers are reported here.
- Death rates in hostel dwellers are several times higher than expected.
- Deaths from excessive alcohol intake, drug use, and suicide are higher than among the general population.

Needs-based response

Ⓟ ⓘ ✓ It might be expected that, while the course of many chronic diseases will not be changed in the short term, improvements in the threatening and intimidating environment of hostels, and more support within hostels, plus alternatives to hostels, will reduce suicide rates and drug-related deaths.

11. Notifiable diseases

A further indication of the health of homeless people can be gained from reports of notifiable diseases to Greater Glasgow Health Board.

Table 30 shows notifications to Greater Glasgow Health Board by each large hostel. Expected annual new cases have also been estimated. Data were searched by hostel name, address, and postcode. The commonest three notifiable diseases are hepatitis C, tuberculosis, and hepatitis B. Both forms of hepatitis are most likely to be have been contracted through sharing drug injecting equipment with carriers of these viruses, although they may also be acquired through unprotected sex, tattooing and other, less common, routes. Tuberculosis is usually a manifestation of re-activation of an old infection as a result of poor general health and it is often associated with older people who drink heavily. These characteristics are reflected in the average age of people with these conditions. The average age of notifications for hepatitis B and hepatitis C are 32 and 30 respectively, while the average age for tuberculosis notifications is 54. There were a small number of other infections - chest infections (atypical mycobacteria), and food poisoning by campylobacter bacteria and other causes.

The particularly high rate of notifications of hepatitis C at Robertson House raises questions about whether an infectious carrier was present.

It should be possible to measure the impact of any interventions to reduce exposure to hepatitis B and hepatitis C - such as through hepatitis B vaccination, methadone prescribing, safer-sex promotion, needle exchanges and education - within a relatively short period.

Table 30 Notifications of infections to Greater Glasgow NHS Board. 1st January 1999-1st August 2002.

hostel	hepB	hepC	TB	atypical myco	campylo bacter	food poisoning	Population
Norman Street Hostel	3	2					107
James Duncan House	1	1	1			1	242
Peter McCann House	4	5	7	1			253
Laidlaw House	3	2	2		2		239
Inglefield Street Hostel	2	4					77
Robertson House		12	7				240
Hope House		3					99
Kingston Halls				1			67
Bellgrove Hotel		1	5				215
TOTAL	**13**	**30**	**22**	**2**	**2**	**1**	
Ann. incid. (estimated)	**8**	**19**	**14**	**1**	**1**	**<1**	

Summary point: notifiable diseases in homeless hostel dwellers

- There is a high incidence of infectious diseases that result from injecting drug use, chronic alcohol use and poor personal hygiene.

Needs-based response

Ⓟ Tuberculosis. Active outreach of health services, with increased vigilance and clinical surveillance (including BMIs, sputum samples, use of standard screening questionnaire), rather than conventional tests such as Mantoux/Heaf test, chest x-ray etc, is recommended. Better nutrition and management of alcohol dependency should also contribute to improved resistance to tuberculosis.

Ⓟ Blood borne viruses. A range of effective interventions is available and should be put into place, namely

Primary prevention through separation of stable, non-injecting drug users from injecting ones; combined hepatitis A & B vaccination of all hostel dwellers; provision of barrier contraceptives; education on safer sex and safer injecting practices; needle exchange

Secondary prevention through earlier detection and management of HIV, hepatitis A, B & C, referral to specialist services

ⓘ Ⓟ Gastrointestinal infections are likely to be greatly under-reported. Improvements in personal hygiene, and handling of food (including obtaining higher quality food outwith hostels) are required to reduce gastrointestinal infections.

12. Morbidity projections from ONS

The Office of National Statistics survey[8] of 225 homeless people that was carried out in August 1999 in Glasgow provides information on self-reported health and well-being. The sample represents the stable hostel population and a sample of rough sleepers, rather than the larger number of individuals passing through Council, RSI projects or other homeless circumstances (see **Figure 2**). In addition, because information is self-reported, there are some notable omissions (such as hepatitis B, hepatitis C, and HIV) and the validity of reported diagnoses and behaviours cannot be confirmed.

In order to get an impression of the likely numbers of people with different conditions in different parts of the homeless services, age-adjusted estimates have been produced below. These indicate the monthly number of presentations to GCC housing services and the numbers within GCC hostels.

Table 31 shows projections of likely numbers of homeless people with health or health-behaviour problems. Every month, about 1000 people present to the Council's housing services, so that the numbers with hazardous drinking or who are drug injectors is very large. It might therefore be suggested that the need for health and addictions services is several times greater among those presenting to homeless services than among those who are established within them.

It is interesting to consider how these self-reported data are reflected in the hospital admission diagnoses shown in Table 22 (page 44). The high prevalence of hospital admissions for head injuries, infections related to drug injecting, and mental and behavioural disorders due to the use of alcohol, all confirm that these self-reported conditions are both highly prevalent and impact upon secondary health care services.

Table 31 Common health problems. ONS survey data used to estimate numbers of homeless presentations to the Council every month (Monthly), every year (Yearly), numbers of people with these conditions who have not been homeless before (New, yearly) and numbers with these conditions at any point in time in Council hostels (point prevalence).

condition	Monthly	Yearly	New, yearly	Point prevalence
Hazardous drinking	506	6072	2024	440
Regular drug injector	318	3816	1272	180
Neurotic illness requiring treatment	338	4056	1352	223
Probable psychosis	69	828	276	48
Smoker	927	11124	3708	690
Both hazardous drinking and drug dependence	212	2544	848	110

The ONS survey extends to questions on education, employment, stressful life events, and health-related behaviour such as smoking. 19% of all respondents had been in local authority care as a child, with 34% of 16-24 year olds in particular reporting childhood institutional care.

Summary point: headlines from the ONS survey

- The ONS survey confirms that hazardous drinking, injecting drug use, and mental illness are highly prevalent among hostel dwellers.
- It omits some important conditions, such as blood borne viruses, and is subject to personal interpretation because data are self-reported.

Needs-based response

ⓘ Ⓟ It is expected that the new Integrated Assessment of homelessness will provide much ongoing routinely available information on homeless people and their wellbeing and that a repeat survey may not be necessary. However, a report comparing the findings of the ONS survey of 1999 with subsequent years may provide a helpful indicator of progress in improving the wellbeing of homeless people in Glasgow.

13. Literature review

This section describes findings from published and grey literature as well as expert views. Together, these can be considered descriptions of normative need.

Eleven reports were commissioned as the Homelessness Task Force research series. They comprised a mixture of literature reviews and analyses of data on homelessness. There were two main strands to these reports - "understanding homelessness," and, "what works." All reports were, however, largely descriptive because there is limited research evidence to describe effective interventions to benefit homeless people. A number of the reports drew largely from expert views of good practice. The themes explored in the descriptive strand of the Homelessness Taskforce reports were:

- a quantitative analysis of structural trends and homelessness[9]
- a profile of homelessness in Scotland[10]
- a review of the evidence on pathways through homelessness[11]
- a description of how people resolve their homelessness[12]
- a description of the characteristics of repeat homelessness[13]

and the themes explored in the research on what works were:

- good practice towards homeless drug users[14]
- the future of hostels for homeless people[15]
- the role of housing management in preventing homelessness[16]
- the role of family mediation in preventing homelessness[17]
- models of intermediate accommodation[18]
- life skills training for homeless people[19]
- good practice in joint working on homelessness
- a review of the eligibility criteria under the homeless persons legislation

A literature review performed by Penrice[20] in 2001 brings together a comprehensive review of published literature from biomedical peer-reviewed journals. **Table 32** presents the main findings. The methodology for this review is given in **Appendix 4**. In many cases, local data from the Glasgow homeless population are available to support these findings.

Table 32 Summary of a literature review on homelessness by Penrice[20].

Mental health	• Homeless people are eight to eleven times more likely than the general population to report mental illness (depression, anxiety or nerves)[8,21] • Between 25% and 50% have a severe mental health problem[22,23] • 50% of hostel dwellers have a mental illness[24] • 66% of older homeless people reported having, or were demonstrated as having, mental health problems[25] • 57% of rough sleepers have some form of mental health problem,[26] 8% of them suffer from psychosis.[27]
Drug misuse	• Up to two thirds[28,29] of 25-34 year single homeless have drug misuse problems[8] • For half of this group, the main drug of misuse was heroin[8]
Alcohol misuse	• One third to one half of rough sleepers and hostel dwellers[8,30,31] and one half of older homeless people have a serious alcohol problem[25]
Physical problems	Common health problems include: • Musculoskeletal problems; • Skin problems; • Poor dental health; • Infectious diseases including TB, gastroenteritis and skin infestations[21] especially in the older homeless population[31]
Women and children	High level of • Physical illness[32,33,34] • Developmental delay[35] • Behavioural disturbance among children of homeless families[36] • High level of mental health problems in both children and mothers[37] • Homeless women and children have many risk factors including domestic violence, abuse and family and social disruption[37, 38]
Mortality	• Lower life expectancy (between 42 and 53 years versus 74 years)[39] • Four times more likely to die from unnatural causes such as assaults and accidents[31] • 35 times more likely to commit suicide compared to the general population.[40]

13.1. Improving access to primary care

Improving access to primary care for homeless people presents a major challenge.[41] The two principal models of provision are:

- **Targeted** specialised primary care services on a fixed site, via an outreach team, or a combination of both, and
- **Mainstream** primary care services with or without health or non-health workers acting as guides and advocates to facilitate access to services

While many homeless people prefer to have their own specialist services[41] with open access rather than fixed appointment times,[43,42] there are concerns that these might add to the segregation of homeless people.[43] Services provided temporarily may also be of poorer quality because medical records are not available.[44] An alternative is to provide appropriate and accessible services to homeless people through mainstream primary care.[45] Research suggests that health care workers, such as district nurses[46] or health visitors[42], can help homeless people engage with services (including non-health services), assess their needs, and prepare them for further health care. Healthcare workers' roles in collaborating with general practices who will fully register homeless people and who will have both the time and the ability to address their complex needs are not discussed in the literature.

Special funding and contractual arrangements may be needed in primary care as it is acknowledged that successfully managing the complex needs of vulnerable groups such as the homeless can be difficult under existing arrangements.[47]

Options to be considered locally for improving access to primary care services, include
- Access to mainstream GP services in the community
- Developing a PMS GP service
- Other area-based primary care responses for homeless people (e.g. through social work area teams, community addiction teams, LHCCs, etc)

13.2. Mental health services

Outreach services have been shown to be effective in engaging the mentally ill in treatment and improving mental health status and quality of life more than conventional case management.[48,49] A form of community outreach known as assertive community treatment has been evaluated in this country and the USA as being effective.[50,51,52]
The main themes that emerge from the literature as being important in providing services for homeless mentally ill population includes: -
- Establishing dedicated community mental health teams;[53]
- Ensuring these community teams have close links to established adult mental health teams[54] and with colleagues in social care settings.[53]

13.3. Drug misuse services

Risk factors for homelessness - such as a history of family disputes, experience of childhood abuse and offending behaviour - are also those that can trigger drug abuse. [55,56]

There is evidence that drug users who are homeless and who have complex and inter-related needs face difficulties accessing services including drug treatments.[57]

A recent good practice report towards homeless drug users[57] highlighted the problems of accessing services as: -
- The lack of supportive GPs in some areas who are willing to prescribe substitution therapy;
- Long waiting lists of GPs as they may only prescribe for a limited number of patients;
- Strict appointment systems.

The complexity and diversity of individual drug users' needs and the variety of types of services in operation make it difficult to make generalisations about good practice.[57] However, the literature does describe examples of initiatives that have been effective. These include: -

- The use of outreach workers to connect people with services; [56]
- "One-stop shops" that provide access to a range of services.[58]

Summary point: literature review

- There is limited information on what is most effective in homeless practice.
- Descriptive reports from other homeless populations confirm similar health problems to those described in Glasgow.
- Homeless people prefer specialist services designed for them but there are political and practical arguments in favour of improving the quality of services for homeless people in mainstream services.

Needs-based response

ⓘ New services for homeless people present important opportunities to evaluate what works and what does not work. Evaluation of effectiveness should be part of all new homeless services in Glasgow.

14. Hostel residents' views

Glasgow Homelessness Network commissioned qualitative research on hostel dwellers through focus groups held at:

- GCC hostels - Laidlaw House, Robertson House, James Duncan House and Inglefield Street hostel
- The Wayside Day Centre
- Glasgow Simon Community Govanhill Women's Project
- Talbot Association's Kingston Halls

The age and sex profile of participants was typical of the hostel population, although responder bias may mean that more articulate, more healthy or in other ways unrepresentative participants may have contributed.

14.1. Hostel closure and service re-provisioning programme

A general observation from the survey undertaken by GHN is that hostel dwellers feel they have been given inconsistent and insufficient information about the proposed programme of hostel closures and reprovisioning. Although this needs to be addressed it should be noted that even at the time of writing the draft Strategy on the Prevention and Alleviation of Homelessness does not have an implementation plan.

A number of recurring themes have emerged - see **Table 33**.

Table 33 Closure of hostels: positive and negative aspects expressed

Positive	Negative
Current hostels too large	Uncertainty about where people will go, particularly vulnerable people
Little or no support at present	Rough sleeping might increase if reprovisioning not properly managed
Anonymous, de-individualised	Loneliness and isolation following closure
Drugs problems unmanageable by hostel staff	

14.2. Hostel closure and resettlement

A number of key themes are already emerging as perceived obstacles to resettlement or failure of resettlement:

- Fear of change
- Fear of being unable to manage outwith the hostel environment
- Loneliness and isolation
- Lack of practical daily living skills
- The negative effects of institutionalisation
- Untreated / unresolved addiction problems
- Lack of appropriate services in the community
- Lack of family support
- Unwillingness to move into tenancy

Hostel dwellers have identified three distinct groups of people currently living in hostels:

- People who want to move to a tenancy and have sufficient skills and resources to do so
- People who say they want a tenancy, but who do not have sufficient skills and resources to do so (some may believe that they do, however)
- People who want to stay in a hostel, whether or not they are able to live successfully in a tenancy. Lack of responsibility in hostel living is considered valuable. This group includes:
  - older people who may have alcohol problems, are institutionalised and whose main friendships and social support structures are within the hostel environment
  - younger people who are drug users, who are not yet facing major health and social consequences as a result of their substance use, and who do not want to address their substance misuse

14.3. Reprovisioning

Focus group participants have made the following recommendations:

- Smaller units should be commissioned to replace large-scale hostels (average 25-30 residents)
- Appropriate support, with suitably trained staff should be available in these smaller units and in tenancies when they are appropriate
- Different client groups (e.g. drug users, alcohol users) should be accommodated in separate smaller accommodation units
- Support should prepare people for resettlement and allow for a period of transition from homelessness to independent living - the Salvation Army's resettlement projects are examples of good practice.
- Greater services for homeless people with addiction problems are urgently required
- Accessible specialist counselling for homeless people with complex needs (particularly those who have experienced childhood sexual abuse), and more generally for those for whom the effects of trauma is an ongoing factor in their homelessness history

14.4. Respondents' preferences for specialist over mainstream health services

- The quality of response and treatment is significantly better (e.g. in terms of being less judgmental, more flexible, and comprising more effective interventions) within the voluntary sector compared to housing and social work sectors
- The strong link between trauma (sexual abuse, physical abuse, bereavement) as a direct or indirect cause of homelessness, and as a factor which compounds the experience of homelessness (and may prevent people from moving on from homelessness)
- Respondents' strong wish to be kept informed in a systematic way regarding hostel closure and re-provisioning
- Respondents' high level of interest in a city-wide service users' forum

Summary point: the views of hostel dwellers on hostel decommissioning

Glasgow Homelessness Network gathered views of hostel dwellers on this subject.

- Hostel dwellers felt that hostels were too large and impersonal, with little support and unmanageable drug problems.
- They feared being moved out of hostels because of loneliness, inability to cope, and lack of support in the community.
- About a third of hostel dwellers do not want to move out; a third want to move out if they had the support and personal skills to cope; and a third would move out now.
- Hostel dwellers suggest that smaller but communal accommodation units are needed, specific to particular client groups (drug users, those with no alcohol or addictions problems, etc) and with appropriate support. These units should prepare current hostel dwellers for more independent living.
- They confirmed the desirability of homeless-specific services.
- More information on hostel closures, and an ongoing role in a users' forum, were suggested.

15. Young people's needs assessment

A health needs assessment of young people experiencing homelessness[59] was completed in April 2003. The assessment comprised 60 semi-structured interviews, 6 individual interviews, and focus groups with service providers. It was jointly funded by Greater Glasgow NHS Board and Barnardo's.

The report found high levels of physical and mental illness (including high rates of self-harm and drug use) but many perceived barriers to accessing appropriate health care and support. Among its 19 recommendations were that youth-specific services were needed. As with adults, flexible and non-judgemental attitudes amongst staff are needed to make services more accessible.

16. Summary of specialist health services for homeless people

The NHS and Glasgow City Council's Social Work Services provide a range of specialist services for homeless people, most of which have been established since 2000. In brief, they comprise:

- The Homeless Addiction Team. A multi-disciplinary service providing medical, social work, occupational therapy and psychological services for homeless people with addictions and alcohol problems. It mainly serves the city centre population.
- Homeless Mental Health Service. Provides mainly outreach work by Community Psychiatric Nurses, plus a consultant psychiatrist and inpatient beds at Parkhead Hospital
- Homeless Physical Health Team. This team of nurses provides a health service for hostel dwellers and other homeless people, principally around the city centre.
- Homeless Families Team. All homeless families who present to Glasgow City Council are referred to this team, which comprises health visitors and a GP.
- PMS Practice. A new two-GP practice began in early 2003, providing a full range of health and allied services (including physiotherapy, addictions services, and podiatry)

Needs-based response

The range of new services has the potential to deliver significant improvements in the health of homeless people in Glasgow. These resources might be most effective if:

Ⓟ Specific targets are set to respond to health needs, for example, childhood immunisation rates, hepatitis B vaccination rates, assessment and offer of opiate substitutes, vitamin B prescription for alcohol dependent patients, et cetera.

Ⓟ ⓘ ✓ There is a systematic approach to disseminating successful good practice throughout health services.

Ⓟ ✓ Specifically, lessons from Glasgow's Starting Well project should inform service provision for homeless families.

Ⓟ ⓘ ✓ The majority of new investments in homeless health services are directed to community-based services in favour of the city centre, so that resources are more appropriately allocated to the homeless population and more emphasis is given to primary prevention.

Ⓟ A systematic approach is made to ensure that all health service policies addressing deprivation, inequalities, social exclusion and the like, incorporate the needs of homeless people.

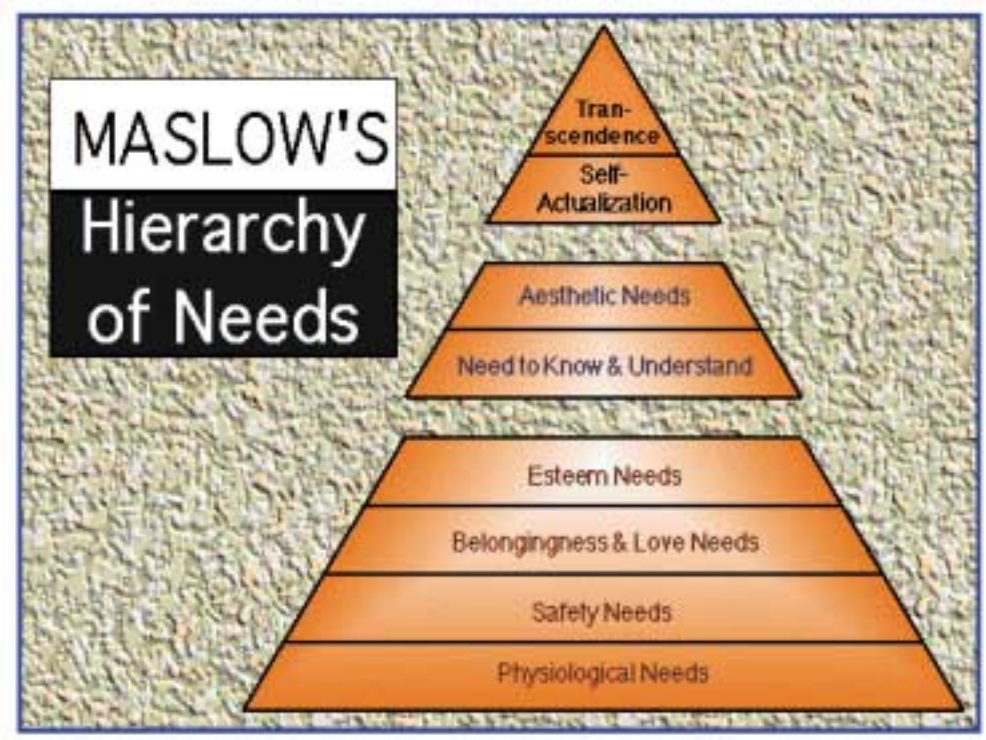
Appendix 1. Definitions of need.

The concept of "needs" of homeless people is broad. Four main definitions[60] might be given:

- Normative need - views from professionals and experts on what the homeless population needs
- Felt need - views from homeless people themselves, their carers and service providers on what is needed
- Expressed need - the way that need is demonstrated, usually by the extent to which existing services are used, so often synonymous with demand.
- Comparative need - using similar homeless populations as a guide to the kinds of services and resources that are likely to be needed in Glasgow

But other definitions are relevant. A broader definition of human needs is provided by Maslow (Figure 8). Maslow posited a hierarchy of human needs based on two groupings: deficiency needs and growth needs. Within the deficiency needs, each lower need must be met before moving to the next higher level. Once each of these needs has been satisfied, if at some future time a deficiency is detected, the individual will act to remove the deficiency. In formulating any service or policy, it is worth remembering that homeless people's major concerns are rooted in Maslow's deficiency needs, and that interventions to provide, for example, education and training, will only be successful when these lower-order needs are met satisfactorily.

Figure 8 Maslow's hierarchy of needs.



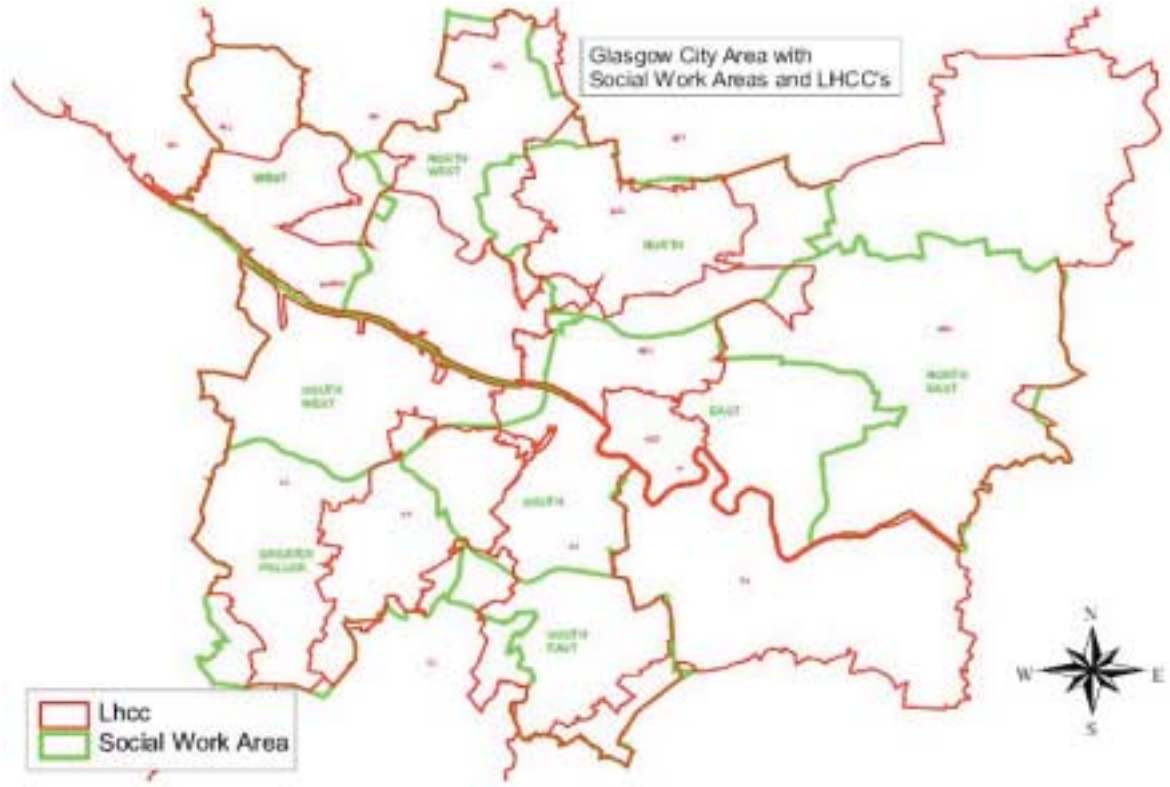
In health care in particular, needs are often defined as the capacity for an individual or population to benefit from a particular intervention.

Stevens and Raftery[60] also stated that:

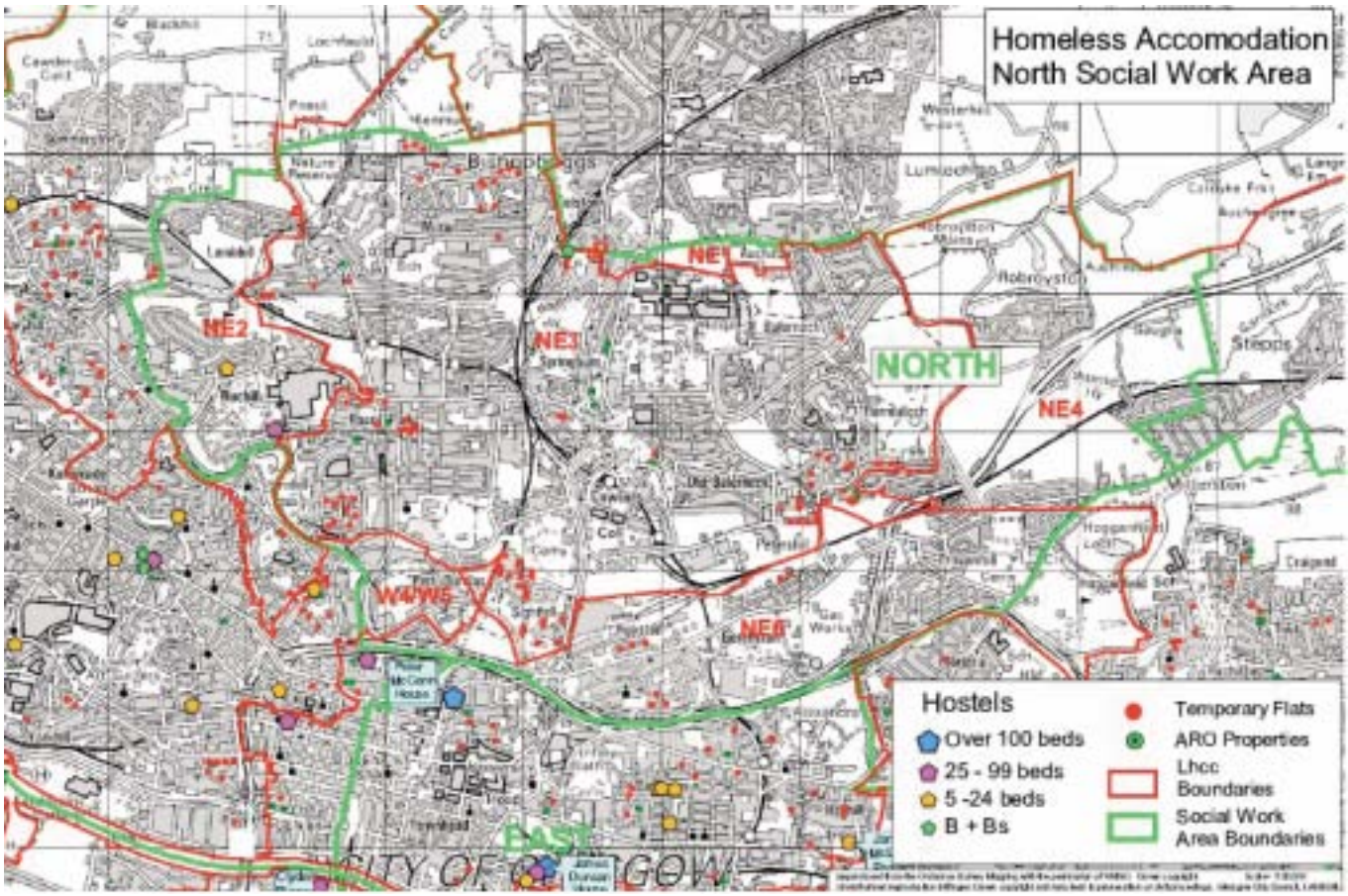
- The population's ability to benefit from health care equals the aggregate of the individual's ability to benefit.
- The ability to benefit does not mean that every outcome is guaranteed to be favourable, but rather that need implies the potential to benefit, which is on average effective.
- The benefit is not just a question of clinical status, but can include reassurance, supportive care and the relief of carers. Many individual health problems have a social impact via multiple knock-on effects or via a burden to families and carers. Hence the list of beneficiaries of care can extend beyond the patient.
- Health care includes not just treatment, but also prevention, diagnosis, continuing care, rehabilitation and palliative care.

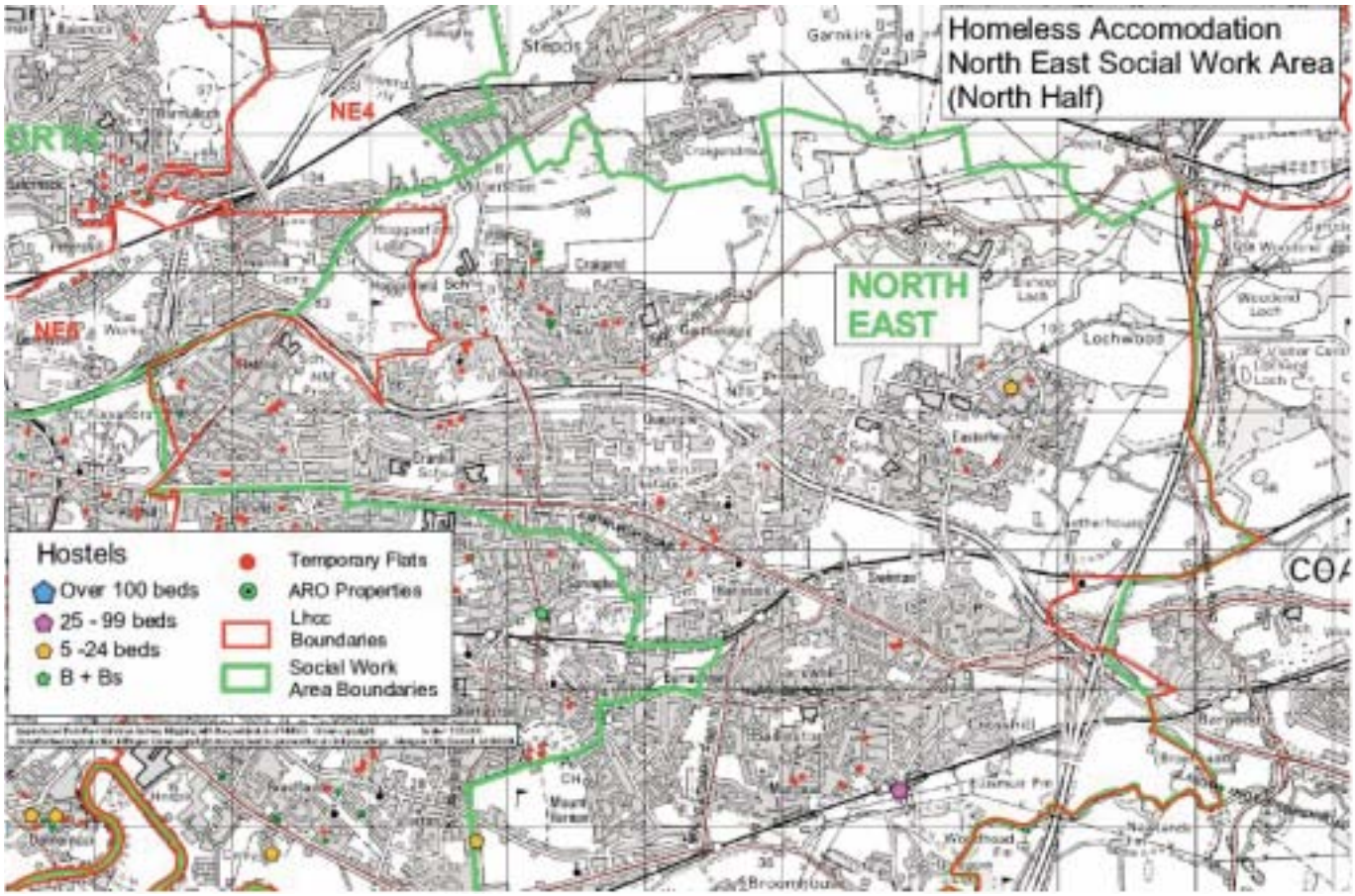
A limitation of this definition is that the absence of evidence to support an intervention makes evaluation of the capacity for a population to benefit almost impossible. However, it is a useful definition for two reasons. The first is that where evidence of an effective treatment exists, its capacity to benefit the homeless population should be evaluated. And the second is that where new interventions are introduced, there is a responsibility to evaluate whether or not they are effective so that the capacity for the wider homeless population can be ascertained.

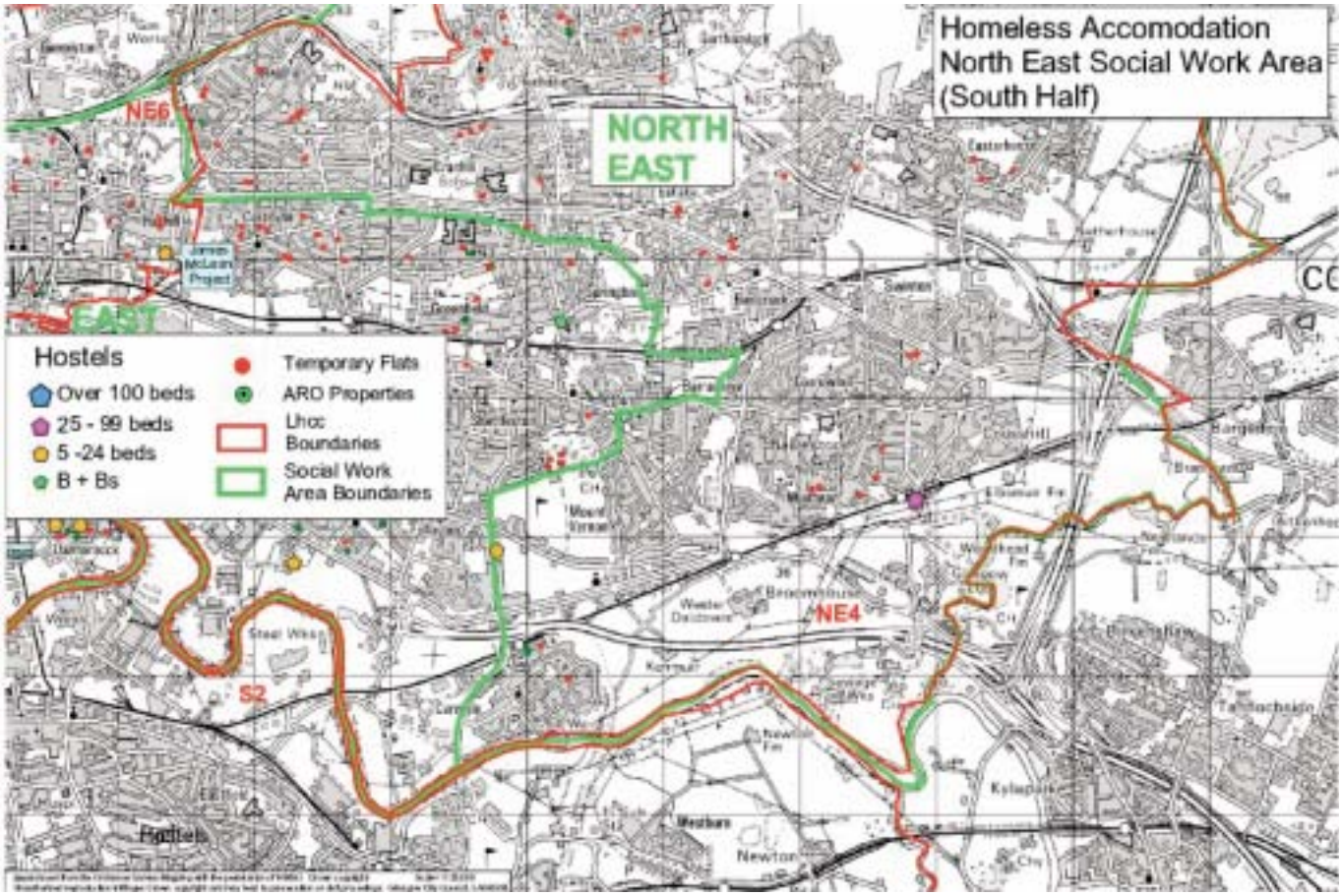
Appendix 2. Homeless accommodation in Glasgow††.



†† PLEASE NOTE THE FOLLOWING: Any Ordnance Survey/OS -based mapping included within this Report is provided by Glasgow City Council under licence from the Ordnance Survey in order to fulfil its public function to make available Council-held public domain information. Persons viewing this mapping should contact Ordnance Survey Copyright for advice where they wish to licence Ordnance Survey mapping/map data for their own use. The OS web site can be found at <http://www.ordnancesurvey.co.uk> "


Homeless Accomodation
North Social Work Area
NE1
NE2
NE3
NE4
NE6
W4/W5
NORTH
EAST
Hostels
Over 100 beds
25 - 99 beds
5 -24 beds
B + Bs
Temporary Flats
ARO Properties
Lhcc Boundaries
Social Work Area Boundaries


Homeless Accomodation
North East Social Work Area
(North Half)
NE4
NE6
NORTH
EAST
Hostels
Over 100 beds
25 - 99 beds
5 -24 beds
B + Bs
Temporary Flats
ARO Properties
Lhcc Boundaries
Social Work Area Boundaries


Homeless Accomodation
North East Social Work Area
(South Half)
NORTH
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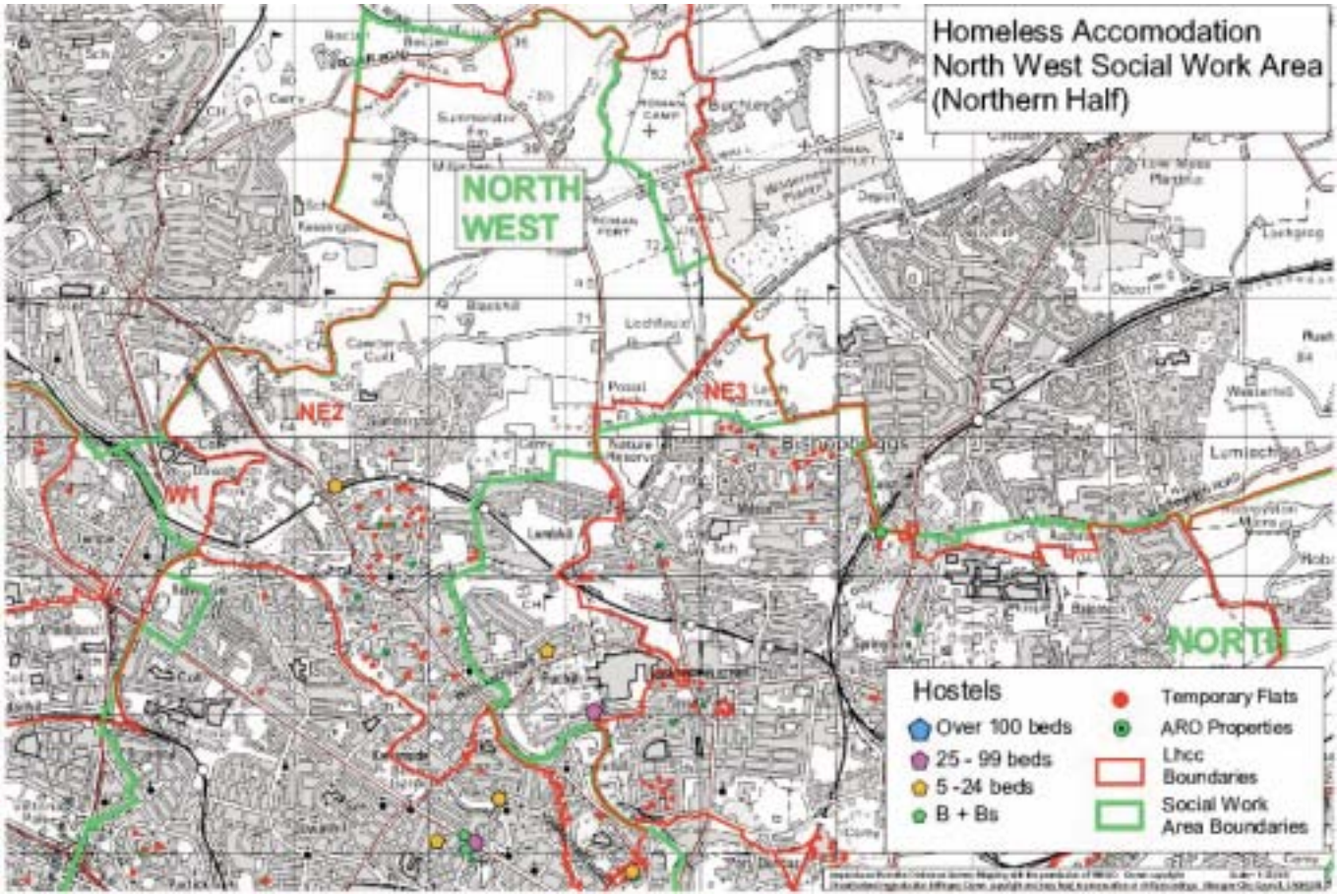
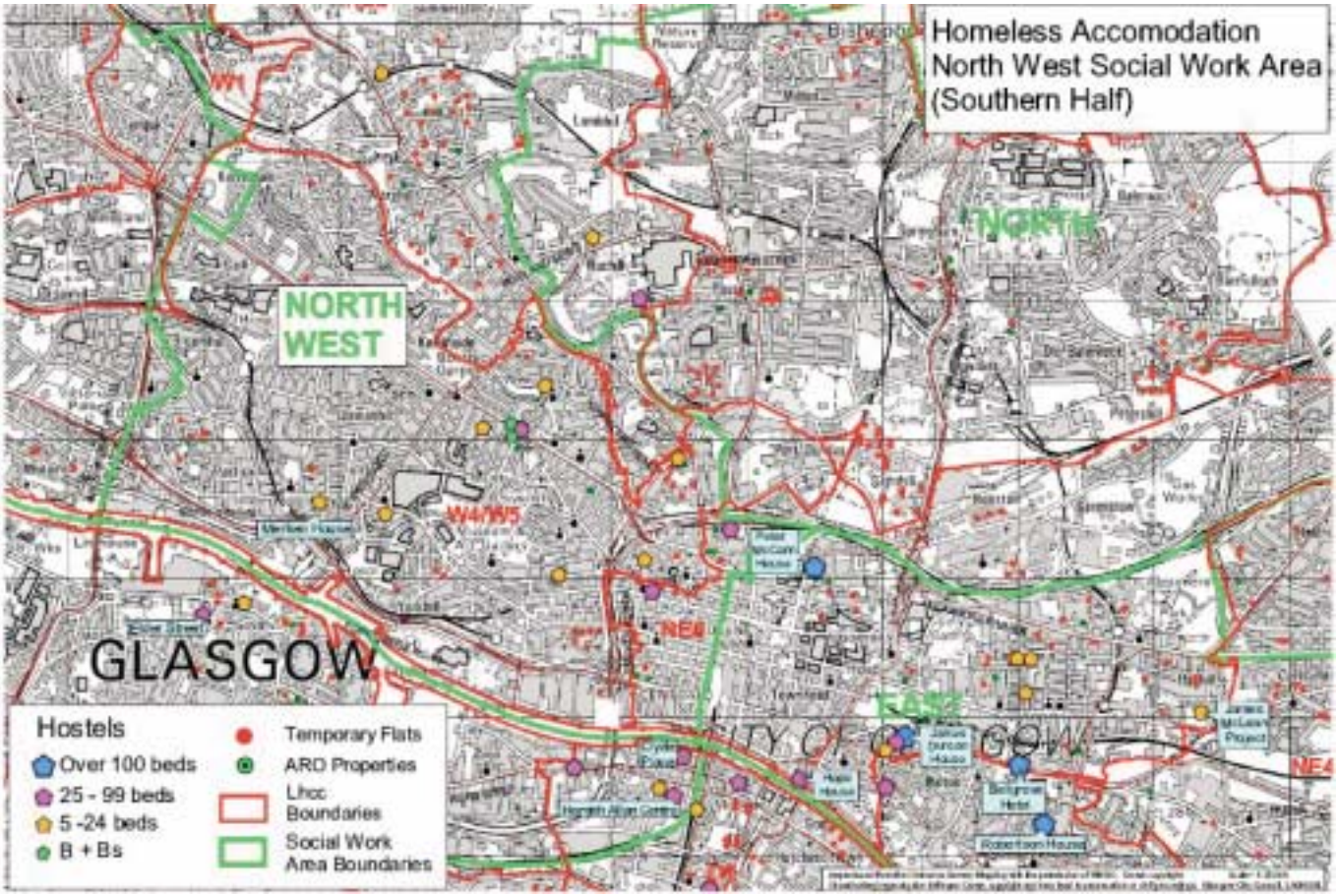
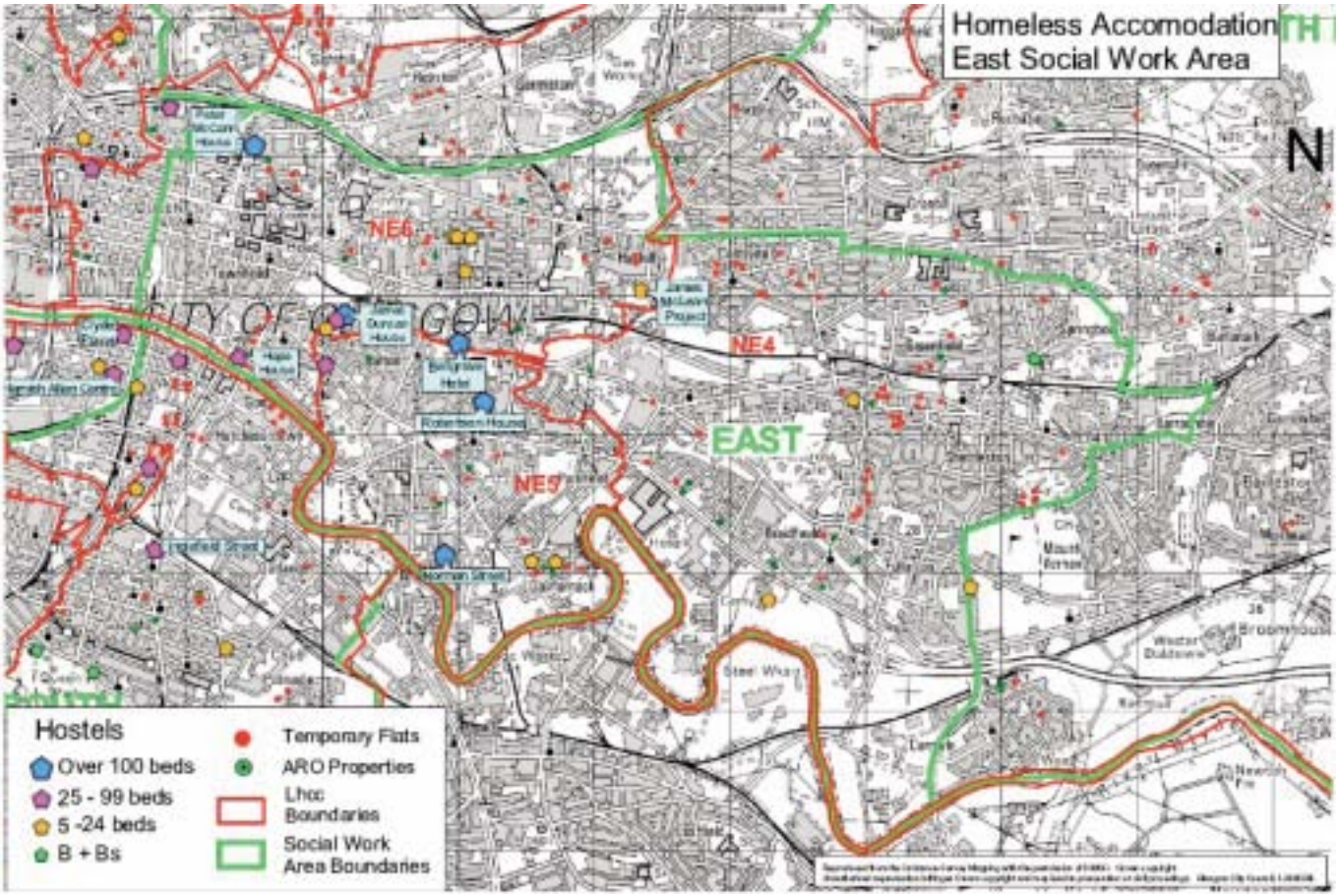
NE4
S2
Hostels
Over 100 beds
25 - 99 beds
5 -24 beds
B + Bs
Temporary Flats
ARO Properties
Lhcc
Boundaries
Social Work
Area Boundaries


Homeless Accomodation
North West Social Work Area
(Northern Half)
NORTH
WEST
NE2
NE3
W1
NORTH
Hostels
Over 100 beds
25 - 99 beds
5 -24 beds
B + Bs
Temporary Flats
ARO Properties
Lhcc
Boundaries
Social Work
Area Boundaries


Homeless Accomodation
North West Social Work Area
(Southern Half)
NORTH
WEST
W1
W4/W5
NE6
NE4
GLASGOW
Hostels
Over 100 beds
25 - 99 beds
5 -24 beds
B + Bs
Temporary Flats
ARO Properties
Lhcc Boundaries
Social Work Area Boundaries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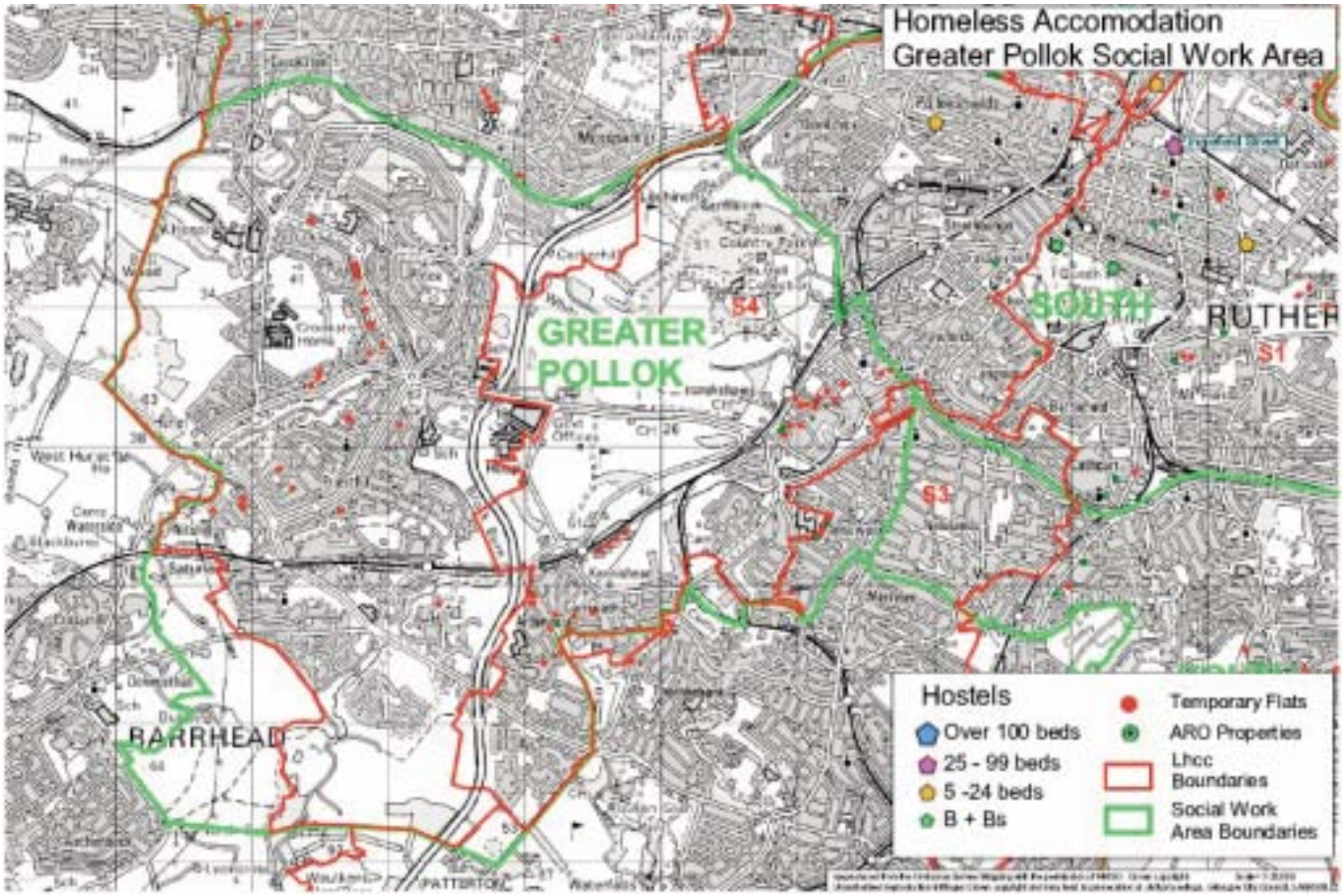
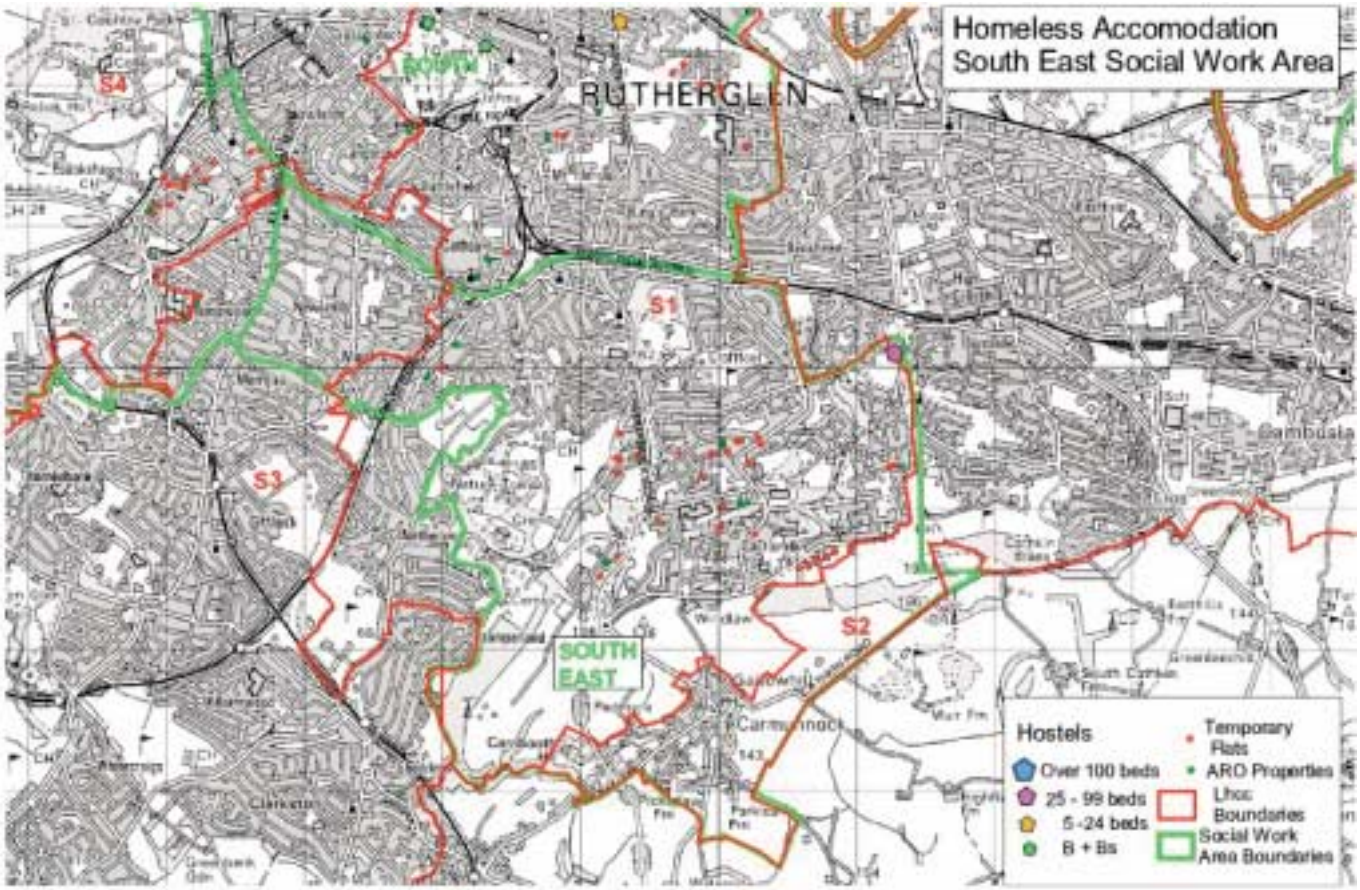
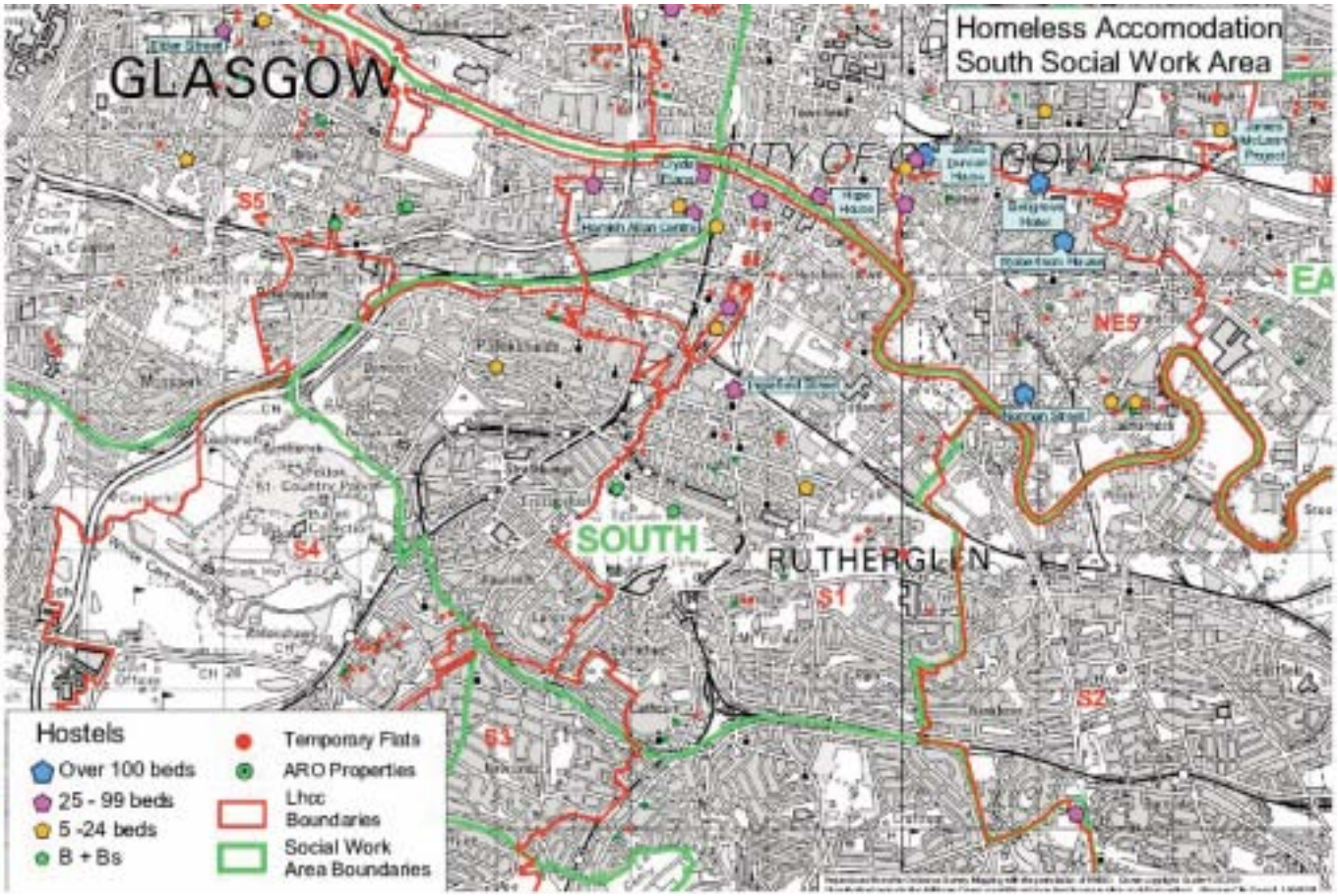
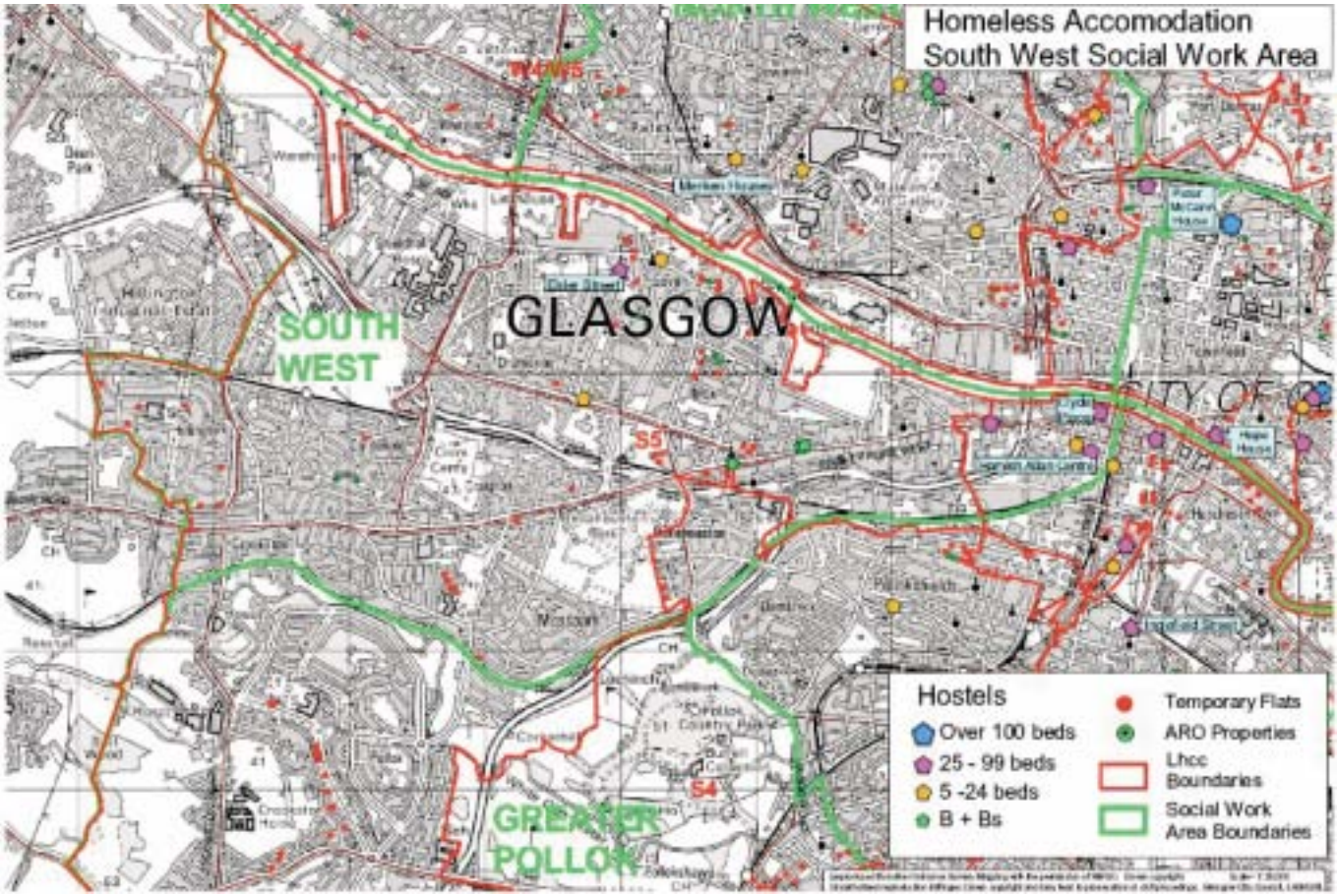
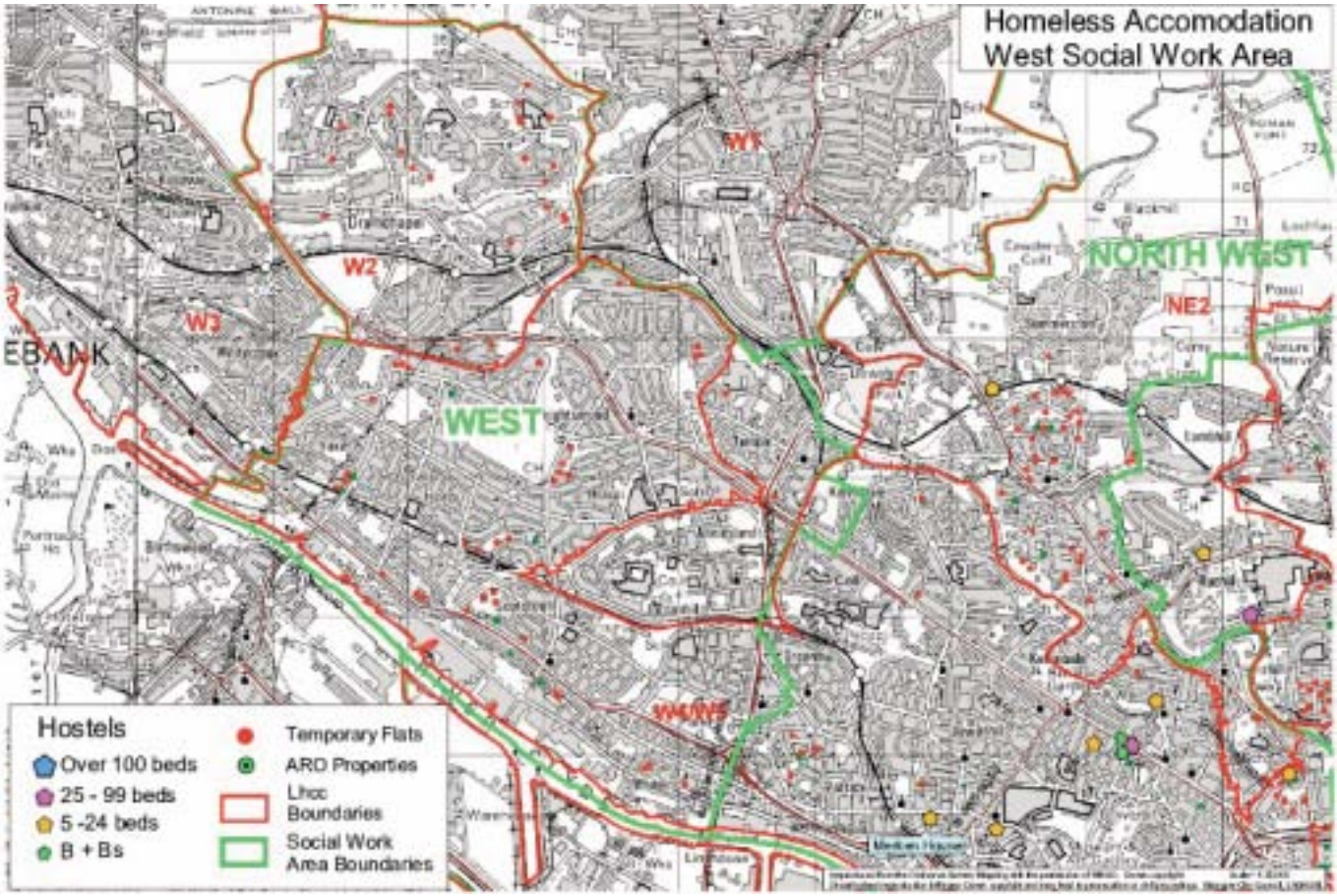
East Social Work Area
N
NE6
NE4
NE5
EAST
Hostels
Over 100 beds
25 - 99 beds
5 -24 beds
B + Bs
Temporary Flats
ARO Properties
Lhcc Boundaries
Social Work Area Boundaries


Homeless Accomodation
Greater Pollok Social Work Area
GREATER POLLOK
SOUTH
RUTHER
S1
S3
S4
BARRHEAD
PATTERTON
Hostels
Over 100 beds
25 - 99 beds
5 -24 beds
B + Bs
Temporary Flats
ARO Properties
Lhcc Boundaries
Social Work Area Boundaries


Homeless Accomodation
South East Social Work Area
RUTHERGLEN
SOUTH
S1
S2
S3
S4
SOUTH EAST
Cambuslang
Hostels
Over 100 beds
25 - 99 beds
5 -24 beds
B + Bs
Temporary Flats
ARO Properties
Lhcc Boundaries
Social Work Area Boundaries


Homeless Accomodation
South Social Work Area
GLASGOW
CITY OF GLASGOW
SOUTH
RUTHERGLEN
S5
S4
S1
S2
S3
NE5
Hostels
Over 100 beds
25 - 99 beds
5 -24 beds
B + Bs
Temporary Flats
ARO Properties
Lhcc Boundaries
Social Work Area Boundaries


Homeless Accomodation
South West Social Work Area
SOUTH WEST
GLASGOW
CITY OF GLASGOW
S5
S4
GREATER POLLOK
Hostels
Over 100 beds
25 - 99 beds
5 -24 beds
B + Bs
Temporary Flats
ARO Properties
Lhcc Boundaries
Social Work Area Boundaries


Homeless Accomodation
West Social Work Area
W1
W2
W3
W4/W5
WEST
NORTH WEST
NE2
EBANK
Hostels
Over 100 beds
25 - 99 beds
5 -24 beds
B + Bs
Temporary Flats
ARD Properties
Lhcc Boundaries
Social Work Area Boundaries

Appendix 3 Homeless accommodation in Glasgow

Table 34 Homeless hostels, day centres & accommodation projects in Glasgow area

Provider	Name	Address	Postcode	No of beds
GCC	Norman Street	93 Norman St	G40 4JS	107 (18+yrs)
GCC	James Duncan House	331 Bell St	G4 0TD	242 (18+yrs)
GCC	Peter McCann House	22 Kyle St	G4 0EX	253 (18+yrs)
GCC	Robertson House	260 Broad St	G42 2TR	240 (18+yrs)
GCC	Clyde Place	35 Clyde Place		55 (18+yrs)
GCC	Inglefield Street	19 Inglefield St	G42 7AY	77 (18+yrs)
GCC	Hamish Allan Centre	180 Centre St	G5 8EE	
GCC	Merken House	18 Purdon St	G11 6AJ	18 (55+yrs)
GCC	James McLean Project	42 –52 Bengairn St	G31 3QT	16 (16 – 18 yrs)
Quarriers	Stopover	189 Pollokshaws Rd	G41 1PS	14 (16-25 yrs)
Quarriers/ GCC	James Shields Project	100 Pollokshaws Rd	G41 1PZ	39 (18-25yrs)
Salvation Army	Hope House	14 Clyde St	G1 5JH	99
SA	Wallace of Campsie	30 East Campbell St	G1 5DT	52 (18+yrs)
SA	William Hunter	70 Oxford St	G1 9EP	40 (18+yrs)
Talbot Assoc	Bob McTaggart House	109 Dunblane St	G4 0HJ	53 (18+yrs)
	Kingston Halls	344 Paisley Rd	G5 8RE	67 (18+yrs)
	Fernhill	2 Fernhill Rd, Rutherglen	G73 4BF	40 (Elderly)
	Copelaw St	75 Copelaw St	G42 7JG	15 (18-25yrs)
	Hill St	122 Hill St	G3 6UA	20 (35+yrs)
	Belmont St	494 Great Western Rd	G12 8EW	26 (18+yrs)
	Riverside Project	892 Govan Rd	G51 3AF	12 (18+yrs)
Simon Community	Dennistoun Project	11 Onslow Dr	G31 2LY	5 (18+yrs)
	Maryhill Project	9, Caldercuilt Rd	G20 0AE	6 (35+yrs)
	Castlemilk Project	86-88 Arnprior Rd	G45 9HE	6 (25+yrs)
	Tollcross Project	17 Carmyle Av	G32 8HJ	10 (25+yrs)
	Govanhill Women's Project	14 Polmadie St, Govanhill	G42 0PL	15
Turning Point	Drug Crisis Centre	123 West St	G5 8BA	
	Link Up	112 Commerce St	G5 9NT	
Archdiocese of Glasgow	Glengowan House	196 Nithsdale Rd	G41 5EU	8 (16-25yrs)
	De Paul House	27 Cruden St	G51 3RP	16 (16-25yrs)
	Rachel House	503 Baltic St	G40 4SG	10 (mother & baby)
	London Road Project	1920 London Rd	G32 8XG	8
Church of Scotland	Dick Stewart Project	40 Circus Drive	G31 2JE	13
	Kirkhaven	107 Somerfield St	G40 4QT	14 (28+yrs)
Milnbank	Walpole	6 Craigpark	G31 2NA	7
HA	Circus Drive	42-44 Circus Drive	G31 2JE	15
Provider	**Name**	**Address**	**Postcode**	**No of beds**
BTHA	Holland Court	339 Sauchiehall St	G2 3HW	28 (18-25yrs)
BTHA	Dorothy McCall House	2, Somerset Place	G3 7JT	12 (16-21yrs)
BTHA	Dumbarton Road	73 Dumbarton Rd	G11 6PW	8
BTHA	Gallowgate Project	211 Gallowgate	G1 5DX	13 (18-25yr)
BTHA	Lochfield Park	10 Dalilea Dr	G34 0EJ	8 (18+yrs)
BTHA	Shettleston	829 Shettleston Rd	G32 7NR	7 (18+yrs)
YMCA	Branston Court (Maryhill)	71-95 Panmure St	G20 7SJ	54 (16-29yr)
Independent	CHYP	171 Wilton St	G20 6DF	10 (16-21yrs)
Independent	Elpis Centre	0/2, 23 Mayfield St, Ruckhill	G20 9RQ	13

Independent	Hillhead House	13 Hillhead St	G12 8PU	23 (16-25yrs)
Queens Cross HA	Fire station Project	509 St Georges Rd	G3 6JX	13 (16-25yrs)
Private	Bellgrove Hotel	607 Gallowgate	G40 2PF	215 (25+yrs)
Private	Monteith Hotel	14 Monteith Row	G40 1AY	28 (18+yrs)

B&B	Address	Postcode	No of beds
Amber Guest House	18 Walmer Crescent	G51 1AT	
Walmer Guest House	15 Walmer House, Walmer Cresent	G51 1AP	
Parkview Hotel	72 Queen's Dr	G42 8BW	
Queen's Park Hotel	10 Balvicar Dr	G42 8QT	
Hamilton House Hotel	4-2 Hamilton Park Av	G12 8DU	
Bellahouston Guest House	526 Paisley Road West	G51 1RN	
Lion Hotel	274 Colston Rd	G64 2BE	
Gartocher House	166 Gartocher Rd		
Inveroak Guest House	8 Bank Street	G12 8JQ	

Total = 2203

Non- accommodation services who may refer, or whose workers may accompany homeless people. Homeless people may also on occasion use the following as care of addresses.

Provider		Office base	
Simon Community	Street Team (25+s)	Janitor's House, 92 Dobbies Loan	G4 9LJ
City Mission	Day/ Evening service	24 McAlpine St	G2 8PT
Wayside	Day/ Evening service	Po Box 140, 32 Midland St	G1 4PR
C of S Lodging House Mission	Day Centre	35 East Campbell St	G1 5DT

Appendix 4 Methodology for literature review[20].

A search was carried out for relevant published literature using the following search strategy.

The initial searches were carried out combining the terms in box 1 with boxes 2,3,4 and 5 in turn. Each term was mapped in the title, the abstract or as a subject heading word.

Figure 9: Search terms

1
homeless*
rough sleep*
hostel dwell*
temporary accommodation
bed and breakfast
destitute
vagran*

2
health
heath care needs
health needs
health problems
health status
ill health
mental health

3
access*
availab*
demand
obtain
uptake
usability
use
utils*

4
assess*
best practice
effect*
efficien*
evaluat*
good practice
outcome*

5
acute services
health care
health services
outreach
primary care
primary health care
secondary care

Publications from 1991 to 2001, in English, in the following databases were sought: -

- Medline;
- Embase;
- Social Science Citation Index (SSCI);
- Cochrane library.

Further relevant literature was obtained by

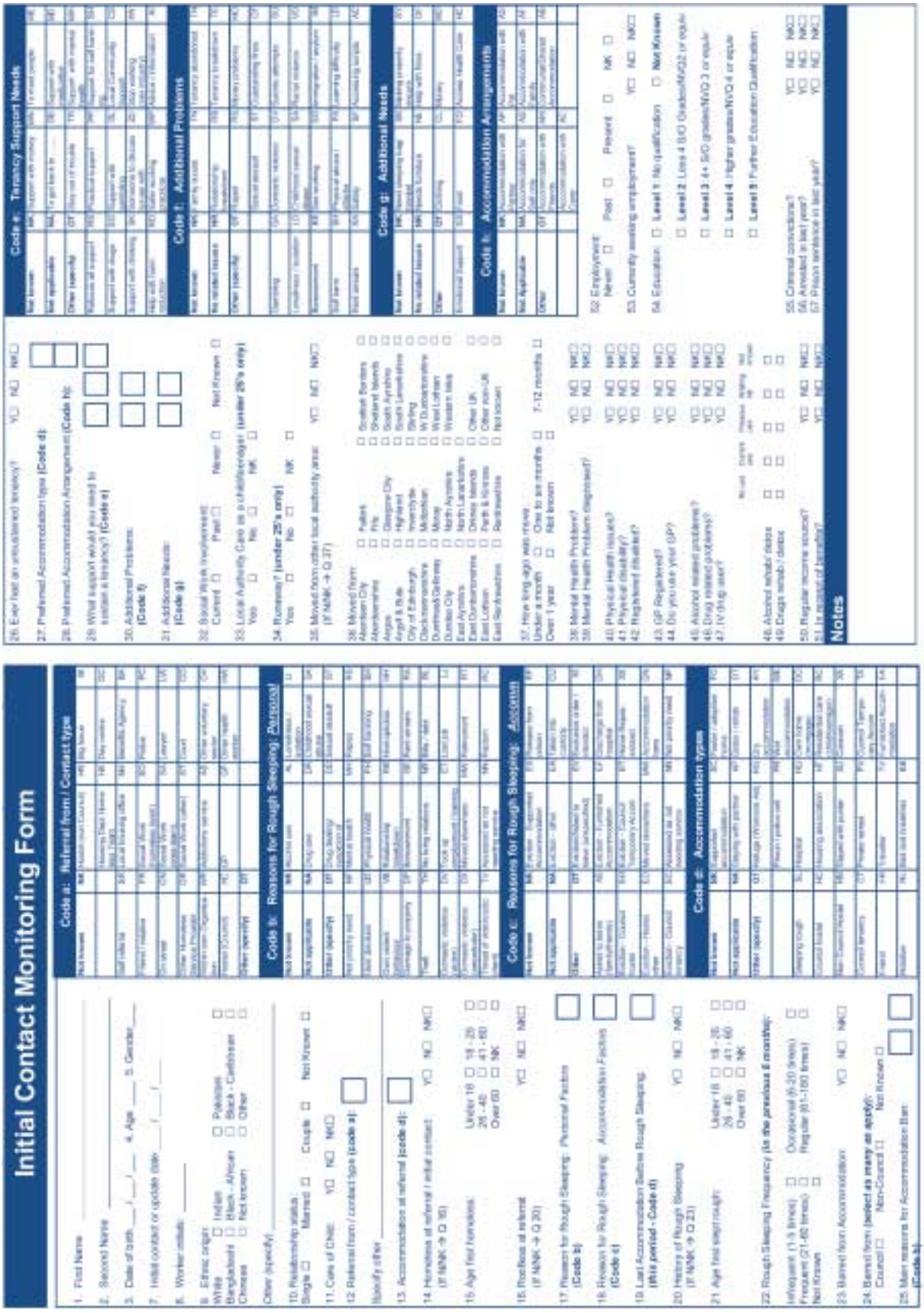
- Approaching contacts working on homelessness in other health boards and academic departments;
- Obtaining relevant government publications and local authorities reports;
- Searching the websites of voluntary agencies working with the homeless for information and publications.

The titles and abstracts of references identified were scanned for relevance and then copies of papers were obtained.

The citation lists of papers found were checked for additional relevant publications.

Although there was a wealth of information about providing services for the homeless in the USA, this has been referred to sparingly due to the differences in the social and health service provision between the two countries.

Appendix 5 Rough Sleepers' Initiative Common Monitoring Forms (pages1-2 of 5)



Initial Contact Monitoring Form

1. First Name: _____
2. Second Name: _____
3. Date of birth: ___/___/___ 4. Age ____ 5. Gender ____
7. Initial contact or update date: ___/___/___
8. Worker initials: _____
9. Ethnic origin: White ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Black - African ☐ Black - Caribbean ☐ Chinese ☐ Not known ☐ Other ☐
Other (specify) _____
10. Relationship status: Single ☐ Married ☐ Couple ☐ Not Known ☐
11. Care of Child: Y☐ N☐ NK☐
12. Referral from / contact type (code a): ☐
Specify other _____
13. Accommodation at referral (code d): ☐
14. Homeless at referral / initial contact (if N/NK → Q 16): Y☐ N☐ NK☐
15. Age first homeless: Under 16 ☐ 16 - 25 ☐ 26 - 40 ☐ 41 - 60 ☐ Over 60 ☐ NK ☐
16. Rooflessness at referral (if N/NK → Q 20): Y☐ N☐ NK☐
17. Reason for Rough Sleeping: Personal Factors (Code b): ☐
18. Reason for Rough Sleeping: Accommodation Factors (Code c): ☐
19. Last Accommodation Before Rough Sleeping (this period - Code d): ☐
20. History of Rough Sleeping (if N/NK → Q 23): Y☐ N☐ NK☐
21. Age first sleptrough: Under 16 ☐ 16 - 25 ☐ 26 - 40 ☐ 41 - 60 ☐ Over 60 ☐ NK ☐
22. Rough Sleeping Frequency (in the previous 6 months): Infrequent (1-5 times) ☐ Occasional (6-20 times) ☐ Frequent (21-60 times) ☐ Regular (61-180 times) ☐ Not Known ☐
23. Barred from Accommodation: Y☐ N☐ NK☐
24. Barred from (select as many as apply): Council ☐ Non-Council ☐ Not Known ☐
25. Main reasons for Accommodation Ban (Code h): ☐

Code a: Referral from / Contact type
Code b: Reasons for Rough Sleeping: Personal
Code c: Reasons for Rough Sleeping: Accom
Code d: Accommodation types

26. Ever had an evicted tenancy? Y☐ N☐ NK☐
27. Preferred Accommodation type (Code d): ☐
28. Preferred Accommodation Arrangements (Code h): ☐
29. What support what you need to sustain a tenancy? (Code e) ☐
30. Additional Problems: (Code f) ☐
31. Additional Needs: (Code g) ☐
32. Social Work involvement: Current ☐ Past ☐ Never ☐ Not Known ☐
33. Local Authority Care as a child/teenager (under 25's only): Yes ☐ No ☐ NK ☐
34. Runaway? (under 25's only): Yes ☐ No ☐ NK ☐
35. Moved from other local authority area: Y☐ N☐ NK☐ (If N/NK → Q 37)
36. Moved from: Aberdeen City ☐ Aberdeenshire ☐ Angus ☐ Argyll & Bute ☐ City of Edinburgh ☐ Clackmannanshire ☐ Dumfries & Galloway ☐ Dundee City ☐ East Ayrshire ☐ East Dunbartonshire ☐ East Lothian ☐ East Renfrewshire ☐ Falkirk ☐ Fife ☐ Glasgow City ☐ Highland ☐ Inverclyde ☐ Midlothian ☐ Moray ☐ North Ayrshire ☐ North Lanarkshire ☐ Orkney Islands ☐ Perth & Kinross ☐ Renfrewshire ☐ Scottish Borders ☐ Shetland Islands ☐ South Ayrshire ☐ South Lanarkshire ☐ Stirling ☐ W Dunbartonshire ☐ West Lothian ☐ Western Isles ☐ Other UK ☐ Other non-UK ☐ Not known ☐
37. How long ago was move: Under a month ☐ One to six months ☐ 7-12 months ☐ Over 1 year ☐ Not known ☐
38. Mental Health Problem? Y☐ N☐ NK☐
39. Mental Health Problem (degree)? Y☐ N☐ NK☐
40. Physical Health issues? Y☐ N☐ NK☐
41. Physical disability? Y☐ N☐ NK☐
42. Registered disabled? Y☐ N☐ NK☐
43. GP Registered? Y☐ N☐ NK☐
44. Do you visit your GP? Y☐ N☐ NK☐
45. Alcohol related problems? Y☐ N☐ NK☐
46. Drug related problems? Y☐ N☐ NK☐
47. IV drug user? Y☐ N☐ NK☐
48. Alcohol whole/ dialysis ☐ ☐ ☐ ☐
49. Drugs whole / dialysis ☐ ☐ ☐ ☐
50. Regular income source? Y☐ N☐ NK☐
51. In receipt of benefits? Y☐ N☐ NK☐
52. Employment: Never ☐ Past ☐ Present ☐ NK ☐
53. Currently seeking employment? Y☐ N☐ NK☐
54. Education: ☐ Level 1: No qualification ☐ Not Known ☐ Level 2: Less 4 S/G Grades/N/VQ2 or equiv ☐ Level 3: 4+ S/G grades/N/VQ 3 or equiv ☐ Level 4: Higher grades N/VQ 4 or equiv ☐ Level 5: Further Education Qualification
55. Criminal convictions? Y☐ N☐ NK☐
56. Arrested in last year? Y☐ N☐ NK☐
57. Prison sentence in last year? Y☐ N☐ NK☐

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