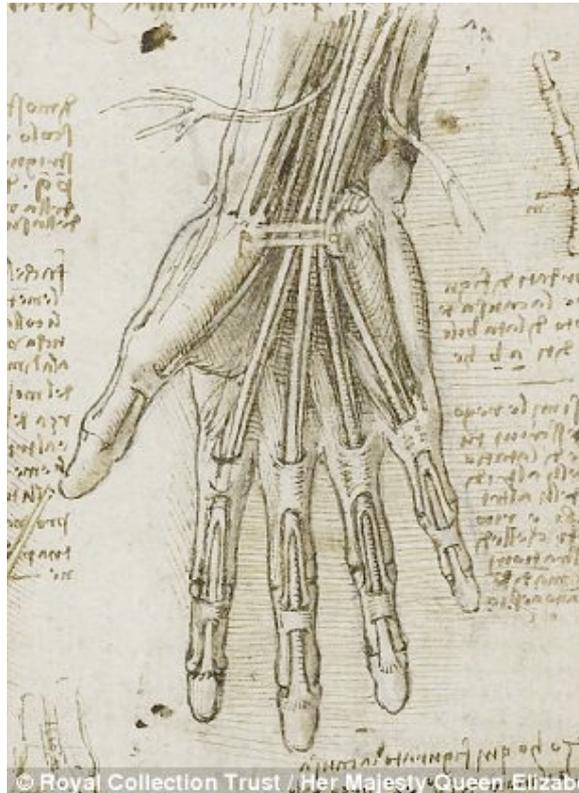


G C S

Great Chapel Street

**A ONE STOP-SHOP MEDICAL CENTRE FOR
HOMELESS PEOPLE IN WESTMINSTER**

**Annual Report
2012-2013**



"I came very close to throwing the towel in and calling it quits but each and everyone of you, your humanity and kindness was, well it was just beautiful." – NF, a service user.

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SERVICE BACKGROUND

Great Chapel Street is a walk in Medical Centre set up to provide enhanced specialist health services to the homeless adult population in Westminster.

We have a multi-disciplinary team offering the following clinics:

- ▶ General practitioners
- ▶ Practice nurse
- ▶ Substance use/mental health specialist
- ▶ Counselor
- ▶ Dentist
- ▶ Podiatry
- ▶ Psychiatrist
- ▶ Visiting benefits advice worker
- ▶ Advocacy/legal advice worker.

Our Clients:

The homeless adult population in Westminster, those who are rough-sleeping, are at risk of or have significant history of, or are resident in a hostel in Westminster, or in a boundary area.

A wide range of clients: entrenched rough sleepers, clients with a significant history of rough sleeping, clients who may become entrenched rough sleepers, hostel, refuge and night shelter residents in Westminster or boundary areas, failed asylum seekers in Westminster, irregular and undocumented migrants, people who have recently left institutions such as local authority care, the armed forces or prison and who are at risk of rough sleeping.

We work holistically towards tackling health inequality and targeting a variety of multiple complex needs of a wide group of adult homeless vulnerable clients in Westminster.

Walk in Medical Centre

Accessible, non-judgmental, opportunistic, inclusive and multidisciplinary

Working in partnership with the voluntary and statutory sectors to tackle homelessness and design services around the needs of homeless people

THE TEAM

General Practitioner Services

▶ Dr. Simon Ramsden, MA, MD, MB, BS, MRCP, MRCGP - Senior Physician.
simon.ramsden@nhs.net

▶ Dr. Philip Reid, BA (OXON), MB, BS, MRCP, MRCGP, DRCOG – Senior Physician. philip.reid@nhs.net

▶ Dr. Natalie Miller, MBBS, Bsc, nMRCGP, DCH, DFSRH - General Practitioner.
natalie.miller4@nhs.net

▶ Dr. Hitesh Mistry - MBBS (LOND) MRCGP BSc. General Practitioner.
hitesh.mistry1@nhs.net

Psychiatric Services

▶ Dr. Elisabeth Jackson, Consultant Psychiatrist. elizabeth.jackson@nhs.net

Dentistry

▶ Mr. Cyril Brazil, MSc Dental Surgeon. Cyril.brazil@nhs.net

▶ Ms. Farah Askaridoust Dental Nurse. farah.askaridoust@nhs.net

Nursing

▶ Ms. Brenda Hamilton, PGDip, BA (Hons) – Practice Nurse.
brendasimmonds1@nhs.net

▶ Ms. Maxine Radcliffe, BA (Hons) MSCPAPTN Practice Nurse and Outreach Nurse. (Outreach Lead Nurse). m.radcliffe@nhs.net

Substance Use/Mental Health Nursing Services

▶ Ms. Liz Abrahams, RMN, BA Hons, PGDip (Dual Diagnosis) (Applied Mental Health) NMP

Counselling Services

▶ Mr. John Conolly UKCP Registered Psychoanalytic Psychotherapist — Lead Counsellor for the Westminster Homeless Health Team (HHT).
john.conolly@westminster-pct.nhs.uk

Social advocacy/Housing and Benefits Advice Services

▶ Mr. Nicolás Vial-Montero, Abogado (Solicitor) DipPJ, MA – Primary Health Care Manager. nicolas.vial@nhs.net

▶ Ms. Zoe Simmons – The London Homeless Services Team, from the Department of Work and Pensions. Zoe.simmons@jobcentreplus.gsi.gov.uk

Administration

▶ Mr. Robert Bolus - BComm - Practice Manager. robert.bolus@nhs.net

▶ Mr. Serdar Aslan - Dip (Law) LLB (Hons) Grad Cert (Psych) reception/secretary. sarslan@nhs.net

▶ Ms. Alison Marks - receptionist/secretary. alisonmarks@nhs.net

SERVICE APPROACH

▶ To reduce social exclusion – To improve access for homeless people to health services and act as a point of contact for linkage to mainstream medical and social services.

▶ To reduce health inequality – To improve the health of the homeless population by recognising and addressing the multiple social and medical needs of our patient group.

▶ To provide continuity of care for patients – To offer a reliable and constant point of contact and follow through to those who lead a transient lifestyle.

Working with the voluntary and statutory sector

Part of our success derives from the fact that we are able to provide specialist services because we are supported by different statutory organisations. The Central & North West London Mental Health Trust provides two psychiatrists, a CNS and one administrator to the surgery, whilst Central London Community Healthcare, (formerly Westminster PCT and as re-branded NHS Westminster) provides nursing, podiatry, dental, counselling, social advocacy and the reception manager. Our team is then equipped to work with other statutory as well as not for profit organisations, such as Community Mental Health Teams, Drug Dependency Units and Social Services; and

voluntary bodies, such as housing providers, rehab centres and drug counselling services.

This is done by way of referring clients to these external organisations and by collaborating with them on the creation of strategies and procedures to tackle the problems surrounding homelessness. We partake in discussion forums, multi-agency and strategic consultation meetings with other stakeholders to table and discuss policies affecting homelessness.

Every Tuesday morning we hold a Practice Meeting where we discuss complex cases and draw appropriate care plans to comprehensively meet presenting needs. Other stake-holders are frequent attendees to our multidisciplinary meetings, including outreach workers from BBS in Westminster, hostel workers and representatives from Turning Point (The Hungerford Project) amongst many others.

METHODOLOGY

- ▶ Offering an integrated model of care with a full multi-disciplinary team. This includes, GP, nursing, psychiatry, substance use, dentistry, counselling, advisory and social care services.
- ▶ Opportunistic engagement: Being able to inter-refer within the team. Multiple needs can be addressed in this way.
- ▶ Having a no appointment system, to obtain engagement and promote compliance with treatment. Appointments are offered to those who want or need longer consultations.
- ▶ Having a harm Minimisation Philosophy e.g.: inoculation with flu vaccine, pneumonia and hepatitis B vaccines and screening for hepatitis C and HIV.
- ▶ Systematic health checks upon registration with the service.
- ▶ We opportunistically offer Pabrinex to patients (multivitamin plus thiamine injections for alcohol-dependent patients).
- ▶ Co-ordinating with voluntary and statutory services. For example referring patients to the Peer Mentor Scheme run by Groundswell – for patients to access services.
- ▶ Pro-active approach towards hard to reach and patients presenting with chaotic and multiple need problems. Case management of complex needs patients to coordinate care and promote the most effective use of resources.
- ▶ Outreach work in conjunction with outreach services in Westminster (tackling the hard to reach cases, fostering engagement and access to services).
- ▶ Every Tuesday we hold practice meetings where we discuss complex cases. External agencies who may be involved with the case list are invited to attend.

▶ Patient centred service: we design services around the needs of the patients. Our hybrid nature: medical care and social care, allows us to go beyond the very essential interventions in medical care. For example, we can escort patients to services for specialist interventions; we facilitate them with clothing or a shower. We are a very flexible service adapted to a very complex client group.

▶ Offering referrals and liaison into specialist services including Wytham Hall Supported Housing (fast track referral route), outreach BBS Services, Westminster Alcohol Service, (WAS), Joint Homeless Team (JHT), Westminster Drug Project, The Hungerford Drug Project, Westminster Drug Treatment Centre and Central & North West London Mental Health Services.

▶ A non-judgemental attitude.

INTRODUCTION

By Dr. Philip Reid

The last two years have seen great changes in the NHS and now the Benefit System is beginning its reorganisation. As the European Union grows and rights of movement and work extend further immigration has increased. Changes to the asylum process affect the numbers who fail or move to London. At Great Chapel Street we see the consequences of these changes on the most vulnerable in society.

It is our purpose to prevent and treat physical and mental illness along with substance misuse. We provide primary care with our GPs and nurses and have a well-developed mental health service with a full time mental health nurse specialist, two sessions with a consultant psychiatrist and a counselling service. We have a dental and podiatric service and are planning a sexual infection and hepatitis C service. We offer help with housing, benefits and immigration problems through our advice service.

We continue our weekly multidisciplinary meetings to develop care plans for our most complex patients.

A major development in the last two years has been the growth of the outreach service that has brought more vulnerable people into the clinic and improved liaison with other services. We provided extra outreach during the winter.

We have joined the Central CCG and are working closely with them to ensure services are responsive to the needs of homeless patients.

Future developments are the setting up of a pilot sexual health clinic and hepatitis C treatment clinic.

RECEPTION REPORT

By Serdar Arslan

RECEPTION MANAGER

Legal Studies (Dip) LLB (Hons) Grad Dip (Psych)

Since our last annual review, it has been an increasingly difficult and painful period for the homeless population across the country. This difficulty is associated with a great deal of changes and transformation within the National Health Service as well as changes in government policies and initiative on health care. The current economic crisis has led the government to formulate a strategy of providing less funding, fewer resources and fewer services for those in great need of help and desperation. Instead, they have introduced incentive to crack-down on bogus claimants becoming a burden on health services, particularly for foreign nationals.

How has Great Chapel Street Medical Centre approached such changes and challenges? The team at the Medical Centre has continued to follow an 'open-door and non-discriminatory policy' and continues to treat patients with physical, drugs, alcohol and mental health problems. In addition, further we have continued our co-ordination, liaison and professional relationships and contact with other services and organisation contributing to the medical centre's ethos and mission statement. Despite the impact of the changes, staffs have a common goal to ensure that medical care is paramount for the homeless community in Westminster.

In the Reception Department, we have implemented changes to the care of our patients. One of the changes introduced in March last year was a new service for patient referrals: *Patient Referrals Service*. Most of our referrals are now submitted via Choose and Book ensuring that referrals are fast and efficient, promoting better appointment system and better patient care. Secondly, as a surgery we have been registering patients permanently since mid-2011 and applying for NHS number, in particular for those patients who are homeless and never accessed a GP in UK. Most recent data shows that we have registered 310 permanent patients. The expansion of the European Union to former Eastern block means that we are registering more non-UK nationals who are sleeping rough in the Westminster area. The permanent registration will ensure that they are officially recognised by the national database system and be eligible to seek hospital treatment and care. Data from medical centre Audit shows (that there are 196 non-UK nationals registered between 2011-13 periods). In essence, the evidence shows that non-UK nationals are reflecting the demographic sample of our population-group. Thirdly, we have introduced a consistent policy to refer patients to local GPs once they have stable housing and their medical needs have been addressed. Our in-house audit shows that we referred 86 patients to access a local GP across different boroughs in London or else.

One of the major administrative changes we introduced to the department involved tackling the number of A/E admissions and liaising with A/E secretaries about patient(s) up-to-date GP details. Often, a homeless patient attends casualty who is a not active patient of Great Chapel Street clinic but discharge summaries are addressed to the medical centre. The implication of such admission cause unnecessary resources and follow-ups. The skill to deal with such cases is to liaise with the Outpatient Department/Casualty about changing GP contact details on their database. This does often require a great deal of patience, persuasion and attention to detail.

As shown above, there are challenges ahead in wake of the continuing changes within health sector. However, as one of the largest medical centre for the homeless community in UK, we believe our knowledge, skills and experience of working with complex and challenging members of society will continue to make the medical centre an appealing and attractive place to access for those who are in great need of help and support as well as working with other services and agencies.

Ms. Alison Marks – Mental Health Administrator

People think homelessness is just about not having a home but they are mistaken. If as a society we managed to consistently give many of the clients that come to GCS a house to live in, a significant percentage would still end up street homeless again within months. The people we target our services at have long term and deep-seated issues ranging from, for example personality disorder connected with past trauma, mental health issues, family and relationship breakdown, refugee and immigration issues, through to drug and alcohol addictions. Many find themselves in a state of continuous crisis and successfully helping is never simple. In a world where so much that we perceive is condensed to sound bytes - linear and quantifiable - helping the homeless population can be very challenging. Staff constantly battle to get treatment for those people who more often than not do not fulfil limited criteria for access to services. People say there isn't enough money and that these restrictions are needed to save money, but they fail to see the long-term implications for the direct and immediate costs to the state and the quality of everyone's day to day life. Since multiple A&E attendances, avoidable critical illness and alcohol and drug related injuries and crimes are far more expensive when neglected, these short-term visions fail everyone. Unless we want to become a society where people rotting in the street is an option, there need to be more flexible and pluralistic policies that enable professionals to make informed and individual decisions about care thereby assisting each other to get on and do their jobs properly and effectively.

I will continue to do my part to direct people towards the help they need and present a consistent, reliable, fair, warm and professional reception experience. I hope that by showing respect and upholding boundaries it will in some way encourage self-respect and that through the information, advice and available services at GCS we can help people to find a way out of the challenging situations life has given them.

I am constantly inspired by the people I work with and I see them under many difficult circumstances, rise to the occasion time and time again. The team at GCS continue to uphold their values and act with professionalism and compassion. GCS is a unique and essential institution, a beacon of light in an ever-darkening climate. Long may it survive.

PRACTICE MANAGER

Mr. Robert Bolus – Practice Manager

Robert has been working in homelessness for more than 27 years. He has witnessed the many changes and challenges the sector has endured over the years. He also manages Wytham Hall Supporting Housing, a charity offering supporting accommodation for the homeless with medium to low supporting needs.

Sadly, Robert is retiring at the end of November 2013. His wealth of knowledge in the field of homelessness will be undoubtedly missed. And we all, team and clients too.

We asked Robert to write a small piece before his departure. The team wishes to thank Robert for all those years of invaluable work and dedication to the cause of homelessness.

Robert's piece

In 1977 I left South Africa for a 2 year travelling trip in Europe which coincided nicely with my call-up for active service to fight the Cuban army supporting the left wing faction in Angola. After travelling in Europe and working in London, in 1978 my insecurities bubbled to the surface by way of wacky backy so that I could no longer ignore them, having been effectively orphaned at age 12.

Hungerford Drug Project directed me to Great Chapel Street where I met the enigmatic Doctor who told me 'You don't seem too anxious sitting there, come and see me at my Notting Hill surgery tomorrow morning 'I obeyed unflinchingly as he gave a sense of knowing what he was talking about.

Thence began 3 years of psychotherapy and involvement with the group I still live with today at Wytham Hall, first by doing reception at the Notting Hill surgery and then by managing Great Chapel Street surgery for the last 27 years. The experience hasn't always been easy but it has always been rewarding and has led to me enjoying life more later on. I will always be grateful that chance led me to these doors as a patient in 1978. Who knows where I would have ended up if not for that fact.

I am now set to retire in November 2013.

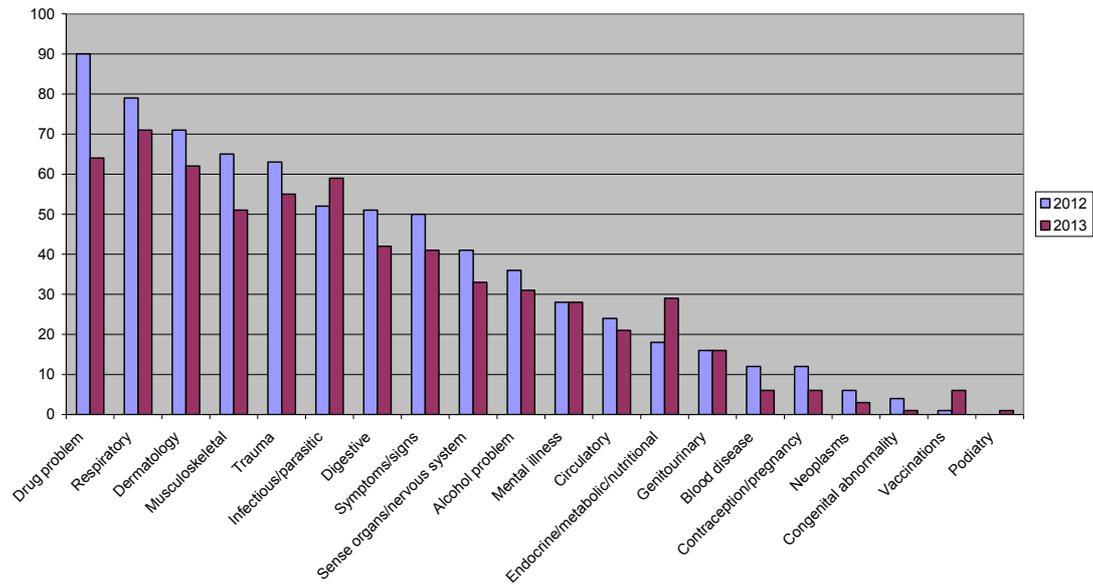
The homeless scene has changed a lot since 1984 when I started working at GCS. There were no resources then and every bit of funding was hard fought. Now homelessness is acknowledged and planned for and well funded. Then it was mainly Scots and English and Irish on alcohol and some drugs. Now it is a mix of East Europeans, Eritreans and some UK heavy drug users. The GCS service has evolved over the years to be a one stop shop and is probably the longest lasting and most renowned homeless centre in the UK. It is time for some fresh blood for the new challenges ahead!

Stats

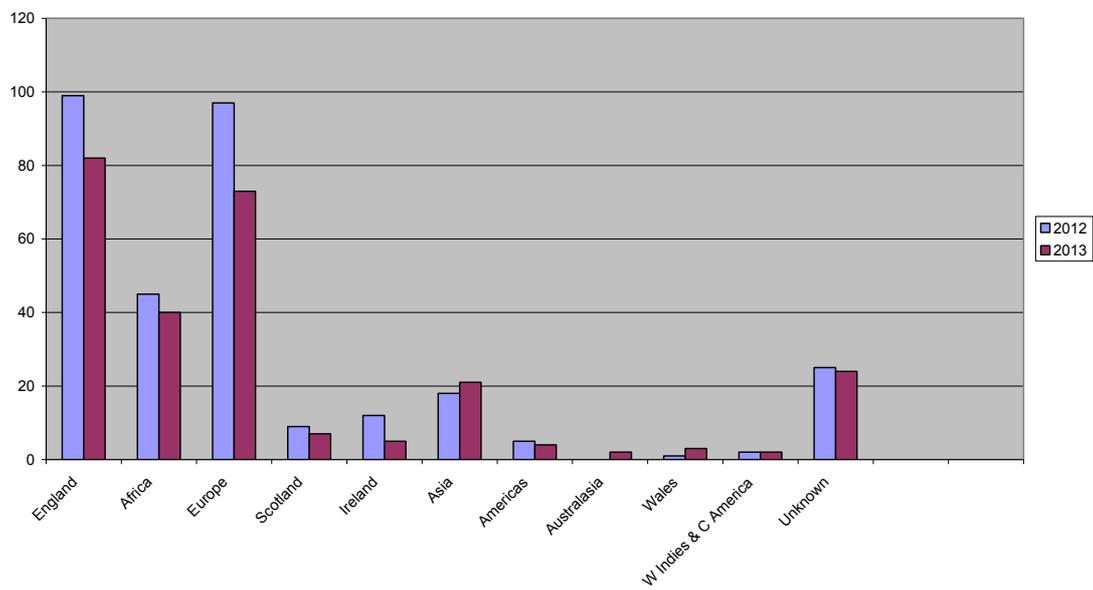
The advice worker saw 934 patients in y/e 2012 and 928 patients in y/e 2013.
The counsellor saw 55 patients in y/e 2012 and 222 patients in y/e 2013.

Patient profile and presenting health problems

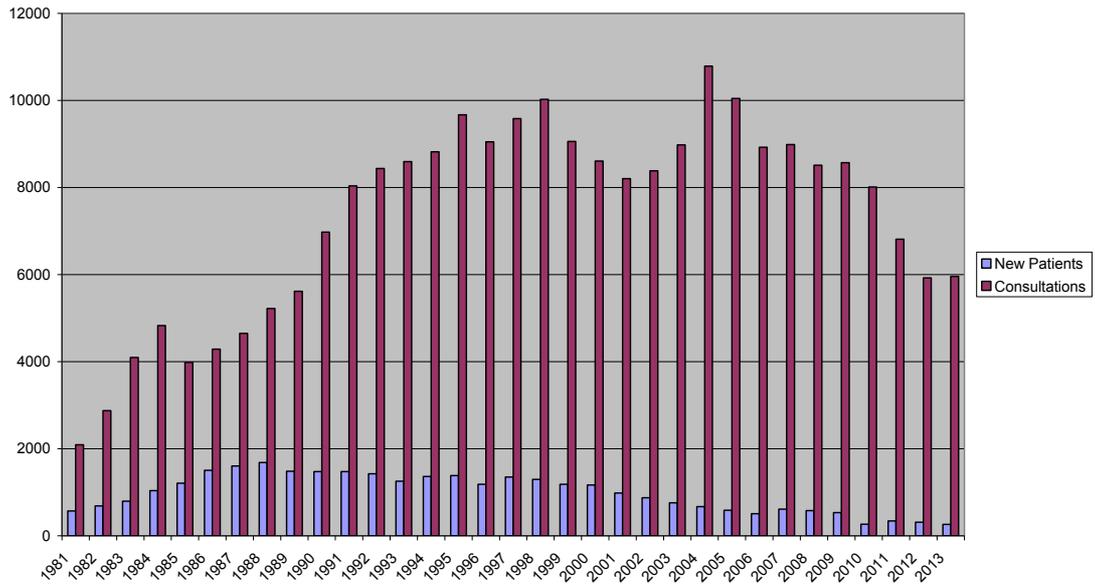
PRESENTING PROBLEMS - new patients



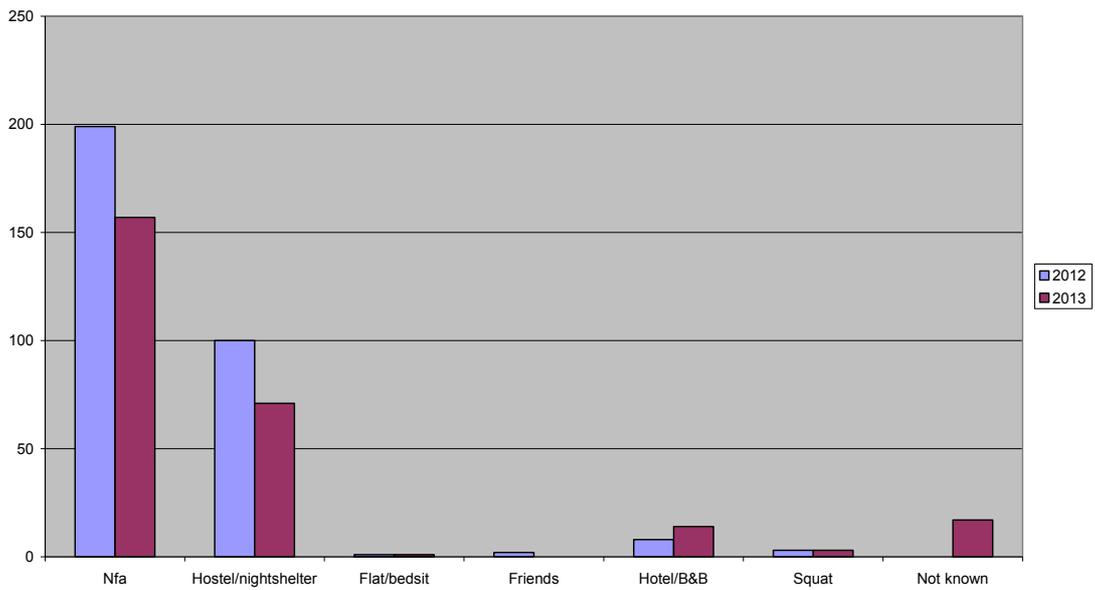
New patients - Place of birth - y/e Mar 2012/13



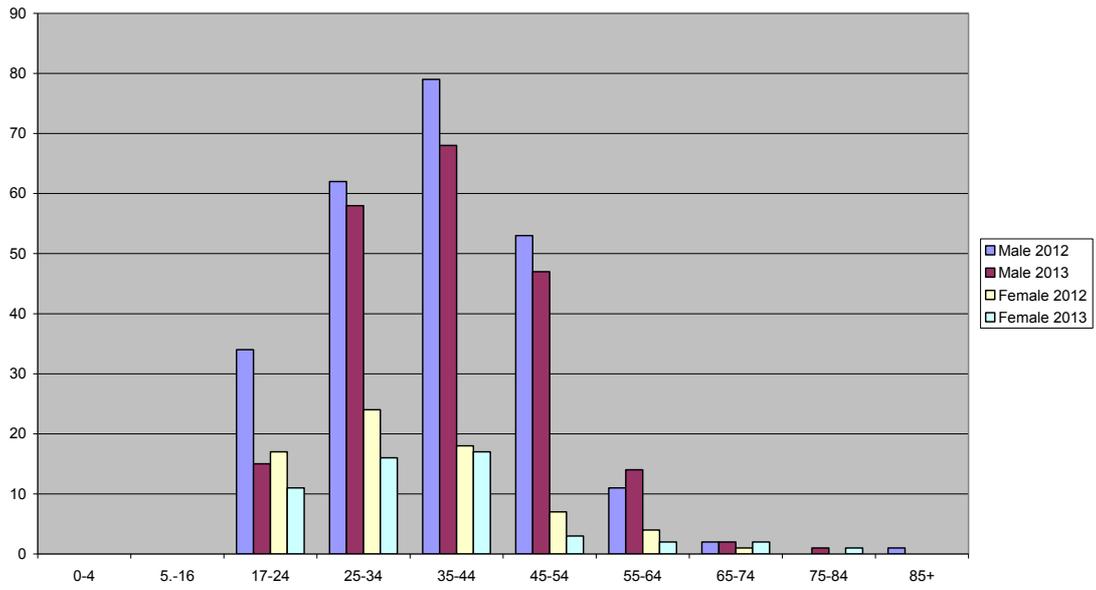
GREAT CHAPEL ST MED CENTRE



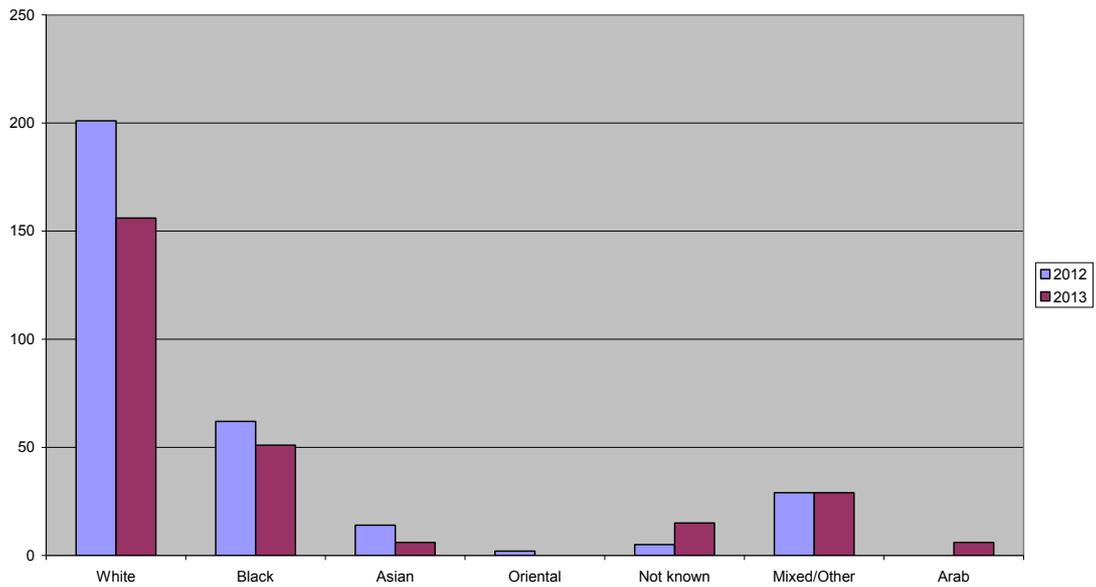
New patients - accommodation y/e Mar 2012/13



New patients - age - y/e Mar 2012/13



ETHNICITY



GCS DOCTORS' REPORT

Dr Philip J Reid

BA (Oxford) MBBS (London 1989) MRCP DRCOG MRCGP

Dr Philip Reid trained at Oxford University and St Mary's Hospital in London. After qualification he trained in general medicine in west London hospitals before gaining the MRCP qualification. He then specialised in general practice obtaining the MRCGP qualification and DRCOG qualification in obstetrics and gynaecology.

We continue to offer 8 GP sessions a week on a walk-in basis for homeless people in Westminster. Dr Reid is the lead GP. Dr Natalie Miller joined the team in 2011 and provides the core sessions. Dr Ramsden and Dr Mistry also run a session each. We are grateful to them for their diligence and resilience in, what can often be, difficult and distressing situations.

GCS continues to offer easy access to medical and social care for homeless people in Westminster. We see individuals who are established homeless people with a connection in Westminster as well as those with no connection and others with even fewer rights such as failed asylum seekers and immigrants for the A10 countries. It is now usual to need an interpreter at some point during a clinical session. The work with these groups is difficult and involves managing acute illness and attempting to control and manage longer term illnesses within the restrictions of their circumstances.

The more traditional homeless population are now represented by those for whom the homeless lifestyle has become a way of life despite offers of housing and support. The challenges of making a genuine engagement with some of these individuals are great. We have addressed this with the development of our outreach service and devoted 8 hours a week of nursing time to this. There have been a number of consequences of the outreach. Firstly we have reached more vulnerable people and drawn a proportion into attendance at the clinic. Secondly we have improved our working relationships with the outreach workers and day centres. Thirdly it has led to better liaison with accident and emergency departments, where attendances of homeless people have been rising. During the winter two staff members worked extra hours in the evening at the cold weather and night shelters to offer medical and social advice and care and to educate the staff (often volunteers) about the services available and how best to use them. (see separate report).

We have continued our Tuesday morning multidisciplinary meetings which allow us to discuss complex cases and liaise with our partners in the care of the patient, particularly those under the care of Turning Point for their addictions or under the psychiatric care of the Joint Homeless team. These meetings also allow us to share our own anxieties about individuals who present excessive vulnerability or risk. We also would like to thank John Connelly, who as Lead Counsellor for the homeless service in Westminster, leads staff support sessions once a month. He has also considerably developed the understanding of people with personality disorders and the services available to them.

Great Chapel Street has joined the Central Community Care Group (CCG), which has brought us closer to the mainstream practices and to the plans to improve care for the people of Westminster. This has allowed us access to the Patient Referral Service,

which has improved the efficiency by which we can get appointments and investigations for our patients. The CCG has been very attentive to the needs of homeless people and is keen to improve the services, the continuity of care and to reduce the inappropriate use of services such as A&E. To this end they financed the extra outreach sessions during the winter.

We look forward to the developments that the current reorganisation of the health services might bring and the opportunities it will give us to represent the needs of our patients and ensure services are adapted to those needs.

Dr Simon S Ramsden MA (Oxford) MD MB BS (Hons. London 1984) MRCP (UK) MRCGP (Dist) - Senior Partner

Dr Ramsden trained at Oxford University and St Mary's Hospital Medical School. He won a number of scholarships and passed finals with distinctions in pathology and pharmacology. He trained in general medicine at London teaching hospitals obtaining the MRCP qualification before re-training in general practice. He passed the MRCGP exam with distinction. After joining the surgery in 1987 Dr Ramsden received a doctorate in medicine from London University for epidemiological work on epilepsy. Special interests include adult general medicine and child health.

Dr Hitesh Mistry BSc, MBBS (Lond), MRCGP

Dr Hitesh Mistry trained at King's College School of Medicine, London. He spent time publishing neuroscience research during an intercalated BSc in physiology, and obtained a 1st class honours degree. He trained in Adult medicine in London hospitals, before completing his specialist training in general practice at St Mary's Hospital in Paddington. He completed his MRCGP with Merit and has been working as a GP in the area for over 4 years.

Dr. Natalie Miller MBBS BSc nMRCGP DCH DFSRH

Dr Natalie Miller trained at Imperial College School of Medicine in London and graduated from there in 2006 with Honours in Surgery. During her training there she did an intercalated BSc degree in Psychology & Psychiatry and was involved in research at the Dangerous & Severe Personality Disorder Unit at Broadmoor Hospital. She completed her General Practice training in North West London gaining her MRCGP qualification alongside a Diploma in Child Health and a Diploma in Family Planning.

It has been an interesting and challenging year for Great Chapel Street Medical Centre. The impact of austerity measures has weighed heavily on our vulnerable population who have been coping with changes to welfare, immigration and resources at a time of greatest need. Our clinics have been busy and there has been an increasing need for outreach work and complex case management.

We have experienced a decrease in the availability of homelessness services for many of our patients as resources are stretched and eligibility criteria tightened and have been expanding our service to meet these growing needs. The completion of minor illness training by our practice nurse Brenda Hamilton has reduced waiting times for

patients, many of whom can now be assessed and treated without having to wait for a doctor.

The development of our nurse-led outreach service run by Maxine Radcliffe has led to improved communication with day centres, secondary care services and accident and emergency departments. It has also meant that the most entrenched rough-sleeping patients are being reached and targeted for healthcare.

We are piloting a community HIV clinic in our surgery in collaboration with the team from 56 Dean Street Sexual Health Clinic and hope to expand this to cover Hepatitis in the near future.

Despite all these changes, the ethos and vision of Great Chapel Street Medical Centre remain the same: providing good quality holistic healthcare to vulnerable homeless people across Westminster. We continue to work hard to promote healthy living with smoking cessation, contraceptive advice, referrals for exercise schemes and specialist support for drug and alcohol problems. We have been offering vaccinations against blood borne viruses and influenza to all our patients and catch-up MMR vaccines for new entrants to the UK. We have also been spending time with our patients who have chronic diseases such as diabetes or hypertension ensuring they understand their condition and optimising their treatment.

Mental health problems remain rife amongst the homeless population. We are lucky to have a fantastic mental health team here including a Clinical Nurse Specialist, Counsellor and Consultant Psychiatrist. As a GP, this is an invaluable resource for referral and advice.

I suspect the coming year will present yet more challenges. The re-organisation of the NHS and ongoing overhaul of Social and Welfare systems will lead to many changes. I hope that throughout this unsettling time, patients will experience some stability and continuity of care at Great Chapel Street Medical Centre.

PRACTICE NURSE

By Brenda Simmonds and Maxine Radcliffe

This has been a busy year for the practice nursing team at Great Chapel Street. We have expanded our outreach and case management capacity whilst still continuing to run clinics every weekday in the medical centre.

Brenda Hamilton has been busy ensuring the smooth day to day running of clinics and chasing all the ongoing screening and other routine work that inexorably builds up. She has also organised a small clothing and other essentials store that patients can access at the nurses discretion since patients often present with heavily soiled or inadequate clothing and shoes.

Maxine Radcliffe has taken a lead on all outreach activities in the practice and has been working in partnership with a number of different teams across Westminster to both see new patients that outreach teams feel have unmet health needs and case manage and support longer term entrenched rough sleepers in managing their health needs.

Teams we have been working closely with include

- St Mungos - West London BBS and Compass teams

- Central St Martin in the Fields outreach and BBS teams
- Turning Point (SWDAS)
- JHT
- Dean St hostel (One housing)
- UCH and Royal Free pathways teams
- 56 Dean st

This is far from an exhaustive list since Maxine has also visited and provided health needs assessment and advice to staff and patients in variety of other organisations such as Hopkinson House, Newman St Hostel, Church Army Womens Day Centre amongst others.

Maxine has also been leading on liaison with A+E departments notably UCH and St Thomas' where many patients attend. We now have named nurse contacts in those departments that we meet with to discuss and plan care. A similar arrangement with St Mary's is in the works.

As a direct result of the case management work that happened around one particular client we have also developed a collaboration with 56 Dean St Clinic providing a new monthly consultant led clinic at Great Chapel Street for Infectious Diseases with a focus on HIV and hepatitis. There is also a drop in GUM screening clinic simultaneously

There are a number of new exciting potential nursing developments in the works for the next year

- Development and delivery of a full Hepatitis C treatment pathway at Great Chapel Street.
- Further expansion of the successful winter outreach program.
- The Great Chapel St Nursing team is part of the London wide Homeless Nursing Network which is organising a London wide conference for the new year

About the nurses

Maxine Radcliffe RN BNurs MSc PH(Man) DTN

I trained in Manchester and worked in Emergency Assessment there. I then became involved in development of wilderness medicine and activist medical training whilst working as a District Nurse in London. I have worked in a variety of settings across the UK and Europe as well as providing healthcare and training with a variety of NGO groups working in Russia, Ukraine, Borneo, Mexico and the USA amongst other places. I am a visiting lecturer on the Diploma of Tropical Nursing at the London School of Hygiene and Tropical Medicine.

PSYCHIATRY

— By Dr. Liz Jackson, Consultant Psychiatrist, MBBS (London 1992) MRC Psych (1997)

Dr. Elizabeth Jackson trained at London University. She has trained as both a psychiatrist and a GP and has been working as a Consultant Psychiatrist in Westminster for the last ten years.

She provides two sessions of psychiatry expertise into Great Chapel Medical Centre.

I have been working two sessions of time at Great Chapel Street for the last eighteen months. These were initially two clinics a week, but I was keen to integrate psychiatry more into the multidisciplinary team and so for half a session I now meet with all other members working at Great Chapel Street and partake in the team meeting where complex cases are discussed. For the other session and a half I run a clinic service. Referrals come from GP's, Day Centres, hostels and outreach services and are initially seen and assessed by Liz Abrahams, a psychiatric nurse specialist. If she feels they need a psychiatric opinion she arranges for them to see me.

I see a broad range of mental illness, including substance misuse, personality disorder, mood disorders and psychotic disorders. The challenges in meeting the needs of the homeless population are specific, needing a holistic, multidisciplinary approach. The homeless population have a high rate of mental illness, and people suffering from mental illness have a higher rate of physical illness so it is good to be able to work so closely alongside the GP's here in the practice.

Mental illness co-exists with homelessness for many reasons one of which is that many factors that may increase the risk of mental illness may also increase the risk of homelessness. These include childhood trauma, familial instability, foster care, family history of mental illness and involvement in the Criminal Justice System.

Sadly the homeless mentally ill are often neglected for various reasons including poor access to services. Many homeless people have suffered previous traumatic experiences which can lead to a basic mistrust of professionals. This is significant as we know the sooner a mental illness is treated the better the prognosis. Here at Great Chapel Street there is a unique opportunity for patients to be seen and to engage with services in the easiest way possible as we are all situated under the one roof. At a time when mainstream health services are facing considerable financial austerity it has been good to be able to engage people and provide a stable treatment environment while all else around them is chaotic.

I have often continued to treat people for a period of time once they are housed to enable them to then link effectively with mainstream psychiatric services.

Great Chapel Street provides an opportunity for patients to be seen and assessed by a psychiatrist and treatment options including medication and psychological treatments discussed. As we are flexible and easily accessible it is more likely that people will engage with services here where we can act as a bridge into more mainstream services further down the line. For some this is their first opportunity for treatment of mental

illness and these challenges patients respond well to treatment which in turn leads to a better quality of life.

CLINICAL NURSE SPECIALIST REPORT

– By Liz Abrahams

I started working at Great Chapel Street Medical Centre as Clinical Nurse Specialist (Mental Health and Substance Misuse) four months ago. Shortly after arriving here I bought a map of the world and stuck it up on the wall next to my desk. Geography never being a strong point of mine, I was keen to locate the numerous countries of origin people who visited me were from.

As Dr Reid commented: ‘The world really does walk in through the doors at Great Chapel Street’.

Homelessness as with mental distress and use of substances as coping mechanisms is no discriminator of class, culture, creed, gender or ethnicity. A fact born out by the diversity of individuals I meet on a daily basis.

My role at Great Chapel Street is commissioned by Central North West London NHS Foundation Trust (CNWL) and I wouldn’t be able to do my job without support from Dr Liz Jackson, Consultant Psychiatrist who is at the Medical Practice two sessions a week (and always available at the end of the phone or by email) and my Supervisor, Mr Richard Craven who is Clinical Lead for Dual Diagnosis at CNWL. Furthermore, I have excellent back up and support from the multi-disciplinary team at GCS.

I usually see people on a drop in basis – My day to day role consists of meeting people and screening and assessing mental health and or substance misuse issues. This is always done in partnership with each individual who is at the centre of their care. Some people continue in treatment with me over a period of days or weeks, others may only be seen for a one-off intervention and sign posting forward. Dr Jackson is available for people requiring further comprehensive mental health assessment and follow up as necessary.

Things have changed a great deal since I started working as a Mental Health nurse in the 1980’s. Back then, people were readily diagnosed/labelled, medicated and more often than not packed off to one of the big old psychiatric hospitals stuck out in the middle of nowhere (alienating people from family, friends and their own communities and further compounding the belief that mental distress should be kept away from every day people in every day society).

Thankfully a lot has changed since then. Nowadays it’s far more likely that people needing mental health support will initially be seen in Primary care without need or desire to remove them out of society and all that is familiar to them. If more intensive support is required than can be offered at Great Chapel Street, we have access to secondary care services via CNWL: the Assessment and Brief Treatment Team, Home Treatment Teams and Recovery teams. Sometimes it is helpful for people to have support from a 24/7 team of mental health professionals – for example in times of crisis or to stabilise in treatment. Where this is necessary we are able to

refer people to the Gordon Hospital. Such admissions are usually short and people are followed up in the Community by an allocated Care co-ordinator under the Care Programme Approach (CPA) – and of course remain under the same GP as prior to their hospital admission.

There is a strong ethos of support here at Great Chapel Street. Both for the people we are seeking to provide a service for and support amongst each other as a staff team.

Life can be hard and someone more eloquent than me, commented that ‘no (wo)man is an island’. Sometimes it feels just like that though. At Great Chapel Street we realise we can’t tackle homelessness by ourselves. It is too overwhelming. We are not an Island – and rely heavily and gratefully on one another and our partners, such as, Connections, Passage, West London Day Centre, Inspire, Shelter from the Storm, Rolling Shelters, Turning Point, St Mungos, Joint Homeless Team and on and on.

Anyone who has experienced homelessness will be no stranger to discrimination. Over recent years some of the major inequalities have begun to be addressed: for example, stigma experienced by those experiencing mental distress or substance misuse and the prevalence of racism within the mental health system. It is imperative, particularly in this time of economic decline and imposed austerity measures that we keep the issues of homelessness at the top of our agenda.

There is no good reason why people lacking a permanent roof over their heads should not have ready access to the same level and quality of primary care as the general population. We haven’t achieved this – yet – but the will is here at Great Chapel Street. The desire is live and kicking. For me this is inspirational and I’m glad to be part of a team that is not just ‘talking the talk’, but actively campaigning and working towards equality for homeless people – for access to timely and appropriate quality mental health and substance misuse treatment. We’re not there by a long shot yet – but I’m pleased to say I think we’re moving in the right direction.

COUNSELLING

By Mr. John Conolly – Lead Counsellor for the Homeless Health Team

Introduction -

The counselling service at GCS this last year provided a total of **232** individual face to face counselling sessions to **44** patients, and **37** Anger Support Group sessions to a total of **144** homeless individuals. This has led to an evolving understanding of the ‘Homeless Mind’; how best to engage with it and hopefully help heal it.

The Homeless Mind

‘Home’ for Papadopoulos (2003), is the primary condition which provides the space for the continuity of secure attachment bonds between an infant and parent, fundamental to the infant developing a secure sense of self.

In this space, (usually called ‘home’), ideally, the infants’ core basic needs are fulfilled by the parent. The need for security, the validation of: needs and emotions, self initiated actions including spontaneous play; and the establishment of realistic limits (via guidance), are more or less met; this leading to the infant developing a secure sense of self, the ability to recognise and regulate its emotions, be spontaneous,

accept limits, and relate to others constructively; thus a person able to make use of the opportunities in its environment.

However, when these needs are not met, the developing infant, child, develops what Young et al (2003) have termed ‘ Mal-adaptive Schemas’; thoughts, feelings, physical sensations, memories and images which drive both destructive and self-destructive behaviours. Mal-adaptive schemas (**MAS**) develop when the infant/child has not had its needs validated and met, but on the contrary has been made to feel rejected, abandoned, worthless, ignored, angry, on a persistent basis. Researchers, (Farrell & Shaw, 2012, Arntz & van Genderen, 2009) see MAS as underpinning Personality Disorders.

Personality Disorder (**PD**) is a controversial yet useful description for a range of longer-term mental health difficulties often first presenting in younger adulthood. The two main sources of diagnostic guidance are the International Classification of Diseases 10th edition (ICD 10) and the Diagnostic and Statistical Manual of Mental Disorders (DSM V).

A history of childhood abuse appears to be associated with the diagnosis of PD (Alwin,2006) and the behaviours observed in people with PD can be described as ways of coping with this and further ongoing and sustained traumatic experiences (DOH, 2010).

Citing research based on unstructured clinical assessments for PD, Maguire et al (2009) suggest a rate as high as **70%** for homeless people in Hostels, and **58%** for research using diagnostic measures.

As a consequence of this emerging body of evidence correlating homelessness and the personality disorders the Department of Communities and Local Government has issued guidance on **PIES** Psychologically Informed Environments, (CLG/MHDU, 2010, Keats, et al, 2012) to frontline homelessness services on how best to recognise and respond constructively to the emotional and psychological needs of homeless people.

‘Homelessness.....could be viewed as both a symptom and a communication of unhoused and dismembered states of mind characteristic of people with personality disorder’ (Scanlon and Adlam, 2006).

These authors go on to question how one could ever feel secure in accommodation when due to the inability to make and sustain positive relationships, one’s own internal space/mind is experienced as chronically empty ? Even when re-settled,how likely is it that someone will stay that way?

According to Seligman (2011), adult emotional well being depends on experiencing regular: positive relationships, and emotions, engagement, meaning & achievement (**PERMA**). Homeless people with PD, even when housed, may well be unable to meet these needs and require ongoing support.

In this sense, being street homeless for some (the mind switching off in its need to focus on basic moment to moment survival and being constantly distracted or numbed) is a perfectly functional coping strategy in the face of unbearable challenges

in negotiating the complexities of (any) relationships, including healthcare ones, and/or deep chronic inner emotional emptiness.

Recovery

In this context helping 'Recovery' must be seen as an enhanced service and clinical response aimed at enabling the homeless person to bear the anxiety of engaging in a healthcare relationship, ultimately geared at helping heal the maladaptive schemas, and further re-integrate into society. Thus a *psycho-social* approach supporting the person to meet their PERMA needs on an ongoing and self-sustaining basis is needed.

Service Activities

The service offers one to one **drop –in and appointments based counselling** sessions, as well as **Anger Support Group sessions**.

It also offers **consultancy based services** in the form of:

Staff self-reflective groups; the co-ordination of the Westminster Personality Disorder Network and PD Awareness workshops

A presence on various advisory panels such as:

- The Tri-borough Homeless Health Steering Group
- The Environmental Health Hoarding Panel
- The Complex and multiple needs Sub-group
- The Well at Home Project Panel

Promotional Activities include:

- Presenting at the Homeless Health and Inclusion International Conference,
- Publications (Conolly, J. and Ashton, P. (2011), Conolly, J.(2012),
- Submitting a bid for a Homeless Personality Disorder Service

¹ References

Alwin, N. 'The Causes of Personality Disorder', Chptr 3, pps 41-58, in 'Personality Disorder and Community Mental Health Teams – A Practitioner's Guide', (2006), Sampson, McCubbin and Tyrer, John Wiley & Sons, Ltd.

Arntz, A. and van Genden, H. (2009), 'Schema Therapy for Borderline Personality Disorder', John Wiley & Sons, Ltd, Chichester.

CLG/MH DU (2010), 'Guidance on Meeting the Psychological and Emotional Needs of People Who are Homeless', www.nmhd.org.uk/complextrauma

Conolly, J. and Ashton, P. (2011), 'Staff and ex-service user co-working: a counselling service's enhanced response to multiple exclusion homelessness', Housing Care and Support, Vol 14 No. 4.

Conolly, J. (2012), 'Psychologically informed services: a counsellor's response', Housing, Care and Support, Vol 15, No 2, pp. 86-87.

Department of Health; 'Healthcare for Single Homeless People', March 2010, Office of the Chief Analyst.

Farrell, J. M. and Shaw, I.A. (2012), 'Group Schema Therapy', Wiley-Blackwell, Chichester.

Keats, H. Cockersell, P. Johnson. R. and Maguire, N. (2012), 'Psychologically informed services for homeless people – good practice guide', www.rjaconsultancy.org.uk

Maguire, N.J., et al. (2009), 'Homelessness and complex trauma: a review of the literature', Southampton, UK, University of Southampton

Papadopoulos, R. k.(2003), 'Therapeutic Care For Refugees', Karnac, London, New York.

Scanlon, C. and Adlam, J. ‘Housing ‘unhoused minds: Inter-personality disorder in the organization?’, (2006), Housing Care and Support, Pavillion Journals, (Brighton) ltd.

Seligman, M. (2011), ‘Flourish’, Nicholas Breadley Publishing, London, Boston

Young, Klosko and Weishaar, (2003), ‘Schema Therapy’, Guildford Press, New York

DENTISTRY

**Dr. Cyril Brazil BDS MSc
and Ms. Farah Askaridou
BSc Registered Dental Nurse**

Dental care differs from GP medical care insofar as it is generally perceived to be mostly elective. Patients usually decide if and when they wish to have dental treatment. The homeless often make the choice to delay examination and treatment till the presenting condition has become so acute and urgent that often the only option is extraction.

The demographics of our clinic are such that we have many patients from societies where regular dental care was never an option. These patients have very high levels of oral and dental disease and need much more treatment than the indigenous population. In our clinic we remove more teeth, have a greater number of surgical extractions and provide more dentures than any other special needs clinic in the Trust. This is our *raison d’être*.

Sadly we also have a high appointment failure rate and uncompleted treatments. This wastage of time results in a higher than normal cost per patient to the trust.

However we must take a positive view of our support for patients. Generally any patient with pain will be seen on the day, and usually provided with treatment to alleviate their suffering usually an extraction, sometimes a dressing or root canal treatment, straight away. Often the extractions are difficult, requiring additional surgery but we are skilled in oral surgery and keep nearly all our treatments in house.

Our client group find referrals difficult. They require consultations elsewhere by appointment arranged by letter followed by another appointment for treatment usually some weeks ahead. Many if not all will find this arrangement daunting and will not see it through.

We remove multiples of rotten teeth, provide many sets of dentures provide aesthetic tooth coloured fillings on front teeth carry out root canal treatments and provide oral health advice and give away toothbrushes and toothpaste.

Unlike any other NHS dental clinics our service is totally free of charge regardless of our patients’ exemption status. With the support of CLCH which is funded by Westminster we are proud to continue to offer this essential service to all our homeless patients.

PODIATRY

Ms. Alison Gardiner
BSc (Podiatric Medicine), HCPC Reg. MChS

Specialist Podiatrist for Homeless and Vulnerable People
Central London Community Healthcare.

Painful feet can be a big problem if you are on the streets!

The podiatry service continues to be well used by patients who present with a diverse range of foot conditions including heel pain, diabetic foot ulcers, and ingrowing toenails. The drop in nature of the clinic makes access easy for those who may have difficulty keeping appointments in mainstream health services.

We try to provide a service that treats patients holistically, is friendly and caring and takes into account our patients individual circumstances.

Podiatry degree students on placement from the University of East London report that they get a lot out of the sessions and gain a better understanding of how socio economic factors including mental health, drug and alcohol issues as well as homelessness can affect access to health care services and how this can be tackled in order to promote health equality.

Foot health screening sessions continue to be carried out in local hostels. This picks up many residents with untreated foot conditions who are then seen in the mainstream podiatry service or at one of the drop in podiatry clinics including Great Chapel Street if more appropriate.

PRIMARY HEALTH CARE MANAGER

Nicolás Vial-Montero

Mr. Vial-Montero is a Spanish-trained lawyer, who initially qualified with the Barcelona Bar Association before moving to the UK. Licentiate in Law by the Barcelona University in 1990. Specialised areas of practice include Intellectual property and commercial contracts but in the past few years he has focused his work on vulnerable people dealing with housing, immigration, welfare rights and debts problems. Has a special interest in criminology and mental health problems.

The Primary Health Care Manager's Report

Changes in policy and economic austerity are still the common denominator when addressing state funded provision for the most vulnerable. Overall services face the difficult dilemma of serving more people with more needs and with fewer resources across the board. Cuts in public expenditure, reforms in welfare, legal aid and the NHS are some of the factors reshaping the homelessness playing field.

Some of the changes affecting the way we work and our service users are the following:

NHS Level

The Health and Social Care Act 2012 encapsulates the most wide-ranging reforms of the NHS since it was founded in 1948; amongst which are the abolition of Primary Care Trusts (PCT s) and the creation of Clinical Commissioning Groups (CCG s). Public Health now rests within the Local Authority control. The Local government being the body responsible to improve health and wellbeing of local people².

Cuts and the influx of Migrants from Central and Eastern Europe

Additionally, other environmental stresses exerting pressure on public services and front line workers include a greater influx of European workers migrating to the UK, many of whom are not eligible for services. Such workers experience the problem of ineligibility for secondary services including welfare, housing and residential care (i.e. alcohol/drugs detox and rehab). Such precariousness can also be manifested in the deterioration of this group's mental health, due to their extreme social circumstances and inability to access services. Alcohol and drug dependence is another by-product of such circumstances. This picture leads to an increasing number of long-term foreign rough sleepers with no immediate plan of intervention and assistance available.

Stretching of services, ineligibility, consequences on the health of those without work and/or residency

High levels of stress and a sense of hopelessness, not uncommonly, can drive people to deliberately self-harm, overdose and to experience suicidal ideations. Homeless people may be temporarily admitted to an emergency bed in a mental health hospital, which are hard enough to find and all too often patients are too readily discharged onto the streets with little continuity of care possible due to their inability to access sustainable accommodation. Many of these destitute workers lacking residency status also present to A&E departments – prompting unnecessary and costly interventions for the NHS³. Each attendance to A&E is charged at a standard tariff rate (depending on complexity of presentations), which is further levied with costs of admissions or out patient follow-ups when necessary.

In conjunction to Ms. Maxine Radcliffe, our Practice Nurse and Lead Outreach Nurse, this year we carried outreach sessions in night shelters during the cold weather period, aiming to provide insitu interventions in order to prevent such high numbers of unnecessary attendances. A report of this Outreach Project is available in this annual report.

Joint Collaboration with other organisations

² Other changes include, establishing the independent NHS Commissioning Board, establishing new local authority health and well-being boards; developing Monitor as an economic regulator.

³ Data collected for 2011-12 – Source: DH Department of Health: 1) the average cost of a day case is £682, 2) the average cost of an elective inpatient stay excluding excess bed days is £3,215, 3) the average cost of a non-elective inpatient short and long stay combined excluding excess bed days is £1,436, 4) the average cost of an excess bed day is £264, 5) the average cost of an outpatient attendance is £106, 6) the average cost of an A&E attendance is £108.

We continue to work closely with other stakeholders in the homelessness community, such as Turningpoint, the JHT, the Homeless Health Team, Groundswell, Dean Street Sexual Health Clinic, and the outreach teams (BBS) in Westminster and other boroughs aiming at putting into practice health and social care plans effectively, thanks to proactive joint working.

Our Tuesday's meetings where we discuss complex cases to devise care plans and follow-ups within GCS team and external agencies attending have become crucial in the work we do. We work through a thorough examination of the patients' conditions and we structure a plan of action to help them with their needs: medically and socially. The intervention of third party organisations is instrumental to achieve these goals. Wednesdays have become a "hub" of sharing primary care know-how and a barometer of good practice.

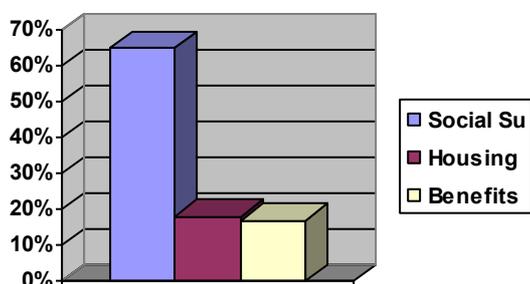
Three main areas of advice:

Housing, Benefits and Social Support⁴.

I saw a total of 934 patients in y/e 2012 and 928 patients in y/e 2013.

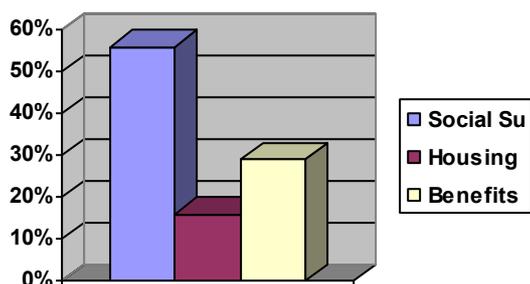
Immigration advice helps with clarifying benefits, housing and medical secondary care options. Helping people to obtain eligibility is the first step towards any action plan of recovery. **Benefits** are the passport for other benefits. Means tested benefits help to obtain other benefits. For example having been awarded JSA will help to obtain Housing Benefit. With benefits clients can access housing and pay for their daily living. **Housing**, undoubtedly helps people to settle, obtain treatment and reincorporate themselves into their communities. **Our social and advice work is instrumental to improving health and wellbeing of patients by helping them to secure accommodation and funds to regain stability.** The advice also tackles homelessness by preventing homelessness, helping with possession proceedings, stopping evictions, helping to reinstate benefits and maximising income so clients can sustain both accommodation and food. The advice is also about accessing housing through the statutory homelessness route or via the rough sleeper's initiative and in collaboration with the LA and their homelessness strategy.

April/May 2011/2012



⁴ **Housing**: applications, representations, appeals, referrals. **Benefits**: applications, representations, appeals. **Social Support**: debt advice, income maximisation, tenancy sustaintment, assessments of needs, liaison, referrals.

April/May 2012/2013



Social support has seen an increase in demand in the last couple of years, ranging from queries around people accessing services, navigating institutions, tenancy sustainment, the move on to mainstream services and social care needs. Housing queries and the ability to refer people to housing schemes and the housing department have gradually decreased due to the systematic shortage of housing opportunities and changes in policy. The greatest demand has been for advice and support around benefits, a consequence of the changes in the welfare system and the increased anxiety amongst clients frustrated by the difficulties in obtaining benefits. This has been manifested in a large number of representations before the Appeal Tribunal and on-going support when benefits have been discontinued.

Problems/challenges

Benefits

The social impact of the Welfare Reforms, Housing Benefit Cap and Universal Credit.

Universal Credit is a single benefit that aims at simplifying the benefits system by bringing together an assortment of working age benefits into one payment. Some of the challenges of these reforms are brought by the abolition of the Discretionary Social Fund, Community Care Grants and Crisis Loans for general living expenses (including rent in advance) have also been abolished. New Local provision will be administered by Las and Crisis Loans are replaced by a new national scheme of short-term advances. The abolition of giro and introduction of the Single Payment System, has made accessing funds harder for those suffering from learning disabilities or cognitive impairment, and generally, people with literacy problems. Online claims will also pose a challenge for those computer illiterate or not having access to, or those who find it difficult to cope with the stress of dealing with such environment, when resources have been reduced. Online submissions will have to include all the paper work required in a claim – all evidence at once – preventing further submissions. This is particularly challenging when people do not have all the paper work at hand or available when making a claim for benefit. Homeless clients struggle with ID and keeping important documents as a consequence to their transientness, chaotic lifestyles or simply because they lose or are subject to their property being stolen.

Benefits and Housing

In a similar vein, other changes include the ‘under occupancy’ rule which means that working-age tenants renting from local authority (LA), housing association or other registered social landlord will have their HB reduced if their accommodation is too big for their needs: 14% for one bedroom; 25% for two or more bedrooms. CTB is abolished and replaced with localised council tax reduction schemes, designed and administered by LAs and the devolved governments. This will be administered by the DWP. The Personal Independent Payment (PIP) will start to replace disability Living Allowance (DLA). In benefits appeals, the introduction of mandatory reconsideration: if a claimant disagrees with a decision, s/he must request a revision before s/he can appeal; direct lodgement of appeals with HM’s Courts & Tribunals Service. The claimant will send his/her appeal directly to HMCTS; time limits for the DWP to return its appeal responses to HMCTS. Contributory JSA and contributory ESA will remain in their present form, but will be administered through the same system as UC so that the treatment of earnings, claimant’s commitment, conditionality and sanctions will align with UC. DLA/PIP will not be part to UC.

The Cap is changing the map of living

From 15 April 2013 the benefit cap was introduced on the maximum amount of benefit that a household can receive: £500 per week per couples (with or without children) and lone parents; £350 per week for single adults. The immediate consequence of such caps has been clients being unable to pay the full rent in the private rented sector and having to rely on their other benefits to meet the shortfall with little money left to pay for food and other living expenses. Evictions have increased and people are moving to cheaper rental areas too, detaching themselves from their network of support, including family and habitual services. When evictions have occurred because of rent arrears, there is the danger of clients being (potentially) deemed intentionality homeless when approaching statutory housing providers, altogether reducing their re-housing prospective.

The psychological effect of the Benefit changes

In addition, there are psychological consequences to these changes. The benefits changes have created a great deal of anxiety to homeless patients. Not only because of the uncertainty of the new processes but mostly because in many cases their benefits have been stopped without the safeguards of the past, triggering a new kind of perverse presentation: “*benefits relapse*”. Benefits for a number of years were one of the few things that homeless people knew was somehow secure for them, something certain and settled. These being taken away has created a ferocious stress reaction in homeless people, often driving them to self-harm, relapse and overdosing.

Localism Act 2011

- provides for a new form of flexible tenure for social housing tenants,
- allows local authorities to discharge their duties to homeless people by using private rented accommodation,
- gives local authorities the power to limit who can apply for social housing within their areas,
- abolishes the Tenant Services Authority and provides for a transfer of functions to the Homes and Communities Agency,
- amends the way in which a social tenant can make a complaint about their landlord,

- Improves the ability of social tenants to move to different areas.

The Localism Act introduces very important changes in the Homelessness legislation. People subject to immigration control cannot be supported and the authorities' duty to all homeless people, who are not intentionally homeless, now ceases if they refuse reasonable accommodation.

Two major consequences: the elimination of the security of tenure and the re-housing in areas far from the actual connections of applicants. Taking away the security of tenure to vulnerable people is controversial as it means that they will not have the safety net of the court's discretion to keep them in accommodation when they may face eviction.

The price of putting people in temporary accommodation

The endemic shortage, for many years now, of social housing has pushed local authorities to temporarily house homeless applicants outside their boroughs with a variety of consequences. As primary care providers this poses the problem of not being able to exercise effectively the continuity of care to patients who may be accommodated far away from their usual services. Also, the risk of having a GP or a community service away from their areas, obstaculising an immediate medical response when necessary. Also this burden is manifested when people are not being able to register locally with appropriate providers due to their insecure and non permanent accommodation status. Some 32,643 homeless households have been re-housed out of their borough since 2009. In the year 2013 to April 10,833 households were re-housed in this way – a 16% rise on the previous 12 months⁵. Other consequences of the current environment include the increasing cost of temporarily accommodating homeless applicants, with £1.88bn spent in temporary accommodation in 12 of Britain's largest boroughs⁶. In Westminster alone the council is predicted to spend £41.8 million on temporary accommodation – a 63.5% increase this financial year. In addition, there has been an approximate 86% increase of rough sleepers in Westminster in the last couple of years. The welfare changes will only exacerbate the problem. In London 7,000 families depending on benefits, stand to lose more than £100.00 a week under the benefit cap and many are expected to become homeless as a result.

Some final thoughts

There is a considerable wave of opinion that argues the need for reforms at all levels, suggesting that it was a matter of life or death for the future sustainability of the welfare state. What seems paradoxically “unhelpful” is that when there is less work available and generally less opportunities for people to access services and recovery, exactly when these major changes are actually happening. Ideally, it would have been better if we were in a period of growth with economy that could respond to such a variety of social and care challenges.

⁵ Info from the DCLG Homelessness Statistics

⁶ Info from The Bureau of Investigative Journalism

PUBLICATIONS

Great Chapel Street Medical Centre

El Kabir D J

British Medical Journal 1982 284:480-81

Tuberculosis among the Central London Single Homeless

Ramsden S S, Baur S, El Kabir D J

Journal of the Royal College of Physicians 1988 22:16-17

Medical Care of the Homeless

Ramsden S S, Royal College of General Practitioners Members' Reference Book 1989:

362-63

A Mobile Surgery for Single Homeless People in London

Ramsden S S, Nyiri P, Bridgewater J, El Kabir D J

British Medical Journal 1989 298:3 72- 74

St. Peter's and the Homeless

El Kabir D J, St. Peter's College Record 1990

Mentally Disordered Homeless Offenders - diversion from custody

Joseph P L A, Bridgewater J, Ramsden S S, El Kabir D J

Psychiatric Bulletin 1990 14:2 70- 71

A Psychiatric Clinic for the Homeless in a Primary Care Setting in Inner London

Joseph P L A, Bridgewater J, Ramsden S S, El Kabir D J

Psychiatric Bulletin 1990 14:270-71

Approaches to the Medical Care of Homeless People in Central London

Ramsden S S

In: Smith S J, Knill-Jones R and McGuckin A (eds): "Housing for Health " 1991

Longman Group.

Quelques Observations sur les Sans-Abris

El Kabir D J

Paris, Les Temps Modernes 567. 1993

A Pragmatic Approach to the Care of the Single Homeless: its implications in terms of human resources.

El Kabir D J Ramsden S S

Dimensions of Community Mental Health Care (ed) Weller M and Mullen M WB

Saunders 1993.

Homelessness, Doctors, le Grand Siecle and St. Catherine's

El Kabir D J, St. Catherine's College Society Magazine 1992

Diversion Revisited

Joseph P

Journal of Forensic Psychiatry 1992 3:219

Non-custodial Treatment: can psychopaths be treated in the community?

Joseph P

Criminal Behaviour and Mental Health 1992 2:192-200

Psychiatric Assessment at the Magistrates Court

Joseph P

Report commissioned by the Home Office and Department of Health 1992

British Journal of Psychiatry 1994 164: 722-24

Psychiatric Court Clinics in the United States

Joseph P

Psychiatric Bulletin 1992 16:557-560

The Perception of Emotion by Schizophrenic Patients

Joseph P, Sturgeon D, Leff J

British Journal of psychiatry 1992 161: 603-609

Psychiatric Morbidity and Substance Abuse among Residents of a Cold Weather Shelter

Reed A, Rainsden S, Marshall J, Ball J, O'Brien J, Flynn A, Elton N, El Kabir D

Joseph P.

'Accessing Primary Care for Homeless People

Field, S (2000) Connect

Meaningful Occupation

Field, S (2000) Connect

Interview with homelessness Tsar

Field S, Mental Health OT Vol 5. Issue 3 p 4-7

Filling the Void,

Field S, Therapy Weekly (3rd August 2000)

Nursing and Homelessness: A review of nursing and the provision of health care for the homeless within the London Region

London Standing Conference for Nurses, Midwives, and Health Visitors, Nursing and Homeless Group (2000)

Meaningful Occupation and Homelessness: Conference report

Hughes, G, Field S, (2000)