
Plymouth Health Action Zone

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Plymouth Homelessness Review



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Contents

ACKNOWLEDGEMENTS	2
1 INTRODUCTION: WHAT IS HOMELESSNESS?	4
2 METHODOLOGY	5
2.1 LOCAL AGENCY INTERVIEWS	6
2.2 HOMELESS PEOPLE’S INTERVIEWS	6
2.3 THE LOCAL AGENCY AUDIT.....	7
3 EXPERIENCING HOMELESSNESS	8
3.1 EXPERIENCE OF LOCAL AUTHORITY CARE.....	9
3.2 OFFENDING BEHAVIOUR	10
3.3 SUBSTANCE MISUSE.....	11
3.4 MENTAL ILLNESS	15
3.5 PHYSICAL AND SEXUAL ABUSE.....	18
3.6 PHYSICAL AND EMOTIONAL ABUSE	19
3.7 RELATIONSHIP BREAKDOWN.....	19
4 WORKING FOR HOMELESS PEOPLE	21
4.1 CO-ORDINATION.....	21
4.1.1 <i>Areas of Benefit</i>	21
4.1.2 <i>Ethos</i>	22
4.1.3 <i>Confidentiality</i>	23
4.2 DIRECT ACCESS SERVICES	23
4.3 MOVE-ON ACCOMMODATION AND TENANCY SUPPORT	25
4.4 IMPROVED ACCESS TO THE PRIVATE SECTOR.....	26
4.5 GREATER CONSISTENCY WITHIN THE STATUTORY HOUSING SERVICES	27
4.6 AN IMPROVED ROLE FOR HEALTH AND SOCIAL SERVICES	27
4.7 THE LONG-TERM NEEDS OF ASYLUM SEEKERS	29
5 CONCLUSIONS	31
5.1 BUILDING A MODEL STRATEGY	31
5.2 MINIMALIST INTERVENTIONS	32
5.3 MOVE-ON, TEMPORARY AND SUPPORTED ACCOMMODATION.....	33
5.4 RESETTLEMENT INTO PERMANENT TENANCIES	34
5.5 PREVENTION OF HOMELESSNESS	34
6 RECOMMENDATIONS	35
6.1 PLYMOUTH HOMELESSNESS FORUM	35
6.2 THE INTER-AGENCY PROTOCOL.....	36
6.3 PRIVATE SECTOR ACCOMMODATION	37
6.4 OPEN ACCESS GP SERVICE	38
6.5 MOVE-ON / TENANCY SUPPORT	40
6.6 HOMELESS PERSONS UNIT	41
6.7 UNIFORM RECORDING.....	42

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David Phillips and Sarah Francis, May 2001.
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1 Introduction: What is homelessness?

The 1996 Housing Act placed a duty upon local authorities to provide assistance to homeless people. The form of help offered, indeed the decision as to whether any help would be offered, was dependent upon the ability of the person presenting themselves to the local authority to pass three tests. The first of which was that the person must have been genuinely 'homeless'.

Section 175 of the Act defined what it was to be homeless, it stated:

- “(1) A person is homeless if he has no accommodation available for his occupation, in the United Kingdom, or elsewhere, which he –*
- (a) is entitled to occupy by virtue of an interest in it or by virtue of an order of a court,*
 - (b) has an express or implied license to occupy, or*
 - (c) occupies as a residence by virtue of any enactment or rule of law giving him the right to remain in occupation or restricting the right of another person to recover possession.*
- (2) A person is also homeless if he has accommodation but –*
- (a) he cannot secure entry to it, or*
 - (b) it consists of a moveable structure, vehicle or vessel designed or adapted for human habitation and there is no place where he is entitled or permitted both to place it and reside in it.*
- (3) A person shall not be treated as having accommodation unless it is accommodation, which it would be reasonable for him to continue to occupy.*
- (4) A person is threatened with homelessness if it is likely that he will become homeless within 28 days”*

(See Arden & Hunter, 1996)

This was by no means the first legislation to impose a statutory duty upon local authorities to provide help to homeless people. A duty, albeit to provide temporary accommodation, was established by the early post-war Labour government in the form of the National Assistance Act of 1948. However, the type of accommodation usually provided by local authorities under this Act owed much to historical precedents in the form of the 'Poor Laws' and often consisted of 'reception centres' in which families were separated. It was not until 1977 that the next major piece of legislation was enacted. The Housing (Homeless Persons) Act has been described by Shelter as '*a huge step forward*' because of the Act's shift in emphasis from the provision of temporary to permanent accommodation (Holmes, 2001).

Nonetheless, both the 1997 Act and the 1985 Act that followed attempted to provide a clear definition of homelessness for the purpose of establishing clear limits to the extent of the duties placed upon local authorities. Consequently homelessness was

defined somewhat narrowly, referring only to a person not having accommodation that they were legally entitled to occupy (along with other members of their household). This definition came under fire as the result of a number of legal challenges in the courts, with the effect that a measure of the inadequacy of any accommodation occupied had to be taken into account by local authorities in determining whether or not an applicant was to be treated as homeless. Inconsistencies in the case law that resulted from these legal challenges made it necessary for the government to clarify the situation. This they did by codifying the definition of homelessness, in accordance with the broader concept (section 5 of the Housing and Planning Act 1986). This broader definition of homelessness confirmed the rights of those people “*who, although enjoying the benefit of one of the qualifying rights of occupation, occupied accommodation so bad that it would not be reasonable for them to remain in occupation of it*” (Arden & Hunter, 1996).

While this, broader, definition was largely welcomed it is still argued, by some, to be inadequate in relation to security, quality and affordability. These issues were, however, considered by a number of government documents that sought to offer guidance on the definition of ‘reasonableness’ used in the broader definition. Both the Department of the Environment (DOE, 1996) and the Welsh Office (Welsh Office, 1996) issued codes of guidance that made recommendations regarding the factors that should be considered by local authorities in determining whether existing accommodation was reasonable. These factors were:

- The physical condition of the property
- Overcrowding
- The type of accommodation
- Violence or threats of violence against the applicant and
- Security of tenure

The second was the ‘Homelessness (Suitability of Accommodation) Order 1996’, SI 1996/3204 “*which essentially applies a means test to the notion of ‘reasonableness’ and thus homelessness*” (Cowan, 1999).

However, the evolution of the homelessness definition has left in its wake a rather messy and often contradictory series of terms and definitions. So that it still remains possible for agencies with different agendas to apply the same terminology in different ways. Perhaps the best and most concise summary definition available is that provided by Shelter. In this definition Shelter contrasts homelessness with what it is to have a home:

“A home is somewhere affordable, of adequate size and design, in good repair, safe, secure and with support when required” (www.shelter.org).

To be without any of these things, is then, to be homeless.

2 Methodology

Insight Social Research Ltd was appointed by the Plymouth Health Action Zone in January 2001 with a remit to examine the health issues experienced by homeless

people in Plymouth, to assess the extent of engagement between homeless people and ‘appropriate’ services and to comment on any difficulties that homeless people might have in dealing with such agencies.

Additionally the research was to conduct an audit of local services and develop a multi-agency strategy for the future planning of services coupled with measurable health related targets.

The research encompassed three principal elements, namely:

1. A number of interviews with service providers in the voluntary, statutory and RSL sectors;
2. 46 semi-structured interviews with homeless people; and
3. An audit of service providers.

2.1 Local Agency Interviews

The interviews with local agencies were unstructured because of the huge differences between the agencies involved and the type of issues to be explored. Some agencies, for example, have a specific housing remit, while others were concerned with one or more of the many other issues that contribute to homeless people’s needs.

We were concerned through these interviews to discuss the agencies’ perceptions of homeless people’s problems and of the particular issues that contribute to homelessness in Plymouth. We were also concerned to identify the work that agencies’ were doing; their aspirations for the future and any barriers that they experienced in their attempts to achieve either.

We do not claim to have held interviews with every agency, however, we believe that we have held discussions with the majority of relevant agencies and have included examples of all types of project (see Acknowledgements) relevant to this research.

2.2 Homeless People’s Interviews

Semi-structured interviews were held with 46 homeless people in all. Each interviewee was a volunteer, but each also received an incentive payment of £15. The policy of making payments to interviewees was adopted for three reasons. Principal among these was the recognition of the value of the interviewee and of the information that they provided. We also recognised that interviewees made a significant investment in the project in terms of the time that they made available to the researchers, but more importantly in terms of the emotional investment represented by discussion of their experiences. Finally, it was a pragmatic way of ensuring that sufficient numbers of interviewees could be recruited.

Interviewees were recruited through a wide range of agencies in order to ensure a wide spread of circumstances and experience.

Table 1 - Sources of Interviewee Referral

Agency	Number
The Ship – Local Authority Direct Access Hostel	5

The Big Issue	4
Plymouth Women's Refuge	5
The Rough Sleepers' Initiative	4
The Shekinah Mission	4
Youth Enquiry Service	6
Local Authority Temporary Accommodation ' <i>The Battery Street Flats</i> '	5
Bed & Breakfast Accommodation	5
The National Schizophrenic Society	3
Stonham Housing Association ' <i>Alma Road</i> '	5
Total	46

2.3 The Local Agency Audit

The purpose of the agency audit was twofold. In the first instance it was intended to identify areas of service provision where there were gaps or duplication. Having collected such data it was possible to compile an up-to-date service directory that identified services and described referral criteria and referral methods.

The audit was conducted by means of a trawl of agencies using existing local directories, national directories, specialist publications and on-line databases. Each agency identified was sent a short questionnaire, designed to illicit only the precise information required and hence to encourage the maximum number of responses. The questionnaire is reproduced at Appendix A.

Agencies who failed to respond were telephoned to encourage a response and offered the opportunity to complete the questionnaire over the telephone.

The resultant directory has been produced as a separate document and is available in hard copy or by email from devon@shelter.org.uk

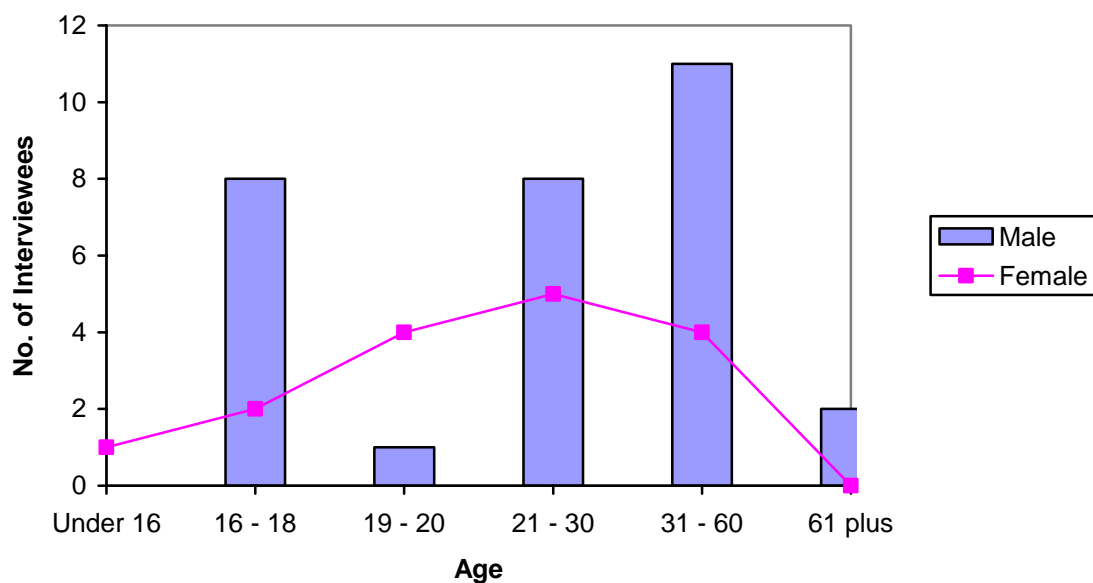
3 Experiencing Homelessness

During the course of this research we have been at pains to collect data that relates to homeless people's experiences and perceptions of what it is to be homeless. The following discussion is an attempt to relate those perceptions as honestly as possible, but without compromising the identity of the individuals. A small number of cameos have been put together to illustrate the experiences of homeless people in Plymouth. These cameos are composite illustrations, each based upon information given by a small number of interviewees with similar experiences. None is based upon any one individual.

The interviews took place with 46 volunteers (from a target of 55) and ranged from 40 minutes to 1½ hours in duration¹.

As expected the majority of interviewees were male (65%) and younger people outnumber older people. The youngest interviewee was a young woman of just 15 years of age, the eldest a man of 71 years.

Figure 1 - Interviewees, by age and gender



¹ See Section 2: Methodology, for more information.

Table 2 - Interviewees, by age and gender

	Number		Percent ²	
	Female	Male	Female	Male
Under 16 yrs	1	0	6.3	0.0
16 – 18 yrs	2	8	12.5	26.7
19 – 20 yrs	4	1	25.0	3.3
21 – 30 yrs	5	8	31.3	26.7
31 – 60 yrs	4	11	25.0	36.7
61 yrs plus	0	2	0.0	6.7
Total	16	30	100.1	100.1

3.1 Experience of Local Authority Care

Although women are outnumbered within this sample the number with experience of the care system is equal to that of men. This may be explained by the younger age profile of both sub-samples (see [Table 3-Table-3](#)).

Table 3 - Experience of the Care System

		Female		Male	
		Prior to	During	Prior to	During
Ex-Care	Under 16	1	-		-
	16 – 18 yrs		-	2	-
	19 – 20 yrs	1	-		-
	21 – 30 yrs	1	-	1	-
	31 – 60 yrs		-		-
	61 yrs plus		-		-

Cameo one, a typical foster placement, is a description given by both female and male interviewees. They complained of a ‘prejudice’ among social services, foster parents and the police, who expected children in care to be problematic and hence treated them as ‘criminals’ reinforcing the young person’s own self-image as unwanted.

The picture painted by these young people was not exclusively bad. One, for example, had found a ‘good atmosphere’ in a local care home with its own move-on accommodation (Independence Training Unit). Here he had found some stability, spending 18 months in one place he had felt secure and was surrounded by people of his own age and in similar circumstances. It should be noted that the importance of his peers in this environment significantly outweighed that of any adult support workers, who he

² Care should be taken when using percentage for such a small sample. Readers might therefore consider that the number of interviews should be considered in preference to the percentage of interviewees.

associated with promises that were not always kept.

Cameo One – Young Person Ex-care

W has no family to speak of. They are there, but they don't want to know, they've got problems of their own.

W went into care as a teenager. Why? W was 'wild', mum couldn't cope, dad wasn't around, and the teachers gave up.

A series of foster parent's followed. Some were nice, W is sorry to have given them so much grief; others were just after the money. None of them seemed to know how to handle a kid with emotional and behavioural problems. For example, they tried to enforce petty rules with the same vigour as more important rules, so that being 10 minutes late became a major incident and led to a test of wills, a permanent state of conflict and a breakdown in the placement.

3.2 Offending Behaviour

Offending behaviour is predominantly a feature of the male homeless population and in most instances predates their homelessness. However, it should be noted that for those interviewees with the most chaotic lifestyles it is difficult to conclude when their homelessness began. For such interviewees it is difficult to identify a period in which their housing could be described as secure even when living in the parental home. However, it is also true that for those interviewees with a history of offending this was in almost all cases a contributory factor to their homelessness, leading to the break-up of relationships with parents and partners alike and sometimes to spells in prison. Offending behaviour was frequently associated with drug misuse; it was also associated with aggressive and violent tendencies. Only two interviewees claimed to have stolen food because they could not afford to eat.

Table 4 - Offending Behaviour

		Female		Male	
		Prior to	During	Prior to	During
Offending Includes 'in trouble with the Police', excludes drug abuse.	Under 16				
	16 – 18 yrs			3	1
	19 – 20 yrs		1		
	21 – 30 yrs			4	
	31 – 60 yrs			3	2
	61 yrs plus				

Similar numbers of homeless people with experience of prison or remand (26%) were observed by Williams et al. (1995).

Cameo Two: Young Person thrown out by Parents

X is in his mid to late teens, unemployed and has no qualifications. He has a younger brother who still lives at home.

X's relationship with his parents has been going down hill since he was 13 years old. It was about then that X first tried cannabis. He had been smoking cigarettes for about a year already, initially to look like one of the gang, but eventually you get used to it. In any case he did not smoke that much, just a couple of fags a week.

By the age of 14 X was drinking regularly and had experimented with ecstasy and amphetamines. At the age of 16 he was stealing regularly in order to pay for his addictions, he frequently stayed out late and his performance at school was at best poor. Frequent fights at home had led to a complete breakdown of his relationship with his father, with the result that he had been asked to leave and had spent a few days sleeping at an older friend's flat before returning home for a few more months.

However, X's behaviour had not improved and in the latest fight punches had been thrown, the police called and this time X did not expect to be allowed to return home.

3.3 Substance Misuse

Substance misuse appears to be widespread; many interviewees (56%) used cannabis, some regularly although none of these saw their cannabis use as problematic. Other recreational drugs, notably ecstasy and to a lesser extent amphetamines, were also widely used, and again their use was seen as unproblematic. In a previous study of health impacts of homelessness in Plymouth, Harrison (1998) also found that interviewees drew a distinction between the recreational use of drugs (that is voluntary use which they felt that they chose) and use as a coping mechanism or because of addiction; "*describing how under difficult circumstances other men at sea would use alcohol and drugs subject seven took pride in the fact that he had only used drugs for pleasure*".³ Tony Adams, a recovering alcoholic, makes the same point. Seeing others as weak because of their addictions, he nonetheless viewed his own heavy consumption of alcohol quite differently because "*I was still enjoying drinking*" (Adams, 1999).

The availability and use of recreational drugs (for example, ecstasy and amphetamines) was largely confined to nightclubs, nonetheless both were also easily accessible from early secondary school age.

The number of interviewees who were or had used heroin was substantial (11%). All of the heroin users recognised heroin use as problematic, but explained their continued use in terms of acute addiction rather than in terms of any pleasure that might be gained from the drug. Only one interviewee claimed to enjoy using heroin.

³ Emphasis added

Likewise only one heroin user admitted sharing needles, having done so in the full knowledge of the possible consequences and knowing that the person who had previously used the needles was suffering from hepatitis C.

Most interviewees, who had been addicted to heroin, highlighted the problems associated with withdrawal. Each of those who had given up heroin had a specific event which could be used to explain their decision / determination. However, these triggers do not appear to fully explain the personal circumstances that are necessary to successfully give up heroin. Similarly significant events – having a child taken into care, loss of home, break-up with partner etc – had occurred at other times in their drug taking career without triggering a successful attempt at detox.

Many were sceptical about the effectiveness of the support offered by GPs and drug workers, arguing that methadone prolongs addiction, but being a poor substitute for heroin leaves the addict exposed to temptation for longer, and that ultimately only the addict’s own will power could sustain them through detox. One former heroin user claimed to have kept a bottle of methadone (bought from another heroin user) in her handbag in much the same way in which many people would keep a bottle of paracetamol, in case she felt ‘rough’.

Table 5 – Use of Illicit Drugs

		Female		Male	
		Prior to	During	Prior to	During
Drugs Excludes recreational use of cannabis	Under 16				
	16 – 18 yrs	1		2	
	19 – 20 yrs	1		1	1
	21 – 30 yrs	2	1	7	
	31 – 60 yrs		1	1	1
	61 yrs plus				

As with offending behaviour, drug use was in almost every case a precursor to homelessness.

The problematic use of drugs is most noticeable in the 21 – 30 years age band. However, alcohol misuse is spread throughout almost the entire age range from 16 years upwards. Research conducted by MORI (Plymouth Health Action Zone, 2000) investigated alcohol consumption among the general population, on behalf of the Plymouth Health Action Zone. Data from that survey is reanalysed below in order to consider the influence of gender, age and employment status / poverty on alcohol consumption among the general population.

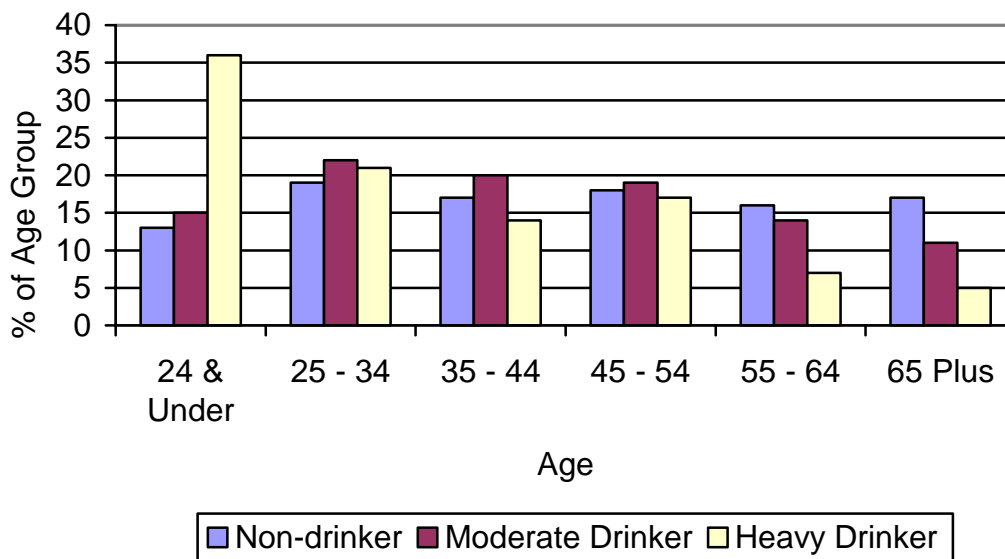
The Health and Well-being Survey found twenty percent of women interviewed could be classified as heavy drinkers and that these amounted to three-quarters of all heavy drinkers in the survey. By comparison only 7% of men were described in this way. However, this does not correspond with the observations of this research in relation to alcohol use among the homeless people interviewed, where problematic alcohol use among men was considerably higher (43%) than that observed among women (25%).

Table 6 - Alcohol Addiction

		Female		Male	
		Prior to	During	Prior to	During
Alcohol	Under 16				
	16 – 18 yrs	1		4	
	19 – 20 yrs		1	1	
	21 – 30 yrs		1	2	
	31 – 60 yrs		1	3	2
	61 yrs plus			1	

The MORI research also found that younger people, within the general population, were more likely to be heavy drinkers and least likely to be non-drinkers (see [Figure 2](#)). This, too, contradicts the findings of our own research in relation to homeless people, among who there is little evidence of any correlation between age and alcohol consumption.

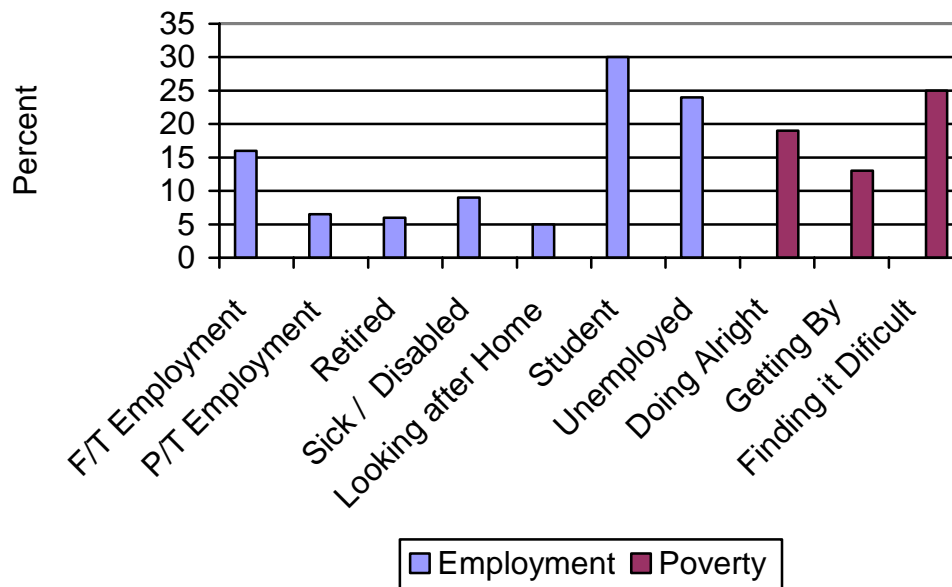
Figure 2 - Alcohol Consumption, by age



Source: Plymouth Health Action Zone, 2000

Finally, the MORI survey appears to demonstrate a relationship between poverty / employment status and alcohol consumption, although this is less clear-cut than the correlation between age and alcohol consumption.

Figure 3 - Alcohol Use, by employment and 'poverty'



Source: Plymouth Health Action Zone, 2000

When asked by interviewers if they would like to cut down their alcohol consumption 78% said that they would not. This high level of acceptance, by interviewees, of their alcohol use may relate to the age structure of this consumption. If, as is suggested by [Figure 2](#), heavy alcohol use is associated with a 'youth culture' and occurs within a social context, then such consumption may be regarded as 'social' or 'recreational' and may then be viewed as different to dependant alcohol use and therefore as suggested by Harrison (1998) and Adams (1999) as more acceptable.

Notably the most dramatic substance misusers began to use alcohol or drugs in their early teens, usually between the ages of 12 and 14 years. Many increased their consumption as they grew older and where able to fund increased consumption, either by selling drugs themselves or by stealing. Only one interviewee raised money for her

drug habit through prostitution, describing it as an easier way, rather than an easy way, to earn large sums of money quickly. The figures for offending behaviour, given in [Table 4](#), do not include the number of interviewees who were dealing in drugs. Three interviewees were dealing, or had previously dealt, in significant amounts of drugs in order to pay for their own drug consumption. Another two claimed to have, or to have had, partners who were dealing drugs, while others had sold very small quantities of drugs to their friends and associates as a way supplementing their income.

The economics of drug supply appear relatively simple. Price is determined by supply and demand, by economies of scale and by the level of risk taken by the dealer. Hence a drug user who buys for their friends as well as themselves is able to demand a lower price from their supplier since they are buying in bulk, by charging the market rate to their friends they are able to raise a small profit. By taking additional risks, for example by buying drugs outside a nightclub and smuggling them inside, they are able to charge an additional premium and hence make a larger profit. However, the opportunities to deal in drugs are limited and for most heavy users of drugs begging and theft are the principal means of raising cash to pay for their own dependency.

Cameo Three: A Survivor of Heroin

Y is a former heroin addict. She started smoking heroin occasionally at the age of 15, within a year she realised that she was addicted. It was then that she had started to inject. She'd been using other drugs, including alcohol, from the age of 13, but by the time she'd realised she was addicted to heroin the other drugs were less important.

When you're addicted to heroin you soon stop taking it because you like it; *"you're enjoying it, but it's a disappointment – so you want more"*, you take it because you need it. You know its bad for you, but you need it.

Giving up was hard. She'd tried before. Lots of times, but this time she'd been prompted by

For the first week she'd felt really rough. She'd ached all over, she felt sick and she'd felt *"really frustrated – in my mind"*. Worst of all she knew exactly how to cure it, and it would only cost £10.

That was 2 months ago. She feels better now, but she still can't sleep so she smokes a little dope, just to help her chill.

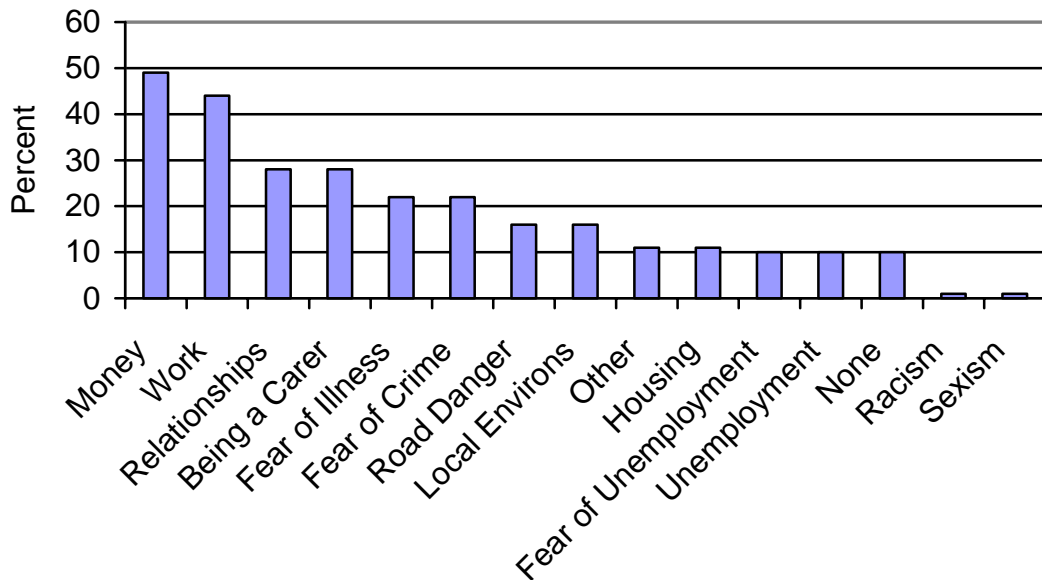
3.4 Mental Illness

Many interviewees 18 (39%) had been or were being treated by their GP, had a CPN or had been admitted to hospital because of their mental health and many more referred to feelings of depression or stress as a result of their homelessness. In fact these figures correlate very closely to those reported by Harrison (1998).

Neither the Williams study nor the MORI survey specifically addressed mental illness. However, the MORI survey (Plymouth Health Action Zone, 2000) did ask

about 'stress' and the causes of stress. Only 10%, of the general population, said that they had not felt stressed at all during the previous 12 months. Among the remainder the most significant causes of stress were money, work, relationships and caring for other members of the family.

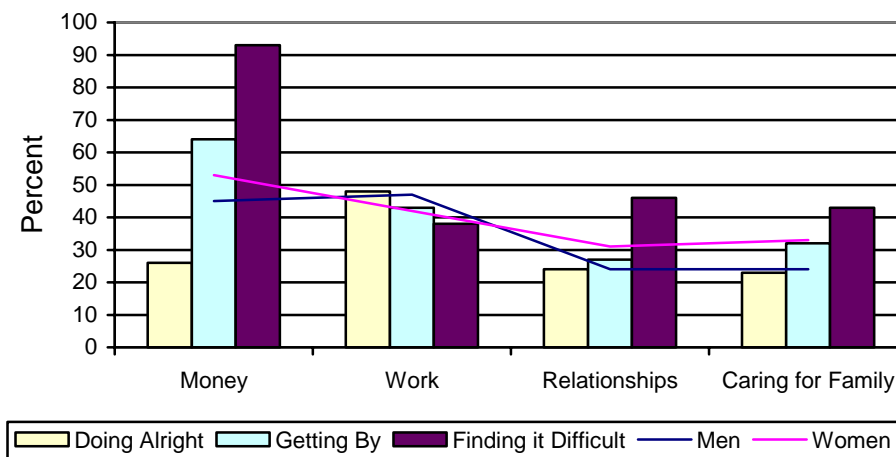
Figure 4 - Experience of Stress, by cause of stress



Source: Plymouth Health Action Zone, 2000

These burdens of stress were not, however, evenly distributed across genders, ages or economic circumstances, as [Figure 5](#) demonstrates.

Figure 5 - Experience of Stress, by gender and 'poverty'



Source: Plymouth Health Action Zone, 2000

Except in relation to work, more women experience stress in relation to each of the most significant causes of stress.

Likewise poorer people are consistently and significantly more likely to experience stress than people who are 'living comfortably or doing alright', again with one exception, that of stress in the work place. It is notable that while stress related to lack of money is the greatest cause of stress among poorer people they are also more prone to stress within relationships and in connection with caring for their families. This would appear to have a considerable significance for homeless people, who are by definition poor. More profoundly, perhaps, the link between relationship failures (between parents and children as well as between adult partners) and vulnerability to homelessness suggests that any programme to reduce homelessness should include policies designed to reduce stress within the family unit and perhaps to address the parenting skills of preceding generations.

Among young men uncontrolled anger and difficulties in accepting authority were manifested in anti-social behaviour, the breakdown of relationships with parents, poor or no educational qualifications, poor work prospects, limited housing options and difficulties in effectively accessing services. Two male interviewees were attending anger management classes and several believed that they had not received services to which they were entitled because they had alienated staff.

Several interviewees had severely low self-esteem, which appeared to have contributed to their use of alcohol or drugs. Equally it undermined their motivation since they expected to fail in their own efforts and did not expect to be entitled to support from elsewhere. These interviewees accepted responsibility for events that had occurred when they were not of an age to have been properly responsible and when one might have expected parents, schools and social services to provide a more adequate response. One interviewee described the difference between his own upbringing and that of his friends – "*their parents' loved them!*"

Moreover these individuals found it difficult to explain to GPs what their problems were and so were unable to access counselling. One interviewee, who had been traumatised as a child had approach three GPs over the course of four years, none of who could understand what he was trying to tell them, one simply told him to pull himself together.

Other interviewees were receiving counselling or psychotherapy as adults that they believed they should have received as children, but were unable to do so because "*it was pushed under the carpet*".

Some interviewees were suffering from clinical depression and many of these had attempted suicide, a few were schizophrenic. However, relatively few had been sectioned under the Mental Health Act or had been hospital inpatients because of their illness. For those who had been treated in hospital community support, although welcome, seemed inadequate in relation to the amount of support that they had received in hospital. In fact they claimed that leaving hospital and returning to the community had been a daunting prospect and one interviewee saw a direct link between the sudden withdrawal of 24-hour support and his experiences of repeated detention under the Mental Health Act, release into the community and re-detention. The report of the previous study of homeless people in Plymouth (Williams et al., 1995) also drew attention to the importance of hospitals and other institutions as

'home'; “respondents in the Plymouth study are more likely to have had prior accommodation in a hospital, or drug rehabilitation unit than was the case nationally and moreover several in the Plymouth study regarded a hospital as home”⁴ (Williams et al., 1995).

Views similar to those expressed by interviewees for this research have been reported among carers (Community Care 7 – 13 June 2001) who saw professionally delivered services as partial or part-time. As one carer put it: “*appropriate, effective services are available between 9am and 5pm, yet disappear for days or even weeks on end over bank holidays, Christmas or New Year*”.

For women in the refuge depression and stress were related to their experience of domestic abuse, but also to the uncertainties of life in temporary accommodation and sometimes to the reaction of their former partner to their decision to leave. For such women the abuse that they suffered at the hands of their partners rarely ended when they moved out and sometimes was exacerbated by the involvement of the ex-partners family or friends and by the increased uncertainty of when or how the abuse would be continued.

Moreover, the conditions in women’s refuges had lead to several families being split up and some children, particularly boys but also older girls, having to live separately from their mother and siblings. This separation was all the more difficult since escaping from domestic violence had led some of the women interviewed to travel significant distances away from home and sometimes to have relocated several times.

Table 7 - Mental Illness

		Female		Male	
		Prior to	During	Prior to	During
Mental Health Where professional help has been sought	Under 16				
	16 – 18 yrs	1			
	19 – 20 yrs	1		1	
	21 – 30 yrs	2	1	4	1
	31 – 60 yrs	1	1	4	1
	61 yrs plus				

3.5 Physical and Sexual Abuse

Of the five interviewees who reported sexual abuse, one related to the abuse of her child by her former partner, two related to women who had been abused as children by a parent or guardian, and two, both male, related to abuse by strangers.

In the case of both of the men they had been vulnerable because of their isolation and the lack of a stable relationship with their families and vulnerable because of their need for friends or for money. Both had been minors at the time of the incidents. In the cases of three women the abuse had occurred within the family environment.

Three of the five interviewees reporting sexual abuse were currently receiving the support of a CPN. Both of the other interviewees had seen their GPs because of their

⁴ Our emphasis

mental health, one had been given anti-depressants, while the other, one of the male interviewees, reported that his GP was “*uninterested*”.

Table 8 - Sexual Abuse

		Female		Male	
		Prior to	During	Prior to	During
Sexual Abuse Includes abuse against interviewees’ children	Under 16				
	16 – 18 yrs				1
	19 – 20 yrs				
	21 – 30 yrs	2		1	
	31 – 60 yrs	1			
	61 yrs plus				

3.6 Physical and Emotional Abuse

The abuse experienced by interviewees varied enormously but included violence, threats against their children, abusive telephone calls, persistent verbal abuse and denial of food. In three cases the abuse was perpetrated by a parent or guardian, two of these being physical abuse and the third emotional abuse / rejection.

Unlike the sexual abuse described above physical and emotional abuse were largely directed at adult victims and in almost all cases resulted in the eventual breakdown of the relationship which in turn had been the direct cause of their homelessness.

Table 9 - Physical and Mental Abuse within Families

		Female		Male	
		Prior to	During	Prior to	During
Domestic Abuse	Under 16				
	16 – 18 yrs	1			
	19 – 20 yrs	2			
	21 – 30 yrs	1		1	
	31 – 60 yrs	2			
	61 yrs plus				

3.7 Relationship Breakdown

For those interviewees who had become homeless following the breakdown of their relationship with their partner the experience of homelessness was sometimes unexpected. In particular male interviewees who had stable housing histories were surprised at their vulnerability to homelessness and the difficulty of extricating themselves. They complained of high rents in the private sector, high deposits and the reluctance of landlords to accept a rent deposit certificate. One interviewee complained that he had been asked to pay a cash deposit over and above the value of the rent deposit certificate, and another that the quality of properties available with a rent deposit certificate was lower than that available to people with cash deposits. Such interviewees tended to be older.

For women made homeless in this way their vulnerability was less of a shock, but the problems of finding accommodation were similar to those of the male interviewees unless they were pregnant or had dependent children. It is almost always the case that women will take responsibility for the children when a relationship fails, and so the consequences of homelessness are that much greater.

Equally common among the male interviewees were those whose homelessness was caused by a combination of drug or alcohol misuse and relationship breakdown. In these cases the failure of a relationship was the trigger for 'a new start' elsewhere. Often the choice of Plymouth as the location for this 'new start' was based upon the interviewee's belief that they could stay with friends in the area. In reality such friends were often unwelcoming, intolerant or had moved on. In other cases Plymouth was simply on the route to somewhere else, principally Cornwall, or drew people in from smaller towns and rural locations around the South West with expectations that there would be more opportunities in the City.

All of the interviewees experiencing homelessness as a result of the breakdown of a relationship were on low incomes or had no earned income.

One interviewee had been widowed, but this does not appear to have been directly responsible for his homelessness.

Table 10 - Relationship Breakdown

		Female		Male	
		Prior to	During	Prior to	During
Separated / Widowed Includes separation for long-term partners	Under 16	-	-	-	-
	16 – 18 yrs	2			
	19 – 20 yrs	1			
	21 – 30 yrs	3		2	
	31 – 60 yrs	3		5	
	61 yrs plus			1	

4 Working for Homeless People

Despite what is perceived of by many as a lack of strategic planning, there is a considerable degree of unanimity among service providers as to the most pressing needs of the homeless in Plymouth. These relate to:

- The lack of co-ordination at a strategic level
- A shortage of direct access accommodation and apparent clogging of bed spaces by residents awaiting move-on accommodation
- The need for more move-on accommodation coupled with independent living and tenancy support
- Improved access to private sector accommodation
- Greater consistency and empathy from ‘non-front-line’ statutory services
- An increase in the priority attached to homelessness by both Health and Social Services;
- The failure of the Social Services and Housing Joint Protocol
- The mental health and long-term housing needs of Asylum Seekers

4.1 Co-ordination

The researchers were struck, early on in the research by the number of agencies with an interest in homelessness operating in Plymouth. In particular it is worth noting the relatively high level of awareness of homelessness and its relevance to agencies working in other fields, for example youth services and services for older people.

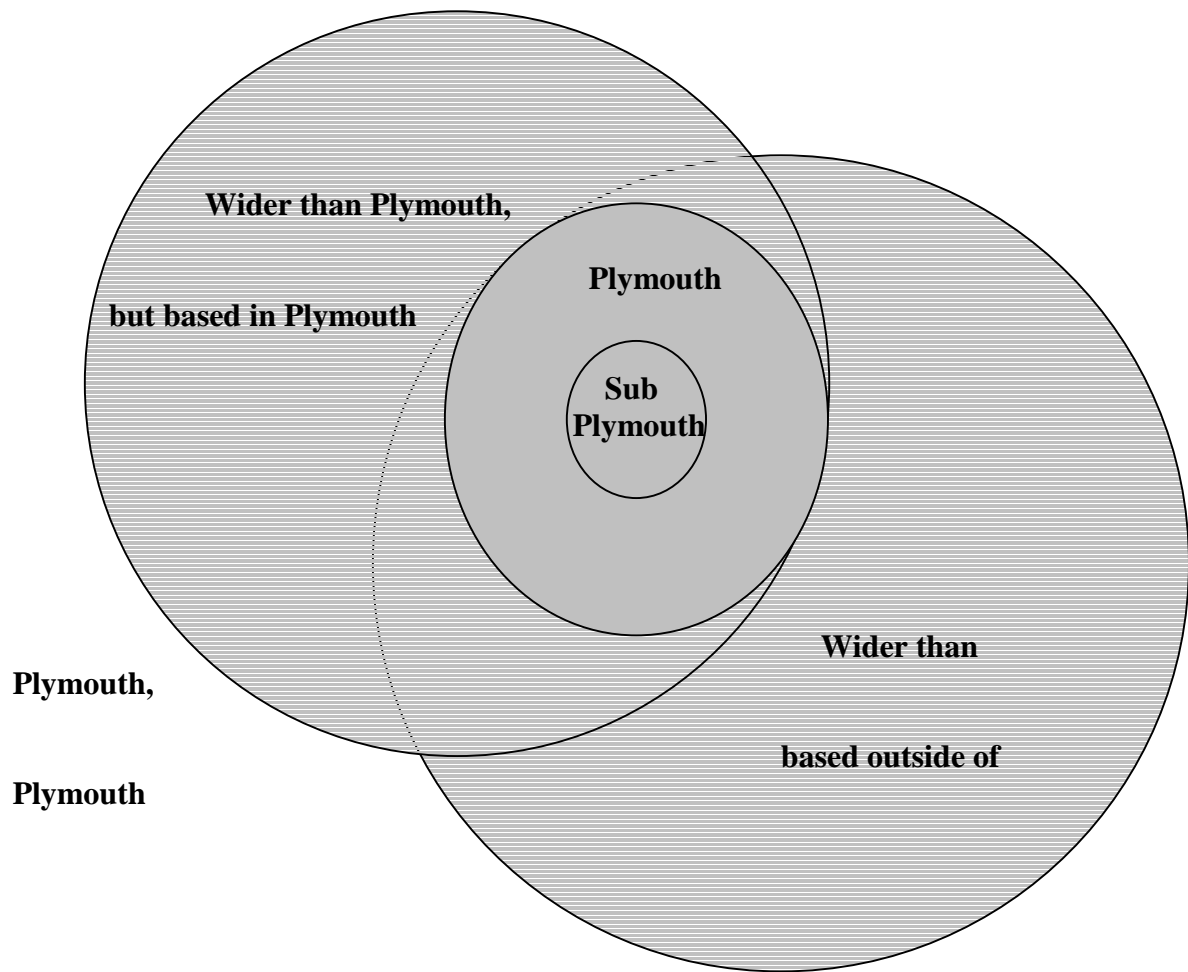
However, the notion that ‘homelessness is everybody’s business’ begs the question as to how such diverse organisations can work effectively together or form a single coherent strategy? Indeed inter-agency co-ordination was described as at best partial or selective and at worst superficial.

4.1.1 Areas of Benefit

One of the barriers to effective interagency working appears to have been the difference in ‘areas of benefit’ that individual organisations addressed, and in particular the location of each agency’s management. Where these coincide it may be easier for agencies to work to the same agenda, but where they deviate priorities may clash.

Many of the agencies operating in Plymouth have a citywide remit, for example most of Plymouth’s statutory services are now organised on this basis. However a small number of voluntary groups, particularly the smaller voluntary agencies are restricted to particular parts of the city.

Figure 6 - Areas of Benefit



A smaller number of agencies have a remit that extends beyond the city boundary, and while their number is small their importance is great since these organisations tend to be larger, better funded and more specialised. Examples of such organisations would include Shelter, whose remit is for the whole of Devon, but who are based in Plymouth and the Big Issue, whose remit is to cover the South West of England and who are based in Bristol.

It is not difficult to see how agencies with a shared interest in Plymouth might nonetheless have different perspectives on the same issues.

4.1.2 Ethos

An additional barrier to close co-operation between agencies may be the different working practices and cultures by which agencies are governed and the impact this might have on levels of understanding and trust.

In particular, some voluntary agencies have raised concerns about the apparently bureaucratic attitude of statutory services; some agencies have been uncomfortable

with the dual role of faith based organisations; and others see the larger and better resourced agencies as being dismissive of the contribution, skills and experience of smaller organisations.

4.1.3 Confidentiality

There was widespread concern at the difficulties imposed by the need to maintain the privacy of clients and the confidentiality of records. This, it was believed, was necessary for the protection of clients – to ensure that they were not prejudged and that misleading or wrong information was not passed on, this latter point being particularly important where clients may have chosen to be selective about the information that they share with agencies and where trust is a key element in building effective client / worker relationships.

However, it was also considered that the lack of a shared confidentiality procedure reduced the effectiveness of joint working and was sometimes harmful to the client who consequently received a poorer service.

4.2 Direct Access Services

Plymouth is served by three direct access hostels, the Salvation Army hostel (60 places) in Devonport, the City Council's 'SHIP' Hostel (28 places) in Millbay and the Guild of Voluntary Service Women's Refuge (11 families or individuals). All are well known among agency workers and homeless people alike. However, each of the larger hostels is operating at or near to capacity and both turn homeless people away on a regular basis.

Moreover, there are some misconceptions as to the nature of the services offered and the conditions inside the hostels. In particular, many agencies regard the Salvation Army Hostel as being a long-term hostel in which many people appear to be permanently resident, while the SHIP has a reputation among homeless people as catering to chaotic drug users to the extent of being too dangerous for others to live in. Both of these perceptions are inaccurate, yet both have an element of truth. The Salvation Army Hostel contains a mixture of direct access, move-on and long-term supported accommodation within one building. In the past there may have been some blurring of these boundaries with the result that some residents remained in the hostel for longer than was necessary.

The SHIP like any other agency working with homeless people does have residents with drug and alcohol problems. However, it would be quite wrong to describe the environment within the SHIP as in any way chaotic, the regime in operation being well structured and professionally delivered. However, it is not an appropriate setting for long-term resettlement work.

The Women's Refuge, too, has a good reputation but is clearly restricted to accommodating women and children. The hostel model chosen for this refuge places additional restrictions upon the management of the service and sometimes requires families to be separated. In particular the refuge's management may consider it inappropriate for teenage boys to be housed in the refuge, while families might consider it inappropriate for teenagers of any sex to have to share a room with their mother and siblings.

There is no 'direct access' GP provision for homeless people in Plymouth. Although one GP is in attendance at the SHIP hostel one morning each week this is for the benefit of residents only. Most of the interviewees who took part in this research had registered with local GPs before becoming homeless or had registered with GPs to whom they were referred by another agency, for example the women's refuge or the Harbour Centre. As a consequence some 5 or 6 GP surgeries are carrying a disproportionate number of homeless people on their patient lists, an observation that would also appear to be true in relation to people with drug misuse problems and to asylum seekers / refugees.

For the minority of homeless people who were not registered with a GP, this did not seem to be an important issue. Such a lack of urgency fits well with the theories of A H Maslow who believed that all human needs fit into a natural hierarchy of importance, with the most fundamental needs (food, water and shelter) at the base. When these needs are met, and only when these are met do the next level of needs become important. The importance of registering with a GP would be relatively great for a stable individual whose housing and food needs had been met. It would, however, be relatively unimportant for any person who was unable or who had difficulty in achieving these most basic needs. Maslow's theory helps to explain why seemingly important appointments with drug workers, GPs and housing officers might be missed by people who are having difficulty in addressing more fundamental issues that most people take for granted.

However, there were a small number of homeless interviewees who had tried to access GP services and had experienced difficulty, these interviewees found GPs 'uninterested' or unable to understand what their problems were. Williams et al. (1995): reported similar results "*whilst most homeless people are able to get medical attention without difficulty there remains a problem for a significant minority*".

The Big Issue in Plymouth appears to provide an important source of income, social interaction, structure and self esteem for a very small, but visible sector of the homeless population. Additionally, the Big Issue appears to be an important route into other services for those homeless people who consider themselves to be travellers rather than homeless. The division between Big Issue vendors and hostel dwellers sometimes evident in other towns and cities is not evident in Plymouth and may reflect the place of the city in the seasonal movement of homeless people / travellers between the south west and other parts of England.

It is regrettable, then, that the Big Issue in Plymouth appears to be one of the least well-integrated agencies within the city having no local management structure with authority to participate in local housing forums and strategies. This must be considered a critical flaw in the operation of this agency.

The work of the RSI Outreach Team is specifically to interact with homeless people in a non-threatening and non-invasive way. Their purpose is to establish a relationship with homeless people who may access other services by referral from the outreach project. This low-pressure approach to work with homeless people is an essential part of delivering services to vulnerable, isolated and disaffected individuals, who find it difficult or impossible to engage with traditionally structured agencies. Such services

provide a vital safety net that allows minimal contact with even the most alienated individuals.

Importantly the RSI outreach project, like the hostels, refuge and Big Issue do not replace other services, but act as a route into existing specialist services, and seek to address the most pressing needs of the individual for food, water and shelter. However, they do so in a way that presents opportunities to access a wider range of services in relation to other important, but less urgent needs.

4.3 Move-on Accommodation and Tenancy Support

The range of move-on, temporary supported accommodation and resettlement support available in Plymouth is relatively extensive. Resettlement teams are operated by:

- NCH (National Children's Homes)
- Plymouth Access to Housing (PATH)
- Stonham Housing Association
- The Assertive Outreach Team
- The NSF (National Schizophrenic Fellowship)
- The Salvation Army
- The SHIP Hostel

While supported housing is provided by:

- Colebrook Housing Association
- Devon & Cornwall Housing Association
- Plymouth Foyer
- Stonham Housing Association
- The Salvation Army
- West Country Housing Association

However, there must be some concern that there are likewise a multitude of mechanisms and criteria for accessing such services. Observation of local agencies in Plymouth would indicate that clients are most likely to be referred to agencies with which the referrer is most familiar, rather than the agency that is necessarily the most suitable for the client. As such any argument that agencies do not work well together might be qualified by the observation that agencies work well only with those other agencies with which they are most familiar. There is perhaps a role for the Supported Housing Section of the City Council in establishing better procedures for accessing such services, possibly in partnership with, what have been called, the principal 'clearing houses' operating in Plymouth:

- Plymouth Access to Homelessness (PATH)
- The Homeless Persons Unit
- The Local Authority Assessment Panels

- The SHIP hostel
- Youth Enquiry Service (YES)

4.4 Improved Access to the Private Sector

The private rented housing sector in Plymouth has variously been described as poor quality, high cost and shrinking. It is clear that most homeless people with any experience of the private rented sector have very poor expectation of private accommodation, while landlords have come to expect that tenants dependent upon housing benefit, and in particular young tenants, will inevitably be bad tenants.

Those landlords who are able to withdraw from the 'lower' end of the private rented sector, either by selling their property or by refusing to accept PATH bonds and tenants on housing benefit, do so. Those landlords that remain at the lower end of the market are frequently those whose accommodation is not of a standard to attract tenants who are paying the rent out of their own pockets. Consequently they are not of a standard to house vulnerable people, or to engender a sense of achievement, ownership or pride.

Thus the private rented sector has become characterised by poor properties, unwilling landlords, disaffected tenants and inappropriate accommodation. Yet it is the behaviour of many of the tenants that has contributed to this position. Several agencies working in the private sector in Plymouth have commented on the behaviour of tenants placed in the private sector having approached an agency in crisis. Such individuals, it was argued, are genuinely in crisis, not because they have nowhere to sleep but because of their lack of social skills often originating from abuse, neglect or the breakdown of the family unit. They were characterised as lacking commitment, motivation, self-esteem and effective social skills.

In return for accommodating the least desirable tenants the private sector is asked to accept rent deposit certificates to a maximum of £150, rather than cash bonds of perhaps double that figure. Additionally, housing benefit payments will be slow in coming and inadequate to meet the full rent for most if not all tenants, but especially where the so called Single Room Rent rule applies. This rule restricts the Housing Benefit payable by assuming that "*exclusive use of one bedroom only, together with a shared toilet and kitchen facilities*" is adequate for a young single person (Cowan, 1999). There would seem to be very little, if any, incentive for private landlords to operate in this sector of the housing market.

The demand for private sector accommodation has two determinants, namely the accommodation needs and aspirations of individuals and their families and their ability to pay for the accommodation that they need or want. The 1999 Housing Needs Study, conducted by Opinion Research Services Ltd (ORS), demonstrated the poor affordability of the private rented sector in Plymouth. The ORS report gives two measures of housing demand; subjective, demand as reported by interviewees, and objective which also considers interviewees ability to pay for the accommodation they aspire to.

The report claimed that "*subjective assumptions reveal a large shortfall of private rented dwellings*" whereas objectively "*there is a significant surplus of private rented*

dwelling”. The report goes on to argue that these imbalances can only be addressed by “*a housing benefit subsidy*” and urges the City Council to adopt such a policy (ORS, 1999).

4.5 Greater Consistency within the Statutory Housing Services

Irrespective of the precise nature of their work each of the agencies discussed within this report saw themselves as playing a part in the wider battle against homelessness. Despite the different cultures, working practices and different priorities each saw itself as addressing, in common with most of the other agencies, a common overarching goal the alleviation of homelessness. The apparent disengagement of two of the most central players within the field of homelessness from this general overarching goal was a matter of great concern.

Both the Local Authority’s Homeless Persons Unit and the Housing Benefit Section were viewed, by other agencies, as administrative functions meeting the Local Authority’s duty under the law, as they saw it. Neither agency was considered to have a strategic view of homelessness or to have contributed to any strategic or policy forum.

Of equal concern was the poor relationship that many, though by no means all, agencies including other sections within the local authority had with both sections and hence the inability of agencies to act as advocates on behalf of vulnerable clients.

Moreover, both sections appear to be quite inconsistent in their treatment of other agencies, so that a support worker might be offered every assistance and courtesy on one occasion and be met with abruptness and disrespect on another.

A similar inconsistency appears to be displayed, at least by the Homeless Persons Unit, towards clients. Many of the interviewees who took part in this research had a very favourable impression of the staff in the Homeless Persons Unit, claiming that staff had been sympathetic, had given them time to explain themselves and had helped them to calm down when they had been distressed. Yet others claimed that staff had been judgemental, rude, and unhelpful. Some interviewees even claimed that their homelessness application had been rejected without any forms having been completed or their application having been recorded.

4.6 An Improved Role for Health and Social Services

The failure of the Social Services and Housing Joint Homelessness Protocol is a matter of widespread concern. Despite having negotiated the protocol some 6 years ago, it was not formally launched until 1999 and still appears not to have been fully implemented. The purpose of the protocol is to help the Housing and Social Services Sections of the local authority to work together when 16 or 17-year-old children present themselves as homeless, to whatever agency.

The two principal criticisms that have been levelled at the protocol relate to a perceived lack of commitment from Social Services, for example, some agencies have complained that Social Services appear not to prioritise homelessness considering it to

be 'only homelessness', while others have complained that senior managers have not taken ownership of the protocol.

An alternative view sees the failure of some social workers to engage actively with the protocol as indicating that it does not address either their priorities or those of the majority of their clients.

Like the Social Services section of the Local Authority, Plymouth Primary Care Trust does not see homelessness as central to its role and has no specific strategy in relation to homelessness. However, many of the issues that the PCT⁵ does consider to be of direct relevance to its role are significant features of homelessness. It is also notable that the PCT sees homelessness specifically in terms of rough sleeping and does not necessarily recognise that young mothers living in poor quality or inappropriate housing might be included within broader definitions of homeless as, for instance, used in this research (see Section 1).

Moreover, the PCT is providing some services to homeless people in a variety of ways through mental health services, drug and alcohol support services, through local GPs and by funding the CPN and Health Worker for the Homeless. However, with the exception of the latter two services, most of the work done with homeless people is carried out by default, that is to say that the services are not specifically intended for homeless people and no additional funding has been sought as a consequence of the additional costs or pressures experienced by the services, for example by GPs.

The PCT is not unsympathetic to the needs of homeless people but points to the need to make a case for all expenditure decisions, since, like social services, the Trust faces demands for expenditure that exceed its income. A particular concern of the Trust is the under utilisation of health services by people in deprived areas. In fact the Cumberland Centre was established in response to an identified need to bring services closer to deprived communities.

It is apparent that the lack of specific support, with the exception of the CPN and Health Worker for the Homeless, for homelessness initiatives results from the failure of any homelessness agency to successfully make the case for the funding of specific health related projects for homeless people. In making such a case it is important to be able to clearly link the aims of any proposed project with the existing priorities of the PCT. In particular three arguments need to be put forward, namely that:

1. Homelessness is not about the small number of rough sleepers, but about a significant number of people, many of them vulnerable, most of whom are living in inadequate or inappropriate accommodation;
2. Services for the homeless address established priorities; and
3. How expenditure on schemes for homeless people can and should support existing services.

⁵ Primary Care Trust

4.7 The Long-term Needs of Asylum Seekers

The treatment of asylum seekers in the UK has recently become a mainstream political issue with considerable opposition to the dispersal policy being implemented by the National Asylum Service (NAS) on behalf of the Government. In particular asylum seekers and voluntary groups working on their behalf see the dispersal programme as potentially damaging to existing informal support networks across extended families and communities. Asylum seekers with severe psychological problems and trauma are isolated by language, by custom and by distance.

It is notable that the previous use of dispersal policies, during the 1980s when Britain saw a rise in the numbers of Vietnamese 'boat people' seeking asylum and during the late 1960s when Britain accepted large numbers of Asian refugees who had been persecuted in East African, were unsuccessful. On both previous occasions having been dispersed, refugees relocated themselves into more coherent communities in order to improve their own informal support networks. Moreover, this process of establishing geographic communities is an historical response to the experience of racism in all parts of the world and can be seen even in terms of long established minority ethnic communities throughout the UK. The significant difference between previous attempts at dispersal and the current programme is the very much more heterogeneous nature of the current asylum caseload, which consists of refugees from many parts of Eastern Europe, West and East Africa and the Middle East.

There is also considerable opposition to the dispersal policy from indigenous communities. This is especially so from poorer communities who believe that they are being singled out to accept asylum seekers and that their own social and economic problems will be exacerbated by the addition of asylum seekers with similar and indeed even greater problems.

Plymouth, it should be noted, has a smaller than average minority ethnic population (0.9%, ONS 1991 Census).

Asylum seekers dispersed through the NAS system to Plymouth are accommodated by Asylum Seekers Management Ltd, under subcontract to the Adelphi Group who work under contract to NAS / Home Office. Asylum Seekers Management Ltd (ASM) is a local SME⁶ formed by the partners of an existing local property company, specifically to house asylum seekers in the private rented sector. Although the quality of the accommodation provided in Plymouth has been criticised by asylum seekers, voluntary sector agencies working across England report that ASM's management is of a typical or slightly better standard than that of comparable agencies elsewhere. Nonetheless the accommodation is at best basic, shared accommodation at the lower end of the housing market. Furthermore accommodation for asylum seekers is temporary and is restricted specifically to asylum seekers. Refugees, that is, asylum seekers who have had their application accepted, are not eligible for accommodation through the NAS dispersal scheme and hence become homeless within 14 days of a Home Office decision on their asylum application.

It is not at all clear to what extent the presence of asylum seekers will have an impact upon homelessness services in Plymouth. It is planned that 500 or so asylum seekers

⁶ Small business – (Small or Medium Sized Enterprise)

will be accommodated in the city by NAS. Some will have problems because of their poor understanding of English cultural and social norms, work practices and language. Many will be especially vulnerable because of the abuse suffered in their previous home including rape, torture, and threats of violence and many will have witnessed the abuse of their families, including children. Until the acceptance of their asylum application their housing is the responsibility of NAS. However, on the acceptance of their application, that is, on becoming a refugee, the responsibility of NAS ends and the refugee becomes homeless.

While those refugees suffering from trauma might properly be considered vulnerable and hence in priority need within the context of the 1996 Housing Act, it is not yet clear whether all refugees should be treated as 'specially vulnerable' and so it will fall to the Homeless Persons Unit to make a determination on a case by case basis. The effectiveness of this mechanism is doubtful for two reasons. In the first instance it is impossible to estimate the rate at which the Home Office will process applications for asylum and so the rate at which asylum seekers will become homeless refugees. Secondly, it would seem quite inappropriate for refugees suffering from trauma as a result of abuse to be interviewed by untrained staff in the setting of the homeless person unit.

5 Conclusions

The strategy proposed in this report is built upon a number of core elements, each of which represents an important part in an overall structure intended to address the varying needs of homeless people. This 'jigsaw' approach to the strategy is intended to reflect the different experiences of homelessness and the varying needs of homeless people throughout their 'homelessness careers'. It also recognises the work undertaken by the agencies already working in Plymouth and the need to enable these agencies to support each other's work more effectively.

Although there are examples of all of the types of service required by homeless people within Plymouth their isolated provision undermines the seamless service required by homeless people, if they are to be supported effectively and efficiently from initial crisis to long-term stability. Among the most important of the recommendations made in this report are those that relate to inter-agency communication, co-ordination and collaboration.

5.1 Building a Model Strategy

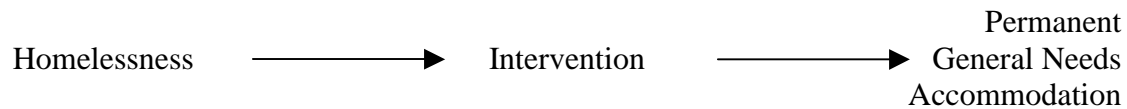
The purpose of an overarching strategy is to identify the problems to be dealt with, the solutions to be applied, the processes by which solutions will be applied, and the ways in which those solutions will be developed to address unmet, new or changing needs in the future.

Rarely is it the case that homelessness is exclusively about housing. More often it is about a range of issues that undermine an individual's or a family's ability to maintain their own home. The issues that confront homeless people and those vulnerable to homelessness vary from case to case and in individual cases from time to time. The needs of somebody who is sleeping rough will be different to those of a person or family in temporary accommodation and different again to somebody who has recently been rehoused in their own tenancy. Equally the needs of any individual will change as and when they progress from rough sleeping to a hostel, supported housing or a permanent tenancy, as predicted by Maslow (Power et al. 1999).

The core elements of this housing strategy are designed to help service managers and policy makers to conceptualise the full scope of support needs and services within Plymouth. It needs to be noted, that this model seeks to categorise services rather than homeless people and it is inevitable that any model will have limitations, models are by definition simplification of the complexity of real life, hence some of the services that have been so neatly labelled here could have been labelled differently or given more than one label. We have, however, resisted the temptation to make the model any more complex than is absolutely necessary.

The model is effectively a simple hierarchy, which assumes the desired outcome of all interventions is long-term permanent general needs accommodation, as represented by [Figure 7](#).

Figure 7: Assumed Desired Outcomes



However, the complexity of homelessness is such that this assumption is not entirely valid. The evidence collected during the course of this research demonstrates clearly that there is no typical experience of homelessness, nor any typical homeless person. Many people who become homeless will require no intervention from either the statutory or voluntary sectors, others will be reluctant or unable to engage effectively with support services, while others will not wish to be rehoused seeing themselves as travellers rather than homeless people.

This strategy takes no account of those individuals (and occasionally families) for whom no intervention is required because they are able to make their own arrangements to access permanent mainstream accommodation. However, it does address the needs of those people who consider themselves to be travellers and hence who do not require accommodation and who may nonetheless experience many of the same problems as homeless people.

5.2 Minimalist Interventions

The minimum level of intervention is the lowest level of our hierarchy and has the most basic, but perhaps the most important aims, these being to provide homeless people with access to food, shelter and ‘immediate necessary medical treatment’.

The purpose of such services is twofold. In the first instance they are intended to maintain a minimum level of health and security, that is, simply to help people to survive by providing a safety net for those living on the margins of society.

Secondly, although such services may be delivered in ways that require no long-term commitment from the homeless person they also provide a first step, easily identified and accessed, towards more extensive or structured services, like move-on accommodation, drug or alcohol counselling, independent living skills and tenancy support.

The range of services seen to fall within this element of the strategy includes:

- The Big Issue
- The RSI (Rough Sleeper Initiative) Outreach Project
- The Salvation Army Hostel
- The Shekinah Mission
- The SHIP Hostel
- The Soup Runs

All of these services are currently operating within Plymouth and performing the function described. However, there are two areas of concern within this provision. The first relates to the lack of free spaces in either the SHIP or the Salvation Army direct access hostels, both of which appear to suffer from the lack of integrated move-on accommodation for their residents. This problem may be remedied by the proposal, by the Salvation Army and Devon and Cornwall Housing Association, to build additional move-on accommodation on land adjacent to the existing Salvation Army hostel in Devonport. This facility, it is proposed, would serve both of the existing direct access hostels.

An additional concern, and one of the few complete gaps in service provision in Plymouth is the lack of a direct access drop-in medical facility. The need for such a facility is hidden by the flexibility displayed by a small number of local GPs who appear to be carrying a disproportionate burden in terms of patients with mental health, substance abuse problems and asylum seekers. Each of these groups represents a potentially greater workload than most other patients and all are found, with the current exception of asylum seekers / refugees, in disproportionately high numbers among the homeless population.

5.3 Move-on, Temporary and Supported Accommodation

For many, but by no means all, single people the route from homelessness to secure long-term accommodation will involve a period of preparation for independence in supported or shared accommodation. This route is particularly likely where there has been previous statutory involvement, for example social services, probation or acute mental health services.

The purpose of such temporary accommodation is to provide a period of security and stability in which residents can gain or regain their confidence and self-esteem and receive advice and support in relation to tenancy management and budgeting skills. Facilities available in Plymouth include:

- Alma Road - Stonham Supported Housing
- Amity Place - National Children's Homes
- Anwyl Court - Stonham Supported Housing
- Castle Close - Stonham Supported Housing
- Colebrook Supported Housing
- Plymouth Foyer – Devon and Cornwall Housing Association
- Plymouth House (formerly the YWCA) – West Country Housing Association
- Raglan Court
- The Salvation Army (Resettlement)
- The SHIP Hostel (Resettlement)
- Spring Project – Devon and Cornwall Housing Association
- The proposed Devonport 'Move-on from Hostel Scheme' - Salvation Army / Devon and Cornwall Housing Association
- Women's Refugee

5.4 Resettlement into Permanent Tenancies

For other homeless people, and for many who receive support in move-on or temporary accommodation, support in relation to tenancy management, budgeting, fitting out a new home and maximising their income through benefits will be necessary when they eventually find themselves, or are allocated, a general needs property.

Such support will be required irrespective of the housing tenure in which people find themselves. Indeed, it may be more important in the private sector where the availability of support to a tenant may give a private landlord the confidence to persevere with a difficult tenant in the belief that he or she is not alone. Indeed, the collapse in the number of private rented properties available to single homeless people requires housing agencies to consider imaginative use of tenancy support to encourage the return of good landlords to this sector of the market.

Resettlement support is provided by a number of agencies within Plymouth, for example:

- NSF Tenancy Support
- Plymouth Access to Housing (PATH) Resettlement Team
- Stonham Resettlement Team
- The Assertive Outreach Project
- The Salvation Army resettlement programme
- The SHIP resettlement programme

5.5 Prevention of Homelessness

Some agencies involved in homelessness deal less with homeless people, and more with people who would be homeless if it were not for their support. These agencies may not necessarily recognise themselves as being central to the homelessness debate, yet ironically they are likely to work with far more (potentially) homeless people than agencies with an overt homelessness remit. For example, the Housing Benefit Section deals with many times more people in housing need than do any of the hostels.

Such agencies must be encouraged to engage more effectively with homelessness strategies and homelessness forums, if these strategies are to be sufficiently comprehensive to have a genuine impact upon the numbers of homeless people in Plymouth.

6 Recommendations

The following recommendations are made in order to address the concerns related in Section 5 of this report. The creation of wholly new services is not seen as a priority, better co-ordination of existing services is.

6.1 Plymouth Homelessness Forum

It is recommended that a new homelessness forum be established whose operation should be governed by a simple constitution and by a new inter-agency protocol, and that the City Council should take responsibility for the co-ordination of that forum.

The City Council is the one agency that has a clear and unequivocal statutory duty to people in housing need. The establishment of the proposed Plymouth Homelessness Forum should be seen as a vehicle to enable the voluntary sector and other statutory bodies to participate in the construction of strategic goals and to support the Local Authority to achieve those goals through a strategic partnership.

The forum should be structured in such a way as to bring together homelessness agencies to share knowledge, information, and good practice. The structure should reflect the key elements discussed in section 5.1 above, avoid burdening members with excessive meetings and debates, be such that the Forum is able to speak authoritatively on behalf of all member agencies, and engender a genuine sense of ownership.

It is recommended that the Plymouth Homelessness Forum should consist of a 'general forum' and three service specific sub-groups; namely the Direct Access Group, Supported and Move-on Group, and the Resettlement and Tenancy Support Group.

It is recommended that most of the Forum's work be conducted at group level. Meetings of the general forum should be regular, but infrequent, perhaps held quarterly, and that this should be specified by the constitution.

It is recommended that meetings of the service specific groups should be more frequent but at the convenience of members. The minimum period between meetings should be specified by the constitution.

No agency should be eligible for membership of the forum without first adopting the protocol. Moreover, any failure to comply with the protocol should result in membership of the forum being immediately withdrawn from the agency failing to comply.

The poor representation of services central to the alleviation of homelessness within local housing forums is a matter of concern.

It is recommended that both the proposed Homeless Persons and Allocations Unit and the Housing Benefit Section of the Local Authority should seek membership of the proposed Plymouth Housing and Homelessness Forum.

It is also recommended that the Plymouth Primary Care Trust should seek membership of the proposed Forum.

6.2 The Inter-Agency Protocol

While it is not appropriate for this report to specify the terms of the protocol in full, it is clear that a repeat of the tortuous and ultimately unsuccessful negotiations to adopt and implement the Social Services and Housing Protocol, must be avoided. To be successful both the proposed new protocol and forum must have the support and credibility of a wide range of agencies at both management and staff levels.

It is recommended that negotiations to draw up the Inter-agency Homelessness Protocol, which must precede the establishment of the Forum, should be time restricted to a maximum of six months.

The protocol should directly address:

- The specific aims and desired outcomes to be achieved as a result of collaborative working
- Confidentiality
- Definition and role of member agencies
- Inter-agency referral mechanisms
- Strategic planning, development and funding proposals for services for homeless people

The importance attached to inter-agency confidentiality issues requires a special note. The nature of the work undertaken by all of the agencies providing services to homeless people is such that the guarantee of privacy is paramount in ensuring that clients confide in key workers and support staff. This privacy must be protected in order to protect individual clients and to ensure the effectiveness of support agencies. However, there are instances where confidentiality policies hinder joint working and hence reduce the effectiveness of the service that clients receive. Any confidentiality policy that allows this to happen must be considered to be failing the people it is intended to protect.

Effective inter-agency work requires that a robust approach to confidentiality and client privacy be taken by all agencies in order to establish a climate in which agencies feel sufficiently confident to work together. An inter-agency confidentiality policy requires three parts:

1. Minimum standards for confidentiality within agencies, in order to set a uniform standard across the forum;
2. Minimum standards for confidentiality between agencies and other agencies who are not members of the forum and hence not signatories to the Inter-agency Housing and Homelessness Protocol; and
3. Standards on confidentiality to be applied between agencies who are members of the forum and signatories to the protocol. These standards must not be

minimum standards but uniform standards and may be so if the minimum standards described in the previous two points are applied.

6.3 Private Sector Accommodation

There are three principal concerns in relation to private rented sector accommodation in Plymouth, viz:

- Poor quality
- Affordability
- Reluctance to accept referrals from agencies working with homeless people.

It is considered that the growing reluctance of landlords to allow their properties to be listed by services like the Youth Enquiry Service and the Council's Housing Advice Section requires concerted action to address some of the issues that prevent or discourage landlords from providing accommodation to these client groups on the one hand and to ensure minimum standards are met on the other. The following recommendations are intended to help make the best use of the available properties in the private sector, to ensure minimum standards and to support good landlords.

It is recommended that a single inter-agency private sector landlord / property register be maintained, by one agency on behalf of all member agencies of the Plymouth Homelessness Forum.

Inclusion on this register must be restricted to properties that comply with the legislation that regulates the private rented sector, particularly in relation to gas and fire safety standards. It will therefore be necessary to hold on file a copy of the current gas safety certificate for each gas appliance and to confirm with the Local Authority that there are no outstanding notices against the property or landlord.

It is recommended that these requirements be checked each time a potential tenant is referred to a property.

However, such a register cannot solve the problem of the declining supply of accommodation in the private sector and action needs to be taken to address those issues that discourage landlords from letting properties to homeless people. Consideration should be given to the establishment of a tenancy support scheme intended to promote the independent living skills of tenants, reduce neighbour nuisance and property damage and protect landlords' assets and income. Such a scheme needs to address the cycle of poor tenants leading to poor landlords leading to poor tenants by combining improved standards of accommodation, guaranteed acceptance of rent deposit certificates, written tenancy agreements and acceptance of direct payment housing benefit for homeless people, with support for landlords in relation to tenancy problems and housing benefit problems. In the long-term this might also be tied into the Local Authority's renovation grant and regeneration strategies such that properties on the joint register will be prioritised for HMO renovation grants.

It is recommended that the development of a comprehensive private sector tenancy support scheme including the setting of minimum standards and the

provision of support for landlords be developed in order to stimulate growth in the private sector accommodation available to vulnerable homeless people and to improve the sustainability of those tenancies.

Such a scheme does not require the establishment of new services, but does require a single coherent strategy to be adopted across the range of floating, tenancy and resettlement support that already operates across the City in order to extend their support to landlords. This is not an extension of their role, but recognition that sustainable tenancies require supported landlords as well as supported tenants.

It is further recommended that local authority support for landlords, for example through HMO renovation grants, should be linked to the comprehensive private sector tenancy support scheme, either exclusively or by prioritising properties registered with the scheme for a minimum period.

The full range of support offered to landlords, under such a strategy, might include:

- Help in finding tenants and minimising lost income from vacancies through the proposed single private sector register;
- Prioritised access to HMO renovation grants;
- Advice on housing legislation and Housing Benefit (Housing Advice Centre);
- The knowledge that tenants are receiving support to enable them to better manage their tenancy; and
- Access to mediation with tenants (support worker or Housing Advice Centre)

The resource implications of these proposals, it is considered, are minimal since all of the elements currently exist.

It is recommended that the Resettlement and Tenancy Support Group of the proposed Plymouth Homelessness Forum be tasked with the development of the Comprehensive Private Sector Development Strategy on behalf of the Forum.

6.4 Open Access GP Service

The difficulty associated with forming clear-cut and meaningful conclusions for the delivery of health services to homeless people is demonstrated by the vagueness of the conclusions and recommendations of many of the few reports that directly address this issue.

Liz Winn (undated) discusses with considerable perception the dilemmas of providing specialist services (health or otherwise) for homeless people, referring to:

- The poor integration of specialist, ad-hoc or one-off projects with other agencies.
- The potential of specialist services to divert homeless people away from mainstream services, with a resultant increase in their marginalisation.
- The possible reinforcement of stigma and stereotype.

- The apparent 'let out clause' for mainstream services that specialist services represent.

However, in contrasting the advantages and disadvantages of specialist and generalist provision the report fails to come down on either side with any conviction.

Likewise the report of the Health Education Authority (1999) addresses only the need for more research, inter-agency co-ordination (perhaps sponsored by local Health Action Zones) and the effective dissemination of existing research in order to spread good practice.

Finally, the Working Group Report of the Standing Committee on Public Health (1994) dedicates just one and a half pages to the delivery of health care to homeless people. Even here the discussion is of the problems involved in delivering health services and recognition of the need for greater flexibility and better co-operation between agencies. There is, however, nothing in the way of specific recommendations.

The provision of a General Practitioner (GP) service to homeless people in Plymouth has no strategic basis. The successful registration of homeless people with GPs is largely the result of the attitudes and special interests of a small number of local GPs, for example those with an interest in mental health or drug and alcohol issues. However, it is inappropriate for this small number of GPs to be excessively overburden by the heavy and demanding caseloads that result. It may also be considered that the level of service provided at present may not be sustainable in the long-term. The loss of any of the GPs, who are inclined to work with homeless people, for example through retirement, would not automatically result in their replacement by a similarly interested or sympathetic GP.

There is an additional need to increase the use of GP services for non-urgent healthcare and to allow GPs and Practice Nurses to address health promotion and education in a more systematic manner. However, the dispersal and heavy workloads of sympathetic GPs, coupled with their responsibility to the other patients on their lists, makes the opening up of GP services to homeless people difficult.

It is difficult to make clear recommendations in relation to medical services. The existing availability of medical services to homeless people is fragile and the researchers would not wish to jeopardise these. However, these services do require some strategic basis.

It is recommended that GPs be represented within the proposed Plymouth Homelessness Forum, either directly or through the Primary Care Trust.

The nature of this representation will require some negotiation with those GPs. We are sure that they would welcome an input, but would also be wary of the additional burden of meetings (as would most other agencies).

The relative ignorance of the Primary Care Trust in relation to homelessness issues is a matter of concern. In particular, representatives of the PCT saw homelessness strictly in terms of rough sleepers and failed to recognise that many of the people that

they described as 'deprived', and who they did see as a priority for health services, might also be described as homeless because of the insecurity or inappropriateness of their accommodation.

It is recommended that the present half-day surgery at the SHIP direct access hostel be extended to allow homeless people who are not resident in the SHIP to make use of the facility.

It is recognised that this may present the staff and management of the SHIP with some difficulties. They would not, for example, wish non-residents to have access to all parts of the building. It may be that an alternative venue for this drop-in surgery is required.

Any extension of this service will also require additional medical support. Since the GP present at these surgeries attends as a volunteer, the support of other GPs would be essential. The support of other GPs is in any case desirable in order to ensure the sustainability of the service even as it stands. However, other staff could also attend. Most general practices have their own nurses and health visitors and this surgery need be no different.

It is recommended that the Health Worker and the Community Psychiatric Nurse (CPN) for the Homeless should regularly attend surgeries at the SHIP. He or she should also make routine visits to homeless people in all of the City's temporary accommodation, for example Raglan Court, the Salvation Army Hostel, the Women's Refuge and Bed and Breakfast accommodation.

6.5 Move-on / Tenancy Support

The Local Authority currently provides temporary accommodation for families at the Battery Street flats (soon to be replaced by Raglan Court) and for single people at the SHIP hostel. However, the shortage of accommodation at the SHIP means that homeless people are often turned away and that vulnerable single people are sometimes accommodated in the family unit.

There is a need for some single homeless people to access supported move-on accommodation in order to begin the process of resettlement and to make the transition into stable and sustainable tenancies in general needs accommodation in either the private or the social rented housing sectors. This need is made urgent by the shortage of bed spaces within both the SHIP and the Salvation Army hostels, many of which are occupied by homeless people who are receiving resettlement support and might more appropriately be housed in medium-term temporary accommodation.

However, unlike the SHIP neither the Battery Street Flats / Raglan Court nor the Women's Refuge has a tenancy support or resettlement worker. This it is considered represents a significant missed opportunity and one that could be addressed by making better use of existing tenancy support or resettlement projects.

It is recommended that alternative accommodation be found for medium-term residents of the SHIP hostel. The appropriateness of the proposed new development by the Salvation Army / Devon and Cornwall Housing Association should be considered in this context.

The introduction, via another agency if necessary, of resettlement support to families accommodated in the Local Authority's temporary accommodation unit at Raglan Court and the Women's Refuge for families should be considered a matter of priority.

6.6 Homeless Persons Unit

It is clear that in the recent past there have been serious inconsistencies in the service received by homeless people, and other agencies, from Homeless Persons Unit. It is recognised that members of staff at the homeless persons unit are frequently very helpful to members of the public who are in distress. However, it is also clear that there are occasions when homeless people are prejudged and their eligibility for help under the 1996 Housing Act is determined without the completion of any formal procedure.

This research project fails to identify the precise reasons for the inconsistencies observed; however, the shortage of staff in the Homeless Persons Unit is a clear contributor. The City Council is undergoing restructuring, which in the short term may have contributed to these problems, but in the longer term offers the possibilities of an improved service. Nonetheless, the employment of temporary and even 'agency' staff is inappropriate and the latter is considered unacceptable.

It is recommended that the homelessness application and investigation procedure be reviewed as a matter of urgency, that staff positions be made permanent, and that staff receive training on their duties under homeless / housing legislation.

It is recommended that all interviews with the general public be logged along with the purpose and the outcome of the interview; such interviews should be logged even when no homelessness application is made.

It is recommended that all applicants receive, on first presenting to the homeless persons unit, a leaflet explaining the procedure for assessing the local authorities duty, the method by which they will be informed of the outcome of the council's decision and what will happen a). if their application is accepted and b). if their application is declined – this should include information on the applicants right to appeal and contact details for appropriate advice agencies.

The lack of an appointments system at the Homeless Person's Unit results in long waits, frustration and sometimes distress for applicants, and pressure to move through the queue more quickly for housing investigators. It is considered that the stress experienced by both homeless people and staff as a result of this continued pressure must undermine the efficacy of the system.

It is proposed that an appointments based system be introduced for 'non-urgent' homeless applications, for example people with notices to quit that are not about to expire, and that it should be possible to book such appointments by telephone or in person at the Homeless Person Unit.

The person/s responsible for making such appointments must be fully trained in order to determine accurately the urgency of each case so that urgent cases are not given

appointments even when this is the initial request. Members of the public requesting or being offered appointments should also be told what information and documentation they will require at their interview.

6.7 Uniform Recording

Consistent with good practice and the demands of funding agencies most of the organisations visited throughout the course of this project kept annual statistics. However, the precise nature of the data collected varied enormously. This it is considered reduces the availability of good quality, easily accessed data on local needs and changes in the nature or demand for homelessness, and other, services.

It is recommended that all members of the proposed Plymouth Homelessness Forum should adopt a complementary recording system, which does not prevent them from collecting additional data, but which does include as a minimum information on the age, race, gender, family status, immediate cause of homelessness and special needs.

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