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Health and well-being for all – holistic health services for people who are homeless

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Health and Well-being for All – Holistic Health Services for People Who Are Homeless

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This policy paper aims to provide decision- and policy-makers in the area of health and homelessness at all levels with a framework for addressing the health needs of people who are homeless. It identifies the key elements of an integrated and coordinated health and social care system that can guide policy and service design, development and implementation. It also reflects on the role of the EU in investing in and promoting such policies.

Background: Homelessness, Housing and Health

A person experiences homelessness when he or she does not have somewhere to live in security, peace and dignity.[1] Homelessness and housing exclusion can take different forms: people sleeping rough and living in public spaces, people using homeless day or night shelters or staying in temporary accommodation, as well as people currently living in state care, hospitals, in prison without adequate housing to return to, and people living in insecure or inadequate accommodation that may be unfit for habitation, overcrowded or that they may not have a legal title to it. [2] Homelessness is caused by the interaction o structural problems such as a lack of affordable housing or unemployment and interrelated individual causes such as debt, family breakdown, or poor health.

Housing is a social determinant of health that impacts on the ability to live a healthy life. The poor quality of accommodation is the cause of many of the health issues homeless people face and often complicates treatment and recovery. Stable and adequate housing supports good health, whilst living in unsafe, unaffordable and unstable accommodation increases the risk of many health problems. There are clear causal and consequential links between homelessness and poor health outcomes. Ill-health can cause, contribute to and exacerbate homelessness and homelessness can cause, contribute to and exacerbate ill health. There is no easy answer to the cause and consequence debate but what we do know is that once a person becomes homeless the impact on both their physical and mental health is significant. People who are homeless experience higher levels of physical and mental ill-health than their housed counterparts.[3] In addition, homeless drug and alcohol users tend to use these substances more frequently, increased quantities and in less safe ways. Risk behavior is correlated with housing instability, with the highest levels of risk being experienced amongst rough sleepers and those in emergency accommodation.[4]

Some people who are homeless, notably rough sleepers and long-term users of homeless shelters and hostels are particularly affected by multiple morbidity including problematic alcohol or drug dependence, mental health issues and physical health problems[5] and high rates of premature mortality. Despite this substantial burden of

[1] CESCR General Comment No 4
[2] For more information on categories: see the ETHOS definition http://feantsa.org/spip.php?article120&lang=en
[3] Identified chronic health issues for people experiencing homelessness include blood borne viruses, particularly Hepatitis B and C, skin infections, tuberculosis, cardiovascular disease, depression, post-traumatic stress disorder, malnutrition, dental decay and tooth loss.
[4] Lawless and Corr, 2005
[5] The complex and interdependent nature of health needs of homeless people are captured in the following definition: a homeless person with multiple needs will present with three of the following, and will not be in effective contact with services: mental health problems, misuse of various substances, personality disorders, offending behavior, borderline learning difficulties, disability, physical health problems, challenging behaviors, vulnerability because of age. If one were to be resolved, the others would still give cause for concern. (Homeless Link, 2002)

illness, people who are homeless lack access to quality health care. This relationship between the need for health and its actual utilisation has been termed as inverse care law. In other words, those who most need it are the least likely to receive it.[6]

Context: A Rights-Based Approach to the Health of People Who Are Homeless

Health and homelessness should be understood in the context of a multidimensional and holistic approach[7] to health and in the framework of human rights and health inequalities.[8] Health inequalities are understood as inequalities in health between groups of people. Mortality in homeless people is an example of extreme health inequalities. People who live on the street die an average of 20 years before the general population.[9] The rights-based approach to health constitutes the recognition of state's responsibility to reduce these health inequalities and protect the right to health for all. The four interrelated elements which are essential to the realisation of the right to health for all are: availability, accessibility, adequateness, and affordability.

- Availability: Health care must be available to all parts of the population. This implies that facilities are capable of actually providing care to all, including people who are homeless.
- Accessibility: Health facilities, goods and services must not only be available, but also accessible. Even when people who are homeless are entitled to receive services they often face informal barriers such as bureaucratic, organisational, financial or social barriers that limit access to services. Stigma, prejudice and discrimination which prevent people who are homeless from receiving adequate health care constitute a significant barrier to accessibility. The lack of information about health care entitlements can also be regarded as an access barrier.
- Adequateness: Mainstream health services are often not adequate to address the complex health needs of people who are homeless. They may be insufficient, often have long waiting times, numerous registration forms, and busy waiting rooms. Due to the lack of flexibility to adjust to the needs of people who are homeless, mainstream health services may also be inadequate to provide the continuity of care for people who are homeless.
- Affordability: In many countries, there are substantial costs associated to accessing healthcare that makes health care unaffordable to people who are homeless.

It is important to note that the full realisation of the right to health[10] goes beyond the provision of access to medical care. It requires action of the social and economic sectors in addition to the health sector by addressing the wider social determinants of health such as housing, education and employment. Also, public health approaches tackling health inequalities should address housing as part of their preventive strategies and must recognise inadequate housing and homelessness as a health issue.

[6] Hart, Inverse care law, The Lancet, 1971

[7] When considering the health problems of homeless people, it is useful to take into account the broad concept of health as set out by the WHO as follows: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". It links the three aspect of health together in a way that is interconnected and can not be regarded alone.

[8] Health inequalities are understood as the "systematic differences in health status between different socio-economic groups".

[9] Psychiatric disorders and mortality among people in homeless shelters in Denmark: a nationwide register-based cohort study. (The Lancet, 2011)

[10] Right to health (Art 12 International Covenant on Economic, Social and Cultural Rights (ICESCR))

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Eight Elements for Developing an Integrated and Coordinated Health and Social Care System

Homeless people experience significantly higher rates of death, disability and chronic disease than the general population. The long-term ill health of homeless people and the identified barriers to the realisation of the right to health of homeless people show that the service structures addressing the health needs of homeless people need to be reorganised. Due to the fragmented health services, homeless patients do not always receive appropriate treatment in the different care settings. The coordination of all the different parts of the health care system, such as GPs, hospitals, mental health care, drug and alcohol programmes could prevent the situation often experienced by people who are homeless of being shunted from service to service and being treated only for the most acute health issue. Instead, it would allow the whole of the health situation to be treated in a holistic way.

To achieve better health outcomes there is also a need to better integrate health services with social and housing services. Evidence shows that only a multi-sectoral response which includes housing organisations, social services and health services can find long-term solutions to the health needs of homeless people. Integrated services claim benefits for the health of homeless people, as they reduce the organisational barriers between different services allowing people who are homeless to receive the support that they need. It is important to note that different funding systems should not be a barrier for the integration of the services. An integrated and coordinated health and social care system would include the following eight core elements:

1. Flexible and Tailored Services for People who are Homeless

Services should be patient oriented, organizing care around the individual and around the needs of the individual. This personalisation of services would allow acting in the best interest of the patient and would allow the flexibility to facilitate access of people who are homeless to care. Good health services for people who are homeless offer low threshold, high quality, flexible, tolerant and individually tailored responses to meet their health needs. They generally work on a drop-in rather than appointment basis and can be fixed-site services (e.g. medical centre at a day centre or hostel) or outreach services (visiting different sites including people sleeping rough). While it contributes to the improvement of health care provision for people who are homeless, targeted services can further reinforce, rather than challenge, stereotypes towards people who are homeless and mainstream providers can feel absolved from their duty to provide health care for all. Specialist services, therefore, have an important role to help people who are homeless make the transition to mainstream services.

2. Accessible Mainstream Health Services

There is a clear need for mainstream health services providers to adapt their existing delivery models to meet the health needs of people who are homeless. Removing the administrative and physical access barriers which people who are homeless face would not in itself result in better access to health care by this cohort. More information about health services and about their entitlements significantly facilitates access. In addition, people who are homeless should be supported in accessing services by "care navigators" (nurses, social workers or peer workers) who assist patients in coordinating all aspects of health care and in navigating in the health care system.

3. Supportive Environment

Distrust of the health care system is a particularly significant access barrier for people who are homeless. Distrust is often rooted in previous negative experience with health care providers and results in people who are homeless feeling unwelcome in health care settings. To eliminate stigma and discrimination against people who

are homeless, increased awareness and understanding of the complex and interdependent nature of health needs of people who are homeless and of homelessness among health care professionals through training is necessary. Treating people who are homeless with respect and within a supportive environment is crucial for successful engagement with them and facilitating their continued access to health services.

4. Effective Hospital Discharge Protocols

Patients who are homeless are often discharged when the primary concern for admission has been dealt with, but other conditions such as mental ill health and methadone treatment may not have been addressed. Early discharge often leaves patients who are homeless too unwell to recover from illness in an environment (may be the street, a hostel or unstable housing) that does not allow effective recovery and, as a result, they often return to emergency care. [11] It is therefore essential to identify patients who are homeless as soon as possible right after admission into hospital in order to introduce effective measures to address their accommodation needs upon discharge from hospitals. One successful model is hospitals working with specialist teams that consist of a homeless health nurse and a GP to ensure that people who are homeless are discharged with somewhere to go and with support in place for their ongoing care needs. As a rule, housing should be a key part of hospital discharge.

5. Prevention and Health Promotion

People who are homeless have a rather positive self- perceived health state which is often in stark contrast with the diagnosed diseases. This is due to the survival mechanism needed to cope with extreme living conditions. In addition to this, other priorities such as seeking shelter, food and safety, take precedent over addressing their health concerns. As a result, people who are homeless ignore symptoms for a longer period than the general public and access health care at an already advanced stage of the illness and usually through emergency services. Health promotion interventions and prevention strategies should be developed where most available for people who are homeless. Examples include screening tests at mobile clinics, or vaccination programmes at the emergency departments. Increasing health literacy[12] should also be part of a proactive approach to address the health needs of people who are homeless.

6. Harm Reduction

Harm reduction is a non-judgmental approach that seeks to minimise and to eliminate adverse health, social and economic consequences of substance abuse for all individuals and communities. Its focus is on prevention of the harm associated with substance abuse rather than eliminating its use. It supports choices about abstinence, safer use or managed use and recognises that different people need different support and help. It also often supports interventions that not only treat the addiction but also considers the underlying structural factors. Harm reduction is seen as an appropriate response to addressing problematic substance use and homelessness. An example of this approach is the Housing First model. It starts with helping people where they are at the moment. It places people in secure and appropriate housing and not contingent on sobriety or willingness to accept treatment. Once housed, client support can vary from little support to assist this individual to ongoing assertive support[13] to ensure the individual remains housed. Evidence shows that adequate housing plus a specialist programme of

[11] Research shows that emergency readmission rates within 28 days of discharge from hospital are particularly high among homeless people.
[12] the knowledge of health and the ability to understand and process related information
[13] Housing First provides case management for those with the greatest support needs, using Assertive Community Treatment model which delivers proactive, intensive, community-based support often on the individual's own residence, available around the clock, if necessary and for those with moderate support needs using Intensive care management model in which single case managers serve as brokers, connecting consumers with various community support and services.

needs-adapted and choice-based support, stabilizes and can reduce drug and alcohol use in case of people who are chronically homeless and suffer from complex health problems. This approach separates treatment from housing, considering treatment voluntary and housing a fundamental human right.[14] Other harm reduction strategies include needle exchange services, substitution therapy[15], safe consumption sites and controlled drinking programmes.

7. Participation and Peer Support

Meaningful participation of people who are homeless in the design and implementation of health interventions that are targeted at them can be an effective means to improve their access to health care. Services can thus be better informed about the health needs of people who are homeless and the gaps in the services available to address these needs. Peer activities such as health promotion and health advocacy can provide additional support and help improve access to health care and improve the overall health of people who are homeless.

8. Independent Living and Housing-led Approaches

Institutional living can have adverse effects on mental health and emotional well-being. For example, people staying long term in temporary accommodation often have higher levels of mental distress and lower self-esteem[16]. Such living environments lack privacy, restricts freedom and autonomy, and are often overcrowded. It is clear that some of the health problems present in people who are homeless stem from institutional environments. However, permanent housing alone does not solve the problems of people who are long-term homeless. Instead, housing-led approaches that incorporate the provision of adequate support for the people in their homes based on their needs have been proven to be effective. Growing evidence suggest that the majority of people who are homeless and who are vulnerably housed can successfully stay housed when the right supports are in place. These services addressing the social and health problems support people where they are and according to their needs rather than expecting them to fit into standardised models.[17] In the long run, supported housing can provide better outcomes at lower costs than traditional high-cost institutional care. It can lead to the reduction in the use of emergency health services, fewer hospitalisations, and can produce improved health outcomes. Independent living and the ability to make changes in one's life also positively contributes to one's well-being, supports recovery and prevents relapses. Supported housing can therefore serve as a positive health intervention, as it improves people's health and well-being, helps them to manage their health, and can prevent the need for more acute and costly services.

The Role of the EU

The economic crisis brought to light the structural problems in the health care sector and the need to deliver health efficiently in the face of reduced public budgets. The crisis has also reinforced the role of the EU[18] in influencing the reform of health care systems in member states through issuing country-specific

[14] Tsemberis, 2006
[15] Procedure of replacing a drug usually heroin with a medically prescribed substitute e.g. methadone
[16] A comparison across settings, a study of people who are homeless in London In: Moore, J. (1995)
[17] Housing lead approaches are a departure from the "staircase" model that dominates homelessness policies across Europe. According to this model, stable housing is the end goal with homeless people being moved through various stages in different residential settings before becoming "housing ready".
[18] While health is essentially an area of national competence, the Lisbon Treaty gives the EU the right to complement member states' actions to protect and improve health by encouraging cooperation between them and providing support. The key role of health has long been recognised at the EU level. Addressing health inequalities is a key action of the EU Health Strategy and many instruments are available to help member states to address the issue. In line with the "Health in all " policies approach, health is incorporated into relevant EU policy areas.

recommendations for policy reform in health care in the framework of the European Semester[19]. Investing in Health[20] is a priority of the recently published Social Investment Package of the European Commission which aims to guide member states to use their social and health budgets more efficiently and effectively. It declares health a value in itself, and also considers it an investment. In its view, investing in good health can prevent high economic and social costs in the future. The framework to address the health care needs of people who are homeless described above is in line with the social investment approach proposed by the European Commission. For example, it highlights the need for better targeted, individualised, and integrated services, which appears to be the most effective model for addressing the needs of people who are homeless. The Commission proposes a number of strategies that can improve the efficiency and effectiveness of health systems. Again, we see that efficiency gains can be made for example by strengthening the access of people who are homeless to primary care or reducing the unnecessary use of emergency departments and hospitals. It is important to note, however, that reforms in the health care sector should go beyond simple cost-saving measures and encourage changes that can improve health outcomes for all, including people who are homeless. To do so, it is necessary to invest in reducing health inequalities through improved access to health care for all and through integrated and coordinated health and social care systems.

[19] The European Semester is an EU –level economic governance structure which help coordinate the macro-economic, budgetary and structural reform policies of the Member States.
[20] http://ec.europa.eu/health/strategy/docs/swd_investing_in_health.pdf

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