Questionnaire for the FEANTSA Annual Theme

The Right to Health is a Human Right:
Ensuring Access to Health for Homeless People

AC members are asked to draft a national report for their country, based on responses to the questions outlined in this questionnaire. The reports should be 10 – 15 pages in length, written in either English or French and they should be submitted to the office by June 15th 2006. AC members are asked to consult with all FEANTSA member organisations in their country in the preparation of the reports; a copy of the questionnaire will be circulated to all FEANTSA members. The European report on Delivering Healthcare to Homeless People will be prepared over the course of the summer, on the basis of the responses received, and will be presented at FEANTSA's annual conference in Wroclaw on the 13th of October 2006.

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Preamble: health and homelessness:

When considering homelessness and the best ways to tackle it, one cannot fail to be aware of the close links between health and homelessness. Looking at health and how it relates to homelessness offers a view of homelessness in health terms that is very useful. A definition of health is set out in the preamble to the World Health Organisation Constitution: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Given that being homeless will certainly affect at least one of these spheres of health, homelessness may, by its very nature, be considered as a state of ill-health.

There is a range of factors, which may lead to a person eventually becoming homeless and often health issues are among them. Health and homelessness have a relationship of both cause and effect: illness (such as mental illness, substance-abuse or illness leading to loss of employment) may be among the trigger factors that lead to homelessness. Once in a situation of homelessness, a variety of health problems may result, such as exposure to infectious illness, mental health problems, development or aggravation of substance-abuse and addiction, or health problems resulting from an unsanitary or overcrowded environment. These health problems may make it harder to break out of a cycle of homelessness. What is more, accessing healthcare is often very problematic for homeless people.

This health perspective offers many people a better grasp of homelessness and can serve to counteract stereotyped visions. Health is one of the elements that has been used to define homelessness in Australia for example: in Australian legislation, homelessness is defined in the Supported Accommodation Assistance Program Act 1994. This act defines a 'homeless' person as follows:
“For the purposes of this Act, a person is homeless if, and only if, he or she has inadequate access to safe and secure housing. “(Section 4) The Act goes on to define 'inadequate access to safe and secure housing' and the very first criteria that is used is that of health: “For the purposes of this Act, a person is taken to have inadequate access to safe and secure housing if the only housing to which the person has access: damages, or is likely to damage, the person's health; or threatens the person's safety…” This offers a concrete understanding of homelessness in terms of a threat to health and well-being that policy-makers are likely to be able to identify with and which is concrete enough to mobilise political will.

Health is a vital factor for social inclusion. Good health is a prerequisite to reintegration and is a vital factor in being able to access and maintain employment and housing. Conversely, having a home and a job are important to good state of mental and physical well-being. Thus the right to health underpins and reinforces the right to employment and to housing. What is more, the right of a person to enjoy the highest attainable standard of health has a strong place in international human rights law and is enshrined in international conventions and charters such as the International Convenant on Economic, Social and Cultural Rights and the European Social Charter. This right has been clarified in the General Comments of the UN Committee on Economic Social and Cultural rights, where it is set down that “the right to health is closely related to and dependent upon the realisation of other human rights, including the right to food, housing, work, education, participation…” So it is clear that health is a good way of framing and approaching these other needs, which are particularly acute in the case of homeless people.

Thus it is clear that health has a role to play in understanding homelessness and in communicating about homelessness. It is also true that health policy is a useful avenue for tackling homelessness in a preventative and also a holistic manner. Health services have a vital role in the fight against homeless, as meeting health needs is an important step towards tackling homelessness and health services should be a gateway to other services. It is for all of these reasons that FEANTSA has dedicated 2006 to exploring the theme of health and homelessness. This questionnaire will try to establish a broad overview of the issues relating to health and homelessness across Europe.

It will look at health profiles of homeless people, access to healthcare, training of health professionals, inter-agency working, data collection on health and the right to health.

Q1: Health profiles of homeless people:

This section aims to establish an overview of the main mental and physical health needs of homeless people in Europe; the public health issues that arise from them; as well as common treatment problems. When answering the questionnaire, it may be useful to refer to the ETHOS (European Typology of homelessness and housing exclusion) categories in order to ensure clarity and comprehensiveness. You will find the ETHOS typology in Annexe 1. It is also useful to bear in mind that many homeless people will present with more than one health problem and that these multiple problems across a range of areas may interact with each other and add up to a high aggregate of vulnerability. Please take multiple needs into account when answering these questions.

For reference, here is a definition of multiple needs:

"A typical homeless or ex homeless person with multiple needs will often present with three or more of the following, and will not be in effective contact with services:

- mental health problems
- personality disorders
- borderline learning difficulties
- physical health problems
- vulnerability because of age.
- misuses various substances
- offending behaviour
- disability
- challenging behaviours

If one were to be resolved, the others would still give cause for concern."
(Definition from Homeless Link Good Practice Briefing "Multiple Needs" August 2002)

It should be noted that these multiple needs may also be complicated by previous bad experience of health or social services and a mistrust of health and social workers.

1.1: Please outline the common mental, physical and substance abuse related health problems of the homeless people bearing in mind the conceptual ETHOS categories. Some of the health problems will reoccur in several categories.

ROOFLESS – People Living Rough:

The rough sleeper population has been generally characterised as[1]:

- 90% male
- 75% aged over 25
- Between 25% - 33% have been in local authority care
- Having a life expectancy of 42 years, in comparison to a national average of 74 for men, and 79 for women
- Thirty-five times more likely to kill themselves than the general population
- Four times more likely to die from unnatural causes, such as accidents, assaults, murder, drugs or alcohol poisoning
- 50% alcohol reliant
- Around 70% misusing drugs
- 30-50% with mental health problems
- 5% from black and minority ethnic groups

Specific health issues identified for rough sleepers include:

[1] Addressing the Health Needs of Rough Sleepers, Professor Sian Griffiths, ODPM, 2002, page 6

- Poor physical health higher rates of TB and hepatitis than the general population, poor condition of feet and teeth, respiratory problems, skin diseases, injuries following violence, infections, digestive and dietary problems and rheumatism or arthritis.
- Mental health problems serious mental illness such as schizophrenia, as well as depression and personality disorders
- Drug and alcohol dependency high misuse of heroin, crack cocaine and alcohol

The key point is that the average age of death (42 years) is approximately half that of the general population.

Poor health is not only a consequence of homelessness but can also help to precipitate it. More generally there is a greater risk of premature death and morbidity amongst the homeless population than amongst the population at large.

There are a wide range of health problems which are more prevalent amongst homeless people than the wider population. These include chronic conditions as well as anxiety, stress, self-harm, other mental health problems and infectious diseases. A significant minority of homeless people are dependent on drugs or alcohol often alongside mental health problems and other multiple needs. A study of homeless people in Aberdeen (Love, 2002) found that only 22% of homeless people in Aberdeen considered their health to be “good” compared to an average of 77% of the general population.

A study by the Office of National Statistics of homeless people in Glasgow (Kershaw, Singleton and Meltzer, 2000) found that:
• 73% had experienced one or more neurotic symptom in the past week and 44% were assessed as having a neurotic disorder.
• Over half experienced levels of hazardous drinking.
• 65% had a longstanding illness.
• 29% had attempted suicide.
• 18% had self-harmed.
The final two figures were substantially higher amongst young people.

It is important to recognise that health problems are not confined to those sleeping rough. **People living in temporary accommodation, with friends or in hostels** have little stability, often have to share kitchens and bathrooms and have little privacy or security. They may also experience problems relating to damp or overcrowded conditions.

In terms of the ethos categorisation**, houseless households** are likely to suffer:
- Mental health problems such as anxiety, depression, stress.
- Children suffer behavioural problems – mood swings, over activity, disturbed sleep, impaired development of motor and speech skills.
- Households generally experience mental health problems which can lead to physical conditions such as weight loss, insomnia (or irregular sleeping patterns) and skin conditions such as eczema. Poor diet, a higher risk of accidents and a higher risk of hospitalisation all feature.

Insecurely housed households and inadequately housed households are likely to experience mental health problems including stress and depression.

Much research evidence about homelessness and health relates to large population centres with correspondingly large homeless populations. Such results may not necessarily apply to small towns. The results presented here relate to mental health issues in a survey in a small town in England. Current mental health problems were reported by 53% of the sample (40 people); of these only 40% (16 people) were receiving treatment. Three people had been admitted to a psychiatric hospital within the past year. Using standard scoring, the ‘GHQ30’ identified as cases

72% (44) of the 61 homeless people who completed the GHQ**. It was concluded that levels of mental morbidity were higher in the homeless group than would be expected in the general population. This finding mirrors those of studies in larger population centres.**

Research also shows that homeless families in **rural areas** may spend longer in temporary accommodation than those in urban areas (Fitzpatrick, Pleace and Jones, 2005). Some of the health problems arising from such circumstances include an increased risk of dermatological problems, musculoskeletal problems, poor obstetric outcomes and a range of mental health problems.

The effect on **children in homeless families living in temporary accommodation** can be serious. There are many detrimental effects on the physical and emotional development of children living in unsettled or overcrowded accommodation with little room to play or do homework. Studies have shown children in these circumstances to be prone to behavioural disturbance, have higher levels of illness and infection, have poor sleep patterns and are more prone to accidental injury (Quilgars and Pleace, 2003).

Homeless young people may also neglect their health needs unless they become debilitating (Quilgars and Pleace, 2003). They may also be reluctant to approach health services because they expect a hostile response.

Health visitor contact can be extremely important and may be the most frequent point of contact, especially for homeless families. However, there can be a perception amongst some homeless people that the health visitor can be judgemental of their circumstances (Fitzpatrick et al, 2005).

It can be more difficult for homeless people to sustain continuity of care, to meet appointments made a long time in advance, or to participate in health improvement and health promotion activities, such as healthy eating and physical activity. Maintaining contact with key workers such as the family GP, social workers, dentists and lawyers can be difficult if the household is accommodated temporarily some distance away from such support networks.

Homeless mentally ill people respond well to an approach that seeks to establish a relationship of trust, over a period of time. Outreach workers are effective if they have a genuine concern for an individual's well being, combined with an acceptance of the person "as they are". Over zealous attempts to impose solutions or help can alarm a homeless person, and so regular contact, responding to needs as expressed, combined with gentle suggestion, is preferable. A good network of contacts with emergency accommodation providers, and a working relationship that develops trust between outreach workers and staff in hostels / shelters is essential to enable the outreach worker to be confident that a homeless person will be accepted on referral. Joint outreach shifts, involving staff from different organizations are particularly effective[2].

One of the main findings of the Evaluation of the Homeless Mentally Ill Initiative[3] was that in order to work effectively with homeless people with mental health problems it was imperative to be able to offer housing solutions as well as mental health interventions and either one on their own was not effective.

In a rural part of Scotland (Argyll and Clyde) a health and homelessness needs assessment was carried out. A total of 119 participants were interviewed with each interview lasting 45 minutes. The results were analysed, and were broadly similar to those in published work, with high

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[2] Ibid

[3] Evaluation of HMII 1995? Craig T et al

proportions affected by family relationships breakdown, physical and mental health problems, and addictions. However, when the results were re-analysed for the proportions of this group with one or more issues, the complexity of problems faced by homeless people became more obvious. In summary, **76% of this sample had three, four or five other significant difficulties in addition to being homeless.** One challenge in the process, not unique to the Argyll and Clyde area, was that of identifying hidden homeless people; hence the needs assessment had a focus on those who had presented to Local Authorities as statutorily homeless.

In Northern Ireland more than two thirds of the homeless population have used drugs at some stage in their life with current drug use at levels 10 times greater among the homeless than observed for the general population[4]. Similarly, a high proportion of alcohol use exists among the homeless in Northern Ireland, the majority using alcohol in a hazardous way, with risk of dependency and harm[5]. There are a higher proportion of alcohol problems within the homeless population than within the general population[6]. Early drug use is a risk factor in becoming homeless and in the majority of cases substance abuse begins before becoming homeless.

There is a relationship between the age of first drink or drug taken and the age of becoming homeless[3]. Substance abuse may lead to other risk behaviours affecting the health of both themselves and others including suicide, unsafe sex (related STIs), physical and mental health problems, criminal behaviour, self-harm, intravenous drug use and the risk of contacting blood-borne diseases such as hepatitis and HIV. The proportion of injecting rough sleepers and homeless people resident in hostels[7] is negligible. Reports suggest that approximately 25 to 30 individuals known to be experiencing housing difficulties (e.g. living in squats), within the Belfast area, are injecting drug users. Alcohol, tobacco, cannabis and prescription drug misuse remain the most significant problems amongst homeless people in Northern Ireland.

Mental health problems among the homeless in Northern Ireland are high and increasing. 35% of homeless people have been diagnosed with mental illness[3] compared to 10-25% of the general population. Indeed, anecdotal evidence from those providing direct services in the Belfast area, would suggest that as much as 60% of homeless people will be experiencing some sort of mental health problem, ranging from mild depressive symptomology to severe mental illness.

A survey of homeless people in Northern Ireland found mental health problems contribute to homelessness and make finding suitable and secure accommodation difficult, with one in five people citing mental health problems as a factor in becoming homeless, while social exclusion associated with homelessness and poverty can also lead to mental health problems[8] Challenging behaviours and personality disorders, which may antecede and sustain homelessness, may also make it difficult to engage these individuals in targeted clinic and health promotion programmes.

Young homeless people are identified as a vulnerable group with a high incidence of diagnosed depression (39%) and other problems including but not limited to anxiety, OCD, ADHD, personality disorders, and stress[9]. These problems, in turn, may make them vulnerable to substance misuse.

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[4] Drug use in Ireland and Northern Ireland - drug prevalence survey 2002/2003

[5] Deloitte MCS (2004). Research into homelessness and substance misuse

[6] Health Promotion Agency Adult drinking patterns in Northern Ireland 2002

[7] There are obvious issues around eligibility for hostel accommodation and disclosure of (injecting) drug use which may artificially reduce the reported or visible numbers in the homeless population.

[8] Fountain, J. And Howes, S. (2002) Home and dry? Homelessness and substance use. London: crisis

[9] Home Office Research Study 258. Youth homelessness and substance use: report to the drugs and alcohol research unit. Wincup,C. Buckland, G. and Bayliss, R. (2003)

Homelessness has been identified as one of the risk factors associated with dual diagnosis, i.e. the co-existence of diagnosed mental health illness and substance use. There is a complex interaction between the use of alcohol or drugs and mental health. Mental illness may lead to substance abuse while substance abuse may accelerate or alter the course of mental illness, or uncover a predisposition to mental illness. Substances may be used to enable people to cope with the symptoms of mental illness. Similarly, homelessness is a major risk factor for self-harm and suicide[10]

1.2 Certain diseases, which are widespread among the homeless population, carry a clear public health risk. This is the case, for example, with tuberculosis. Tuberculosis incidence is much higher among homeless people than among the general population and there is a risk of the spread of this infectious disease and the development of multi-drug resistant strains. For this reason, some countries have put in place specific programmes or strategies to combat tuberculosis among homeless people. Please outline list any public health risks associated with the health of homeless people and actions taken to alleviate these risks.

Tuberculosis in the homeless population:

Tuberculosis rates have doubled in the UK over the past 10 years, and the homeless population is particularly vulnerable to this disease.

Homeless Link has a website dedicated to this issue: http://www.homeless.org.uk/tb/index

This Homeless Link website aims to improve the knowledge and skills of staff working in the homelessness sector around tuberculosis and its treatment.

There is endemic Hepatitis C, and levels of other blood bourne viruses are several times higher in the homeless population than in the general public[11]. An unknown number (especially of heterosexual men) of homeless people are selling sex to fund their homelessness or drug habits. There is therefore a significant risk of blood bourne virus transmission from the homeless population to the general public through the purchase of sexual activity. This is ignored by most public health departments, with little or no specific provision for this client group and no funding to even research the numbers let alone work with the people involved.

There are no definite figures for tuberculosis amongst the homeless population in Northern Ireland, because reported cases are not categorised as 'homeless'. In 1999, the 'Single Homeless Health Care, North and West Belfast Health and Social Services Trust' screened the local homeless population and found no active cases of Tuberculosis, and one case of inactive TB.
Similarly, no definite, official figures exist for the rates of Hepatitis C amongst the homeless population, though it is recognised that it is a growing problem, especially in terms of drug use and STIs.

TB cases are now being found clustered among ethnic minorities and immigrants, raising new public health concerns: in 2005, there were 84 cases of TB in Northern Ireland, with 25 of these being new entrants to the country. The Port Health Authority carries out screening and dedicated nurse visits ensure that these people receive the necessary health care and vaccinations. There are certain problems with implementing screening of immigrants in the UK – not least the fact that many people who enter the country from high prevalence areas would not be subject to the screening programme, key examples being tourists, those returning home, illegal immigrants and

[10] *Shelter, report on homelessness 1997*

[11] St Mungo's Snapshot Survey 2005

those from the EU. There are also obvious political issues involved with testing immigrants for a stigmatised disease, and possibly incarcerating them during treatment.

1.3: Certain health conditions experienced by homeless people pose significant problems of treatment. (For example: tuberculosis treatment can be rendered difficult by a mobile and chaotic lifestyle and overcrowded conditions; there may be availability problems for mental health treatment and drug and alcohol treatment etc…) Treatment of mental health problems is evolving and deinstitutionalisation has taken/ is taking place in many countries, but this too has given rise to new challenges and problems. Multiple needs are another factor that can make treatment problematic. Please outline treatment problems encountered when trying to ensure access to health for homeless people.

This question can be split into two key elements: barriers to healthcare and solutions.

Barriers

Barriers which prevent homeless people from having their health needs met may be structural, policy based or attitudinal.

Homeless people have more difficulty in accessing services than the general population. In order to gain access to services homeless people must first know that they exist, have details about the services and know how to access them. Local health service providers should be aware of the needs of homeless people in their area in order to ensure services are accessible and meeting those needs.

For example, homeless people may be living in temporary accommodation away from their local community, with a distance to travel.

Understanding which services are used or not used by homeless people may lead health service providers to consider whether these are accessible to homeless people or to remodel services to overcome such problems.

Barriers may be structural (for example an inflexible appointments system), policy based (for example that a homeless person must have a permanent address to access a service), or may be related to attitudes towards homeless people. Mainstream services should be systematically audited to ensure they are designed in ways which improve reach for the most disadvantaged groups and which identify and overcome barriers.

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Lack of services for mental health problems (and for alcohol and substances misuse issues) was a problem identified by Homeless Link in a survey **in Wales** during April 2006. Access to dental care is also a problem because of the lack of services and general high demand.‘Findings indicate that many homeless people in Wales experience significant difficulties accessing healthcare services, particularly in areas outside the urban centres.’

(Homeless People’s healthcare needs and access to healthcare provision in Wales, April 2006), p.3.

In **Northern Ireland** homeless people experience more health problems than the general population they also have greater difficulties accessing health care services. The conditions associated with homelessness have been shown not only to have a profound effect on an individual's ability to maintain good health but also to get treatment when health is compromised and indeed to recover even after treatment is received.

In one study[9] some respondents reported having had experienced difficulties in registering with a new GP. Reasons were mainly attributed to the bureaucracy associated with the system. The length of time taken to transfer medical notes from one practice to another was also highlighted. Some had a positive relationship with their GP but a large proportion perceived that GPs and receptionists discriminated against them because they were homeless. They considered that GPs held stereotypical views because they lived in hostel accommodation. Focus group participants said there was an inconsistency between hostels in the availability of information on health related issues. Variations also existed in the access to and relationships some hostels had with healthcare professionals in comparison to others and this was identified as a problem. The majority of participants said they would welcome more information being made available and the provision of more services within the hostel setting such as nursing, GP and counselling services[9].

The stress associated with becoming homeless can have a significant negative impact on both physical and mental health. At the same time, accessing health services, such as registering with a GP and obtaining referrals, may become more difficult, particularly if a household is living in emergency or temporary accommodation. It has been reported that some residents in temporary accommodation felt that service providers treated them differently when it was known that they were hostel dwellers, and some difficulty getting registered with a GP when moving to a new area.[12]

Accessing health care for people who are homeless living with multiple needs and the challenge of this client group for the health services[13]:

The question arises regarding the degree to which this group of people who are homeless are problematical i.e. they are seen as difficult and complex, and to what degree is this complexity about the co-ordination and demarcation of services as opposed to being within the individual?

In February 2004, Crisis produced "Lost Voices"[14] which sought to explore the characteristics and life experiences of individuals struggling with competing health issues, critical life situations, which are further exacerbated by stigma, poor social and life skills, and limited opportunities[15].

This important report found that people who are homeless continued to experience considerable difficulty in obtaining information, accessing services and receiving any coordinated response from health providers. Sometimes inflexible structures within the system of provision, and the very real needs of the clients, meant that the tensions were never resolved. There was a range of obstacles cited in "Lost Voices" that prevented homeless people with multiple health needs from gaining the support they so clearly needed:

- Availability of services was problematic for this client group
- Flexibility or lack of it presented a further hurdle revealing the tension between the desire to provide flexible services and the practical realities of delivering services within traditional but sometimes rigid structures

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[12] *Promoting Social Inclusion of Homeless People. Addressing the causes and effects of homelessness in NI. PSI Working group. Nov 2004*

[13] This section is taken from a chapter: "Difficult People, unresponsive services" Pip Bevan, – to be published Autumn, 2006

[14] "Hidden Homelessness: Lost Voices, the invisibility of homeless people with multiple needs", Clare Croft-White and Georgie Parry-Cooke, London

[15] ibid page 2

- Provision of appropriate care has continuing gaps, especially in the need for comprehensive check-ups, health screening, and lack of drug and alcohol detox services
- Non-prejudicial treatment is an issue, with some services working in a non-prejudicial way, but others were perceived as holding negative attitudes towards homeless people, thereby discouraging their use of services.

Solutions

What has emerged most clearly is the need for dedicated health and homelessness services that have the capacity to go out to people in hostels and other venues. There is concern that individuals often receive inappropriate, inadequate, and sometimes no treatment due to prejudicial attitudes and 'buck-passing' between healthcare professionals. Due to the diversity of need and the often transitory and elusive lifestyle of many homeless people with multiple needs, health care services should be creative and opportunistic in their design and delivery[16].

People with multiple health needs challenge the very structure of the way in which health services operate. They have grown up with clearly defined silos of medical specialisms that are seemingly watertight: mental health, drugs and alcohol (sometimes even these are split), physical health, learning disability, and so on. Each has its own long history and its own philosophy, borne out of years of focusing on a single discipline. This has been necessary in order to have the greatest knowledge about the particular medical condition. But the very thing which has led to excellence will often militate against a holistic approach and the multi-disciplinary way of working which this client group so desperately needs. Take for example, motivation. Whether someone is motivated to change or not is not an issue for mental health services, but it is clearly an issue for drug and alcohol services, often used to ration services in some areas.

Like the rest of the population, homeless people have a right of access to appropriate health care services… research by Crisis found out that, in reality it was not always easy for homeless people to use these services even when presenting with a single health issue. Where multiple needs were present, professional boundaries frequently intervened, as a 'dispute' appeared to arise between health care specialists as to which need should be addressed first[17].

Single issue services have been reluctant to engage with people with more than one need, often playing one need off against another. This approach is not acceptable if we are to engage effectively with this client group. Each health care service needs to be mindful of the client, and the way in which their service impinges and relies on the other service inputs. No one agency can successfully support people with multiple health needs. It requires a team effort and a new and creative exploration of the methods of multi-disciplinary working.

Multiple needs, particularly mental health and substance use problems, continue to make treatment problematic. Even specialised provision for people with personality disorders, such as the Henderson Hospital in Surrey, do not work with people who actively use substances. The work is left to hostels and the voluntary sector.

In **Northern Ireland** currently a model[18]service is being delivered in the Greater Belfast area for multi-needs assessments of homeless people
But clearly, there are gaps in direct services for homeless people. Among services which it is felt should be provided in the Northern Ireland context are:

[16] Ibid, page 3

[17] Lost Voices, Crisis 2004, page 7

[18] *e.g. Homeless Multi-disciplinary Support Team & healthcare co-ordinator / Nurse for the homeless*

- ‘Door step’ delivery of services to ensure timely access, and to address problems around adherence to treatment and appointments;

- The provision of specific drugs and alcohol services for homeless people;

- The provision of GP clinics in hostels;

- The extension of the homelessness district nursing service, health related support and similar services regionally;
- Central Services Agency to examine issues of a more efficient transfer of GP/medical records for homeless people.

Specialist or mainstream

There may be a need to create targeted services where these are essential to meet people’s specific needs. But mainstreaming health and social care needs should also be prioritised: mainstream services should be examined to ensure that they can meet the needs of homeless people and play a part in preventing homelessness.[24]

In one study, research participants referred to the stress of living in a hostel. Having to live with strangers, no privacy and a lack of autonomy increased levels of stress. Stress on occasions was exacerbated by feelings of alienation and isolation. This was attributed to estrangement from family, unemployment and financial worries. Many felt detached from the outside world and felt stigmatised. A large proportion of participants said they suffered from depression brought about by feelings of powerlessness to change their current situation.

Rural areas can pose additional problems of access to services. In one rural area of **Scotland** (Dumfries and Galloway), the health authority has brought together representatives from local businesses, education services, housing services, primary care services and the full range of voluntary sector providers to address the specific needs of their rural communities.

Public Health Practitioners have been identified as the locality leads for the development of services which cater for the health needs of homeless people, and they also sit on their Local Rural Partnership. As a result they are able to both raise awareness about the specific health needs of homeless people and influence the development of services in such a way as to cater for these needs.

By this use of existing structures the needs of the homeless population and the response from the community is coordinated from the outset. This is also a particularly useful approach in an area such as Dumfries and Galloway which has a diverse mix of small- and medium-sized communities within a large rural area. By localising the approach to improving the health of homeless people a greater understanding of the issues can be developed by local people.

More generally in **Scotland** the Homelessness Task Force identified the problem that some services were only available to homeless people who were not actively using substances (drugs or alcohol). One of the recommendations, which all Scottish Health Boards must address in their health and homelessness action plans, is to ensure that being drug or alcohol free is not a condition of access to services. Progress towards this goal is slow but the services are improving.

Q2: Social Protection: Healthcare entitlements of Homeless People
The healthcare entitlements of homeless people vary from country to country according to the social protection system in place. It may also relate to their administrative status (whether they have registered). It may also vary according to whether the homeless people are nationals or non-nationals. This question seeks to examine the impact on access to healthcare and quality of care available to homeless people.

2.1: What are the healthcare entitlements of homeless people in your country (for nationals; for non-nationals, including asylum seekers and undocumented migrants)? What are the registration requirements etc.?

Overall in the United Kingdom health care is free of charge at the point of access to services and should be open to all citizens equally. Some ancillary service, such as podiatry, optical and dental services have a mixed economy – some are wholly private and some are part National Health Service and private. Certain groups are entitled to free dental and foot care. Others will face a charge. The situation varies across the UK in relation to charges. The Scottish Parliament has abolished charges for eye tests and dental check ups for everyone (for example).

In theory homeless people have the same entitlements as everybody else, though this may be limited by the structure of health services and whether particular services have sufficient capacity.

Health Care in Britain

This is a site which is an introduction to social policy and deals with the following areas very succinctly:

- Definition of health
- Inequalities in health care
- Financing health care
- Health care in Britian
- NHS in principle
- NHS and the hospitals
- The organisation of the NHS

Website: http://www2.rgu.ac.uk/publicpolicy/introduction/health.htm

A particular concern from a public health point of view is that when **asylum seekers** have reached the end of the process and been refused refugee status, they are only entitled to 'essential treatment' for prescribed diseases. This includes TB but does not include HIV. This is not a tenable situation as there is a lot of co-morbidity. People in this circumstance have no income so getting to hospital for treatment may be difficult or impossible.

More generally non nationals can access the National Health Service and should be able to see a GP, though there may be more formalities to complete. Undocumented migrants require a National Insurance card (which relates to employment) to access general health services, but even without one, emergency treatment is free of charge.

2.2: Has the health system evolved in such away that it is getting harder for homeless people to access their entitlements?

The situation appears to differ in the different parts of the UK. In **Wales,** the theory is that access should be getting easier. Health, Social Care and Well-being Strategies should address the needs of homeless people and assist in access to health services for homeless people. The theory in the

guidance and policy papers has not translated into practice which means that it is still difficult to access health services.

In **Scotland** every health board is implementing health and homelessness action plans and seeking to implement national standards on health and homelessness. Registration with a GP is no longer a major issue for homeless people and there are a broad range of improvements. However improvements are not universal and in many cases are still in their very early stages.

In **England**, increased devolution of power to the local level within the health service, and subsequently to practice-based commissioning, means that 'undesirable' and 'low-priority' patients like homeless people have less and less specialised services. Choice is increasingly denied as increased pressure is put on hospitals or specialised surgeries to only work with "local" homeless people. Secondary care referrals also become more limited because of local residency issues.

There is no evidence, however, that this is an issue in Scotland

In **England** much healthcare, eg detox and rehab, is gatekept by social services under increasing budgetary pressure to assess people as not needing a service. They make value judgements on the 'deservingness' of individuals and refuse them services because they are e.g. "not sufficiently motivated" if they've already done several detoxes. London social services have a blanket refusal to fund longterm (1-year plus) rehabs, even though shortterm rehab may have failed users time and again.

However, in **Scotland** the national Health and Homelessness Standards, which health authorities must implement are designed to challenge this kind of attitude – looking at an individual's needs for services rather than placing a barrier on access to services based on a subjective view of whether they are 'deserving' or not.

In **England**, members report that people are refused hospitalisation because of a lack of beds in psychiatric facilities, or are refused a crisis house and forced to take up a hospital bed because of lack of funding for non-medical crisis provision, or are refused assessment because of 'localness' considerations.

More generally barriers include:

- homeless people, often being seen as undeserving because of substance use, self-harm etc.;
- Under-assessment, because of multiple needs and because of 'over-neediness' – many homeless people's problems are so severe in some respects that other aspects, which would be seen as problematical in another individual, are simply overlooked;
- stigma – homeless people may find it difficult to present in eg GP's waiting rooms because they are dirty, or smell, or they may react to perceived negative attitudes by professionals, receptionists etc;
- challenging behaviour – some people are barred from hospitals in their area because of their behaviour;
- ability to communicate – many homeless people are not articulate about their needs, and some professionals are not interested enough to really find out;
- distrust – many homeless people have a poor experience of health professionals in one way or another, and so are wary;
- lack of effectiveness – many treatments are not effective, but often the homeless person takes the 'blame' for being difficult, and they do not want to repeat this process;
- time – many homeless people want or need things now, and will not or cannot wait, which is part of their pathology but is not accommodated by most medical services.

2.3: What do you consider to be the main barriers facing homeless people in your country when they try to access healthcare (stigma, financial barriers, administrative barriers, etc.)?

The different parts of the UK show some similarities and some differences in this respect.

In Wales in 2003 a literature review commissioned by the Welsh Assembly Government reported that:
'Mainstream medical, care and support services do not generally meet the needs of homeless people. Staff, and the public often hold negative attitudes towards homeless people. Homeless people are often unaware that such services exist. Some service providers, for example General Practitioners, commonly discriminate against homeless people. The review identified that one of the barriers to accessing services is the perceived negative attitude of staff towards.'

The impact of negative attitudes is echoed in **Northern Ireland** as is the problem if inflexible and inappropriate appointment systems.

Other barriers identified included:

Formal appointment systems
The complex health care needs of homeless people – dual diagnosis etc. and the 'un-professional' structure of health care services.

The review found that improving the services to homeless people required:

- Incentives to health professionals to provide better services.
- Services to be available at unconventional times.
- Equipment to be provided in order that services could be provided in the community.
- Developing better joint working and strategies at a local level.
- Monitoring and evaluation of services.

(Homeless People's Access to Medical, Care and Support Services A Review of the Literature, WAG September

Homeless Link in **Wales** also carried out a survey of members which found that there was a lack of specialist and dedicated services e.g. facilities for alcohol, drug rehabilitation.

- There were difficulties registering for health care.
- The structure of health delivery and inflexibility of appointment systems were problematic
- There were unacceptable waiting lists for services such as assistance with addiction to drugs or alcohol.
- There was discrimination and/or the lack of knowledge of the needs of providing services for homeless people.

In England a summary of barriers is covered succinctly in Crisis' publication Critical Condition [19]
Key findings:

- Although, homeless people have some of the worst health problems in our society those interviewed were almost 40 times more likely not to be registered with a GP than members of the general public. They were over five times more likely to have problems getting on to or staying on a GP's list than the general public
- Four our of five (81%) of GP's interviewed believe it is more difficult for a homeless person to register with a GP than the average person

[19] *Critical Condition Crisis 2004*

- A&E was the main service that homeless people turned to when they couldn't speak to a GP – 79% of them use A&E. They were over four times more likely to turn to A&E when they could not access a GP than the general public

GP registration is less of a problem **in Scotland** where the main barrier has been identified as how to gain access to effective services, which relates once again to appointment times, receptiveness of staff etc).

The Scottish Health and Homelessness Standards require health boards to 'take action to ensure homeless people have equitable access to the full range of health services.' The introduction to Standard 4 states: :

Homeless people have more difficulty in accessing services than the general population. In order to gain access to services homeless people must first know that they exist, have details about the services and know how to access them. Local NHS service providers should be aware of the needs of homeless people in their area in order to ensure services are accessible and meeting those needs.
For example, homeless people may be living in temporary accommodation away from their local community, with a distance to travel.
Understanding which services are used or not used by homeless people may lead Boards to consider whether these are accessible to homeless people or to remodel services to overcome such problems.
Barriers may be structural (for example an inflexible appointments system), policy based (for example that a homeless person must have a permanent address to access a service), or may be related to attitudes towards homeless people. Mainstream services should be systematically audited to ensure they are designed in ways which improve reach for the most disadvantaged groups and which identify and overcome barriers.

2.4: Have attempts been made to overcome these barriers? Have they been successful?

In **Wales** there is a Specialist GP service in Cardiff and an outreach nurse service in Swansea. There are other projects e.g. CAIS-Shelter Cymru project in Wrexham, where homelessness services work closely with drug/alcohol services.

The various Welsh strategies mentioned above emphasise the need for health to consider the needs of homeless people.

Personal Medical Services – GP contracts providing health care specifically to vulnerable groups e.g. homeless people, have been tried in **England.**

'The Personal Medical Services (PMS) contract introduces new flexibility to primary care, in order to encourage creative approaches to service delivery and to promote local solutions to often intractable problems.'

One of the conclusions was that access to services was enhanced for vulnerable groups.

(NATIONAL EVALUATION OF FIRST WAVE NHS PERSONAL MEDICAL SERVICES PILOTS SUMMARIES OF FINDINGS FROM FOUR RESEARCH PROJECTS THE PMS NATIONAL EVALUATION TEAM (MARCH 2002))

Homelessness and health information sheet: Personal Medical Services (pdf available)
ANTHONY J. RILEY, GEOFFREY HARDING, GEOFFREY MEADS, MARTIN R. UNDERWOOD, & YVONNE H. CARTER, An evaluation of personal medical services: the times they are a changin', JOURNAL OF INTERPROFESSIONAL CARE, VOL. 17, NO. 2, 2003

Anthony J Riley, Geoffrey Harding, Martin R Underwood and Yvonne H Carter, Homelessness: a problem for primary care?, British Journal of General Practice, June 2003.

In Scotland the Performance Requirements linked to the Health and Homelessness Standards seek to ensure that action is permanently embedded in the day to day work of health authorities. The performance requirements say:

4.1 The Board ensures the information needs of homeless people are assessed in order to ensure access to services and an appropriate response for those who need to use them.
4.2 The Board ensures partner agencies have appropriate information on access to health services for homeless people.
4.3 The Board ensures that being alcohol- or drug-free is not a prerequisite of accessing services.
4.4 The Board provides information to primary care and acute sector practitioners about homelessness in their area.
4.5 In ensuring equitable access to all its services the Board takes account of the needs and lifestyles of homeless people, including literacy and numeracy.
4.6 The Board monitors and evaluates which services are used/not used by homeless people and uses this information to refine and improve services.
4.7 The Board ensures that the attitudes of those providing health and well-being services for homeless people do not create barriers to accessing services.
4.8 In the development of Single Shared Assessments the needs of homeless people are taken into account.

Q3: Ensuring Access to quality healthcare

This question will explore why homeless people across Europe have difficulty accessing the good quality healthcare that they need. There is a range of services that homeless people should access in order to enjoy good health: these include medical treatment; but also preventative services (screening, check-ups etc.); specialised services such as dental services; and health promotion services.

3.1: Are you aware of specialist and/or outreach healthcare centres that have been put in place specifically for homeless people? Do you consider that this is a good way to meet the health needs of homeless people? What are the costs and benefits of targeting homeless people in healthcare provision?

In Scotland the balance between specialist and mainstream provision for homeless people was debated at length during the development of the Health and Homelessness Standards. The conclusion was that homeless people are entitled to receive the same range of health and well-being services as the general population, though their circumstances may make it more difficult to participate equally in a range of health-related programmes, or to receive the continuity of care experienced by the housed population. Specialist services may be appropriate for homeless people for a period of time, but the existence of such services should not mean that everyone who is homeless is automatically channelled through this route; the aim must be to incorporate homeless people within mainstream services and to ensure these services are designed in ways which meets their needs.

In Scotland £18million has been spent in setting up specialist services. However, where they have been introduced one key factor is that they must be able to evidence that assisting homeless people to move to mainstream services is integral to their activities. This is both to prevent a culture of dependence on specialist services by homeless people, and to ensure that mainstream health services cannot opt out of providing services to homeless people by referring all homeless people to specialist services.

In Wales there is a recognition of this issue as well. There is a specialist GP service in Cardiff and a homelessness nurse/outreach service in Swansea. The evaluation of services suggests that specialist services are initially more costly.

Specialist services do allow easier access to health services, flexibility in appointments etc. and this was also a conclusion of the literature review completed for the Assembly Government in 2003 which said that the most successful services were those provided away from traditional settings and in locations frequented by homeless people (via temporary accommodation or mobile units). However they may be in a way further excluding people from mainstream health services and more work needs to be done to improve access to mainstream health care for homeless people in general. It is also important to raise awareness amongst health professionals in general of the needs of homeless people.

In England too a similar approach is taken. Members state that we need both specialist outreach medical services for homeless people , especially in large urban areas, where there are large numbers of homeless people. But we also need access to mainstream GP surgeries which will be the only source of health care in smaller towns and rural areas. 86 PMS schemes around the country focus on homelessness and successfully provide primary medical services for this group.

Examples of services can be found in appendix 2.

3.2: Are you aware of any health promotion/ preventative health initiatives that are accessible to homeless people? Do you think that these impact positively on access to employment?

The impact of social and cultural activities on the health and well-being of homeless people, was published in October 2005 and the research carried out by Broadway on behalf of Westminster PCT. The research found that activities have wide-ranging health benefits from social and cultural activities especially in the area of mental health. The report also outlines suggestions for increasing the positive health outcomes of activities.

Available in full or as an executive summary at
http://www.broadwaylondon.org/broadwayvoice/policy_detail.asp?id=47

EQUAL round 1 – 'Endeavour Partnership Mainstreaming report'

The Endeavour project was a transnational partnership formed under EQUAL Round One. It brought together domestic EQUAL partnerships from Austria, France, Germany, Ireland, The Netherlands and Northern Ireland. With each of the domestic partners working to achieve labour market integration for a wide range of groups experiencing disadvantage (including individuals who are homeless) in their own countries, they came together to collectively focus on two main objectives:

1) To develop a joint understanding of employability issues affecting the individual and their operating environment

2) To generate a synergy which will help develop a better understanding of the underlying problems associated with the demand and supply barriers to employment.

A particular aim of the partnership was to actively explore, through research in each national domestic partnership, the extent of the connection and impact between 'health and employment' and 'policy and employment'.

Some of the key recommendations of the project, in relation to health and employment, were:

- Screening for physical, psychological and mental health issues should be encouraged in all organisation that work with unemployed people
- All labour market interventions should be accompanied by health interventions/promotion

Both health and employment interventions should have a clear long-term strategy for supporting unemployed people[20]. (Further details in appendix C.

3.2: How do homeless people in rural areas access health care?

Across the UK many health services are in urban areas and smaller towns within rural areas. Outside the bigger towns and cities it is difficult to access, for example, dental services. (Homeless Link paper – page 13.) Dental care is an issue in Wales generally with care difficult to access in many areas. This is echoed across many parts of the UK with access to dental care not only a problem for homeless people, but the settled population as well.

Many homeless people (those in unstable situations, living with friends, sleeping rough etc.) will access services through Accident and Emergency services in hospitals because of the difficulty in accessing services through other means. This places additional pressure on this service.

Accessing healthcare in rural areas can be even more difficult than in urban areas. The importance of stigma, attitudes of frontline staff, the difficulties of sustaining anonymity or confidentiality, difficulties of public transport access to health services and a lack of choice in services, are all examples of how homeless people may find accessing services more difficult in rural areas.

In Scotland remoteness can be a serious issue. The Highland area alone is sparsely populated but has a landmass the size of Belgium with limited public transport services. However there are good examples, for example in the Shetland Islands where services are small, and partly because of the size, excellent work is carried out dealing holistically with homeless people's needs. Cross sectoral work, partnership working and information sharing can all be managed more easily on such a small scale.

3.3: Do you consider the healthcare received by homeless people in your country to be comparable, in terms of quality of care, to that received by the general public? In what health areas is there the greatest lack of access to care and why?

Where homeless people can readily register with a mainstream GP, or in areas with high homeless populations where a PMS specialist service is operating, then treatment is generally comparable to that experienced by the general public.

Agencies report that dental health services, mental health and substance misuse are particularly difficult areas to access.

When services can be accessed the quality of treatment is normally the same as for the general population, the issues are gaining access to the services and continuity of care (which can be extremely difficult for those in temporary accommodation or constantly moving.)

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[20] *Source: Mainstreaming Report - Endeavour, a report by the Centre for Economic and Social Inclusion, 2005. Available from http://www.equal-endeavour.org/.*

However it has been generally reported in the UK that those in most need – in situations of deprivation – have less access to health care. (Lancet 27 Feb 1971).

Access to services for those with dual diagnosis has been problematic and continues to be the case. Homeless Link found that: 'Due to alcohol use being the main issue with clients, some services are reluctant recognise that they may have a secondary problem – eg the Community Mental Health Team will blame alcohol misuse for a person's individual problems, and fail to recognise that there may also be a mental health problem.'

3.4: In some countries, a specific policy framework and action plan around health and homelessness has been put in place in order to ensure that homeless people can get full access to quality care. Has such an approach been tried in your country?

In **Wales** there is recognition that health and well-being is determined by a wide range of factors – including housing and homelessness, and that there is a correlation between poverty, deprivation and poor health. This is identified by the chief medial officer reports, The Black Report, Aecheson report etc.

Prioritising, investing and delivering in improving housing, approaches to homelessness and health is the issue. **Wales** does not have health and homelessness strategies (as Scotland does) – however the importance of providing health services to homeless people is included in the national homelessness strategy 2006-08, recognised in local strategies and in guidance for other strategies such as Health, Social Care and Well-being Strategies (HSC&WB) (although not carried forward in the strategies themselves it appears). The HSC&WB strategies should ensure that the needs of specific populations are assessed and addressed.

There has been an Assembly led task group to provide good practice guidance for Local Health Boards in providing services to 'minority groups' of which homeless people is included. This included gathering data, making links with groups, removing barriers to GP services, and considering establishing specialist GP/nurse services e.g. for homeless people with mental health problems, and outreach services.

This took 2 years and the end result was in the most part already available. It remains to be seen whether the guidance produced stimulates Local Health Boards and partners into action. It does suggest establishing enhanced services for vulnerable groups if assessments indicate that this is necessary.

In England the answer is no. Despite there being a commitment to addressing health inequalities in the Priorities and Planning Framework there have been no performance measures or key targets in place around health care for homeless people in England. PCT's (Primary Care Trusts) are tied to their performance targets so despite the guidance below on shared health and homelessness outcomes being produced this has been largely ignored as they do not have to deliver on it. It is also striking that this initiative was driven by the Office of the Deputy Prime Minister and not the Department of Health.

There is also government guidance and advice relating to Health and Homelessness for England detailed in appendix D

Achieving positive shared outcomes in health and homelessness

Introduction and summary

1. This guidance provides advice on positive shared outcomes that the Office of the Deputy Prime Minister's Homelessness and Housing Support Directorate would like to see local

authorities, Primary Care Trusts and other partners achieve on health and homelessness. It does not represent statutory guidance.

2. This guidance has been produced by the Homelessness and Housing Support Directorate in conjunction with the Department of Health's Health Inequalities Unit. It is based on analysis of good practice, data and research. It sets out the health issues and health inequalities faced by homeless people and those vulnerable to homelessness, and relates these to existing statutory and non-statutory targets.

3. The recent Wanless Report recommends that local Primary Care Trusts and local authorities agree joint local objectives for tackling health inequalities and their local needs. By working together to achieve shared outcomes, local housing authorities and health providers can deliver:

   - marked improvements in the health of homeless people;
   - reductions in homelessness caused by poor health;
   - reductions in poor health caused by homelessness;
   - reduced public expenditure on health and housing;
   - improved health support to enable vulnerable clients to maintain their tenancies and reduce health needs.

4. This guidance suggests five key positive outcomes which health and homelessness partnerships might work towards:

   1. improving health care for homeless families in temporary accommodation;

   2. improving access to primary health care for homeless people;

   3. improving substance misuse treatment for homeless people;

   4. improving mental health treatment for homeless people;

   5. preventing homelessness through appropriate, targeted health support.

5. This guidance sets out possible actions to achieve these outcomes, and includes examples of where these actions are already making a positive impact. It also suggests measures to assess performance. Agencies may choose additional or different positive outcomes and performance measures[21].

However the reality is that as far as we are aware only two PCTs have signed up to these shared outcomes.

In Scotland there is a specific framework which has been developed since the year 2000. In parallel to Scotland's Homelessness Task Force a national Health and Homelessness Steering Group was set up involving representaitves of different departments of government (health, social justice), representatives from Health Boards, voluntary sector representatives, representatives from local authority housing and social services and representation from health and homelessness

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[21] ODPM Website: http://www.odpm.gov.uk/index.asp?id=1149794#TopOfPage

projects. A civil servant was specifically appointed in the Dept of Health to develop the policy and progress chase its implementation.

Joint guidance on Health and Homelessness was published signed by the Minister of Health and the Minister of Social Justice in 2001 requiring Health Boards to draw up Health and Homlessness Action Plans based around a framework outlined in the guidance. Development of the plans was patchy, and the Steering Group visited every Health Board more than once to offer support and establish how work was progressing.

Housing legislation compelled local authorities to produce homelessness strategies, and part of the requirement for homelessness stratgies was that they had to be integrated with health and homelessness action plans. Simultaneously Health Boards were required as part of their performance reporting to demonstrate that health and homelessness action plans were integrated into the homelessness strategies of the relevant local authorities in their area. The key message was that integrated and partnership working were essential.

The next phase has been to seek to embed health and homelessnesss activity into the everyday processes and policies of health boards. National Health and Homlessness Standards (which Health Boards must comply with) were published in March 2005.

The difficulty is in maintaining momentum for the policy and ensuring that enough time and energy is spent in monitoring whether health authorities are implementing the standards. Work is being developed this year to examine how this can be done better.

Northern Ireland:

1. Promoting the Social Inclusion of homeless people (PSI): Under the Promoting Social Inclusion initiative, the Department for Social Development has taken the lead on a cross-departmental and cross-sectoral review of the problems encountered by people who are homeless. The working group will consider how Government departments and other relevant agencies can best work together to ensure,
    1. that the risk of homelessness is reduced,
    2. that the full range of appropriate services is available to those who find themselves homeless, so that they can make the choices required to play a full part in society.

The working group produced a draft policy and a co-ordinated strategy document for public consultation in November 2004.

2. Northern Ireland Housing Executive Homelessness Strategy: The Housing Executive has had statutory responsibility for dealing with homelessness since the introduction of the Housing (NI) Order 1988. Since then many thousands of households have been assisted. However, it is clear that the nature of homelessness has become more varied and complex and traditional responses to the problem are no longer adequate. The Homelessness Strategy and Services Review have identified a wide range of improvements that need to be implemented.
3. Each Health Trust will have Action Plans with a focus on vulnerable people, including homeless

Q4: Training of health professionals

Homeless people sometimes encounter a lack of understanding and reluctance to engage with them from healthcare professionals that might be overcome through training for health workers on how to work with homeless people, as well as on their specific health issues. The problem of homeless people presenting with multiple needs can also be professionally challenging for healthcare workers. This is another area where training would be useful.

4.1: Do you know of any such training courses (in all areas of healthcare – nurses and doctors, but also mental health workers, dentists, podiatrists etc.) or plans to put them in place, as part of medical training or as follow-up training?

There needs to be a more widespread recognition that health care is not just a task for medical professionals – it requires psychological and practical support work too, and for this client group it is often best provided outside of the medical profession. What is needed is multi-disciplinary work and training which is multi-disciplinary in orientation.

We also would like to have more training done by homeless or ex-homeless people. There is a real shortage of funding to train people who have experienced homelessness to train professionals, despite all the educational and learning skills grants the EU makes through ESF. We would like to see more funding specifically for training people experiencing homelessness and who also have mental health and or substance use problems to become trainers of health professionals.

In **Wales** there is no evidence of such training.

In **Scotland** as part of the homelessness framework there are a number of very good examples of local authorities, working with health authorities and other partners (ngos, police, etc) to deliver joint awareness training on the needs of homeless people. Much of this concentrates on front line staff (such as GP receptionists) to ensure that the problems of stigma and attitudes begin to be addressed and that staff know how to be proactive in signposting homeless people to appropriate services.

On the more academic side **in England** an academic course has been developed: HEALTH CARE FOR PEOPLE EXPERIENCING HOMELESSNESS - OXFORD UNIVERSITY DEPARTMENT FOR CONTINUING EDUCATION UK

It is envisaged that this online training will be for graduates across the primary health care spectrum, from podiatry to psychiatry.
Academic Content

(a) What are the aims of the course?

Course aims are:

- To raise awareness of the health needs of homeless people
- To develop a understanding of the experience of being homeless
- To encourage and enable work across disciplines to identify the barriers and solutions to health care needs in the homeless population
- To provide the foundation through interactive working for the development of a locally enhanced service for homeless people

Upon completion of the Certificate, students will have developed a range of transferable key skills, including the skills to:

- recognise opportunities to influence health and social policy and practices
- educate others to enable them to influence health practice
- formulate a plan for communicating, disseminating and implementing evidence, set within a realistic time scale and taking account of finite resources
- monitor and review the ongoing effectiveness of the planned activity
- adopt the principles of reflective practice and lifelong learning
- demonstrated ability to introduce the principles and practice of health care for homeless people in the candidate's work-based setting

Commencement of online course, September 2006
Contact: Dr. Angela Jones, Dr Janet Harris, at Kellogg College, Oxford University

Website: http://www.kellogg.ox.ac.uk/

In Northern Ireland student community nursing and District nursing training (through University of Ulster and Queen's University of Belfast) includes sessions on vulnerable groups, including homeless, and there are plans to incorporate other public health models (e.g. travellers, ethnic minorities)

Q5: Interagency working
Ideally, accessing healthcare should provide a route into other care and integration services, through referral and transfer practices between homeless services, social services and health services.

5.1 Are you aware of instances of this kind of networking in your country?
Improved inter-agency working is a key issue on the agenda of those working for improving the health of homeless people in the UK. The majority of homeless people have multiple needs in addition to their homelessness.[22] Addressing their health needs in isolation from their housing or their social needs is clearly less effective.

In **Scotland** this is one of the key principles underlining the Health and Homelessness Standards and homelessness strategies

In **Wales**, homelessness assessments (when making a homeless presentation) should include any health needs and a referral to a relevant organisation. This is the theory although in practice it rarely happens.

In general in Wales it is difficult to involve health services in discussions about the needs of homeless people. Local homelessness fora should have representation from Local Health Boards and vice versa but this is not consistently the case.

The health of homeless people is a key area of concern for voluntary sector homelessness providers and they have a good record in making links with health services on behalf of the client group. This may be arranging visiting GP or nurses to provide specialist sessions within hostels and day centres or ensuring that all residents can be registered at a local GP surgery or making contact with specialist homeless health teams if one exists in the area.

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[22] *Multiple Needs Good Practice briefing Homeless link August 2002*

Lost Voices The invisibility of homeless people with multiple needs Croft White C, Parry-Crooke G, Crisis 2004

In England it would be a fair generalisation to state that the making of links and the referral and transfer practice is mainly from homeless sector agencies into mainstream health and social services and that referral in the other direction from mainstream health and social services to the homeless sector is less developed and less effective.

Examples can be seen at appendix E.

5.2: Are health and social services supportive of this type of working? Have administrative procedures or agreements been put in place to facilitate transfer and sharing of information and cooperation between different services? What are the discharge practices from hospitals in your country?

In **Wales**, the National Homelessness Strategy says:
There is a strong correlation between poor health and poor housing. Homelessness can have an adverse effect on peoples' health, whilst at the same time homeless people are more likely to have difficulties accessing health care.'
and
'Planning frameworks are in place to address these needs, but at the moment they are not working adequately to secure the provision of the services that are needed to homeless people.'

However, joint working between homelessness services and health and social services remains problematic. Sometimes case conferences work well. Information sharing is still a problem with confidentiality leading to mistrust and poor services.

In **England,** the boundaries between housing and health and social care definitely put bureaucratic and administrative barriers in the way of joint working and of sharing information constructively and in the interest of clients. There is a big issue for homeless people about repeat assessments as they move from one local authority area to another and from one service to another and get asked the same set of questions but there is no co-ordination between services or passing on of assessments that have already been carried out. Good assessments that have been carried out in the past are wasted or lost or undone by poor assessments further down the line. This was one of the findings of the 2002 report into the multi agency assessment service 'Under one Roof'[23]. Among the reports recommendations are better staff training on assessments, improving managers understanding of the assessment process, increasing trust between agencies, encouraging networking , pooling resources and reappraising confidentiality policies. Many of the same issues have come out of the work done by Health Link, referred to earlier, who are promoting the use of a single assessment process that can be transferred across agencies so that assessments are not always repeated.

Government policy and strategic priorities lend support and encouragement to tackling health inequalities through better joint working across sectors. The NHS Planning and Priorities Framework 2002-2006 prioritised tackling Health Inequalities for the first time. Homeless people are identified as a priority group in the cross cutting review on tackling health inequalities and the Wanless report recommends that local Primary Care Trusts and local authorities agree local objectives for tackling health inequalities. This has been backed up by a joint ODPM /DH paper Achieving Positive Shared Outcomes for Health and Homelessness[24] which suggest five key outcomes which could be adapted locally and would move towards marked improvements in the health of homeless people and reductions in homelessness. Section 31 of the Health Act 1999 opened up the way for more flexible working between health and local authorities including pooled

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[23] *Someone and Anyone: Assessment practice in voluntary sector services for homeless people in London Graham Park Kings Fund 2002*
http://www.kingsfund.org.uk/funding/work_we_have_supported/under_one_roof.html

[24] *http://www.odpm.gov.uk/pub/793/AchievingPositiveSharedOutcomesinHealthandHomelessnessPDF223Kb_id1149793.pdf*

funding, joint commissioning and integrated provision. It can be used for simple partnerships and collaborations right through to social care trusts for a wide range of NHS and social services operations.

However despite this facilitation of joint working by central government and recommended ways of pushing forward the health and homelessness agenda there is scanty evidence that these options have been acted on by local authorities and PCTs. They do not have any weight behind them and both local authorities and PCTs have so many key deliverables that are part of the performance measurement framework that it is hard to find room to prioritise other optional areas. If the government is serious about this agenda it will need to be made part of the performance measurement of PCTs and local authorities.

There are however examples of Primary Care Trusts that have responded in a comprehensive way to the needs of homeless people in their area and have established services alongside mainstream services, the aim of which is to ensure that homeless people have equal access to good quality health care. Examples of these services in London can be found in a Crisis guide to models of delivering health services to homeless people.[25] :

In Scotland, the new homelessness framework seeks consistently to encourage joint working. However it is a complex process and there are a number of fundamental issues which can create difficulties. The first is professional boundaries. Health professionals and social work professionals have their own areas of expertise – often with a different approach. It can be challenging to find a path which allows them to work in a completely joined up fashion. Protocols need to be developed on information sharing; funding streams are too often restricted either to health services or to social services, and finding technical means to enable joint funding can be complex. The approach to understanding an individual's circumstances can be very different – the 'medicalised' model is very different from the social welfare ethos.

However there is good progress towards developing 'single shared assessments' where an individual only has to be assessed once on all their needs, rather than answering the same questions several times in different assessments for different professional interventions.

The Health and Homelessness Standards have a performance requirement that 'in the development of Single Shared Assessments the needs of homeless people are taken into account.' (Standard 4.8)

Discharge from hospitals

> Guidance from the Department of Health in **England** on Hospital Discharge states:
>
> All acute hospitals should have formal admission and discharge polices which will ensure that homeless people are identified on admission and their pending discharge notified to relevant primary care services and to homeless services providers. In addition, for patients in psychiatric hospitals/units a post-discharge care plan will be drawn up well in advance of discharge and procedures put in place to ensure that appropriate accommodation and continuity of care is in place for each person discharged.[26]

However the reality is that very few hospitals have developed working policies on the safe admission and discharge of homeless people. A stay in hospital, which could be used as a time to make positive interventions in a homeless persons life, instead often means that the medical

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[25] *Guide to models of delivering health services to homeless people Crisis Health Action Sarah Gorton 2003*

[26] *Guidance on Hospital Discharge, Department of Health*

issues are addressed but the person is discharged to the same unhealthy housing options with no services to provide adequate after care. This results in a high level of readmission to hospital. Another problem is the high level of self discharge of homeless patients due both to general alienation form services and to substance dependence and the difficulty addressing these issues adequately in the hospital environment.

The ODPM have produced one of their series of information sheets on hospital discharge for homeless people with some examples of good practice including a flow chart from Leicester on discharging homeless people.
http://www.odpm.gov.uk/pub/856/HomelessnessandHealthInformationSheetHospitalDischargePDF157Kb_id1149856.pdf

Homeless link is currently working on guidelines on developing a protocol for the discharge of homeless people. This project is jointly supported by the ODPM and DH and when the guidelines are ready later in 2006 they will be available on the HL website www.homeless.org.uk

In Scotland the Health and Homelessness Standards address this issue directly. Under Standard 5 there is a performance requirement that: 'The (Health) Board's procedures ensure that no-one who is subject to a planned discharge is discharged into a situation of homelessness. This will necessitate good joint working with other agencies.' Of course this is an aspiration which Boards are working towards, but some improvements are already being seen.

5.3: Have you encountered instances where there is an obvious breakdown in this kind of networking? (eg: homeless people being retained in hospital because no other option has been found for them to move on to other services).

In Wales the example of a homeless person called Geoffrey highlights some of the problems in that part of the UK. Geoffrey has been prescribed anti-psychotic drugs for years – now mental health service is saying that he does not have a mental illness. Shelter Cymru experienced difficulty in securing cooperation from other agencies on his case. He is currently in custody and won't be released on license.

He has not had a social worker since leaving the half way house and has not got a CPN (since he threatened to kill one of them). The half way house has said that he does not have a mental health issue – but has psychosis from previous drug use.

With his release date very close – within the next few weeks – Geoffrey's case is becoming more urgent. The local council's Homelessness Services fear he may be 'unplaceable' (although this is not a legal option open to the council). Homelessness services are yet to hear from the dual diagnosis worker as to where might be suitable for him on release. Being released as homeless, possibly to unsuitable temporary accommodation and without specialist support could clearly exacerbate the problems he exhibits.

Geoffrey has been prescribed anti-psychotic drugs for years – now mental health service is saying that he does not have a mental illness. Shelter Cymru experienced difficulty in securing cooperation from other agencies on this case. He is currently in custody and won't be released on license.

Homeless Link have identified that the whole hospital discharge issue in **Wales** is problematic – both people retained in hospital unnecessarily and people discharged into inappropriate or non existent accommodation

In **England** members report that It is harder to find instances of where the networking is functioning adequately than to find instances of breakdown, the most common practice is breakdown of appropriate referral and transfer. The issues that lie behind this are:

- Restricted budgets leading to defensive practice where local authorities, housing and social services act to prove that a homeless person is not their responsibility, either does not have a local connection or in the case of social services is not the responsibility of the mental health team because they have alcohol problems or vice versa. There is an incentive for particular departments to try to shift responsibility rather than act in the best interests of the person presenting for help.

- Responding to homelessness is not part of the training for health practitioners; they are ill equipped to understand the needs of homeless people or to know where to refer them to. (An on-line course being developed for health practitioners at Kellogg College Oxford[27] is seeking to address this gap in learning resources.)

- There is not a tradition of holistic services which cater to the whole needs of a person, the tradition in the health service is to respond narrowly to the medical issue being presented

- A combination of lack of awareness and discrimination in GP practices and lack of confidence and self worth in the homeless population means that many homeless people are not registered with GPs. GPs are the gateway to the health service as a whole, so through that exclusion homeless people's needs are not being addressed.

- The homelessness sector is not without blame in this area, in 2002 Homeless Link surveyed its members about the extent of their working with people experiencing homelessness and having multiple needs. We asked a question about whether they as a voluntary sector homelessness agency had formal links and service liaison contracts with statutory health sector service providers, and the number of respondents was less than 50%. It was even lower of those who had formal protocols to allow the exchange of confidential information. There is a great deal of work which needs to be done to ensure that the statutory health sector and the voluntary homelessness sector achieve good and fruitful partnership working.

A feasibility study into the intermediate care needs of homeless people in one London borough illustrates how common it is for the transfer of care not to happen adequately and for people to be discharged from hospital or to self discharge with high unmet care needs. [28]

In **Scotland**, although there are still many instances of inappropriate discharge the implementation of the Health and Homelessness Standards combined with homelessness strategies should be creating a marked improvement. The fact that local authorities and health authorities are obliged jointly to plan services for homeless people makes information sharing and the development of appropriate discharge protocols less difficult and more likely to happen.
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Q6: Health indicators, data collection and research

It is not always easy to access information on the health situation of homeless people. Yet

[27] *http://www.kellogg.ox.ac.uk/*

[28] *The Road to Recovery. Robyn lane 2005*

http://www.cat.csip.org.uk/_library/IC%20feasibility%20study%20final%20version.pdf

such information can be crucial to making the case for political investment in healthcare for homeless people. This question seeks to establish possible effective ways of accessing reliable data on the health situation of homeless people.

6.1: Is data collected on any area related to the health of homeless people in your country? (such as the different illnesses suffered by homeless people, number of homeless people using specialist health services, number of people using general services, causes of death, life expectancy, etc.) If so, who collects it? (hospitals, homeless service providers, A&E, youth care centres, psychiatric services, etc).

In **Wales** HSC&WB strategies should assess the needs for services for homeless people and monitoring should be part of this., but there does not appear to be systematic collection of data. Individual services gather data e.g. Shelter Cymru's monitoring system gathers some information on the mental and physical health problems of clients.

A person's housing status is not monitored comprehensively within the health service. This means that there is no systematic collection of the health needs of homeless people across **England** by any agency. There is therefore no detailed or robust collection of data on homeless people's health needs. As with England**, Northern Ireland** has no systematic collection of such data.

Hospitals only monitor admissions that are of no fixed abode, so those who literally have no address to give, and even this information is not easy to extract. There has been no detailed analysis of the needs of people stating that they are no fixed abode.

There have been a number of small studies that have looked at specific issues. i.e. for older homeless people there is research evidence[29] [i] that the hospital admission rate is three times greater than for the general older population, despite the average age of the homeless sample being 16 years lower. There is also evidence of a highly increased rate of re-admission of patients living in hostels (35%) compared to those admitted from their own homes (10.8%).

Agencies will collect and monitor an individual's health needs in a general sense e.g. mental health, physical health needs. In each individual's case file there will be a more detailed description of their illnesses, but there has been no cross agency analysis of these needs.

However evidence on the different illnesses suffered by homeless people, number of homeless people using specialist health services, number of people using general services, causes of death, life expectancy is mainly from small studies or anecdotal which makes it very difficult to make the case for political investment or to identify areas for action.

In Scotland there is no central data collection on the health of homeless people gathered by the health authorities. There is, however, some basic centrally held information gathered through local authorities when homeless people apply for assistance. This is gathered through then 'HL1' form, which records a range of information about homeless people: household type, age (in rough bands), gender, and 'priority need status.' A homeless person can be found in priority need because of a physical or mental health problem or a personality disorder. At this very basic level information is recorded, but staff completing the forms are not medically trained. So the data gives a very basic, unreliable and understated figure.

In **Scotland** specialist health and homelessness services do collect good data. In addition, Health and Homelessness Standards require health authorities to ensure that the health needs of homeless people are addressed. This implies that they should have data on those needs at local

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[29] *The discharge of older homeless people from hospital Blood 1 2003 Help the Aged /hact*

level. This area of work is still being developed and in most areas is not very sophisticated at present, but should improve over time.

6.2: Do you know of any research undertaken on the health of homeless people by academic or other bodies? (eg: Government reports, NGO reports, scientific reports, etc.)

Aside from the research referenced throughout the report, the following are a selection of research on health:

I Would Hate to Think it was because I was Homeless.. Health Needs Assessment of Young People Experiencing Homelessness.
http://www.crashindex.org.uk/database/974.htm
Housing, Homelessness and Health: A Report of the Standing Conference on Public Health
http://www.crashindex.org.uk/database/376.htm
Healthy Hostels - A guide to promoting health and well-being among homeless people
http://www.crashindex.org.uk/database/798.htm
Housing or Homelessness: A Public Health Perspective: A Report from the Working Group on Housing and Health of the Committee on Health Promotion (second edition)
http://www.crashindex.org.uk/database/211.htm
Feeling Bad: the Troubled Lives and Health of Single Young Homeless People in Edinburgh
http://www.crashindex.org.uk/database/289.htm
Health and Homelessness in London: A Review
http://www.crashindex.org.uk/database/869.htm
Homelessness and Ill Health
http://www.crashindex.org.uk/database/830.htm
Survey of the health and well-being of homeless people in Glasgow
http://www.crashindex.org.uk/database/568.htm
The Health of Single Homeless People
http://www.crashindex.org.uk/database/823.htm
Health and Social Needs of Single Homeless People in Derby City
http://www.crashindex.org.uk/database/283.htm
Homeless People's Experience of Health Care Services in Glasgow
http://www.crashindex.org.uk/database/308.htm
Health, homelessness and access to health care services in London
http://www.crashindex.org.uk/database/429.htm
Nowhere else to go: increasing choice and control within supported housing for homeless people with mental health problems
http://www.crashindex.org.uk/database/574.htm
Analysis of Concepts of Health and Expressed Health Needs Among the Homeless People of Leeds. MSc Dissertation.
http://www.crashindex.org.uk/database/933.htm
Reaching Out: A Study of Black and Minority Ethnic Single Homeless People and Access to Primary Health Care
http://www.crashindex.org.uk/database/893.htm
Homelessness, Health Care and Welfare Provision
http://www.crashindex.org.uk/database/212.htm
"Keeping a Lid on it? Youth Homelessness and Mental Health
http://www.crashindex.org.uk/database/275.htm
Homing in on Health: Resource Pack on Health and Homelessness
http://www.crashindex.org.uk/database/150.htm
Health selection in the housing system: access to council housing for homeless people with health problems
http://www.crashindex.org.uk/database/877.htm
Health, health promotion and homelessness
http://www.crashindex.org.uk/database/871.htm

Homelessness and Mental Health
http://www.crashindex.org.uk/database/254.htm
Not Mad, Bad or Young Enough. Helping Young Homeless People with Mental Health Problems
http://www.crashindex.org.uk/database/328.htm
A Primary Health Care Study of Vendors of The Big Issue in the North
http://www.crashindex.org.uk/database/500.htm
Pressure Points: Why People with Mental Health Problems Become Homeless
http://www.crashindex.org.uk/database/518.htm
Youth Homelessness and Substance Use: Report to the Drugs and Alcohol Research Unit.
http://www.crashindex.org.uk/database/987.htm
Access to general practice for people sleeping rough
http://www.crashindex.org.uk/database/653.htm
Homelessness: A Primary Care Response
http://www.crashindex.org.uk/database/72.htm
Homelessness and Health.
http://www.crashindex.org.uk/database/1005.htm
The health of single homeless people
http://www.crashindex.org.uk/database/428.htm
Health Inclusion: The First Evaluation Report.
http://www.crashindex.org.uk/database/1000.htm
Beyond Help? Improving Service Provision for Street Homeless People with Mental Health and Alcohol or Drug Dependency Problems
http://www.crashindex.org.uk/database/310.htm
Battling Through the Barriers: A Study of Single Homelessness in Newham and Access to Health Care
http://www.crashindex.org.uk/database/468.htm
A Nursing Service for Homeless People with Mental Health Problems.
http://www.crashindex.org.uk/database/1068.htm
Type of accommodation and subjective health status in a population of homeless women in Southampton
http://www.crashindex.org.uk/database/453.htm
Delivering Health Care to Homeless People: An Effectiveness Review.
http://www.crashindex.org.uk/database/1007.htm
'Survival is not trusting': research into the resettlement and support needs of Bristol rough sleepers with mental health problems
http://www.crashindex.org.uk/database/697.htm
Homelessness and Mental Health.
http://www.crashindex.org.uk/database/1006.htm
Problematic substance use and the young homeless: implications for health and well-being
http://www.crashindex.org.uk/database/761.htm
A Guide to Publications on Homelessness: Alcohol, Drugs and Mental Health.
http://www.crashindex.org.uk/database/980.htm
Health promotion: what homeless people think
http://www.crashindex.org.uk/database/693.htm
Associations between migrancy, health and homelessness: A cross-sectional study.
http://www.crashindex.org.uk/database/976.htm
Homelessness, Smoking and Health.
http://www.crashindex.org.uk/database/1011.htm
Primary health care services for single homeless people: defects and opportunities
http://www.crashindex.org.uk/database/803.htm
Delivering Health Care to Homeless People: An Effectiveness Review.
http://www.crashindex.org.uk/database/961.htm
Up from the streets: a follow-up study of people referred to a specialist team for the homeless mentally ill.
http://www.crashindex.org.uk/database/959.htm

Tackling the Needs of the Homeless: A Controlled Trial of Health Advocacy.
http://www.crashindex.org.uk/database/1065.htm
Still Dying for a Home
http://www.crashindex.org.uk/database/850.htm
Can a Health Advocate for Homeless Families Reduce Workload for the Primary Healthcare Team: A Controlled Trial.
http://www.crashindex.org.uk/database/1067.htm
The Impact of Overcrowding on Health and Education: A Review of Evidence and Literature.
http://www.crashindex.org.uk/database/1039.htm
Housing and Public Health.
http://www.crashindex.org.uk/database/1070.htm

Opening the Door to Health Simon Community NI(2000)
http://www.simoncommunity.org/filestore/documents/Opening_the_Door_to_Health.pdf

Research into Homelessness and Substance Misuse Simon Community NI (2004)
http://www.simoncommunity.org/filestore/documents/Research_into_Homelessness_and_Substance_Misuse.doc

McGilloway, S. & Donnelly, M. (1996) 'Don't Look away' Homelessness and mental health in Belfast. CHNI, Belfast

'From Hostel to Home'. A study into the needs of long-term homeless people (1998). CHNI, Belfast.

Other research (Northern Ireland):

- Semple, S. (2005) the dental health of Homeless people (N&WBHSST) – yet to be published: the dental health of the homeless population is similar to that of the general population, though it is exacerbated by the lack of dental hygiene facilities and equipment. Mouth cancer rates are higher in the homeless population than the general population.
- Food safety Agency is currently examining diet and nutrition of young homeless people.
- Flanaghan, C. (1996). An evaluation of single homeless healthcare projects. (N&WBHSST) – unpublished.

Wales

Welsh Assembly Government:
Homelessness Commission, August 2001;
Homeless People's Access to Medical, Care and Support Services A Review of the Literature, (WAG September 2003)

Journals etc. for example:

James J. O'Connell, Dying in the shadows: the challenge of providing health care for homeless people, JAMC • 13 AVR. 2004; 170 (8) (Canadian)

Wendy Bines, The Health of Single Homeless persons, Discussion paper 9, Centre for Housing Policy, University of York, 1994

Inequalities in Health: Report of a Research Working Group, The Black Report, DHSS, 1988.

Donald Aecheson, Independent Inquiry into Inequalities in Health (The Aecheson Report). London, UK: The Stationery Office, 1998.

Promoting Social Inclusion and Tackling Health Inequalities in Europe – an overview of good practices from the health field, www.eurohealthnet.org

International Perspectives on Homelessness and Mental Illness, National Resource Center on Homelessness and Mental Illness, November 2003 (cites articles from journals in several countries)

V Tischler, P Vostanis, T Bellerby, S Cumella, Evaluation of a mental health outreach service for homeless families, Arch Dis Child 2002;86:158–163.

Panos Vostanis, Mental health of homeless children and their families, APT (2002), vol. 8, p. 463 Advances in Psychiatric Treatment (2002), vol. 8, pp. 463–469

Hilary Thomson, Mark Petticrew, David Morrison, Housing Improvement and Health Gain: A summary and systematic review, MRC Social & Public Health Sciences Unit Occasional Paper No 5 January 2002

Panos Vostanis, Eleanor Grattan, Stuart Cumella, Mental health problems of homeless children and families: longitudinal study, 1998;316;899-902 BMJ

Roy Carr-Hill, IMPACT OF HOUSING CONDITIONS UPON HEALTH STATUS (21 April 1997)

Lissauer T, Richman S, Tempia M, Jenkins S, Taylor B, Influence of homelessness on acute admissions to hospital, Archives of Disease in Childhood, Vol. 69, 423-429, 1993; p.427.

The impact of overcrowding on health and education: A review of evidence and literature, (ODPM, May 2004)

Shelter Cymru:
Somewhere to call home? (2001),

Housing and ill-health (April 2002),

John Pritchard and John Puzey, Homelessness – On the Health Agenda in Wales? In Reviews on Environmental Health, Vol.19. nos. 3-4, 2004. (References are made to international research on homelessness, poor housing and ill-health.)

Hidden (June 2006)

Shelter:
Sick and tired: The impact of temporary accommodation on the health of homeless families

Homeless Link:
Homeless People's healthcare needs and access to healthcare provision in Wales, April 2006

In Scotland in addition to those mentioned above are

Health and Homelessness Guidance
(Scottish Executive Health Department 2001
Health and Homelessness Standards
(Scottish Executive 2005)
Health Scotland website: www.healthscotland.gov.uk

6.3: Do you know of data collection in the following areas that might be relevant in relation to the health to homeless people?

- Health determinants including lifestyle factors, drug and alcohol abuse and smoking
- Environment and health
- Access to health
- Mental Health

Not generally. Individual projects in **Wales** have gathered data on the impact of improving house conditions e.g. in Riverside Cardiff, the Housing and Neighbourhoods and Health (HANAH), Neath Port Talbot, the EAGA studies in Cornwall

There is a project run by the Department of Psychological Medicine, Cardiff University, that is 'conducting a pilot study of mental and other health problems in the homeless in Wales' They are looking at risk factors contributing to Homelessness and reducing opportunities for reintegration.

'*We do a very extensive assessment, spread out over two occasions. Amongst others, we collect information on homelessness history, education and employment, mental health problems, substance problem use, legal problems, family relations, social problems and childhood factors. We have a psychiatrist on the team and also do a full-scale psychiatric interview, including mood disorder, psychosis, personality disorder*, ADHD etc.' (Dr Marianne van den Bree)

Local Health Boards – in developing services under their HSC&WB plans should be monitoring access to health/mental health services for different groups, in order to gauge need etc. but I'm not aware of this generally happening.

In Scotland some data collection will have a bearing on this. Health Scotland's index of deprivation is an interesting source of data and some of the drug use monitoring will also cross over into this area. Otherwise work may be developing in local areas.

6.4: Do you know of any indicators used to measure the effectiveness policies/services in the following areas that might be used to get information on the health and well being of homeless people?
- Health determinants including lifestyle factors, drug and alcohol abuse and smoking
- Environment and health
- Access to health
- Mental Health

In Scotland work is being developed at local level to develop indicators. Health and Homelessness Standards require Health Boards to understand the health and wellbeing needs of homeless people in their area, and for them to design services to meet those needs. Again work on this is progressing but not yet complete in most areas of Scotland.

Sometimes "self-perceived health status" is used as an indicator to collect health data - do you think this is useful in relation to homeless people?

"Self-perceived health status" would be a particularly valuable tool for use with people experiencing homelessness, and was the basis for St Mungo's 2002 Survey of residents in their Endell Street hostel.
It can be useful as information on health and well-being, although obviously limited. It can be useful as one indicator (among many), but should not be used instead of carrying out professional assessments of the health status of homeless people.

6.5: In relation to housing, are you aware of any comparisons undertaken between the health of the well and poorly housed populations? In relation to employment, do you know if comparisons between the health and well being of homeless or formerly homeless people who have access too employment and those who don't?

No Home No Job

OSW's research found that respondents reported the following barriers to regular attendance at training and employment services:

26% Specific ongoing health/mental health problems
14% Dependency issues (drug/alcohol)
8% Health reasons, such as doctor and hospital appointments

Respondents noted that 'Current or ongoing health issues (physical/mental)' was one of the most common main barriers to work.

Available from www.osw.org.uk.

Homelessness and temporary accommodation v general population

The work of Wendy Bines, referenced above does this as do:

Stephen W. Hwang, Homelessness and Health, CMAJ 2001, 164; 229-233.

T.W. Holohan, Health and Homelessness in Dublin, Ir Med Journal 2000, 93: 41-43.

Homelessness – Cause and Effects: The Relationship between Homelessness and the Health, Social Services and Criminal Justice Systems: A Review of the Literature, British Columbia Ministry of Social Development and Economic Security, and BC Housing Management Commission, February 2001.

Hwang SW, Mortality Among Men Using Homeless Shelters in Toronto, Ontario, JAMA, April 26, 2000; Vol.283, No.16.

Cheung AM, Hwang SW, Risk of death among homeless women: a cohort study and review of the literature, CMAJ Apr. 13, 2004 170 (8).

Spence S, Cognitive Dysfunction in homeless Adults: A Systematic Review, J R Soc Med 2004; 97: 375-379.

Nordentoft M, Wandall-Holm N, 10 year follow up study of mortality among users of hostels for homeless people in Copenhagen, BMJ Vol.327; 12 July 2003.
Fichter MM, Quadflieg N, Prevalence of mental illness in homeless men in Munich, Germany: results from a representative sample, Acta Psychiatrica Scandinavica, Vol.103, Issue 2; February 2001.

In Scotland at national level the Scottish Index of Deprivation and the Arbuthnott Report which recommended a reallocation of resources to more deprived areas give some information on this area.

Q7: The Right to Health

The right to health is enshrined in several international human rights texts. You can find the articles on health brought together in FEANTSA's brief on the right to health. It is further strengthened by the right to non-discrimination in the area of access to health. Tackling health inequalities is an ongoing priority at European level. For this reason, expressing

homelessness in terms of health has the potential to be a powerful political tool. The right to housing, the right to employment and to access to the services you need are all underpinned by the right to be healthy and to enjoy a state of well-being.

7.1: Do you know of any examples where a rights-based approach has been adopted in relation to health for homeless people or other vulnerable groups, whether in the form of court cases or campaigns?

In Wales this is generally done in the form of lobbying e.g. the Inquiry into the effect of homelessness and poor housing in 2006 is looking at health, education etc.

Court cases may provide rights e.g. through disability discrimination etc.

British Dental Association launched a plan to care for homeless people's teethThe report argues for a flexible dental service that responds to the particular needs of homeless people by employing a combination of surgery and outreach locations to deliver care. It also says that, wherever possible, the service should be delivered in a way that enables homeless people to use mainstream dental services. The report further calls for training and funding issues to be properly addressed so that all sectors of dentistry can play their part in delivering the dental care that homeless people need.

Website: http://www.bda-dentistry.org.uk/advice/news.cfm?ContentID=1081

The Mental Health Needs of Homeless Children and Young People

Homeless young people warrant specific attention as a key group among the general homeless population because of their highly vulnerable position due to their age. They are also affected by different legislation than the adult homeless population and have differing access to health services. The experience of homelessness among young people can exacerbate existing mental health problems or contribute to the onset of mental health problems. Mental health problems are also a risk factor for homelessness in its own right.

Website: http://www.mentalhealth.org.uk/page.cfm?pagecode=PBUP0322

Homeless people's rights - Shelter

Website: http://england.shelter.org.uk/advice/advice-135.cfm

Homeless people's rights – Shropshire County Council

Know your rights...

If you are homeless or threatened with eviction, you may have legal rights to stay in or return to your home. Apart from being entitled to help from the council, you may also be entitled to help from Social Care. Your Council has a legal obligation to help you.

Website:
http://www.shropshire.gov.uk/homelessness.nsf/open/05AADE7B2C93002380256EF500404579

Statement on Homelessness and Primary Care – Royal College of General Practitioners - 2002

All people have a right to equity of access to primary care services and to receive services which will enhance their dignity and independence

Individual professional advocacy is important in homelessness at all levels, from the consultation where the quality of the practitioner-patient relationship is paramount, to local, regional and national arenas.

Website: http://www.rcgp.org.uk/default.aspx?page=2262

The inextricable link between health and homelessness in **Northern Ireland** is already contained in 'Caring for People Beyond Tomorrow, a Strategic Framework for the development of Primary Health and Social Care for Individuals, Families and Communities in NI'. In particular, goal 2 states:

> "To develop more effective partnership working across organisational and professional boundaries to provide more effective and integrated team working".

This goal is further developed in objective 5:

> "To develop multi-agency strategies and approaches to homelessness, social exclusion, sexual abuse and domestic violence that meet need at an early point to maximise the potential for positive change"

And the implementation of this objective is stated, i.e.:

> "By 2007, evaluate and review the implications for primary care identified in the multi-agency strategies to homelessness, social exclusion, sexual violence and domestic violence".

The vision in 'Caring for People Beyond Tomorrow' for primary care, highlights the need for responsiveness, quality, accessibility and an emphasis on prevention as part of a high quality and seamless integrated service. In the past primary care has often suffered through resources been channelled to acute services reactively.

In Scotland there is not a rights based approach. It is rather an approach based on a monitored duty placed on local authorities and health authorities to ensure homeless people get equitable access to health services.

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7.2: Is the health of homeless people a political issue in your country? Could it be a useful campaigning point? Why? Why not?

In Wales it is an issue that is recognised in policy and strategy e.g. approaches to homelessness, National Homelessness Strategy, Local Strategies, guidance, LA's placing people in temporary accommodation must consider their health needs Housing in Wales (suitability of Accommodation) (Wales) Order 2006. (Statutory Instrument)

Organisations such as Shelter Cymru are seeking to raise the profile of the issue and secure greater political prioritisation to tackling homelessness by showing its wider effects and the effects on health, education, crime and re-offending etc. We believe health and well-being is a useful campaigning point and our inquiry into homelessness and the effects on families and children is looking at this issue during 2006.

In Scotland it has been an important issue, though the political backing for it from the health side has not been as high profile in the last year. Health Inequalities and deprivation are a major issue, and of course, homelessness is an important part of that agenda. The fact that Health and Homelessness standards exist, that there is a Health and Homelessness Steering group and that the Scottish homelessness framework is overseen by a Homelessness Monitoring Group which

reports to the Parliament means that the issue retains a certain profile. It also allows ngos the opportunity to raise the profile through the parliament if necessary.

Health and Homelessness is not a major priority for health boards in Scotland. That is why it is important that progress on the Standards is monitored and that we seek to ensure that homelessness issues are encompassed by a range of other health priorities (inequalities, health improvement, deprivation, childrens services etc) and not simply seen by health authorities as something which is an irritating extra on the agenda.

Please return your completed questionnaires to dearbhal.Murphy@feantsa.org before June 15th 2006.

Annexe 1: ETHOS TYPOLOGY

ETHOS European Typology of Homelessness and housing exclusion

Homelessness is one of the main societal problems dealt with under the EU Social Inclusion Strategy. The prevention of homelessness or the re-housing of homeless people requires an understanding of the pathways and processes that lead there and hence a broad perception of the meaning of homelessness.

FEANTSA (European Federation of organisations working with the people who are homeless) has developed a typology of homelessness called ETHOS.

The ETHOS typology begins with the conceptual understanding that there are three domains which constitute a “home”, the absence of which can be taken to delineate homelessness. Having a home can be understood as: having an adequate dwelling (or space) over which a person and his/her family can exercise exclusive possession (physical domain); being able to maintain privacy and enjoy relations (social domain) and having a legal title to occupation (legal domain). This leads to the 4 main concepts of Rooflessness, Houselessness, Insecure Housing and Inadequate Housing all of which can be taken to indicate the absence of a home. ETHOS therefore classifies people who are homeless according to their living or “home” situation. These conceptual categories are divided into 13 operational categories that can be used for different policy purposes such as mapping of the problem of homelessness, developing, monitoring and evaluating policies.

ETHOS European Typology on Homelessness and Housing Exclusion

Conceptual Category		Operational Category		Generic Definition

ROOFLESS	1	People Living Rough	1.1	Rough Sleeping (no access to 24-hour accommodation) / No abode
	2	People staying in a night shelter	2.1	Overnight shelter
HOUSELESS	3	People in accommodation for the homeless	3.1 3.2	Homeless hostel Temporary Accommodation
	4	People in Women's Shelter	4.1	Women's shelter accommodation
	5	People in accommodation for immigrants	5.1 5.2	Temporary accommodation / reception centres (asylum) Migrant workers accommodation
	6	People due to be released from institutions	6.1 6.2	Penal institutions Medical institutions
	7	People receiving support (due to homelessness)	7.1 7.2 7.3 7.4	Residential care for homeless people Supported accommodation Transitional accommodation with support Accommodation with support
INSECURE	8	People living in insecure accommodation	8.1 8.2 8.3 8.4	Temporarily with family/friends No legal (sub)tenancy Illegal occupation of building Illegal occupation of land
	9	People living under threat of eviction	9.1 9.2	Legal orders enforced (rented) Re-possession orders (owned)
	10	People living under threat of violence	10.1	Police recorded incidents of domestic violence
INADEQUATE	11	People living in temporary / non-standard structures	11.1 11.2 11.3	Mobile home / caravan Non-standard building Temporary structure
	12	People living in unfit housing	12.1	Unfit for habitation (under national legislation; occupied)
	13	People living in extreme overcrowding	13.1	Highest national norm of overcrowding

For more information please see FEANTSA's 2005 Review of Homeless Statistics in Europe (Edgar et al.) at www.feantsa.org

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[i] The discharge of older homeless people from hospital, Blood I Help the Aged and hact 2003.