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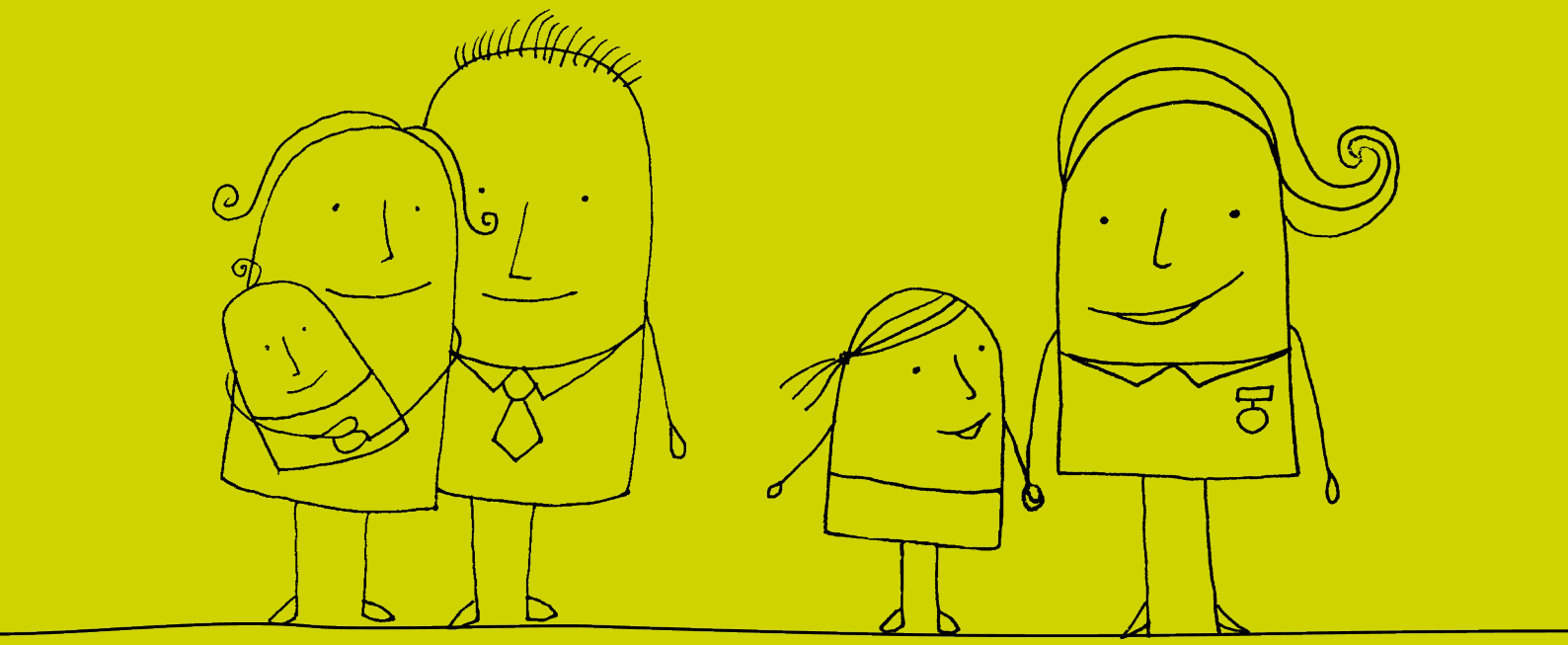
Patient and Client Council

Issues faced by people who are homeless in accessing health and social care services

Report of an initial scoping exercise

March 2015



Your voice in health and social care

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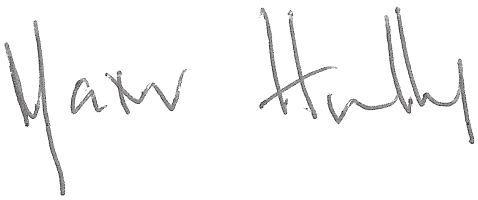
Foreword

Dear Reader,

Access to health and social care services for people who are homeless is problematic due to a lack of information about available services and issues with how these services are coordinated to best meet particular individual needs. This report shows that in particular, people without a home of their own face many barriers when accessing Northern Ireland health and social care services. Consequently, they are not receiving the care and support they need.

Whilst there are examples of good work being carried out to support people who are homeless in accessing the services that they need, experts that we talked to as part of this project have told us more needs to be done. This includes more education on issues of homelessness, better and more coordination between organisations and health and social care services and easier access to services in the community.

The Patient and Client Council would like to thank all those who contributed to this report. In taking this work forward, we will seek to raise awareness of the issues highlighted by the people that we talked to. In doing so, we will ensure that we engage with experts across the statutory and community and voluntary sector who work specifically with people who are homeless to improve lives and contribute to better health and wellbeing. We will also talk to people who are, or have been homeless so that we understand what changes are required so health and social care services are better able to support their needs in the future.



Maeve Hully
Chief Executive

Executive Summary

Background and aims

Many barriers exist for homeless people in accessing health and social care services and studies have shown that homeless people experience some of the poorest levels of health among the general population.[3-5]

Despite the evident challenges faced by homeless people accessing health and social care services and poor levels of health faced by this group, there has not been a recent regional exploration of homeless people's experiences of access to health and social care services in Northern Ireland.

Therefore, the aim of this particular study is to understand the key issues with regard to people who are homeless accessing health and social care services and to scope out what work has already taken place in Northern Ireland, both in terms of audits, evaluation and research and current or recent initiatives looking at how people who are homeless can better access services.

The specific objectives of this study were to:

1. Understand the complex needs of a vulnerable group within society, specifically in relation to the types of health and social care services they require regular access to;
2. Establish the key issues and barriers in relation to homeless people accessing health and social care services across the UK and elsewhere;
3. Report on the experiences of homeless people in accessing services across Northern Ireland, as provided by those who work most closely with them in the community;
4. Set out recommendations for how the PCC can continue to pursue the issues highlighted in this study, to ensure the needs of homeless people, specifically in relation to accessing a full range of services are addressed.

Our Approach

This study consisted of two stages:

- A review of key literature on the health needs of homeless people and issues they face in accessing health and social care services.
- Face to face interviews with 18 stakeholders who either worked with people who were homeless or worked in an organisation (statutory, community or voluntary) which has looked at or is directly involved in working on issues in relation to homelessness in Northern Ireland.

This study did not include direct experiences of people who are homeless as it was felt that a greater understanding of the complex needs of homeless people would need to be established prior to engagement with this group. Governance and ethical requirements would also need to be considered.

Definitions and factors which cause homelessness

Homelessness is often misunderstood by the general population and it was noted that often people have a stereotypical image of a homeless person being someone who sleeps on the streets and has alcohol or drug dependency issues. However, this is not always the case.

Homelessness is not just about those who sleep on the streets. FEANTSA* developed a European Typology of homelessness and Housing Exclusion (ETHOS)[2] which provides a definition and a common language when talking about homelessness within the European Union (EU). ETHOS defines homelessness as:

1. **Rooflessness** e.g. sleeping rough;
2. **Houselessness** e.g. living in temporary accommodation;
3. **Insecure housing** e.g. where individuals are living in abusive environments or have been evicted; and
4. **Inadequate housing** e.g. unfit housing or extreme overcrowding.

A total of 18,862[21] people presented to the Northern Ireland Housing Executive (NIHE) as being Homeless between April 2013 and March 2014. However, this is not a measure of the full extent of homelessness in Northern Ireland (NI). These figures only relate to those who present themselves to the NIHE as homeless. Thus, they do not take account of the 'hidden' homeless, who do not seek help and live in unsuitable conditions or those who sleep rough. As a result, it is difficult to understand and measure the true nature of the homeless problem in Northern Ireland.

Homelessness is not the result of one factor alone; generally it is a combination of a number of factors. The main reasons provided by those who are presenting as homeless were sharing breakdown / family dispute, accommodation not reasonable and loss of rented accommodation. However, looking at the bigger picture often mental health and addiction has an impact also.[11,18-23]

Evidence has shown that wider economic pressures can lead to increases in the total number of people who are homeless with people defaulting on mortgage payments or not being able to pay their rent. This could happen to anyone at any stage of life.

Health issues faced by people who are homeless

There are a wide range of health problems which are more prevalent amongst homeless people than the wider population. However the most prevalent health issues highlighted amongst this group are physical health problems, mental health issues and alcohol and substance misuse, all of which help contribute to premature deaths.

Research has shown[36] that the age of death for homeless people is on average 30 years lower. The average age of death for the homeless population is 47 compared to 77 for the general population (43 for women and 48 for men). This data relates more specifically to those who are sleeping rough and those residing in shelters and homeless hostels.

** FEANTSA, is the European Federation of National Organisations working with the Homeless and was established in 1989 as a European non-governmental organisation to prevent and alleviate the poverty and social exclusion of people threatened by or living in homelessness. It is the only major European network that focuses exclusively on homelessness.*

There is evidence to suggest that there are variances in health amongst the homeless population, with the Joseph Rowntree Foundation[41] identifying rough sleepers as having more prevalent health problems, with 6 out of 10 reporting more than one health problem, compared to 4 out of 10 single homeless people, and 2 out of 10 in the general population.

Physical Health

The literature suggests that the majority of homeless people have multiple physical health needs, the most common of which include general aches and pains, chest and breathing problems, colds and flu, eyesight, dental, and skin problems.[4,14,42]

Rough sleepers are more likely to have physical health problems. Common health issues reported amongst this group are pain or stiffness in joints, chest pain or breathing problems, ulcers, dehydration, frostbite, and hypothermia.[11,43]

Mental Health

Multiple studies have found that mental health problems are disproportionately higher amongst homeless people than amongst the general population.[4,6,48,49] The literature reports that affective disorders, such as depression, bipolar disorder and anxiety disorders, psychotic illness and substance misuse are particularly common in the homeless population.[50,51]

Homeless Link,[52] conducted an audit of 2,500 homeless people and found that 80% of people reported some form of mental health issue and 45% have been diagnosed with a mental health issue, compared to 25% of the general population. High rates of mental ill health have also been reported in populations of young people who are homeless.[7,14,15]

As well as having more physical health problems, rough sleepers are 11 times[41] more likely to have mental health problems. Dual diagnosis is a common problem with this population as many tend to have alcohol problems as well as mental illness. Due to the nature of their conditions, rough sleepers require intensive services.[16]

Despite such high occurrence of mental ill health amongst the homeless, it has been suggested that less than one third of homeless people with mental health problems receive treatment.[6]

Alcohol / substance misuse

Evidence has also indicated that alcohol and substance misuse problems are more dominant amongst the homeless population.[50] In the Homeless Link[52] audit of 2,500 homeless people, 39% said they take drugs or are recovering from a drug problem. A further 27% have or are recovering from an alcohol problem.

These findings suggest that homeless people are amongst the most vulnerable. Yet, the literature shows that despite the established link between homelessness and poor health, homeless people face more barriers when accessing health and social care services than the housed population and many do not receive the care and support that they need.[11,12]

Key issues faced when accessing health and social care

Health care should be made available to everyone; however, people who are homeless can come across a number of issues when trying to access health and social care services.

GP Access

GP access was highlighted as one of the key issues regarding accessing health and social care for people who are homeless. The problems with GP access focus on the individual not having proof of identity or a permanent address, making it difficult to register and therefore poses as a barrier to people who are homeless accessing healthcare. This could be avoided if awareness among health and social care staff was raised to highlight not having a permanent address need not be a barrier to registering with a GP as individuals can register using the GP surgery address.

The second issue with GP access surrounds those who are already registered and their need to maintain a GP which can often be difficult if they have moved away from the area. This removes the element of consistency of care, can cause problems with re-registering, and delays in notes being transferred between practices. The knock on effect of this on the individual is that they may not be able to access medication particularly in crisis situations.

GP services are a gateway to other health and social care services such as secondary, hospital based care and wider social care services. Difficulty in accessing GP services therefore has broader consequences of not being able to access a wider range of other services. Homeless people use GP services less and attend A&E services five times as often as the general population.[62]

Geographical location of services

Gaining access to services due to their location was reported as an issue which increased the difficulty of accessing health care and made some services inaccessible for clients.

Difficult and chaotic life circumstances

The chaotic behaviour in the lives of the homeless population, often caused by alcohol and drug use can be a barrier to accessing services which are appointment based. Other issues in their life make it difficult for them to manage their appointments and prioritise their health.

Mental health

People who are homeless and have mental health problems face many barriers in accessing health and social care services. A lack of collaboration between mental health, social welfare and homeless services was highlighted as a barrier along with a lack of mental health outreach provision. Lack of access to primary care results in needs not being met and emergency services accessed instead.

Timely access

Timely access to services can also prove to be a barrier. This may include moving Trust areas and being moved to the bottom of the waiting list for a service, or providing support when it is needed i.e. getting professional help when someone wants to stop drinking and not being put on a waiting list for support.

Stigma, low self-esteem and discrimination

People who are homeless may be reluctant to access health services because they expect a hostile response or have a previous bad experience of accessing health and social care services. Negative self-image, lack of self-esteem and feelings of worthlessness can also mean that many homeless people lack the ability and confidence to seek out appropriate health care. Some stakeholders held the opinion that if the "homeless" label was removed and this group were treated as individuals and not a "homeless person" they would be more likely to be treated as a person and not just a stereotype.

Fear and denial

People who are homeless may also be reluctant to seek health care because of a fear of being stigmatised or because their own health is not their priority. Alternatively, they may be unwilling to acknowledge mental health issues and are therefore reluctant to seek assistance. Unwillingness of the homeless population to engage with services was a barrier where some people choose not to avail of services.

Learning disabilities

A number of stakeholders raised the issue of learning disabilities and access to services after the age of 18. It was reported within interviews that young people are often diagnosed as having a learning disability however, in the transition period to adulthood, reference to their 'learning disability' often changes to 'learning difficulty'. The consequences of this change in reference from 'disability' to 'difficulty' often means the level of support they receive is reduced compared to what they received in adolescence when they were diagnosed as having a learning disability.

This transition period can cause difficulties for people who are homeless in particular as they may lose some of the support they had.

Dual diagnosis and need for coordinated care

Stakeholders reported that often being homeless may mean an individual may have a mental health illness and an addiction at the same time i.e. dual diagnosis. People who are homeless need coordinated help from different aspects of the health and social care system. Numerous studies have highlighted a lack of coordination and consistency between services as being a barrier to overall quality of service provision. A number of stakeholders highlighted that dual diagnosis causes difficulty in accessing services as it is often hard to decide which problem should be treated first.

Lack of long-term care provision

The literature and some of the stakeholders reported a lack of long term respite and end of life care for the homeless population. There is a need for better provision of nursing care services for those who need palliative care or have addiction problems.

Context of work in Northern Ireland

The Northern Ireland Housing Executive's Homelessness Strategy for Northern Ireland (2012-2017)[16] sets out the strategy for tackling homelessness and establishes guiding principles for the development and the delivery of homelessness services. The aim is to eliminate long term homelessness and rough sleeping by 2020 and to ensure the risk of a person becoming homeless will be minimised through effective preventative measures and also ensure that through enhanced inter-agency cooperation services to the most vulnerable homeless households will be improved.

Tackling homelessness requires the collaboration of a wide range of organisations from the statutory, voluntary and community sectors. Community and voluntary organisations play an important role in providing services to people who are homeless sharing knowledge and providing support. Some examples of initiatives which are carried out across Northern Ireland across a range of organisations are outlined below.

ECHO (Enhancing Healthcare for the Homeless) steering group

The ECHO steering group is currently running a GP registration referral pilot with GP practices and hostels in the Ballymena area. Checklists have been provided to GPs and hostels outlining information required to register as a new patient. The GP practices are taking part in a rolling rota where each week a different GP practice accepts patients from the various hostels in the area. The key to the success of the ECHO programme has been developing strong links and partnerships with a wide range of statutory agencies, voluntary organisations, community groups and private sector organisations. The success of the service has also been attributed to the good example of coordinated care, resulting in benefits to people who are homeless.

Homeless Public Health Nursing Service, Belfast Health and Social Care Trust

The Homeless Public Health Nursing Service is a dedicated advanced nurse led initiative which works with single homeless people in the Belfast Health and Social Care Trust. The service offers "door step" delivery of health care through one to one open access clinic sessions in 23 homeless facilities across the Belfast Health and Social Care Trust area. These clinics are held on a weekly basis within the hostel setting and assistance with GP / Dental registration is offered. The success of the service has been attributed to the integrated multidisciplinary team approach and demonstrates the difference to health care that can be achieved when everyone works together with a common goal for the good of the homeless.

Regional working group on health and homelessness

The Regional Working Group on Health and Homelessness was set up by the PHA to tackle the needs of homeless people. The group is made up of statutory, community and voluntary

organisations and is involved in contributing to the implementation of the Homelessness Strategy for Northern Ireland (2012-2017). A smaller sub group is also looking at care pathways in relation to the continuum of health needs of people who are homeless.

Areas for improvement

Stakeholders suggested areas for improvement with regard to supporting the homeless population to access health and social care services. The key suggestions were to educate professionals on the issues of homelessness and how they can help, the need for collaboration between different organisations, the provision of quicker access to services and access to services in the community. Stakeholders were agreed that everyone has a role in taking control and making changes to help this group of individuals. However, they also agreed that responsibility for making changes lies with those with authority in the Department of Health, Social Services and Public Safety, the Housing Executive and the Department for Social Development.

Summary and conclusion

This report outlines the challenges of meeting the health and social care needs of people who are homeless. Providing services to people who are homeless is complex. There is evidence of some good examples of groups and organisations working to ensure that the health and social care needs of homeless people are addressed. However access to health and social care services for people who are homeless is problematic due to a lack of information about available services and issues with how these services are coordinated to best meet particular individual needs. In addition there is no one definition of homeless which further complicates service delivery.

It is recommended that the issues highlighted in this report are pursued further by the Patient and Client Council as this would represent a timely and appropriate response to the issues raised. This could include organising a conference or workshop, which would focus on raising awareness of homelessness and the issues faced by this group of individuals in accessing services. It would seek to bring experts who work with people who are homeless, and people with direct experience of being homeless together to identify what needs to be done, highlight good practice, and showcase what is already being done in this area.

1.0 Background and aims of the study

At its most basic, being homeless means being 'without a home'.[1] However, this explanation does not describe the ways in which people can become homeless or summarise the different types of homelessness that people experience.

Studies have identified a variety of groups or categories of people as homeless. These include roofless homeless, or people who sleep rough, 'sofa surfers', that is those that are houseless but with a place to sleep, those with insecure housing arrangements who can be evicted at a moment's notice and people with inadequate housing arrangements, be it temporary, unfit or with extreme overcrowding.[2]

For some people, being homeless is short term, or transitional. Some people find themselves homeless but are assessed and rehoused relatively quickly without becoming homeless again. Others are repeatedly, or episodically homeless, often due to events in their personal lives. A third group are those that have been described as chronically homeless – this group is often categorised as 'rough sleepers' i.e. people without a place to shelter.

Studies have shown that homeless people experience some of the poorest levels of health among the population.[3-5] Being homeless means you are more likely to experience poor physical and mental health,[6,7] higher mortality rates,[8] and higher levels of alcohol, drugs and substance abuse,[8-10] in comparison with the general population. However, the literature shows that despite the established link between homelessness and poor health, homeless people face more barriers when accessing health and social care services than the housed population and many do not receive the care and support that they need.[11,12]

Across the UK, a key issue highlighted in some studies is access to GP services. Often, GP practices require forms of identification and/ or address details which people who are homeless may not have.[13] Subsequent registration with the GP practice is therefore difficult. Individuals can register with a GP practice using the practice address as a proxy address, however this is widely unknown amongst health and social care staff and the general public. The transient nature of homeless individuals, whereby they often move from one area to the next means that their registered GP practice is not always local and therefore accessible to them. This means that, with often chronic health conditions or complex health care needs, they do not receive regular or consistent care from a GP who knows their medical history.

The chaotic lifestyle of some people who are homeless can contribute to difficulties in accessing services.[13] Homeless people can make appointments, but don't always keep them. Long waiting times can contribute to people who are homeless not planning ahead and subsequently missing appointments. Furthermore, in addition some services such as particular regional services might not be easily reached by homeless people who may find it difficult to arrange travel to other areas.

Literature also emphasises the specific needs of people who are homeless, such as the importance of accessing mental health services and barriers to accessing treatment have also been found here. A 2012 European study[6] which assessed service provision for homeless people with mental health problems in 14 capital cities found that in all 14 locations levels of active outreach were low, out-of-hours service provision was inadequate and high levels of service exclusion were evident.

Furthermore, the study concluded that prejudice in services towards homeless people and a lack of

co-ordination amongst services were also common. Several studies on health and young homeless people have also found mental health to be the key health issue for this group, yet some young homeless people with mental health problems are mistrustful of health professionals providing clinical services and can be reluctant to seek help.[7,14,15]

In Northern Ireland, there have been a number of community based studies focusing on the needs of homeless people. This includes an oral health needs assessment of 317 homeless people living in north and west Belfast in 2007 which found that the majority of participants showed evidence of poor oral hygiene.[10] What is more, the survey reports that 33% of participants reported they had a mental health problem and 43% an alcohol addiction, which provides an indication of some of the wider health issues affecting the homeless population in Northern Ireland.

Despite the evident challenges faced by homeless people accessing health and social care services and the poor levels of health experienced by this group, there has not been a regional exploration of homeless people's experience of access to health and social care services in Northern Ireland.

1.1 Aim of the study

This project arose from anecdotal evidence and local intelligence received by the Patient and Client Council (PCC), such as routine monitoring data collected through the PCC Complaints Support Service which indicates that there are currently particular issues with people who are homeless being able to access health and social care services.

Given the complexities of health care needs of some homeless people and the subsequent challenges in understanding issues in accessing health and social care services, the PCC decided that the aim of this particular study would be to understand the key issues and to scope out what is happening already in Northern Ireland, both in terms of audits, evaluation and research and current or recent initiatives looking at how people who are homeless are being helped to access the services they need.

The specific objectives of this particular project were to:

1. Understand the complex needs of a vulnerable group within society, specifically in relation to the types of health and social care services they require regular access to;
2. Establish the key issues and barriers in relation to homeless people accessing health and social care services across the UK and elsewhere;
3. Report on the experiences of homeless people in accessing services across Northern Ireland, as provided by those who work most closely with them in the community;
4. Set out recommendations for how the PCC can continue to pursue the issues highlighted in this study, to ensure that the needs of homeless people, specifically in relation to accessing a full range of services are addressed.

Note to reader
The literature on homelessness varies on how this population is referred to. For example some studies use the term "homeless people" whilst others talk about "people who are homeless". We understand the importance of using appropriate terminology when describing people and the (often transitional or temporary) circumstances they can find themselves in. For the purposes of reporting, given that both the terms "homeless people" and "people who are homeless" are used within literature and that the terms were used interchangeably in some interviews, both terms are used within this report.

2.0 What we did

This chapter provides an outline of the approach used to address the aims and objectives of this project.

2.1 Overview of our approach

The initial stage of this project involved undertaking a literature review to explore key issues. Following this, a series of stakeholder interviews took place. Interviews were conducted with stakeholders identified as working in the area of homelessness, initially using the contacts and people the PCC knew that worked in this area. Where appropriate, interviewees were then asked to nominate other people they knew who it would be important to talk to, to assist in meeting the aims and objectives of this study.

A summary of our approach is detailed in **Figure 2.1** below.

Figure 2.1: What we did

2.2 Literature review

A rapid evidence assessment approach was used to find key issues in relation to the following areas:

- definitional aspects of homelessness;
- the extent of homelessness in the UK and in Northern Ireland;
- factors which can lead to someone being homeless;
- the health and social care needs of people who are homeless; and
- issues in relation to accessing health and social care services.

Literature searches focused on key international literature, recent UK and Northern Ireland literature (<10 years, unless deemed to be important for inclusion) and policy and strategy reports and other grey literature[†] .

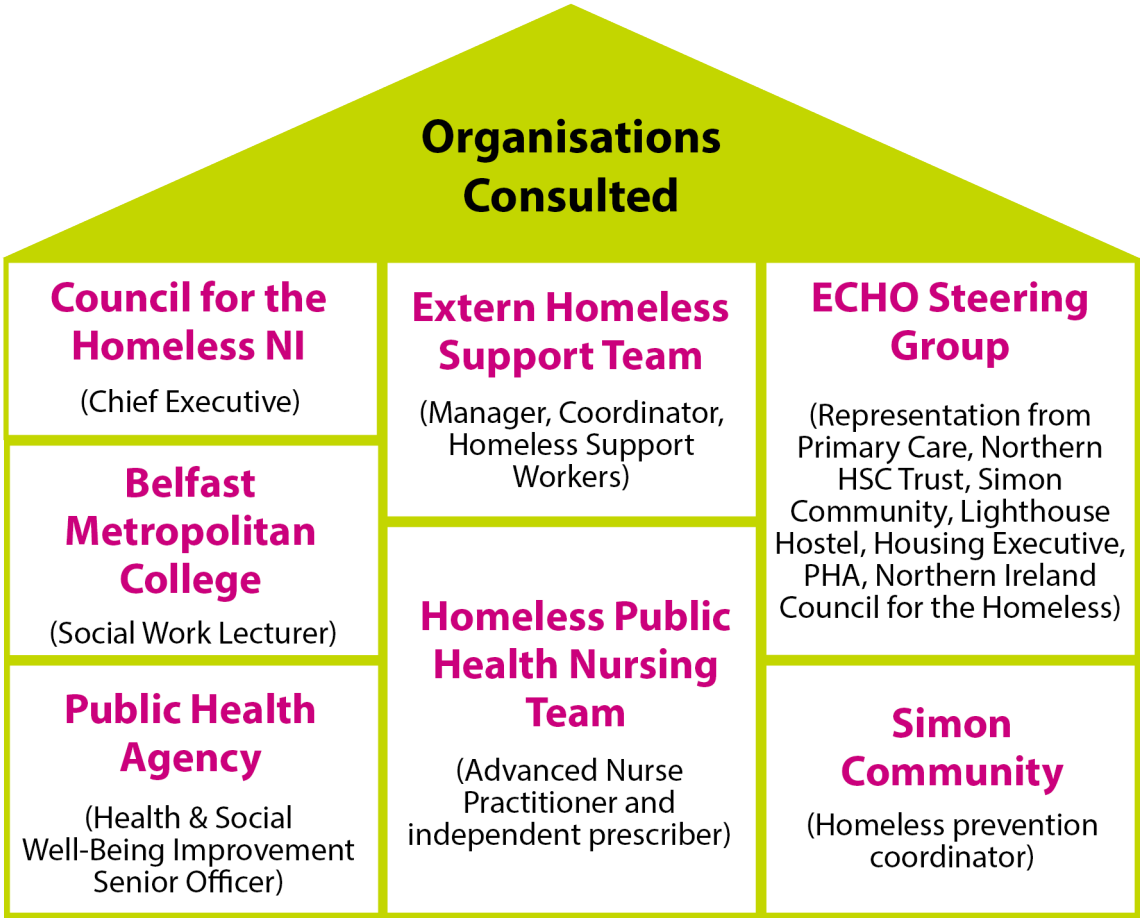
A total of 84 key sources were included as part of this scoping exercise (see **Appendix 1**).

2.3 Stakeholder consultation

As part of the evidence base for this report we consulted with 18 stakeholders who either worked directly with people who were homeless, belonged to organisations with the direct aim of working with and helping homeless people, or people who had an interest or portfolio which included working in this area within a particular organisation.

The organisations which were involved in the consultation were either statutory or voluntary and community agencies within Northern Ireland and are shown in **Figure 2.2**.

Figure 2.2: Organisations which took part in the stakeholder consultation process



The consultation process involved face to face conversations which lasted up to one hour, bar the ECHO steering group which was a group discussion. The format of the interview was structured into three main sections exploring (1) the interviewees role and involvement in the area of homelessness (2) the needs of the homeless population and difficulties in accessing health and social care services and (3) what is happening in Northern Ireland and what needs to happen to improve access to services in the future. Stakeholder interviewees were also asked to provide any particular examples of the types of experience that homeless people in Northern Ireland had had in relation to accessing health and social care services, however it was noted that the particular issues involved and

† *Grey literature has been defined as: 'That which is produced on all levels of government, academics, business and industry in print and electronic formats, but which is not controlled by commercial publishers.*[84]

circumstances meant that specific examples could be potentially disclosive and were therefore not pursued.

Each interview was digitally recorded and fully transcribed. The interviews were then analysed to identify key themes and issues regarding access to services for the homeless population.

2.4 Limitations of this study

As outlined, this study has focused on developing an understanding of the key issues which affect people who are homeless in accessing health and social care services.

Direct experiences of people who are homeless are not included in this particular study. At the outset of this particular project, there were a number of considerations as to why this did not take place as detailed below.

- The chaotic and transient lifestyles of some people who are homeless would present particular challenges in terms of directly engaging with homeless people during fieldwork. These issues would need to be considered further, ideally in partnership with those who have knowledge and expertise in this area;
- Governance and ethical approvals would likely need to be secured and appropriate timings to allow this process to be worked through would be required;
- The population of interest has particular, often complex health needs and a greater understanding of key issues in relation to these issues would be needed before direct engagement with a vulnerable group could take place;
- Appropriate support networks/ referral agencies would need to be in place before discussing health needs with homeless people, so that appropriate information and signposting could be provided if discussions raised particular issues for research participants; and
- The particular training needs for researchers in working with a vulnerable, seldom heard group would need to be considered. Again, this could be considered further with guidance from those who have knowledge and expertise in this area.

Whilst direct experiences of homeless people have not been considered as part of this particular study, it is envisaged that this project could be used to develop a follow-on study aimed specifically at capturing the views of a seldom heard group within Northern Ireland.

3.0 Definition and factors which cause homelessness

This chapter provides a definition of homelessness, gives an overview of the extent of homelessness across Northern Ireland and outlines some of the factors which may lead to people becoming homeless.

3.1 Definitions of homelessness

At its most basic being homeless means being 'without a home'.[1] However, this simple explanation fails to explain the circumstances and different experiences of people living without a home.

Homelessness is often misunderstood by the general population. Within a number of discussions with stakeholders, it was noted that often people have a stereotypical image of a homeless person being someone who sleeps on the streets and has alcohol or drug dependency issues. Some of the people we talked to also noted that the consequences of this stereotype is often followed by an assumption that homelessness in Northern Ireland is not a big issue because the public does not always see people living and sleeping on the streets.

> ***"I did an event and someone said to me… 'It's only now it's hit me. I was homeless and a number of the implications you talked about, I'm still living through it.' That person's relationship had broken up, he found himself staying with other people for six months, but had never thought of that as homelessness."***
>
> (Stakeholder interviewee – Role in providing policy/ strategy/ direction in relation to homeless issues)

In 2007, a local study looking at oral health needs assessments for homeless people living in north and west Belfast also called for a move away from a stereotypical view of people who are homeless, highlighting the varied nature of the homeless population and the range of factors that can contribute to homelessness.

"The homeless population is comprised of a varied, dynamic group of people who defy stereotyping. The image of the homeless person as a shabbily dressed older man is very wide of the mark."[10]

FEANTSA[‡] developed a European Typology of Homelessness and Housing Exclusion (ETHOS)[2] which provides a definition and a common language when talking about homelessness within the European Union (EU). The ETHOS typology highlights that there are three domains which constitute a 'home'. These three domains are:

- **Physical domain** – having an adequate dwelling or space which a person/ family can possess;
- **Social domain** – maintain privacy and enjoy relations; and
- **Legal domain** – having a legal entitlement to occupation.

[‡] *FEANTSA, is the European Federation of National Organisations working with the Homeless and was established in 1989 as a European non-governmental organisation to prevent and alleviate the poverty and social exclusion of people threatened by or living in homelessness. It is the only major European network that focuses exclusively on homelessness.*

The ETHOS definition categorises people by their living situations. Classification of a person as homeless falls into one of the four categories as shown in **Figure 3.1**.

Figure 3.1: ETHOS Homelessness definition

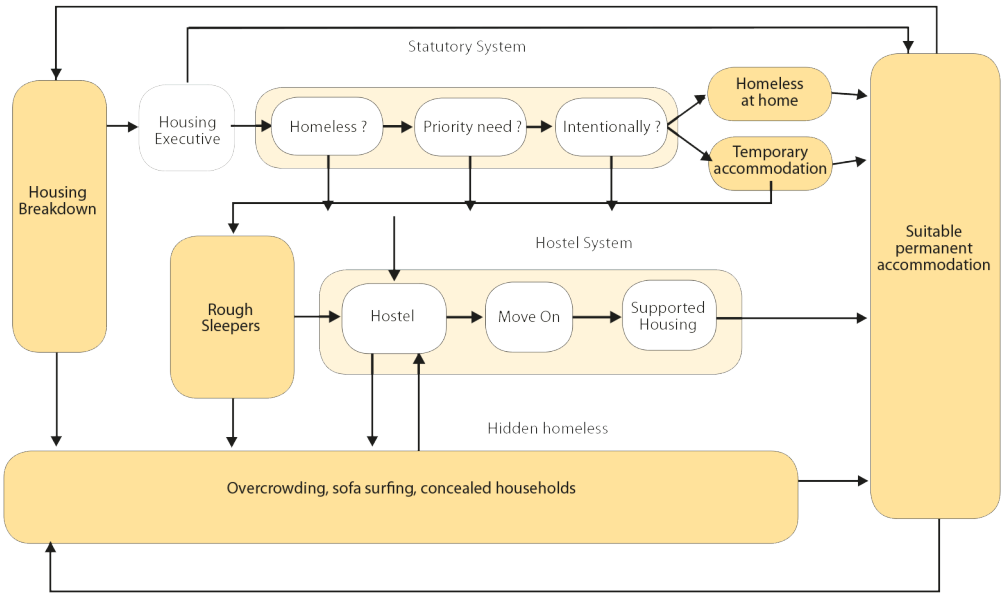
Rooflessness	Houselessness	Insecure Housing	Inadequate Housing
Without shelter of any kind	With a place to sleep but temporary	Insecure accommodation Eviction Domestic violence	Temporary / non-conventional structures Unfit housing Extreme over-crowding

Source: FEANTSA. ETHOS Typology on Homelessness and Housing Exclusion.[2]

Homelessness has therefore been shown to relate to types of insecure housing status and clearly highlights that 'rooflessness', which includes people sleeping rough describes only one aspect or circumstance of what it means to be homeless.

The Homelessness Strategy for Northern Ireland (NI) 2012-2017[16] recognises that people can move in and out of homelessness and that, for some people, being homeless is a transitional part of their lives, whilst for others it is a regular or even chronic issue for them. Three subsets within the homeless population are noted by the Strategy, summarised as (1) transitional homeless who enter into a homeless status but are able to be assessed and rehoused relatively quickly, without them becoming homeless again; (2) repeated or episodic homeless people, where events or circumstances bring about homelessness; and (3) chronic homelessness, more often characterised as 'rough sleepers'. **Figure 3.2** outlines the pathways in which people can find themselves coming in and out of homelessness.

Figure 3.2: Summary of the pathways in which people can find themselves coming in and out of homelessness



Source: Housing Executive Homelessness Strategy for Northern Ireland 2012-2017[21]

The pathways in and out of homelessness, as outlined in the Homelessness Strategy for NI also recognise the issue of the 'hidden homeless'. Defining homelessness by groups of people, Crisis identifies (1) people who sleep rough, (2) single homeless people living in hostels, shelters and temporary supported accommodation, (3) statutory homeless households who are seeking housing assistance and also notes a group that can be described as the (4) 'hidden homeless'. This group is categorised by those living in overcrowded conditions and sharing households, including people staying with family and friends (sometimes described as 'sofa surfing') because of a lack of accommodation and those about to be evicted from their accommodation with nowhere else to live.[16] These forms of hidden homelessness are rising across Great Britain[17] and are an area for concern. Given their nature, it is difficult however to understand the full extent of the problem.

3.2 Who is homeless in Northern Ireland?

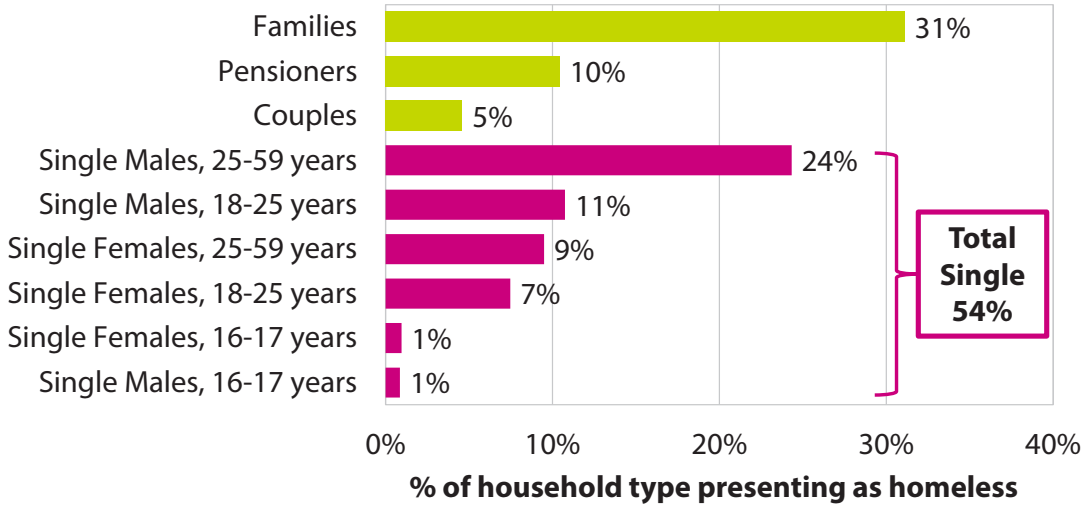
The number of households[§] presenting to the Northern Ireland Housing Executive (NIHE) as homeless from April 2013 – March 2014 was 18,862,[21] of these, the NIHE accepted 51% (9,649) as Full Duty Applicants (FDA)[**].

Based on household type those that presented to NIHE were:

- Single – 54%
- Families – 31%
- Pensioners – 10%
- Couples – 5%

20% of those that presented were under the age of 25 with one in ten of these being aged 16-17. The breakdown presenting by household type is shown in **Figure 3.3**.

Figure 3.3: Household type presenting as homeless in 2013 / 2014.



Base: 18,859
Source: DSD / NISRA Northern Ireland Housing Bulletin 1st January – 31st March 2014[21]

[§] Homeless households are those households without a shelter that would fall within the scope of living quarters.[83]
[**] If homeless or threatened with homelessness, the Housing Executive will need to satisfy itself whether the applicant has a priority need for accommodation and whether they became homeless or threatened with homelessness intentionally. Where the Housing Executive concludes that an applicant is eligible, homeless (threatened with homelessness), in priority need and unintentionally homeless it owes them the full housing duty in line with the provisions of the The Housing (NI) Order 1988. An applicant to whom this full housing duty is owed is operationally referred to as a "Full Duty Applicant" (FDA).

These figures relate only to those who present themselves to the NIHE as homeless. They do not take account of those who were described earlier as "hidden" homeless and who do not go to the NIHE for help, live in unsuitable conditions, sleep on a friend's sofa, many of those sleeping rough and those who, according to wider definitions could be defined as homeless but who may not consider themselves as homeless.

In England statistics on rough sleeping counts have been published over the last three years. These counts and estimates are single night snapshots of the number of people sleeping rough in local authority areas. The Autumn 2013 total of street counts and estimates in England was 2,414.[17] This is an increase of 5% from the 2012 figure of 2,309. The figure is made up of estimates from 278 local housing authorities in England and a count in 48 local housing authorities.

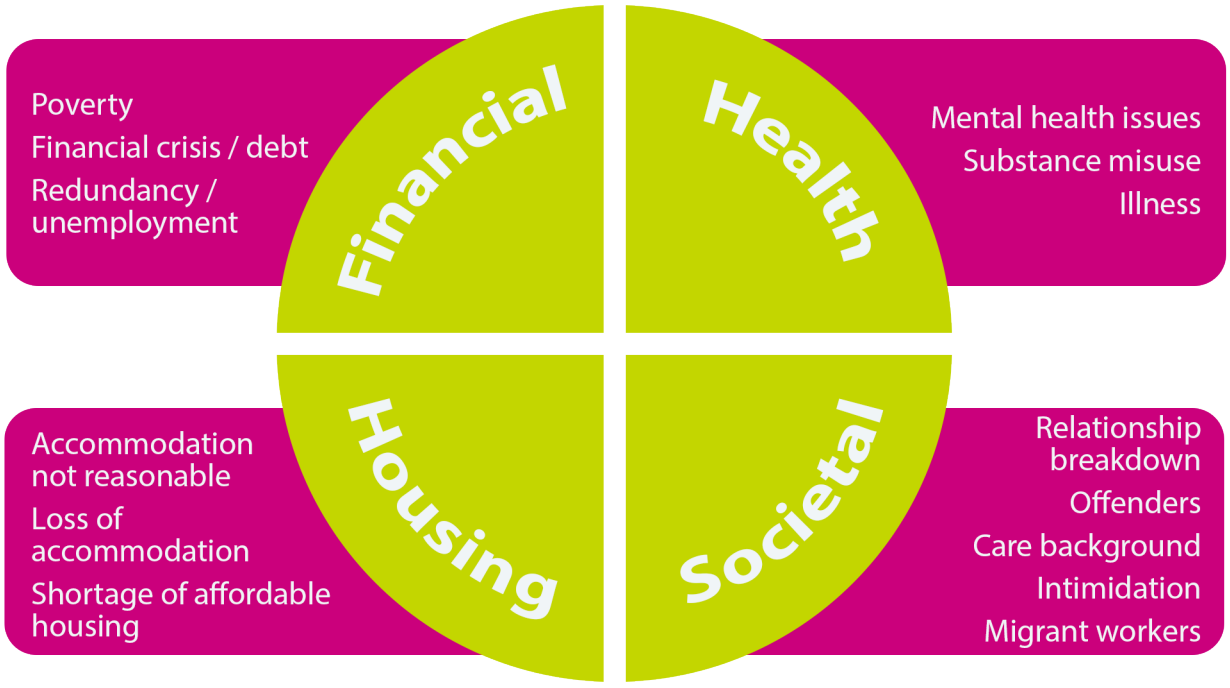
A total of 543 of these in Autumn 2013 were rough sleeping in the Greater London area. The rate of rough sleeping per 1,000 household's stands at 0.11 for England and 0.16 for Greater London.[17]

In Northern Ireland, the Homelessness strategy for NI[16] highlights that rough sleepers form a very small percentage of the homeless population (fewer than 10 individuals sleep rough on any given night).

3.3 Factors which cause homelessness

Homelessness is a complex issue and the information gathered as part of this scoping exercise indicates that there are many reasons why a person may become homeless. **Figure 3.4** provides a summary of some of the main factors described during stakeholder interviews and within literature on what causes people to become homeless.

Figure 3.4: Factors which can lead to homelessness[11,18-23]

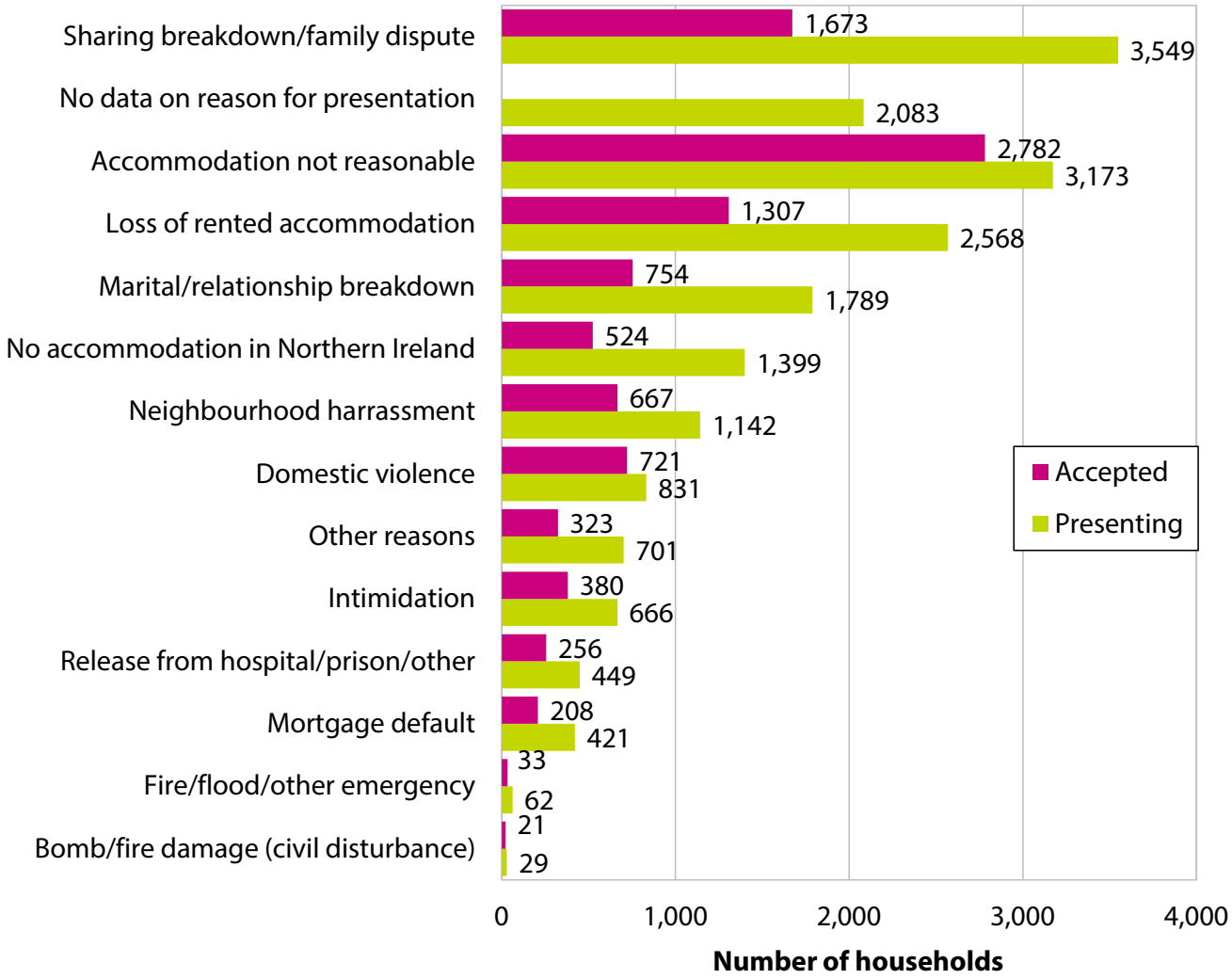


This is not intended as a definitive list but to provide an overview of the key factors highlighted in the stakeholder discussions and in the literature. Furthermore studies show that often it is not just

one factor which leads to someone becoming homeless, but a series of events or circumstances.[24] The literature[25] also identified that homelessness is rarely attributable to one factor, arguing that it is a result of a combination of issues, which can be grouped into categories: housing issues, drugs and alcohol, mental health, relationship breakdowns and individual choice. This indicates that no one factor leads to homelessness, but rather it is a complex issue, which is usually the result of a culmination of problems or events.

Figure 3.5 below shows the reasons recorded by the Northern Ireland Housing Executive for households presenting as homeless compared with the numbers which were accepted as homeless for each reason.[21]

Figure 3.5: Reasons for households presenting as homeless and number accepted: Northern Ireland 2013/14



Bases: Accepted: 9,649 and presenting: 18,862
Source: DSD/NISRA Northern Ireland Housing Bulletin 1st January – 31st March 2014[21]

In Northern Ireland, information collected from the Northern Ireland Housing Bulletin shows that family dispute/sharing breakdown is the top reason why people present as being homeless. Wider studies across the UK also note breakdown in relationships as a common factor contributing to someone becoming homeless.[22,24] This could include leaving the parental home following arguments, marital or relationship breakdown, the death of a partner, or the breakdown of a relationship with a friend(s) the person was staying with.[26]

Stakeholder discussions highlighted however, that with relationship breakdowns, there are often underlying health (such as addiction or mental health problems) or abuse issues which have contributed to a breakdown in personal relationships.

> ***"A lot of them [people who are homeless] have severe medical problems but they didn't say those they just said their accommodation wasn't reasonable for them as there were stairs and they couldn't manage the stairs but this was because of other medical reasons."***
>
> (Stakeholder interviewee– Role in providing policy/strategy/direction in relation to homeless issues)

> ***"Quite often what they tick the box as and what the statistics are saying, when you go down deeper it's very different."***
>
> (Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues)

> ***"To put it in one box is a very difficult thing; there is always a reason behind why someone is intimidated out of an area. There is always a reason why there is a conflict in a relationship or a marriage breakdown. There are always reasons behind why these things happen."***
>
> (Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues)

> ***"It's not about a row with your partner and having to leave the house. It's all the other stuff like domestic violence, chronic alcohol and drug misuse, trauma and mental health problems. These are things that will maybe cause the family breakdown but the statistics include them as relationship breakdown."***
>
> (Stakeholder interviewee – Working directly with homeless)

The majority of stakeholders indicated that addiction and mental health issues were widely associated with homelessness. However these can be both a contributing reason for becoming homeless, but can also be exacerbated by a person being homeless.

> ***"Somebody with mental ill health, it's a bit like the chicken and egg, which comes first? Do they have the addiction because they have mental health problems or do they have mental health problems because they have an addiction?"***
>
> (Stakeholder – Role in providing policy/strategy/direction in relation to homeless issues)

In Northern Ireland, accommodation not being reasonable is the second most common reason people give when they present as homeless. Stakeholders reported that this can include current accommodation not being big enough to house all occupants, not being suitable due to location or layout and/or the condition of accommodation not being fit to live in.

Loss of rented accommodation is the third most common reason given for people presenting as homeless in Northern Ireland. It was noted within a stakeholder interview that the high incidence of loss of rented accommodation as a reason for presenting as homeless can sometimes be due to being unwell for long periods of time, with subsequent employment and financial difficulties impacting on the person's ability to keep up rental payments. Again, drug and alcohol abuse issues were also noted, whereby it is difficult for a person with episodic homelessness to sustain long term rental accommodation.

> ***"There are a lot of people who have been homeless for a long time and have lost family ties and have no community links. They are very isolated; they bring other people in that they have met on the street for company. That turns into a drinking binge, parties, anti-social behaviour orders, eviction, losing the tenancy or someone else taking over the tenancy and that person saying they can't live there even though it was theirs originally."***
>
> (Stakeholder interviewee - Working directly with homeless)

Offenders and those who have been in care are also more likely to experience homelessness. Offenders leaving prison and young people leaving care often have nowhere to live and therefore as a result may end up homeless. Research has found evidence which highlights the challenges faced by ex-offenders accessing accommodation. This includes a range of structural, procedural, financial and attitudinal barriers,[27] as well as often having problematic housing histories.[28] The literature[29] also suggests that some offenders may have experienced a lifetime of social exclusion and have high levels of need, such as drug or alcohol misuse, and require support to find suitable accommodation. Additionally, offenders may lack family and social support, which may also impact on their ability to find housing,[30] resulting in them ending up homeless.

Migrant workers can end up homeless if they come to Northern Ireland and can't find work or have found work and then lose their job. Shelter Cymru[23] looked at the housing experiences of migrant workers living in Wales. Of those studied, around a third (30%) experienced homelessness whilst living in Wales. Furthermore, most migrants also indicated experiences of poor or insecure housing. Factors contributing to homelessness amongst migrant workers were generally similar to those faced by the general population, including unemployment, poverty and relationship breakdown. Findings also indicated that a small proportion of migrant workers slept rough, whilst others stayed temporarily with friends and family, thus, falling into the 'hidden homeless' category.

> ***"We also have a growing population of minority ethnics, we used to have Polish and Lithuanians come in strands for a while and then they got a job. Now the jobs have dried up and they are back into our setting again. We are seeing clients from five years ago coming back into our system as they lost their job and home."***
>
> (Stakeholder interviewee – Working directly with homeless)

The Simon Community[31] suggests that the current economic pressures are creating the perfect storm for homelessness to thrive and that most families are now less than two pay packets away from losing their homes. Crisis UK, the national charity for single homeless people, also reports that all forms of homelessness have risen due to a combination of economic pressures, housing shortages and welfare reforms.[32]

Defaulting on mortgage payments was highlighted by some stakeholders as becoming an increasingly common factor for homelessness over the past number of years. Whilst this is a small percentage of the overall homeless population there was a noticeable rise between 2007-2008 and 2010-2011 during the UK recession[††]. **Figure 3.6** clearly shows an increase in the number of people presenting as homeless from 2008/2009 until 2010/2011. The figures drop after this date, however, they are still high in comparison with pre-recession figures from 2006/2007 and 2007/2008.

Figure 3.6: People presenting to the Housing Executive as homeless between 2006 and 2014 due to defaults in mortgage payments

Bases: 2006/07 - 21,013; 2007/08 – 19,030; 2008/09 – 18,076; 2009/10 – 18,664; 2010/11 – 20,158; 2011/12 – 19,737; 2012/13 – 19,364; 2013/14 – 19,354

Source: DSD / NISRA Northern Ireland Housing Bulletins 2008 – 2014[21, 33-35]

This group of homeless people are not people which the general public would expect to be calling "homeless". These are simply people who have lost their jobs and cannot keep up their mortgage payments. This highlights the issue that homelessness can happen to anyone at any stage in their life.

> ***"We have a growing group of new homeless people, those who are homeless and cannot afford their houses, either mortgage or rent. These are not the general public's view of what homeless people are, these are people like you and me who, because of money and money alone cannot afford their homes."***
>
> (Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues)

[††] *A recession is defined as a "period of temporary economic decline during which trade and industrial activity are reduced, generally identified by a fall in GDP in two successive quarters" [82]*

4.0 Health issues homeless people face

This chapter outlines the specific health issues which people who are homeless face, looking specifically at physical and mental health and alcohol/substance misuse. The evidence to support this chapter was taken from the literature review documents, strategy and policy documents and stakeholder interviews.

Studies have shown that homeless people experience some of the poorest levels of health among the general population.[3-5] Being homeless means you are more likely to experience poor physical and mental health,[6,7] and higher mortality rates.[8] Levels of alcohol, drugs and substance abuse are also reported to be high amongst the homeless population.[8-10] However, the literature shows that despite the established link between homelessness and poor health, homeless people face more barriers when accessing health and social care services than the housed population and many do not receive the care and support that they need.[11-12]

As a result there are higher mortality and morbidity rates and health risk taking behaviour among homeless populations compared to the housed populations.[8] Research has shown[36] that the age of death for people who are homeless is on average 30 years lower. The average age of death for the homeless population is 47 (43 for women and 48 for men) compared to 77 for the general population.[36] This data relates more specifically to those who are sleeping rough and those residing in shelters and homeless hostels.

In 2010 Homeless Link carried out an audit of the experiences of more than 700 homeless people from across England which found that 8 out of 10 homeless people have one or more physical health need, 7 out of 10 have one or more mental health need, and 1 in 3 regularly eat less than 2 meals per day, which gives some indication of the types of health issues that homeless people face.[4]

Whilst it is generally assumed that health problems will be more prevalent amongst the homeless population compared to the wider general population, direct health comparisons are rare, as 'most datasets do not include both groups'.[39] However, there is some evidence which highlights how health problems are more prevalent amongst homeless people. Comparative evidence, which focuses particularly on the homeless population and the general population, has indicated that homeless people are more susceptible to certain health problems.[40] Generally speaking, 'homeless people have worse health status than their housed counterparts'.[39]

There are a wide range of health problems which are more prevalent amongst people who are homeless compared to the wider population. However, the most prevalent health issues highlighted amongst this group are physical health problems, mental health issues, and alcohol and substance misuse. All of which help contribute to premature deaths.

> ***"They [people who are homeless] don't all fit into boxes, they overlap e.g. you could have one person with a learning disability and also some mental health problems and addiction and misuse problems. The needs of the homeless are very complex."***
>
> (Stakeholder interviewee – Working directly with homeless)

There is also evidence to suggest that there are variances in health within the homeless population,with the Joseph Rowntree Foundation[41] identifying rough sleepers as having more prevalent health problems, with 6 out of 10 reporting more than one health problem, compared to 4 out of 10 single homeless people, and 2 out of 10 in the general population.

The Homelessness strategy for NI reports that rough sleepers include "people who misuse alcohol and drugs, people with mental health problems, people leaving prison or other institutions and people who have experienced family or relationship breakdown including domestic violence". Dual diagnosis is a common problem with rough sleepers as many tend to have alcohol problems as well as mental illness. Due to the nature of their conditions, rough sleepers require intensive services.[16]

4.1 Physical health

The literature suggests that the majority of people who are homeless have multiple physical health needs, the most common of which include general aches and pains, chest and breathing problems, colds and flu, eyesight, dental, and skin problems.[4,14,42]

Physical health problems are particularly common and pronounced amongst those who are 'roofless' or sleeping rough; common health issues reported amongst this group are pain or stiffness in joints, chest pain or breathing problems, ulcers, dehydration, frostbite, and hypothermia.[11,43]

Wagner et al[40] indicated that physical health problems are more prevalent amongst homeless people compared to the general population. The study described the health situation in Vienna, Austria, by comparing a single homeless group, with a non-homeless control population. The study looked at 66 homeless people and 132 non-homeless controls (two for each homeless case) which were matched by age and sex. Findings from this comparative study indicated that physical health problems are more common amongst the homeless population, including respiratory problems. In general, the Joseph Rowntree Foundation[41] found that there was a high incidence of physical health problems amongst single homeless people. They found that breathing problems and frequent headaches were twice as high among the single homeless and three times as high among rough sleepers. This highlights that homelessness is a complex issue and further health differences exist within the homeless population.

Evidence[44] has also indicated that homeless people generally have a poorer nutrition status compared to the general population. As noted earlier, the Homeless Link audit found that almost a third of participants usually eat less than two meals a day and a similar percentage do not eat any fruit or vegetables at all.[4] Other studies have found that the percentage of homeless people eating the government recommended 'five-a-day' is very low compared with the general population.[14]

Lebrun-Harris et al[39] directly compared the health status and health care experiences of homeless people in health centres, with their non-homeless counterparts in the United States utilising data from the 2009 Patient Survey sponsored by the Health Resources and Services Administration (HRSA). They reported that 'one quarter of homeless individuals said they experienced food insufficiency, compared with 10% of housed individuals'. These findings indicate the prevalence of poor diet and nutrition amongst homeless people, which further contributes to their health needs and may possibly be a contributing factor to their overall health status being much worse.

Evidence[41] also indicated that musculoskeletal problems, vision impairments, wounds and skin complaints are also more common in people who are homeless. Several studies have also reported

on the high prevalence of poor oral hygiene and dental care amongst homeless populations compared to the general population in the UK and Ireland.[8,10,39] This is further supported by Sun et al[45] who directly compared health related quality of life amongst homeless people with a general population sample in Stockholm. Findings suggested that a higher proportion of people who are homeless had 'refrained from seeking dental care due to economic difficulties, in spite of a perceived need'.

Studies[40,46] have also highlighted how chronic conditions are more prevalent amongst the homeless population compared to the general population. Evidence[47] found that people who are homeless are more likely to experience 'every category of chronic health problems, with the exception of heart disease and cancer.'

This supports how homeless people are more prone to health issues, but barriers prevent them from accessing the services they require.

> ***"Homeless people smoke more, they don't eat properly, they don't brush their teeth properly, they have more dental caries and they are more prone to having mouth lesions."***
>
> (Stakeholder interviewee – Working directly with homeless)

4.2 Mental health

Multiple studies have found that mental health problems are disproportionately higher amongst the homeless population compared to the general population.[4,6,48,49] The literature reports that affective disorders, such as depression, bipolar disorder, anxiety disorders, psychotic illness and substance misuse are particularly common in the homeless population.[50,51] For example, one systematic review of the prevalence of mental health disorders among the homeless in Western countries found that homeless people were substantially more likely to have alcohol and drug dependence than the general population, and a higher prevalence of psychotic illnesses and personality disorders.[50]

Homeless Link,[52] a homeless charity conducted an audit of 2,500 homeless people and found that 80% of people reported some form of mental health issue and 45% have been diagnosed with a mental health issue, compared to 25% of the general population. The Deloitte Centre for Health Solutions[53] also found that homeless people have 'twice the level of mental ill health than the general population', highlighting how mental ill health can contribute in making people homeless, or indeed, may be a consequence of being homeless. Additionally, Lebrun-Harris et al[39] found that psychological distress and anxiety are more prevalent amongst the homeless population, who were also twice as likely to have received some form of mental health treatment or counselling. Strikingly, Crisis[54] looked at homeless mortality in England for the period 2001-2009, finding that psychosis is 4-15 times[‡‡] more prevalent than the general population.

Adding to the complexity of health issues amongst the homeless, the Joseph Rowntree Foundation[41] identified differences in mental health amongst homeless people. The study found that, in comparison with the general population, mental health problems were eight times as high

[‡‡] *The factors which led to the wide variances include whether they stay in a hostel, public sector leased accommodation or night shelters and whether they are alcohol or drug dependent.*

amongst single homeless people, whilst 11 times higher amongst rough sleepers. They identified that rough sleepers reported the most health problems, suggesting that they have the poorest levels of health. This further indicates that health issues vary amongst the homeless population, conveying the complexity of homelessness and poor health.

High rates of mental ill health have also been reported in populations of young people who are homeless[7,14,15]. One study suggests that rates of psychological health problems amongst young homeless people are not only very high, but that they are more pronounced than physical health problems, for example suicide ideation and self-harm[7] and other studies support these findings. Research on the health of young homeless people by Depaul UK in 2012 found mental health to be the 'key health issue' with regard to young homeless people. It found that compared to the general population of young people surveyed, young homeless people were more likely to be depressed (40% of homeless compared to 21% general population) and/or diagnosed with a mental health condition (27% of homeless compared to 7% of general population).[17]

The literature consistently finds that many homeless people with a mental health need also have issues with alcohol or drugs.[7,9,48] In the Homeless Link survey (2010) 44% of participants with a mental health problem said they 'self-medicated' with drugs or alcohol.[4] While there has been little research into the health issues facing homeless people in Northern Ireland specifically, Collins and Freeman (2007) report in an oral health needs assessment of homeless people living in north and west Belfast that 33% of participants indicated they had a mental health problem and 43% an alcohol addiction, which provides an indication of the mental health and alcohol problems affecting the homeless population in Northern Ireland.[10]

Substance misuse also appears to be a health issue amongst young people who are homeless; one study found that young homeless people were significantly more likely to have used illicit drugs in the previous six months than their housed counterparts.[7] However, substance misuse and drug addiction is also prevalent among older homeless populations. For example, a census of homeless adults in the North of Dublin city conducted in 2005 found that drug misuse had superseded alcohol as the main addiction since the previous census in 1997, with twice as many homeless people reporting past or current drug misuse. The study concluded that a changing disease profile among the North Dublin homeless population, such as higher prevalence of depression and anxiety and high rates of blood-borne infection and dental problems, was consistent with growing drug use.[8]

Despite such high occurrence of mental ill health amongst the homeless, it has been suggested that less than a third of homeless people with mental health problems receive treatment.[6] Many older homeless people are isolated and estranged from their family and friends, a factor which can both contribute to poor mental health and increase the likelihood that they do not have the necessary support to seek treatment for their illness.[11]

One of the stakeholders highlighted that it is often assumed depression is the main mental health issue faced by homeless people. However, it may simply be the inability to cope and deal with high levels of anxiety or a lot of life events happening at once.

> ***"Not being able to cope and think clearly, that isn't necessarily depression, that's an inability to have a coping mechanism and that can feel like a mental health issue."***
>
> (Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues)

4.3 Alcohol / Substance misuse

Evidence has also indicated that alcohol and substance misuse problems are more dominant amongst the homeless population.[50] In the Homeless Link[4] audit of 2,500 homeless people, 39% said they take illicit drugs or are recovering from a drug problem. A further 27% have or are recovering from an alcohol problem.

Lebrun-Harris et al[39] directly compared the health status and health care experiences of homeless people in health centres, with their non-homeless counterparts in the United States utilising data from the 2009 Patient Survey sponsored by HSRA. They found that homeless people were much more at risk of alcohol and drug dependency, with 31% receiving treatment for alcohol or drug use, compared to a mere 4% of the general population. Similarly, Homelessness and Health Research[55] found that 36% of homeless people had taken drugs in the past six months, compared to a mere 5% of the general population.

5.0 Accessing services - key issues

This chapter examines the issues which are faced by people who are homeless whilst trying to access health and social care services. This chapter looks at the different areas in which this group may experience difficulties focusing on the following:

- GP access;
- Geographical location of services;
- Difficult and chaotic life circumstances;
- Mental health;
- Timely access;
- Stigma, low self-esteem and discrimination;
- Fear and denial;
- Learning disabilities;
- Dual diagnosis and need for coordinated care; and
- Lack of long-term care provision.

The evidence to support this chapter was taken from the stakeholder interviews, literature review documents and strategy and policy documents.

Health care access has been defined as the "fit among personal, sociocultural, economic, and system-related factors that enable individuals, families and communities to have timely, needed, necessary, continuous and satisfactory health services."[56]

The World Health Organisation (WHO) Constitution "enshrines the highest attainable standard of health as a fundamental right of every human being and the right to health includes access to timely, acceptable, and affordable health care of appropriate quality."[57] Therefore a UK Citizen should have access to health and social care services within the UK whether they have accommodation or not.

People who are homeless can come across a number of issues when trying to access health and social care services. The following sections outline some of the key barriers which the homeless population can face when trying to access services.

5.1 GP Access

One of the key issues regarding accessing health and social care for homeless people in both the literature and the stakeholder interviews was getting access to GP services.

There are two key issues with regard to GP access. The first issue is registering with a GP, often problems arise as the homeless person will need proof of identity and proof of a permanent address in the catchment area to be able to register. Without this documentation it is often difficult for a homeless person to register with the GP and this can pose a barrier to homeless people's access to healthcare.[13]

Being homeless can also cause embarrassment in the GP surgery, particularly when individuals are

asked to give their personal details, such as their address. This can cause embarrassment for the individual as they have to explain to the receptionist that they don't have one, or that they live in a hostel. Due to the layout of surgeries, others often overhear conversations which can cause further embarrassment. Indeed, a study in America found that young people preferred it when reception staff took them to a separate room to ask them personal questions or give them information rather than talking in front of everyone in the waiting room.[58]

> ***"When you go [to the GPs] people will immediately ask 'well what's your address' and I don't know about you but every time I've been in the doctors surgery, you are sort of announcing it like you are in the middle of a supermarket, everybody hears "what's your house number/flat number", well in a hostel you'll probably not have any of these things, so that's awkward then."***
>
> (Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues)

> ***"There's a gap and for us that's becoming more difficult and I suppose that's because they are asking for two forms of identification and sometimes our clients don't have any identification."***
>
> (Stakeholder interviewee – Working directly with homeless)

Research has also highlighted registration as a key issue with practice staff requiring evidence of a permanent address before they are able to offer permanent registration. However, Crisis (a homeless charity in the UK)[59] notes that the address of the surgery or any care/of address can legitimately be used instead, this is also the case in Northern Ireland. This does not appear to be widely known by professionals or the homeless population.

The second issue relates to those who are already registered and their need to maintain a GP. Due to the transient nature of being homeless, individuals often have to move away from the area where they live and, as a result, will need to register with another GP. This may result in the individual experiencing some of the issues noted above. However, it also removes the element of consistency of care, especially in relation to having a GP who knows your medical history. This is an important element of any individual's care whether homeless or not.

> ***"Homeless people will very often move and it's that kind of continuity of care that they need. It's not like these people are not capable of going and getting a doctor but they may have left one area to go to another area and may not know how to register."***
>
> (Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues)

The literature indicates that many homeless people are registered only as temporary patients. As a result their previous medical records do not get transferred to the practice they are with which impacts on their continuity of care.[59]

Stakeholders also reported that when an individual registers with a new GP, the GP will not automatically have access to that person's medical records. This means the GP may be unable to access their medical records and medication and, as a result, often will not give out a prescription. This can lead to problems particularly for those who are in crisis situations and need medication urgently.

> ***"The GP is instantly suspicious if they are homeless and looking for medication and will not necessarily prescribe the medication until they get their records and it becomes a very difficult situation. People end up on the streets who are not getting antipsychotic medication and end up in prison or in police cells or whatever because they have not had access to their records to have access to their medication."***
>
> (Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues)

> ***"In terms of criminal justice, people coming out of prison their medication often doesn't follow them or the prison doesn't give enough medication out. Some that come out are IV drug users and sometimes the script isn't ready for them and we've had several people died because they haven't had proper medication."***
>
> (Stakeholder interviewee – Working directly with homeless)

Literature suggests that those with chronic health problems are more likely to use Accident and Emergency (A&E) services. However, primary care services, such as GPs can be most appropriate for the care of chronic problems.[60] Lack of access to primary care can lead to an individual's health deteriorating and needing more expensive secondary intervention.[61] For example, homeless people attend A&E services five times as often as the general population and are admitted to hospital four times as often, where they tend to stay three times longer. This equates to £85million healthcare spend on the homeless.[62]

> ***"If people move out of catchment areas, GPs don't keep the cases on for too long, they close them and then there is that gap i.e. if someone was in an Antrim GP practice and move to Belfast their notes haven't followed them and they haven't got an appointment for three weeks to see their new GP. That's the problem; you are trying to access A&E services to get a script for somebody until they can see their GP."***
>
> (Stakeholder interviewee – Working directly with homeless)

> ***"A lot of people who have drug or alcohol issues end up going into hospital as they have seizures and it's not safe for them to detox in a hostel setting and therefore they have to go to A&E, so they are blocking up A&E and then you'll find them at the end of the ward causing havoc whilst they detox as there's no suitable accommodation for them."***
>
> (Stakeholder interviewee – Working directly with homeless)

Limited consultation times often do not allow for a full assessment to determine how best to respond to a person with multiple and complex needs.[3] One stakeholder believed it was important that GPs should be made aware at the time of booking an appointment for an individual, who is homeless, particularly the more vulnerable groups who sleep rough or live in hostels as they may not have been to a GP for some time. This would allow time for a thorough examination to take place and the individual's needs to be fully assessed.

> ***"They [GP] just get them in, give them what they need and let them go again. I'm concerned that a real assessment of their health needs isn't carried out at the beginning. GPs need to be more caring to that individual rather than just writing them a script."***
>
> (Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues)

Some stakeholders reported that other health and social care services are accessed through the GP, therefore if the homeless population cannot get access to a GP they are more likely to struggle to get access to other services.

A few stakeholders highlighted that GP access for homeless individuals was an issue they faced in the past. However, they now find that most of the homeless people they deal with are registered with a GP practice. It was highlighted that, despite being registered with a GP, they do not visit the GP very often and may have a lot of physical health issues as a consequence of alcohol/drug abuse and poor mental health.

Similar to these findings, an audit of 2,500 homeless people in England found that 90% of those who took part were registered with a GP. However, a significant number still reported that they are not receiving help with their health problems and 7% had been refused access to a GP or dentist within the past 12 months.[52]

5.2 Geographical location of services

The literature also indicated that gaining access to services due to their location, was also an issue which increased the difficulty of accessing health care and made some services inaccessible for clients.[12,63] This was also highlighted through the stakeholder interviews. An example was given of a drop-in clinic for Sexually Transmitted Disease (STD) screening which was being held in two locations in Northern Ireland. However, these services were not accessed by the homeless population as the location of the clinics meant transport was needed to access them. As the majority of people who are homeless do not own a car, these services were not accessible to them.

Furthermore, as clinics were held in the evening, fewer hostel staff are on duty, which, in turn, reduced the possibility of a member of staff being able to drive the residents to the clinic. As a result a service is currently being piloted within the Northern Health and Social Care Trust area where STD screening clinics are brought to the client in the hostels. To date this has worked well with good levels of uptake with hostel residents. Had the service not been accessible in the hostel there is a high chance that these residents would not have taken part in the screening.

"It's really beneficial, there is at least 50-60% of residents will access it every time it comes in. When the service was in the Tech they had access to it but they didn't avail of it, but because it came to them they avail of it."

(Stakeholder interviewee – Working directly with homeless)

5.3 Difficult and chaotic life circumstances

Within the homeless population, alcohol and drug use can cause confused or chaotic behaviour in the lives of the homeless population.[13] Many health services work on an appointment basis with appointments issued weeks in advance, and operate strict attendance and compliance rules which can become a barrier for the very vulnerable homeless who have urgent needs but chaotic lifestyles.[64]

Problems with not being able to access services therefore, can often come as a result of individuals not being able to manage their appointments. When an appointment is made for a GP or a specialist service such as mental health or addiction services, often this group of individuals cannot keep the appointment. If an appointment is made the individual needs to be at an address to receive the letter, be able to read it and attend the appointment.

"The big thing is people having the capacity to keep their appointments. If someone is referred to the community addictions team, they've got to be able to open the letter, read it, ring through and say they are going to keep the appointment, remember to keep the appointment and go on the day. That is actually quite difficult if you've got addiction problems or mental health illness."

(Stakeholder – working directly with homeless)

"One of the big things for homeless people is that a lot of services at the minute like mental health are appointment based services, they don't prioritise that and won't. If you get an appointment for a community mental health team in three weeks' time, you need somebody there that is going to make sure you go."

(Stakeholder – Working directly with homeless)

Low motivation and poor social skills have also been reported as a barrier to accessing services for people who are homeless.[11,63] This group of individuals do not prioritise their health or appointments. Other issues in their lives take priority and attending appointments is at the bottom of their list. Providing access to services is one issue but motivating a person to attend the appointment and realise the importance is a secondary issue which needs to be dealt with also.

> ***"The clients we get in are so chaotic with significant alcohol history, for 20 years etc. that they aren't at the stage where they can go to appointment based services. That's one of the difficulties with working with homelessness in general; it's not the access to services, it's getting somebody to actually be motivated enough to prioritise that over getting a house or somewhere to live, or whatever else."***
>
> (Stakeholder interviewee – Working directly with homeless)

Contacting and maintaining contact with patients with chaotic lifestyles can also be an issue.[65] Some stakeholders indicated that if a homeless person receives a letter and cannot read[§§], as a result, they may miss the appointment. They also stated that, in some instances, services work on the "three strikes and you're out" policy where if you miss three appointments you are removed from the service, resulting in the person being back at the start of the process and possibly on a waiting list for the service again.

> ***"Many a time after a support worker has rung a service, they've said, 'well we've wrote to the individual three times' but they are sometimes not in the position to read it. They may have learning difficulties so they may just bin it. That's why it's important if they are in a hostel that the support worker works with them to make sure the client is getting to their appointments."***
>
> (Stakeholder interviewee – Working directly with homeless)

Finance can also become an issue for those who miss appointments particularly for dental services where a "Did Not Attend" may result in a charge. This can become a barrier for an individual accessing that service again in the future as they have a fee to pay for missing an appointment.

> ***"Finance as well for things like the dentist, because they do have a tendency not to go to appointments and then they get hit with a £20 fine which they can't pay so they're not going to go back. A lot of dentists say if you don't pay the £20 you're not getting another appointment. That's that service null and void because they don't have that money lying around just to pay."***
>
> (Stakeholder interviewee – Working directly with homeless)

One of the stakeholders interviewed reported that some services in their area have introduced texting services to remind individuals about their appointment. Service user feedback on this service to date has been positive.

[§§] *Stakeholder interviewees reported the homeless population having an increased chance of having learning difficulties. However within the limits of the literature review we did not find evidence to suggest a higher prevalence of learning disability in the homeless population compared to the general population.*

5.4 Mental health

It has been reported that many homeless people with mental health problems are not served by statutory services[11] and less than one third receive treatment.[66] A number of studies[6,63,67] reported that many barriers exist for homeless people with mental health problems in accessing health services.

A study by Canavan et al, found that experts identified that a lack of collaboration between mental health, social welfare and homeless services was a key barrier to accessing care, along with a lack of mental health outreach provision.[6]

Case study A: Ex-Service user who did not receive the support they needed

Client A had been abused growing up and was bullied throughout their school life. These experiences growing up contributed to low self-esteem and a feeling of isolation and resulted in them self-harming regularly.

At a young age, Client A ended up homeless, moving around different areas and hostels. Regular self-harming however made it more difficult to stay in a hostel, as hostel staff were not able to cope with someone who regularly did so.

Client A regularly tried to access health and social care services, including GP services and a social worker, but always felt that they were being passed from one person to another without getting the help they wanted or needed.

Based on their experiences, Client A feels that there needs to be more understanding about what it means to be homeless and people should not be stigmatised because they are homeless, but rather treated as a human being in need of treatment and care.

Other studies[6,43,68] indicate that problems registering with health services within the Primary Care setting results in needs not being met and the homeless population using emergency services instead. Problems with accessing primary care arise from factors such as opening times, appointment procedures, location and discrimination.[69] Those who present at A&E with mental health problems are unlikely to receive the appropriate care and treatment[69] and input from mental health professionals was generally reported as being low.[6]

A study which looked at the views of 119 front-line managers of services for homeless people in London reported that managers believed the majority of clients wanting help to detox usually have long waits for admissions. Clients with mental health problems or drug addictions also experience long waiting times.[13] A number of stakeholders also raised the issue of waiting times to be seen by specialist services such as mental health services or getting an appointment to see a GP when newly registered.

"It's the waiting list for everybody, things like accessing a new GP it's three weeks away, if somebody's got severe mental health problems, they've lost their medication or haven't taken it or something like that it can be difficult and you end up using out of hours or A&E services."

(Stakeholder interviewee – Working directly with homeless)

"Whenever patients register with GPs they see the nurse, they fill in a registration form but it might be a three week gap before they get to see a GP."

(Stakeholder interviewee – Working directly with homeless)

Reluctance by a person who is homeless to acknowledge that they have a mental health issue, or other problems, often means they are reluctant to seek assistance.[70] Stakeholders reported that when a homeless person approaches a professional with a desire to stop drinking or taking drugs they need help at that particular point in time. If they have to wait weeks or months for support it may be too late.

"When young people are in crisis you very often have a window of opportunity in order to act that would make a lot of difference in those young people's lives but it doesn't happen and you've lost that chance."

(Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues)

5.5 Timely access

Waiting lists for services can also cause difficulty for the homeless population. Due to their transient nature they may move out of one HSC Trust area and into another. This can mean they are put to the bottom of the waiting list for services within the new Trust as there is no joined up approach when moving across the Trusts.

"If you are waiting on a hip replacement you are on a regional waiting list whereas for mental health or addiction you are placed on a Trust waiting list and if you move Trust area you're back down to the bottom of the waiting list again."

(Stakeholder interviewee – Role in providing policy/ strategy/ direction in relation to homeless issues)

Stakeholders also indicated that when a homeless person approaches a professional with a desire to stop drinking or taking drugs they need help at that particular point in time. If they have to wait weeks or months for support it may be too late.

"When someone wants to come off alcohol or come off drugs that isn't something that can wait until three months down the line. That is something that when your mind is set on doing that, you need to do it, you want to do it now. So very often there is a window of opportunity that is missed because you can't get services for those people at that time."

(Stakeholder interviewee – Working directly with homeless)

One stakeholder reported that if a homeless person goes for a mental health assessment and turns up intoxicated they send them away and tell them to come back when they have detoxed. This means they are put back at the beginning of the process again and more time passes before they are seen.

"Sometimes getting a quick response from mental health is ridiculous because clients go into hospital and then there is this argument that it's because of the drugs they are psychotic or it's because of the alcohol and if they have any amount of alcohol taken they can't be assessed for mental health properly. They say you need to take them away and detox them properly, how do you detox someone who's got an addiction who keeps on coming back round that revolving door again."

(Stakeholder interviewee – Working directly with homeless)

5.6 Stigma, low self-esteem and discrimination

People who are homeless may be reluctant to access health services because they expect a hostile response.[19] Literature reported that people who were homeless felt they were not well received when they tried to use health services. Reports were received of inadequate treatment or poor reception at A&E departments, as well as prejudice and unwillingness or difficulty in the health services to accommodate the complex needs often presented by homeless people.[3,6,12] As a result the homeless population report receiving poor quality of service with service providers often having a negative attitude towards them and feeling like they are being judged by their appearance.[11,71]

One stakeholder found that one of the biggest complaints from service users they work with was the attitude at A&E, particularly for those who have alcohol or drug problems.

"They get the idea that they're not wanted and that the staff are trying everything to get them to walk out and it's on more than one occasion and it's more than one person, a lot of them [service users] come back and say, I just knew that doctor didn't want me to be there."

(Stakeholder interviewee – Working directly with homeless)

"I brought a girl up [to A&E] who had been feeling suicidal and had cut her wrists and the consultant basically turned round and said 'you want to kill yourself the best way to do it is to slice up your arm.' I've experienced that attitude while I'm sitting there, I think the guy thought I was just a friend of hers rather than a worker from somewhere so felt able to say what he said. I was shocked by it, so I tend to think when a lot of the clients come back and say the attitude of the staff was less than good, I have a tendency to believe them."

(Stakeholder interviewee – Working directly with homeless)

"I know something has to be done about missed appointments, but sometimes it's the attitude of the professionals, the attitude of the staff when they're talking to or engaging with people who are homeless, this is a client group that thinks that society looks down on them anyway. When someone comes across with that same kind of attitude they're going to disengage."

(Stakeholder interviewee - Role in providing policy/strategy/direction in relation to homeless issues)

Stakeholders reported that stigmatisation can be an issue but they were more aware of a stigmatisation around chronic alcoholics or street drinkers who continue to drink no matter how much help they receive. These individuals may present to health services frequently and health professionals can feel exhausted trying to help them as they may present back again a few days later. One stakeholder emphasised that these individuals are unwell whether, mentally, or through addiction or physical health and they deserve the same health care as anyone else.

"There is the argument they are difficult in hospital and won't comply with treatment but there are also attitudes to homeless people, not from everybody but from other professionals. Stigmatising attitudes still exist in health and social care services there is no doubt about that."

(Stakeholder interviewee – Working directly with homeless)

Research also raised the issue of negative self-image, lack of self-esteem and feelings of worthlessness which can mean that many homeless people lack the ability and confidence to seek out appropriate health care.[3] They may also feel embarrassed or ashamed to seek help[72] or lack communication skills or the ability to be assertive when contacting healthcare services.[63]
Some stakeholders held the opinion that if the "homeless" label was removed and this group were treated as individuals and not a "homeless person" they would be more likely to be treated as a person and not just a stereotype. A study which involved nurse practitioners also identified the importance of developing relationships through learning about their story and acknowledging them as a person rather than someone who is homeless.[46] Good practice should be about working with clients in an individualistic way. This was referred to as being either person or client centred".[72]

> ***"You [interviewer] have a certain status and position that brings you a certain currency with people. If you're homeless you don't have much of that and also your self-confidence is pretty poor."***
>
> (Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues)

> ***"You have somebody who is homeless who has been rejected by their family, rejected basically by society, are being pushed from pillar to post, they go to a service they then get the service saying "you missed an appointment that's really bad", it's another form of rejection which will make them withdraw from the service because their self-confidence is so low. They are very very sensitive to criticism because it's another rejection."***
>
> (Stakeholder interviewee - Role in providing policy/strategy/direction in relation to homeless issues)

5.7 Fear and denial

Fear and denial was highlighted in the literature as a common barrier to accessing health care.[73] People who are homeless may be reluctant to seek health care because of a fear of being stigmatised or because their own health is not their priority.[74,75] They may also be unwilling to acknowledge mental health issues and are therefore reluctant to seek assistance.[70] Stakeholders agreed with this and believed that often people who are homeless have so many other issues going on in their life that their health is not a priority. Often they will not seek assistance until their health is critical.

> ***"We have clients at the minute that are actually drinking themselves to death and will refuse to go in an ambulance even with ambulance staff standing over them and saying "you are drinking yourself to death" and the GP telling them they are going to die if they keep drinking. It may be to do with their dependence on alcohol and the worry that they can't drink in hospital and that is all that is important to them."***
>
> (Stakeholder interviewee – Working directly with homeless)

Some individuals with serious addictions which are making their health much worse can lose focus on their health and therefore disregard healthcare.[76] Homeless drug users may be reluctant to approach professionals because they are afraid of arrest or anxious about children being taken into care.[72]
A research study reported that unwillingness of the homeless population to engage with services was a barrier.[6] This was reiterated by some stakeholders who work directly with the homeless population reporting that they choose not to want healthcare and choose not to go into that 'formal' and 'sterile' setting.

"I have seen rough sleepers who are walking around and don't want to go to hospital, they can be walking around with the most horrendous illnesses, wounds and injuries and they don't want to go to hospital."

(Stakeholder interviewee – Working directly with homeless)

Stakeholders felt the reason for people who are homeless not wanting to go to hospital could be due to the fact they would be "different" to everyone else on the ward. Others on the ward would have friends and family coming to visit them every night and they would have no-one. Alternatively, they may have an addiction problem and they know that if they go into hospital they won't be able to satisfy their addiction needs.

"You lie there and you don't even have a bottle of juice or a handkerchief, do you want to stay there because everybody comes in at night and they are staring at you and looking at you and they are bringing stuff to their relatives and you're on your own completely. So they want out of there as quickly as possible. Now sometimes they want out of there as quickly as possible because addiction calls but sometimes they just want out of there as quickly as possible because they are just different on the ward."

(Stakeholder interviewee – Working directly with homeless)

Young people who have been in care during childhood and adolescence often have adverse experiences of these services which make them unwilling to use statutory and non-statutory services once homeless.[76]

5.8 Learning disabilities

A number of stakeholders raised the issue of learning disabilities and access to services after the age of 18.

It was highlighted that young people are often diagnosed as having a learning disability however, in the transition period to adulthood, reference to their 'learning disability' often changes to 'learning difficulty'. The consequences of this change in reference from 'disability' to 'difficulty' often means the level of support they receive is reduced compared to what they received in adolescence when they were diagnosed as having a learning disability. This transition period can cause difficulties for people who are homeless in particular as they may lose some of the support they had.

"There's not the same statutory responsibility and support for learning difficulties."

(Stakeholder Interviewee – Role in providing policy/strategy/direction in relation to homeless issues)

"In terms of supporting and managing those young people's needs in supported style living, the transition between child, adolescent and then adult services is an issue."

(Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues)

"They were maybe in children's learning disability services as well and once they turn 18 they're not [in that service any longer]. We've had some horrendous situations where people have been assessed at a certain level and all of a sudden when they turn 18 their IQ or whatever system they use, they go up and they are no longer available for services."

(Stakeholder interviewee – Working directly with homeless)

A similar issue was raised with individuals who are going through the criminal justice system who have learning disabilities. One stakeholder stated that learning disability services are reluctant to engage with those who are in hostels as this is seen as temporary.

Another stakeholder stated that the majority of the individuals with learning difficulties would not need intensive specialist supported accommodation. However, many can't read or write, budget their money, they have no family support and self-care is poor and often they have alcohol issues and criminal behaviour. Taking all these factors into consideration means, generally, they cannot sustain a tenancy and as a result keep returning to homelessness.

5.9 Dual diagnosis & need for coordinated care

Stakeholders reported that often being homeless can mean an individual may have a mental health illness and an addiction at the same time i.e. a dual diagnosis. Homelessness may also mean there is a higher chance that you will be unable to access the services you need.[4]

People who are homeless need coordinated help from different aspects of the health and social care system. For example, GPs, hospitals, hostels, drug and alcohol detoxification programmes, psychiatric help, social services and dentists. Numerous studies have highlighted a lack of coordination and consistency between services as being a barrier to overall quality of service provision.[6,42,63,78]

As a result of their dual diagnosis people who are homeless need access to a number of different services and with the many issues that are going on in their lives, they may not turn up for appointments, or if they do turn up, they might not engage with the service.

"I think if someone has an addiction, the mental health services find it hard to deal with as they are not turning up for appointments because they have an addiction. If they do, they're not engaging because they are under the influence of something."

(Stakeholder interviewee – Working directly with homeless)

> ***"I have a guy at the minute who badly needs to see orthopaedics and he just can't keep his appointments, so it's a big thing to have somebody who will help them."***
>
> (Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues)

A number of stakeholders highlighted that dual diagnosis causes difficulty in accessing services as it is often hard to know which problem should be treated first. For example, it can be difficult to distinguish whether the mental health issue is caused by the addiction or if the addiction is caused by the mental health issue.

> ***"If someone has a drug and mental health problem which do you work on first? That's where you find people fall between services or don't engage in services."***
>
> (Stakeholder interviewee – Working directly with homeless)

It has been reported that one of the greatest problems for homelessness is that no single organisation has a statutory responsibility to ensure that vulnerable homeless people are served, or seek out those who do not present as homeless. The transient nature of this population also makes it difficult to determine which geographical area has responsibility for their care. This means that this group fall between housing and health and social services and as a result have a wide range of unmet needs.[11]

5.10 Lack of long-term care provision

The literature and some of the stakeholders reported a lack of long term nursing care and end of life care for the homeless population. There is a need for better provision of nursing care services for those with addiction problems as nursing homes are not suitable. Those who have been in hospital for a period of time and have detoxed, are likely to return to their old habits if they go back to the environment they came from. However, if they were moved to accommodation where they could recover and detox fully they may have a better chance of making a full recovery.

> ***"If you're in hospital for four weeks and fully detoxed and then discharged out into the same scenario as there is often nowhere to put younger people. Where do you put a 23, 28, 35 year old in the end of a nursing home? That's not suitable and they aren't going to stay there."***
>
> (Stakeholder interviewee – Working directly with homeless)

"There are a cohort of elderly people very often with early onset of dementia or dementia caused by alcoholism or substance misuse problems who really need to have permanent accommodation but nursing homes are not right for them because they are still drinking."

(Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues)

Research shows that having appropriate discharge arrangements in place is an important factor in effective service delivery for homeless people.[76] Furthermore, improved support following discharge, flexible delivery models and improved staff training would also improve health services for homeless people.[13]

Case study B: Service user who was discharged from hospital with nowhere to go.

Client B was an 83 year old gentleman who had an alcohol problem. He was brought into hospital with a minor stroke and was rehabilitated. Hospital workers discovered he was homeless and contacted a homeless support worker to do an assessment. The homeless support worker asked the social worker on the Monday not to discharge him until a place in a hostel or a fold could be secured for him. On the Tuesday the gentleman arrived down at the Housing Executive having been discharged from the hospital with nowhere to go. Due to this man's age and because of his vulnerability the hostel took him in right away however there is usually a referral process. When questioned as to why the man was discharged with nowhere to go, the hospital social worker said 'he was medically fit for discharge and we needed the bed'.

There is also a need for a facility which provides permanent housing with nursing care for this particular group, to provide somewhere for them to stay for the remainder of their lives. Deloitte[53] stated that end of life care is a particular issue for homeless people due to their lack of settled home and the poor social network available to support them. Access to specialist palliative care units is especially poor for the homeless.[79]

"For us there is a need for palliative care patients. We have lots of clients who would have reached that palliative care stage and many of those are being looked after in hostels especially our wet hostel."

(Stakeholder interviewee – Working directly with homeless)

6.0 Context of work in Northern Ireland

This chapter provides an overview of some of the work which is conducted in Northern Ireland around homelessness. The focus is on current policy and work which is being carried out in Northern Ireland to help homeless people have better access to health and social care services. The following areas are covered within this chapter:

- Community and voluntary sector activity;
- Northern Ireland Housing Executive Homelessness Strategy for Northern Ireland (2012 – 2017);
- ECHO (Enhancing Healthcare for the Homeless) steering group;
- Homeless Public Health Nursing Service, Belfast Health and Social Care Trust;
- Regional working group on health and homelessness; and
- Areas for improvement.

The evidence to support this chapter was taken from strategy and policy documents and stakeholder interviews.

6.1 Community and voluntary sector activity

As part of this study we talked to a number of community and voluntary organisations and based on these discussions it was very clear that they play a critical role in providing vital services to people who are homeless. These organisations work directly with the homeless population and provide a wide range of services on a daily basis to meet their needs. Some examples of the support and services they provide include: accommodation, drop-in centres, drug/alcohol misuse advice and support, general advice and information, helplines and counselling.

The services provided may not all be directly related to accessing care, but are often based around providing people who are homeless with the practical support they need which is extremely important for this population.

> ***"There are a lot of people who have been homeless for a long time and have lost family ties and have no community links. They are very isolated and need a lot of support around them. We have a floating support team but a lot of it is around practical support not emotional support."***
>
> (Stakeholder interviewee – Working directly with homeless)

Community and voluntary groups have a significant role in the delivery of services and support to the homeless population. Stakeholders reported the importance of statutory, community and voluntary groups working together to complement each other and provide services. When these different organisations work together they can share their knowledge to better support those who require access to services.

> ***"There is an openness to talk to staff and there is a dependency on the voluntary sector to do that as opposed to the public sector. The voluntary and community sector have broken down those barriers rather than the public sector saying that homelessness and health is an issue that needs to be talked about."***
>
> (Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues)

The following sections within this chapter outline some of the key health and social care initiatives which are in place across Northern Ireland specifically in relation to improving access to health and social care services for the homeless population. This should not be considered as a comprehensive list but provides an overview of the initiatives which were discussed within the limits of this scoping exercise.

6.2 NIHE Homelessness Strategy for Northern Ireland (2012-2017)

The key organisations with regard to the policy and strategy for homelessness are the Northern Ireland Housing Executive which is sponsored by The Department for Social Development (DSD) who also work closely with the Housing Executive in directing social housing policy in Northern Ireland.

The Northern Ireland Housing Executive Homeless Strategy for Northern Ireland (2012-2017)[16] was published in April 2012 following The Housing (Amendment) Act (Northern Ireland) 2010 placing a duty on the Housing Executive to formulate and publish a homelessness strategy.

The 2012-2017 strategy expands on the first homelessness strategy for Northern Ireland which was published in 2002 and highlights numerous reasons for homelessness such as family dispute, breakdown in living arrangements, addiction, mental ill health, debt and tenancy breakdown. It set outs the strategy for tackling homelessness between 2012 and 2017 and establishes guiding principles for the development and the delivery of services for people who are homeless. The aim is to eliminate long term homelessness and rough sleeping by 2020. The strategy aims to ensure the risk of a person becoming homeless will be minimised through effective preventative measures and ensures through enhanced inter-agency cooperation, services to the most vulnerable homeless households will be improved. The strategy has four strategic objectives as shown in **Figure 6.1** below:

Figure 6.1: Strategic objectives of the Homelessness Strategy

The fourth strategic objective focuses on improving services to vulnerable homeless households and individuals. These services are not specifically health related but provide more of a social aspect of care. Targeted services include services in response to domestic violence, sexual and violent offenders, women offenders, migrant workers/persons from abroad, rural and youth homelessness.

The Strategy acknowledges that *"homelessness impacts on individual lives for years and this influence goes beyond the immediate lack of accommodation, impeding the individual's health, financial and social well-being."* It also acknowledges that tackling homelessness will require the collaboration of a wide range of organisations from the statutory, voluntary and community sectors. These organisations need to work together to deliver housing, employment, health, financial support and welfare services to those who experience homelessness.

6.3 Enhancing Healthcare for the Homeless (ECHO) steering group

One initiative which demonstrates statutory, community and voluntary organisations working well together is the Enhancing Healthcare for the Homeless (ECHO) steering group which was developed in 2010 in the Northern Health and Social Care Trust area after it was highlighted by hostel staff in the area that there was a need for better access to GP services for homeless people.

> ***"Communication between social services, GPs and services working with the homeless needs to be improved and more consistent."***
>
> (Hostel staff – taken from ECHO documentation)

> ***"Referral pathways to be made clearer and easier for residents."***
>
> (Hostel staff – taken from ECHO documentation)

The group meets as required and is chaired by a GP and the vice chair is a Hostel Manager. ECHO was developed by a group of local voluntary, community and statutory groups in the Northern HSC Trust area to work alongside relevant organisations to improve the health and social wellbeing of people who are affected by homelessness. The organisations represented on the group are shown in **Figure 6.2** below.

Figure 6.2: Organisations represented on the ECHO steering group

ECHO has taken their first steps to improving access to Health and Social Care services for homeless people in Ballymena. The key aims of the ECHO group are to:

- develop a regional strategy for people affected by homelessness;
- provide a local focus on health and social care issues concerning people affected by homelessness;
- advocate on behalf of people affected by homelessness to improve access to HSC Services;
- provide advice, information and signposting to statutory/ voluntary organisations and community groups on HSC issues and current services;
- identify gaps in HSC services/provision and advocate to have these gaps addressed; and
- monitor current HSC services and work with relevant organisations to improve the health and social wellbeing of people who are affected by homelessness.

As part of their strategy the ECHO group introduced a GP registration referral pilot with the majority of the GP practices and the Lighthouse Hostel in Ballymena with the aim of monitoring and improving access to general health care. The pilot commenced in November 2012 and aimed to prepare and support homeless people to access health care provision in GP practices.

The pilot was initially planned to finish in March 2013 however it has now been extended until 31st March 2015 when an evaluation will be carried out.

As part of the pilot a checklist was provided to hostels and GP practices in the area. The checklists for reception staff in GP practices outlined what to do if someone turned up who was staying in temporary accommodation or had no fixed address. The document pointed them to actions such as completing GP registration forms, acquiring medical cards and obtaining past medical history.

The checklist for hostel staff outlined the documentation which a GP practice would request in order to register a new patient and what information the individual would need to take with them when registering. It was hoped this process would allow a smoother referral and better joint working practices for the GPs, homeless individuals and their support workers.

The majority of GP practices in the Ballymena area are taking part in the pilot and have been placed on a rolling rota which means a different GP practice accepts patients from the various hostels in the area each week. At the outset the pilot was conducted with the Lighthouse Hostel only, however as the pilot has progressed it has now been rolled out to all three hostels in the Ballymena area.

An evaluation of the pilot is currently being conducted with primary care practice staff and hostel staff. Initial findings are very positive based on 11 evaluation forms which were completed by hostel staff. **Figure 6.3** overleaf provides some of the benefits of the pilot which were highlighted.

Figure 6.3: Benefits of the ECHO GP referral scheme pilot as reported by Hostel staff

The key to the success of the ECHO programme has been developing strong links and partnerships with a wide range of statutory agencies, voluntary organisations, community groups and private sector organisations. It is hoped that these links and partnerships will help promote better awareness of the health and social care services available to people affected by homelessness and will result in increased uptake of those services.

6.4 Homeless Public Health Nursing Service

The Homeless Public Health Nursing Service is a service provided by the Belfast Health and Social Care Trust. As a result of an increase in the number of homeless people presenting to the local community nursing service for crisis health care intervention, a three year project was carried out to research the needs of this population. The Homeless Public Health Nursing Service was implemented in 1999 as an outcome of the research.

Single Homeless Health Care is a dedicated advanced nurse led initiative which operates with an

identified group of single homeless people within the Belfast Health and Social Care Trust. The service has expanded since 1999 from 4 temporary hostel accommodations in North Belfast to 23 homeless facilities across the Belfast Trust Area, including night crash facilities and a day centre for those who street sleep or who may be at risk of losing their own accommodation. The aims of the service are shown in **Figure 6.4**.

Figure 6.4: The aims of Homeless Public Health Nursing Service

The service offers "door step" delivery of health care through one to one open access clinic sessions. These clinics are held on a weekly basis within the hostel setting and assistance with GP/Dental registration is offered. The health care coordinator, also a qualified nurse practitioner is able to conduct physical examinations and differential diagnosis. Her role as an independent and supplementary prescriber ensures timely access to treatment and medication for the homeless group.

Prescribing appropriate and timely medication has allowed treatment at the point of access especially for acute infections, skin conditions, infestation problems, sexually transmitted infections, wound care and pain relief. The service has also prevented avoidable use of hospital and emergency services. The uptake of the services is a clear indication of success. Some 300 people access specialist screening services each month, 800 homeless clients attended for podiatry over a one year period and 500 clients had dental health screening over a one year period. Health promotion programmes are also run to help prepare some of the clients to integrate back into the community. Training is also provided for hostel staff in areas of infection control.

The success of the service has been attributed to the good example of coordinated care, resulting in benefits to people who are homeless.

Presently this is the only service in Northern Ireland dedicated primarily to meeting the physical needs of this population and has been recognised as a model of good practice by a range of organisations. The service has received excellence awards both at home and in the UK.

Research has acknowledged the importance of the nurse practitioner in addressing the healthcare needs of the homeless and reported that homeless patients who use nurse practitioners have been shown to use A&E less, have shorter hospital stays and spend less on medication.[80]

6.5 Regional Working Group on Health and Homelessness

A key goal for the Public Health Agency (PHA) is to promote and protect the health of the population, secure high quality Health and Social Care (HSC) services and in particular to reduce health inequalities.

The PHA have highlighted that the needs of homeless people present as a clear priority and one which requires an integrated and interagency approach.[81] As a result a Regional Working Group on Health and Homelessness was set up in 2012 to tackle this issue. The group membership includes members from the PHA, HSC Board, HSC Trusts, Integrated Care, Department for Social Development (DSD), Northern Ireland Housing Executive, and community and voluntary organisations.

Through the regional working group the PHA, along with the above mentioned organisations, is contributing to the implementation of The Homelessness Strategy for Northern Ireland (2012-2017).

The working group, as part of their terms of reference, will specifically focus on "determining the health needs of those individuals and families who present as homeless in Northern Ireland and identify appropriate strategies for intervening to address them, including improving access to HSC and new service delivery models."

They also aim to promote and protect the health of those individuals and families who present as homeless by securing and improving access to high quality evidence based HSC services and other interagency action in order to reduce health inequalities.

A small sub group of the Regional Working Group has been set up to look at care pathways for homeless people in relation to the continuum of health needs of people who are homeless. The group will look at good practice in other areas and examine what can be done in Northern Ireland.

The Northern Ireland Housing Executive (NIHE) is also developing a common assessment tool which will collect information about an individual, this information will be added onto a central system. When an individual presents at different services their information will already be available however, not all information will be available to everyone, keeping certain information about individuals private. This tool helps avoid different people asking the same questions over again and individuals not having to divulge personal information to everyone they come into contact with. This tool will be used with people who present as homeless and will also link with the work the Regional Working Group is doing regarding care pathways.

The PHA Regional Working Group on Health and Homelessness also shares the vision of the NIHE Homelessness Strategy for NI, regarding the need for organisations to work together to deliver all aspects of services for those who are homeless.

6.6 Areas for improvement

The stakeholders who were consulted as part of the research for this report were asked to provide suggestions on how the homeless population could be further supported and who should be responsible for moving things forward. The key areas which were suggested are outlined in **Figure 6.5** and further information on each is provided in the paragraphs which follow.

Figure 6.5: Stakeholder suggestions on how to improve access to services for people who are homeless

6.6.1 Education and awareness of professionals

Many of the stakeholders felt there needed to be more awareness amongst professionals in the NHS about homelessness. They reported a need for professionals to be educated about who can become homeless, what homelessness means, challenge the stereotype but also impress on them what the more stereotypical homeless person needs in terms of identification of risk.

It was suggested that GPs in particular should be made aware of the risk factors of becoming homeless and be able to identify those who are at risk of becoming homeless in the future. They should then be able to provide advice and support before the individual becomes homeless. Only when professionals are aware of the issues surrounding homelessness can they begin to understand the needs of service users.

> ***"Many of the GPs in primary care don't know what services are out there and they don't know how to join up the dots."***
>
> (Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues)

> ***"As a GP I would have had very little awareness about homelessness because by default they have difficulty getting to us. I think there is education needed for GPs."***
>
> (Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues)

"Increased awareness and raising the bar of education around homelessness as a societal issue and done in a way where it challenges professionals' thoughts on homelessness. There is a massive amount of that being done with young people, school kids, but we need to educate the professionals."

(Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues)

"We really need to be raising awareness among GPs. They need to know what the risk factors are if somebody comes to them with severe depression or they just can't get out and pay the bills. They should be recognising the possibility that they could be homeless and then directing them to floating support services or whatever they need to help them maintain their home. That kind of work needs to go on and it doesn't."

(Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues)

6.6.2 Collaboration

The majority of stakeholders reported that there needs to be a joined up approach to providing access to services for the homeless population. There needs to be collaboration between statutory, community and voluntary organisations, and they need to work together to provide services. Working together and having networks in the community will raise awareness of services available therefore organisations will be more aware of where to send people when they need help rather than passing individuals from one service to another.

"It's about building networks with people, not having unrealistic expectations and not referring people who don't actually need a service. We work with individuals to work out what their prevalent needs are rather than sending them to five different agencies."

(Stakeholder interviewee – Working directly with homeless)

"I would love to see a much more coordinated service in the community."

(Stakeholder Interviewee – Role in providing policy/strategy/direction in relation to homeless issues)

> ***"There are too many silos and although we say we sometimes work together, we work together in crisis but we don't work together to meet needs. What is really required is a centre of excellence for homeless people and under that hood of centre of excellence there should be social work, mental health, podiatry, dental, ophthalmology, physical healthcare needs, screening, vaccinations and sexual health screening."***
>
> (Stakeholder interviewee – Working directly with homeless)

> ***"I think really it's joined up working across all the agencies. I don't think anyone can do it on their own because there are such complex needs that it needs us all around a table...there needs to be more joined up working."***
>
> (Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues)

A few stakeholders suggested that there needs to be an individual employed in each of the Trusts who could advocate for the homeless population and work with other organisations (statutory, community and voluntary), to lobby and signpost to services. The advocate could help organisations who are having issues getting access to services for a person who is homeless, and provide them with information and advice on services which are available for individuals who need specific services.

> ***"One of the key things that each Trust should have is a homeless coordinator who actually coordinates work between the community, voluntary and statutory sector so that that person can feed in and have an advocacy role to join up the dots."***
>
> (Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues)

6.6.3 Quicker access to services

Timely access to mental health services was raised as an issue by stakeholders and some suggested a fast track service to allow those who are homeless to access these services quicker. Hostel staff would like to be able to refer these individuals directly to services without having to wait long periods of time, which can cause problems for some people who are homeless.

> ***"We have all had training and can near enough assess what we think the mental health condition might be. They might have to wait 9-12 weeks before they get a proper assessment and within that time if they are not medicated correctly their behaviour may lead to them no longer being in our service, so they are starting off the whole process again."***
>
> (Stakeholder interviewee – Working directly with homeless)

6.6.4 Access to services in the community

Some stakeholders felt that providing services in the community would give people who are homeless better access to services. They also felt that taking services to the client would also work better for this particular group of people. This would fit in with "Transforming Your Care" which aims to provide more services in the community setting.

> ***"Having services in different places rather than having one central point where everybody has to come out to an appointment in three weeks' time."***
>
> (Stakeholder interviewee – Working directly with homeless)

> ***"Services need to be provided where the homeless people are. Mental health services in particular, the problem is accessing them and when you do access them, the problem is getting someone to respond and come out when you need them, lots of our client group actually end up detained."***
>
> (Stakeholder interviewee – Working directly with homeless)

> ***"The delivery of more services in the community that are targeted towards homeless people because it's more cost effective, you meet a vast quantity of people."***
>
> (Stakeholder interviewee - Role in providing policy/strategy/direction in relation to homeless issues)

6.6.5 Who should be responsible for making changes to support this group?

Stakeholders were agreed that everyone has a role in taking control and making changes to help this group of individuals. However, they also agreed that responsibility for making changes lies with those with authority in the Department of Health, Social Services and Public Safety (DHSSPS), the Northern Ireland Housing Executive (NIHE) and the Department for Social Development (DSD). It needs to be the decision makers and those who can do something about it, who take responsibility.

> ***"From a health point of view, it has to come from those in authority that have clout, there is no point in us saying this is what we need, those in authority have to know what we need."***
>
> (Stakeholder interviewee – Role in providing policy/strategy/direction in relation to homeless issues)

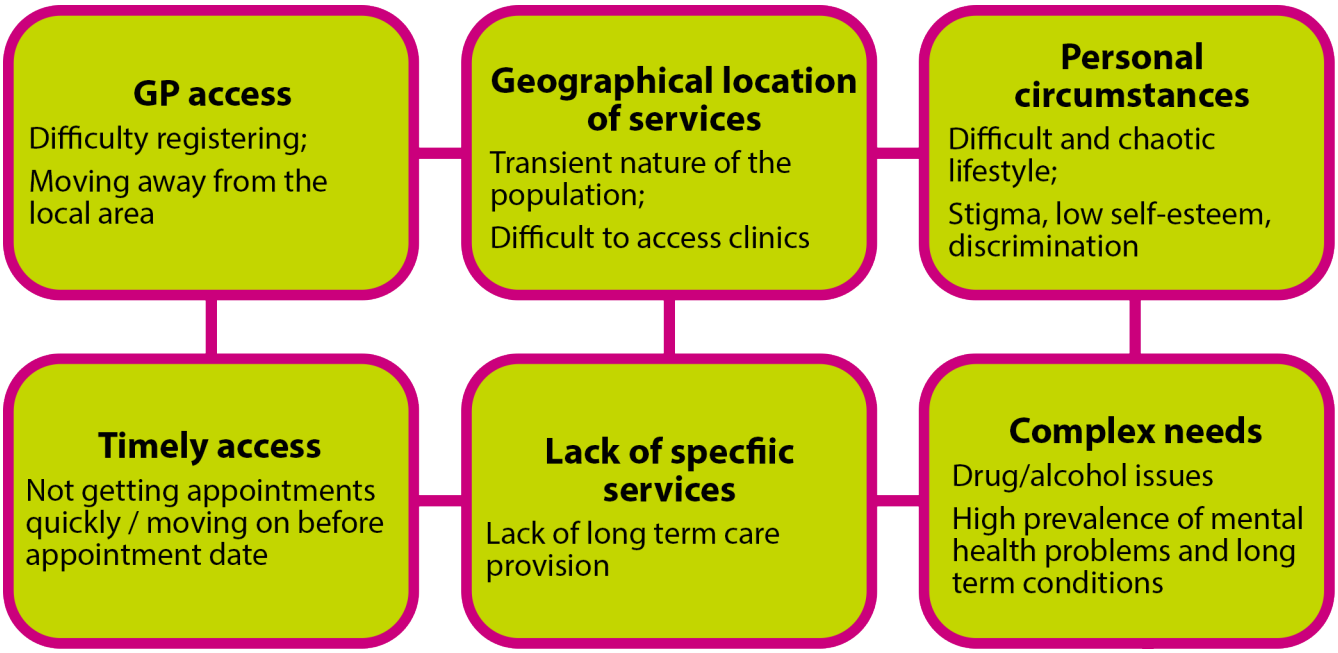
7.0 Conclusion and next steps

This report outlines the challenges of meeting the health and social care needs of people who are homeless. Providing services to people who are homeless is complex. There is evidence of some good examples of groups and organisations working to ensure that the health and social care needs of homeless people are addressed. However access to health and social care services for people who are homeless is problematic due to a lack of information about available services and issues with how these services are coordinated to best meet particular individual needs. In addition there is no one definition of homeless which further complicates service delivery.

7.1 Highlighting the issues emerging from this report

A review of key literature and discussions with stakeholders within this project highlights that there has been considerable work undertaken to understand the needs of homeless people. This includes studies which seek to establish the barriers faced by people who are homeless when trying to access health and social care services. However, in Northern Ireland it is clear that people who are homeless face more barriers when accessing health and social care services than the housed population. As a consequence, combined with the complex needs which some homeless people have, the implications for the health and wellbeing of people living without their own home can be severe.

Figure 7.1: Identified and inter-related issues contributing to poor access for homeless people to health and social care services in Northern Ireland



Part of the solution to resolve issues relating to access may lie in further promotion and highlighting of the issues found in this report. For instance, awareness that not having a permanent address need not be a barrier to successfully registering with a GP practice is not widely known by all Health and Social Care professionals nor all people who find themselves without a home. Equally, an understanding of the unique and often challenging circumstances which people who are homeless find themselves in may contribute to change in how future services can best be delivered for vulnerable groups.

In taking this work forward, the Patient and Client Council will seek to raise awareness of the issues highlighted within this report. We will do so whilst acknowledging the expertise which exists across the statutory and community and voluntary sectors who work specifically with people who are homeless in order to improve lives and contribute to better health and wellbeing. It will also be important that the PCC engages with people who are or have experience of being homeless to understand directly what they feel needs to change for them.

It is recommended specifically that a conference or workshop, bringing together experts and people with direct experience of being homeless would represent a timely and appropriate response to the issues raised within this report. The Patient and Client Council will work to ensure that this takes place with key aims of raising awareness of issues relating to access to health and social care services for homeless people, promoting good practice and highlighting examples of work already being undertaken across Northern Ireland which are helping people without a home to access the services they need.

Appendix 1 - References

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Appendix 2 - Acronyms and abbreviations used

- **A&E** – Accident and Emergency
- **DHSSPS** – Department of Health, Social Services and Public Safety
- **DSD** – Department for Social Development
- **HSC** – Health and Social Care
- **NI** – Northern Ireland
- **NIHE** – Northern Ireland Housing Executive
- **PCC** – The Patient and Client Council
- **PHA** – Public Health Agency
- **STD** – Sexually Transmitted Disease

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