Health and homelessness in North Lanarkshire
A rapid health needs assessment
FINAL DRAFT (23rd Feb 2016)

Executive Summary

A secure and safe home is one of the key foundations upon which health and wellbeing is built[1]. Security of housing must therefore be seen as a core outcome for meeting the health and social care needs of individuals and communities.

Homeless people are a key vulnerable group and experience health inequalities with higher morbidity and mortality than the rest of the population. Tackling and preventing homelessness will therefore contribute to reducing health inequalities.

A rapid Homelessness Health Needs Assessment (HNA) was undertaken to assess the health needs of the homeless population across North Lanarkshire utilising 2014/15 service data available through North Lanarkshire Council Housing Department and NHS Lanarkshire and by linking client data from homelessness (HL1) applications with NHS service usage data and comparing this cohort (referred to throughout the report as the HL1 cohort) with the wider North Lanarkshire (NL) adult population.

Key findings

- A total of 1957 people made a homeless application to North Lanarkshire Council in 2014/15. Single people represent the largest group with one parent families the next largest cohort and one third involve children and young people.

- Younger adults under 25 are disproportionately affected by homelessness.

- Almost half of all homeless applicants identify they have support needs, of which 23% have multiple needs. A small number of clients with multiple and complex needs can have difficulty sustaining accommodation

- The HL1 cohort was five times more likely to have attended A&E three times or more in the preceding year than those in the NL population.

- The HL1 cohort was 20 times more likely to have presented at A&E due to self harming than those in the NL population.

- Multiple emergency admissions were three times more frequent for those in the HL1 cohort compared to the NL population

- Those in the HL1 cohort had emergency admissions for alcohol seven times more frequently, 18 times more frequently for drugs and 23 times more frequently for self harm, than the NL population.

- The rate of psychiatric admissions was tenfold higher for the HL1 cohort when compared to the NL population.

- The percentage of new outpatient appointments not attended was three times higher for the HL1 cohort compared to the NL population.

- Young women under 20 were five times more likely to give birth than those in the same age group in the NL population.

The findings of the HNA show that people experiencing homelessness are a key vulnerable group and homelessness is often the end product of a long period of severe health and social inequality. The data demonstrates the significantly poorer health burden experienced by this vulnerable population, particularly in relation to mental health and substance misuse.

The needs assessment findings also suggest there are significant barriers to accessing services for people who are homeless both in terms of how services are delivered and also the perceived negative attitudes of staff towards this client group.

Drawing on the findings of the HNA the following **recommendations** are made:

- The stark physical and mental health inequalities experienced by many people who present as homeless are unacceptable. Through Community Planning and the integration of Health and Social Care priority should be given to upstream approaches which tackle wider life circumstances and to better support those with mental health and substance misuse issues as early as possible in order to reduce these health inequalities and reduce the number of people presenting as homeless.

- A Health and Homelessness multiagency outcome focused action plan should be developed and implemented with accountability to North Lanarkshire Partnership. The data gathered for this HNA provides a baseline for measuring progress and relevant indicators should be incorporated in to the Health and Social Care Joint Strategic Needs Assessment dataset to allow progress to be measured over time. A more proactive multi agency approach has the potential to not only improve outcomes for individuals and families but also improve service efficiency and effectiveness.

- All health and social care assessments should include questions on housing provision and financial security in order to ensure basic needs are being met and to identify and mitigate any risks to future security. Community based staff should be trained to identify signs that clients are at risk of losing their accommodation.

- For those experiencing homelessness there is a need for better joined up multi agency working with all services taking responsibility to support this vulnerable client group, particularly at transitional points and as early as possible in the process. Housing currently appears to have sole responsibility.

- Better data sharing and tagging of records between agencies may help facilitate an more integrated approach and there is also a need to consider the health needs of all members of a couple or family presenting as homeless.

- For clients with more complex needs, input from all services need to be sustained over time. The potential for an intensive case management support model, such as Housing First, could be considered for the small cohort of clients who have high needs and have difficulty maintaining a tenancy.

- All services providing care and support should be more responsive and flexible to the particular needs of people experiencing homelessness. Workforce development focusing on attitudes and values using rights based approaches and the emerging evidence around psychologically informed services should be considered to improve service response. Consideration should also be given to how those who disengage with services can be better supported through proactive engagement, review and distress/crisis management planning.

- The provision of 24 hour emergency care for people who are homeless should be reviewed with particular consideration given to improving access to primary care emergency services. Further analysis should also be undertaken to identify those who are accessing emergency services most in order to look at how these clients can be better supported.

- The high incidence of self harm within the younger homeless population should be explored and plans put in place to better identify clients at risk of self harm earlier and to reduce repeated self harming behaviour, supported through the *Improving Responses to Distress in Lanarkshire Working Group.*

- There is a need to review support around mental health and substance misuse for those that are homeless and living in temporary or supported accommodation with a view to intervening as early as possible in the client journey and ensuring out of hours access to support is available.

- Extension of the Joint Strategic Needs Assessment (JSNA) programme to other data sets should be considered to allow the outcomes of referrals from the Health and Homelessness team to other services (e.g. mental health and substance misuse services) to be reported in order to review client outcomes and further areas for improvement. Uptake of preventative services such as screening by people experiencing homelessness should also be reviewed.

- The JSNA programme should also be extended to consider the financial costs associated with the current health and social care response for this client group and the benefits that could be realised through earlier intervention approaches.

- Children within families who are homeless are a particularly vulnerable group. Whilst no data relating to children was included in this review given the vulnerability of this group it would be useful to consider what data is available and to audit the pathways in place between Housing and Health in order to identify any areas for improvement.

- Given the variance in referrals to the Health and Homelessness team across localities there should be further exploration to determine why some areas are less likely to refer and actions taken to improve referrals from these areas.

- The issues of clients moving locality to access temporary accommodation need to be reviewed in terms of the potentially detrimental impact of relocation on clients and their families and to ensure continued access to primary care services.

- Young pregnant women who present as homeless appear to be a key vulnerable group within the homeless population and further work may be required to better support these clients during pregnancy.

- It was not possible to include the views of service users in this assessment however opportunities for consulting with users should be built in to future service reviews and planning processes in order to ensure service developments meet needs.

Introduction

Health inequalities, and inequalities in general, are a key priority for the Scottish Government, local authorities, the NHS and Community Planning Partnerships (CPP). The need for upstream preventative approaches at societal, community and individual level are well documented to both reduce deep rooted inequalities within society and also to reduce demand on public services.[2]

The recent Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities undertaken by Health Scotland[3] suggests actions that are more likely to be effective in mitigating the effects of health inequalities at an individual level requires targeting those most vulnerable and with greatest needs with intensive tailored support (proportionate universalism).

Homeless people are a key vulnerable group and experience health inequalities with higher morbidity and mortality than the rest of the population. Tackling and preventing homelessness will therefore contribute to reducing health inequalities.

The NHS and community planning partners have a key role in improving the health and wellbeing of homeless people and in preventing homelessness.

The North Lanarkshire Partnership (NLP) Health and Wellbeing group have identified homelessness as a key priority to be addressed by the partnership and a short life working group has been formed to take this forward.

The aim of this rapid Homelessness Health Needs Assessment is to undertake an assessment of the health needs of the homeless population across Lanarkshire utilising existing data sources. The outcomes from this assessment will be used to make recommendations for consideration by the NLP Health and Wellbeing Group.

Following consideration of available intelligence, information is presented under the following headings:

1. Review of health and homelessness literature and policy
2. Profile of people who are homeless in North Lanarkshire
3. Service provision for people who are homeless in North Lanarkshire
4. Local service data on the health needs of people who are homeless
5. Qualitative research with key stakeholders
6. North Lanarkshire Council homeless applications and NHS Information Services Division data linking exercise.

1.0   Review of health and homelessness literature and policy

Maslow's well known hierarchy of needs theory states that shelter is one of our most basic needs and that only when basic physiological and safety needs are met can needs related to wellbeing such as respect, self esteem, a sense of belonging and personal growth be focused upon.[1] Safe and secure housing must therefore be seen as a core outcome for meeting the health and social care needs of individuals and communities.

People experiencing homelessness form one of the most vulnerable populations in society. The homeless population is not a homogenous group and people experiencing homelessness do so for a variety of complex reasons. Some people will experience homelessness only once, (crisis homelessness), whilst others will experience homelessness repeatedly (chronic homelessness). In between these categories are those who experience intermittent homelessness which refers to people who move in and out of homelessness over time and can be common with families who experience homelessness. Homeless can also be hidden such as those who stay temporarily with friends or family, often known as sofa surfing. The most challenging group to gather information on are people who are homeless and living on the street. A useful summary of trends in homelessness is provided by the Homelessness Monitor series[5] which reports on a longitudinal 5 year independent analysis of the impact of economic and policy developments on homelessness.

NHS Health Scotland and ScotPHN have recently (May 2015) published the report *Restoring the Public Health response to Homelessness in Scotland* [6]. As part of this work, a literature review was completed and relevant studies are referenced throughout the report. The reader is directed to these and to the ScotPHN report[6]. This chapter of the needs assessment aims only to summarise the current situation nationally, highlight some of the key issues including key policy issues and reiterate a number of recommendations available in the literature that are relevant to the health needs of homeless people in Lanarkshire.

1.1   Homelessness in Scotland

In the last financial year, there were 35,764 applications to local authorities under the Homeless Persons legislation in Scotland. This was 1,470 (4%) lower than the number of applications received in the same period in 2013-14. The majority of households applying to local authorities were single-person households (66%) of which most were men. Single parents, predominantly women, accounted for the next largest group at twenty-one per cent. Twenty-eight per cent of applications included children. Approximately 10,500 households were placed in temporary accommodation; a two per cent increase from the previous year: 2662 of these involved children, an increase of seven per cent on the previous year[7].

In November 2012 the Scottish Parliament approved the Homelessness (Abolition of Priority Need Test) (Scotland) Order 2012. This ensures that from 31st December 2012 onwards, local authorities no longer apply the priority need test to homeless households. As a result all unintentionally homeless households in Scotland are entitled to settled accommodation[7].

The Housing Support Services (Homelessness) (Scotland) Regulations 2012 came into force on 1st June 2013. These regulations place a duty on local authorities to assess the need for housing support services for any applicant the local authority has reason to believe may be in need of housing support services and who is unintentionally homeless or threatened with homelessness. Local authorities are expected to view housing needs more holistically to try

and prevent crisis homelessness presentations. If an assessment of a need for support is made, local authorities must ensure that a service is provided to the person who needs it. This is one of the key policies to address homelessness nationally and is called Housing Options. The latest Housing Options (PREVENT1) statistics, covering the full financial year of 1st April 2014 to 31st March 2015, suggest that it could be having a positive impact on reducing the number of homeless presentations. National guidance on the provision and operation of the Housing Options Approach is expected to be published early in 2016.

Local authorities have strategic and operational responsibilities to prevent and alleviate homelessness, expressed through statutory Local Housing Strategies. Health and Social Care Integration will provide further opportunities to redesign services to ensure they are appropriately joined up and needs led.

1.2   Impact of homelessness on health

The evidence on homelessness and its impact on health is unequivocal. The average age of death for a homeless male person is 47 compared to 77 in the general population. In 2013-14, the average age of death for a Crisis Service user in Edinburgh was 36 years[6].

In comparison to the general population homeless people have higher levels of mortality and morbidity from a range of causes including drug and alcohol dependence, mental ill-health, smoking, COPD, musculoskeletal disorders, infectious diseases, TB, respiratory tract infections, skin problems, poor nutritional status and dental decay. Homeless people experience long term conditions at a much earlier age, present to health services later and present mainly to acute services[6]. As a result, disease severity is therefore very high when services are accessed.

The life circumstances of many affected by homelessness contributes to their health status and their high health and social care needs. Many are subject to great adversity, social exclusion and extreme poverty. Homelessness risk can be heightened in line with wider issues such as relationship breakdown, domestic violence, bereavement, deterioration in health, particularly mental health, social isolation, substance misuse, life trauma and leaving hospital, prison or care. Poverty is identified as being a key contributory factor to homelessness. The risk of homelessness may therefore further increase as a result of the economic downturn and cuts in public spending. Welfare reform have included cuts in housing benefits through the bedroom tax, the introduction of a benefit cap and changes to Jobseekers Allowance, Disability Living Allowance and Employment Support Allowance. Whilst the Scottish Government are underwriting the cost of the bedroom tax this may not be sustainable long term. Further, people who are homeless may be more vulnerable to sanctions given their chaotic lifestyles.

Dual diagnosis of mental health issues and substance misuse are common. The prevalence of mental illness among the homeless population is high at 42% in comparison to 13% amongst the general population and suicide is nine times more common in people experiencing homelessness compared to the general population[8].

Much evidence is emerging on "multiple exclusion homelessness" whereby homelessness is the result of a number of issues which housing cannot solve alone. This is described as deep social exclusion including homelessness, mental health problems, substance misuse, street culture activities and institutional experiences and research has found early childhood trauma can often be the root cause[6]. This research has led to the recommendation for psychologically informed service environments for those services working with these client groups. Homeless is therefore not just a housing issue and, for many, is the result of complex and chaotic life experiences.

It is also important to note that homelessness is both a cause and consequence of poor health and wellbeing. Many homeless people often present to the local authority as homeless after prolonged contact with health and social care services such as mental health, substance misuse, the criminal justice systems and social work. This suggests services are not meeting the needs of individuals adequately.

It is also useful to consider the relationship between homelessness, hopelessness and health.

Service users may be perceived as lacking motivation or commitment to attend appointments that are sometimes crucial to improving or maintaining their health and wellbeing. They may be given opportunities to address the issues that impact upon them but don't take up that opportunity. With demand pressures on services it is perhaps not surprising that many homeless people fall out of the system however there may be multiple reasons why someone experiencing homelessness may not engage in health services. Other priorities take precedence, chaotic lifestyles don't marry well with the way services are delivered, behaviours that result in exclusion, feeling 'unwelcomed' by services or an underlying sense of hopelessness[9].

In tackling the health inequalities people experiencing homelessness experience, services need to therefore take a broader view of the challenges service users have in being motivated and engaged in their own health. Psychosocial factors can play a significant role in health inequalities. Not only can hopelessness create a barrier to engagement but it is also a strong predictor of adverse health outcomes, independent of depression[10]. Hopelessness is a pervasive condition that has significant health impacts, exacerbating underlying long term conditions and rendering the person helpless to take action to improve their wellbeing. You can't have good physical health without good mental health and you can't have a better future without hope.

Understanding the psychosocial determinants on motivation should mean that services need to look again at how this group of service users can be reached. It will necessitate flexible, responsive and even assertive approaches[11].

1.3 Impact of homelessness on children

Research evidence suggests that the negative impacts on children of living with a parent or in a family affected by SMD needs to be given greater consideration by services[6]. Due to many of the drivers of homelessness, it has a strong potential to affect children's health and wellbeing adversely and can manifest itself through developmental delay and higher rates of acute and chronic health problems. Furthermore, homeless children and families tend to consume foods that have a lower nutritional quality and therefore children experience higher rates of malnutrition, stunted growth and obesity.

The loss of a stable, familiar, nurturing home and learning environment can mean that homeless children are an extremely vulnerable group[6]. Homeless children are at an increased risk of, and exposure to, abuse, violence, psychological trauma and emotional distress. Frequent housing moves also interrupt education and impact on learning and academic performance. All cumulating in the potential that life circumstances will indeed lead them to homeless presentations themselves as young adults.

Young care leavers may be a particularly vulnerable group at risk of homelessness. The Children and Young People (Scotland) Act 2014 expands the Corporate Parenting role to Housing Services as well as wider agencies. The act amended the definition of care Leaver

and expanded Corporate Parenting responsibilities to these young people until they are 26 years old. This means that there are additional factors to be considered when dealing with young care leavers which will require a multi agency approach to supporting this vulnerable group.

1.4   Prevention

Homelessness is often the end product of prolonged and severe health and social inequality and as a result requires collective action across the social determinants of health. The Commission on Housing and Wellbeing (2015)[12] recently published an independent, evidence-based assessment of the importance of housing for general wellbeing in Scotland. In order to tackle the significant inequalities in society, the commission have selected eight areas of wellbeing that are relevant to the benefits of good housing, with the view that having a safe, secure and suitable home is essential to allow people to fulfil their potential. These eight areas of wellbeing are housing as home; neighbourhood, community, employment, income, health, education and environmental sustainability. The report outlines actions to improve all eight areas and strongly advises that the link between housing and wellbeing is recognised in the National Performance Framework.

Opportunities should be maximised to embed homeless prevention and mitigation into more upstream programmes of partnership work which tackle broader life determinants including early years, education, work with looked after children, mental health improvement, substance misuse, community safety and employability.[6]

The ScotPHN report also stressed that action on homelessness must be seen as only one part of the work required to address the inequalities evident in Scotland[6]. Locally, the Community Planning Partnerships through the Single Outcome Agreements, Joint Integration Boards through Strategic Commissioning Plans and NHS Scotland through Local Delivery Plans have a key role to play in the long term prevention of and mitigation of the associated social and health impacts of homelessness. In addition to taking action to reduce the wider contributory factors to inequalities, their role is to:

- ensure equity in access to services by providing services that meet the needs of all people including homeless people

- provide coordinated, appropriate and timely services to vulnerable adults and families with a view of preventing homelessness for those at risk

Scottish research on the views of homeless people suggest that ensuring equity of access should involve simple, quick access to services at a time they are needed; support with the practicalities of everyday life; involvement in decision making; peer support; respect from staff, including health workers and effective joint working and communication[13,14]. People living with multiple exclusion homelessness experience increased barriers to accessing services as mainstream services lack flexibility and there are gaps in services specifically for homeless people where universal services are simply not appropriate[15].

The literature picks up on a number of ways in which service delivery can be improved to meet the needs of homeless people. In particular, the provision of integrated and supportive case management has been highlighted as an effective method. Some studies have suggested that effective case management can improve both health and housing outcomes by improving adherence to and completion of courses of treatment and community based programmes[16]. Interventions that provide case management and housing and social care support in tandem are most effective for those with complex needs.

Housing First is one model that seems to demonstrate positive outcomes for homeless people with substance misuse problems, and is operational in a number of Scottish Local Authority areas. It is based on the principle that if secure housing is provided for people without a prior requirement for them to address substance misuse or wider health and social care issues - along with intensive support to help them manage the tenancy – their ability to stabilise their lifestyle and move towards independent living is significantly improved.

In summary, it is the focus of resources targeted to those most at need through well-established joined up services that may make the difference in preventing homelessness in the first circumstance and subsequent repeat homelessness presentations in the future.

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2.0   Profile of people who are homeless in North Lanarkshire

North Lanarkshire Council are currently consulting on a new Local Housing Strategy for 2016-21.

The most recent data shows there has been a declining trend in homeless applications in North Lanarkshire in recent years with a 51% reduction in applications in 2014/15 compared to 2004/05. This has mirrored the position across Scotland which has been attributed to the introduction of the Housing Options model and homeless prevention activity as discussed earlier. However, the rate of reduction has slowed and a rise in applications was witnessed between 2013/14 and 2014/15 suggesting renewed focus is required if further reductions are to be achieved.

In the last financial year, North Lanarkshire Council undertook 3,525 housing options interviews and 1,957 went on to make a homeless application on the same day which is an increase of 4% in comparison to the previous financial year. As a proportion of all households in North Lanarkshire the number of homeless applications increased by 0.3% to 0.58% in 2014/15 however remains below the Scottish average of 0.67%. This recent rise may be a feature of the reducing number of available lets in the social sector and may be also be related to the impact of recent welfare reforms and the wider socio-economic factors which impact on peoples income and security. As part of their housing options activity and discussions, locality housing teams have reported reluctance by people to consider options other than the social rented sector, with few people expressing an interest in the private rented sector. However; a broader range of options may have to be considered due to the continuing pressure and lack of availability of social rented stock to meet all needs.

As noted earlier hidden homelessness, also known as concealed households, can be difficult to quantify however the Homelessness Monitor 2015 analysis estimates there are approximately 9.3% of households in Scotland contain concealed households. Two thirds of these are estimated to be non dependent children, one quarter unrelated single adults and the remainder concealed families. The Monitor shows little progress has been made in reducing the proportion of hidden homelessness over the last 10 years. Overcrowding is another indicator of hidden homelessness and the Monitor data shows this is more prevalent in areas of poverty.
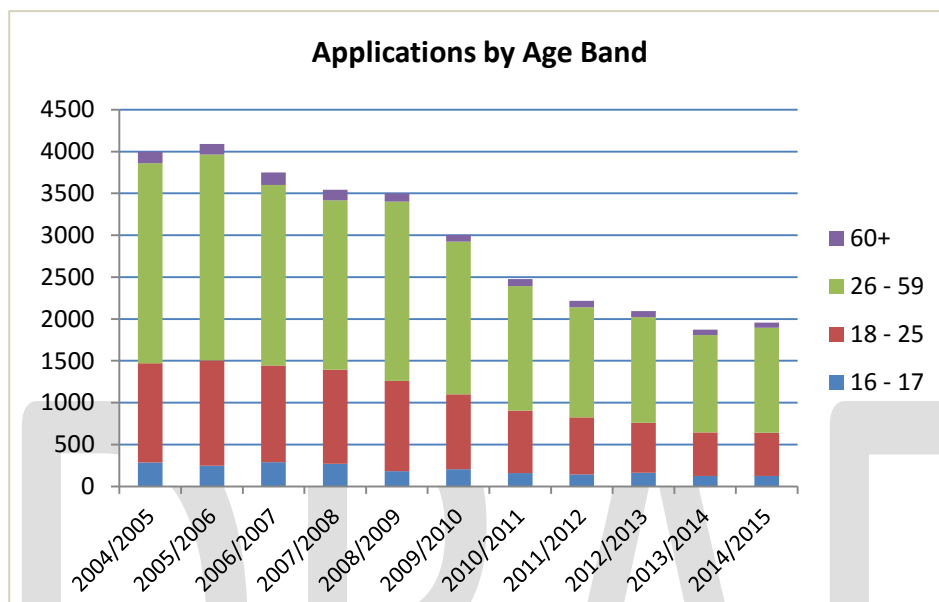
In North Lanarkshire there are currently over 8000 people on the Councils Common Housing register listed as General Needs applicants who don't have a Scottish Secure tenancy, either living with family/friends or renting in the private sector for example. However, it is not possible to identify how many of these individuals may be experiencing "sofa surfing", which is an acute form of housing need. Nevertheless, the Council are able to confirm that a relatively high proportion of applications are from households with combined health, social care and housing needs, which exacerbate and add to their housing insecurity.

2.1   Applications by age

As shown in Figure 1, 64% of homeless applications are made by those aged 26-59 years. This figure has risen by 4% in last 5 years and may be due to clients who were previously assessed as non priority reapplying now this restriction has been lifted. Over the last ten years (2004/05 – 2014/15), the biggest decrease in applications received (-56.5%) was seen in the 16-17 age band, which saw a drop of 56.5%. Young people (16-25 years old) represent 12.5% of the population but 37% of all homeless applications demonstrating that young people are still disproportionately affected by homelessness. Older people over 60

represent 3% of applicants and this has been fairly static in recent years. It is worth noting that the under 35 age group will potentially experience the greatest challenges in securing permanent accommodation due to the shared room rate of the Local Housing Allowance under the Welfare Reforms.

Figure 1 Total homeless applications by age 2004/05 to 2014/15

2.2 Applications by gender and household profile

Just over half of all applications made (53%) were from male applicants compared to 48% from female applicants. Single people represented the largest percentage of presentations at 1156 cases (59%). As shown in Table 1, one parent families represented the second largest percentage of presentations at 512 cases (26%) whilst a further 129 cases were couples with children (7 %). In total, across all categories, 34% of applications were households with children although it should be noted that applications involving children have seen the largest decline in the last 10 years.

Table 1 Homeless applications by household type: comparison over 10 years

Household type	2004/05	2014/15	% difference
Single person	2123	1156	-45.5%
Single parent	1251	512	-59.1%
Couple	242	115	-52.5%
Couple with children	301	129	-57.1%
Other	33	25	-24.2%
Other with children	50	20	-60.0%

2.3 Applications by ethnicity

The ethnic origin of homeless applicants in North Lanarkshire is predominantly White Scottish and represents 91.8% of the total homeless population. A further 5.8% are recorded as White with 3.2% British and 2.5% other ethnic group. A further 1% is recorded as Other and includes those of mixed race, whilst 0.6% are Asian and 0.6% are Black.

When compared with the general population some ethnic minorities appear to be disproportionally represented, specifically 'White Other' and 'Other Ethnic backgrounds' whereas Asian people represent 1.6% of the population but 0.6% of homeless applicants. These differences may be due to increased migration from European countries such as Poland and less established supports and networks in communities to support these individuals.

2.4   Reasons given for homelessness

Reasons for homelessness have tended to be consistent over the years with the most commonly cited reasons being that family, friends or relatives were no longer able to accommodate them or household disputes/relationship breakdowns. By far the largest the largest group presenting as homeless from an institution are those leaving prison. In 2014/15 this population accounted for 3% of all homeless applications. Ten homeless applicants defined their pre homeless accommodation as long term roofless or sofa surfing in 2014/15.

Table 2 Reasons given for homelessness (2014/15)

Reason given	No.	%
Asked to leave by parents, family or friends	514	26.3%
Non violent relationship breakdown	284	14.5%
Violent relationship breakdown	209	10.7%
Mortgage default and actions by landlords (rent arrears, anti-social behaviour)	288	12.8%
Fleeing domestic violence	177	9.0%
Discharged from an institution (prison, care, hospital)	3.2	3.2%
Other reason (including terminating tenancy)	485	23.5%

Following assessment, 74% of applicants were found to be homeless or threatened with homelessness whilst 10% were assessed as not homeless. A further 8% were assessed as intentionally homeless, this is higher than the national average of 5% and as such the Council continuously reviews intentionality homeless decisions to ensure that appropriate decisions are being made. The remaining applicants resolved their homelessness prior to assessment decisions or lost contact with Housing Services. With regards the latter it is not always clear why applicants lose contact and there are concerns for young people who may be particularly vulnerable.

The length of time people remain homeless has increased to 30 weeks in the last couple of years and the reasons for this are three-fold. Firstly, the abolition of priority need means more people require permanent housing. Secondly, the number of available permanent social lets has reduced and thirdly a significant number of applicants are refusing offers of permanent housing. The latter is most likely due to the type of housing stock available and in particular the small number of one bedroom properties.

2.5   Repeat applications

Sixty-nine (3.5%) repeat homeless applications were made in 2014/15 and this figure has remained static over the last few years. It may be that the small group of people with very complex health and social care needs is represented in this figure. Supporting people to maintain their tenancies is a key priority of the Local Housing Strategy and in 2014/15, 83% of tenancies to homeless people were sustained for at least 12 months.

3.0 Service provision for people who are homeless

A baseline mapping was undertaken in August 2015 by the working group participants to establish all services provided across North Lanarkshire for homeless people.

3.1 Housing support and advice services

Housing support services including homelessness applications and support needs assessments, General Housing Options advice and income maximisation services are delivered by the Council through six locality area housing offices.

In addition the Council commission floating housing support for both young care leavers and adults from Barnardos and the Simon Community respectively. The Council also commissions Supported Accommodation services from SAMH and Blue Triangle Housing Association (BTHA). With the exception of the BTHA service, all other services have recently been the subject of a re-tendering process to award new 3-year contracts from April 2016. Barnardo's successfully bid for the young persons' service and Simon Community Scotland will be taking over a new combined Supported Accommodation and floating support service from April 2016. The Council also funds independent housing advice and support for people who are homeless or at risk of homelessness through local Citizens Advice Bureaux and a specific housing advice service is also provided within Addiewell Prison in partnership with West Lothian Council.

3.2 Housing provision

The local authority is required by law to provide all homeless households with temporary accommodation whilst their homeless application is being assessed and data from 2014/15 suggested approximately 90% of all applicants stay in temporary accommodation at some point. There are a range of temporary and supported accommodation options available across North Lanarkshire by both the Council and third sector; however, demand outstrips supply, particularly for transitional accommodation and there is a mismatch between the needs of applicants and the accommodation available. For example, the welfare reforms have resulted in a reduction in housing benefit for people under-occupying accommodation.

There are approximately 650 units of accommodation available for use as temporary and supported accommodation across North Lanarkshire. This includes:
* 471 dispersed houses and flats across all localities
* 19 specified refuge spaces in Coatbridge
* 53 specified hostel places in Motherwell and Airdrie
* 36 supported transitional accommodation managed by third sector organisations including 12 specifically for young people

North Lanarkshire Council completed a modelling exercise in 2014/15 to ascertain future requirements in line with the needs identified. This suggests that 711 units are required to meet needs. The modelling exercise also showed that demand is likely to increase by approximately 5% over time to 2021/22, mostly as a result if the impact of the welfare reform changes. Through the draft Local Housing Strategy (2016-21) recommendations are being taken forward to address these issues such as sharing of flats in some temporary accommodation, reclassifying accommodation and a restructuring of rental charges for temporary housing.

3.3   NHS Lanarkshire Health and Homelessness service

The Health and Homelessness (H&H) service provides an immediate response to health care issues for homeless households across North Lanarkshire. The aim of the service is to ensure that individuals and families presenting as homeless have immediate access to healthcare, to ensure continuity of health care, and to support integration into mainstream services. Issues addressed include mental health, alcohol, drug and substance misuse, domestic abuse, adult support and protection, child health issues, and child protection. The core team comprises of 1.0 wte Team Leader, 1.6 wte Public Health Nurses, 3.6 wte Mental health/Substance misuse nurses, 0.5 wte Podiatrist and 1.0 wte Administrator Facilitator.

The service objectives are to:

- Assess and meet the immediate health needs of individuals affected by homelessness who have issues relating to mental health and substance misuse.

- Support individuals to access and engage with Mental Health and Substance Misuse services.

- Provide a partnership approach to care with other stakeholders such as Barnardos Street team, Simon community and Scottish Association for Mental Health.

- Provide NLC staff with support and guidance to support individuals and families affected by homelessness.

- Improve access to health services for families affected by homelessness who have difficulty accessing mainstream services and ensure continuity of healthcare

- Provide a clear pathway for NLC staff to access health care for individuals and families affected by homelessness.

The H&H Service and North Lanarkshire Council Housing and Support Services have an agreed pathway whereby housing staff refer all children affected by homelessness to the Health & Homelessness service and the service will link with the respective Health visitor to ensure the children needs are met.

The H&H Service consists of a team leader and administrator, 1.6 wte Public Health Nurses, 2.6 wte mental health nurses/substance misuse nurses, and 0.5 wte podiatrist.

An evaluation of the Health and Homelessness team was conducted in 2010 which included focus groups with over 20 service users and consultation with approximately 40 staff working with homeless clients. The evaluation affirmed the invaluable role played by the Health and Homeless team in providing a response to the immediate health needs of homeless people and in helping homeless people access the health services they need, and specifically people who have multiple and complex needs.

The evaluation report highlighted issues for clients in accessing mainstream services due to constraints on access and engagement. A number of barriers and blockages were identified particularly around access to GPs and dentists and some access issues for mental health and substance misuse services. Moreover it was recognised that homeless people with complex and challenging needs often require additional support to access structured appointment based services appropriately and that mainstream services may have a poor understanding of homelessness and their specific needs. The report highlighted the need for more collaborative working, providing a holistic response to people with multiple and complex needs and reducing the stigma experienced within mainstream services.

4.0 Local service data on the health needs of people who are homeless

In order to consider the health needs of homeless people across North Lanarkshire information has been drawn from the following sources:
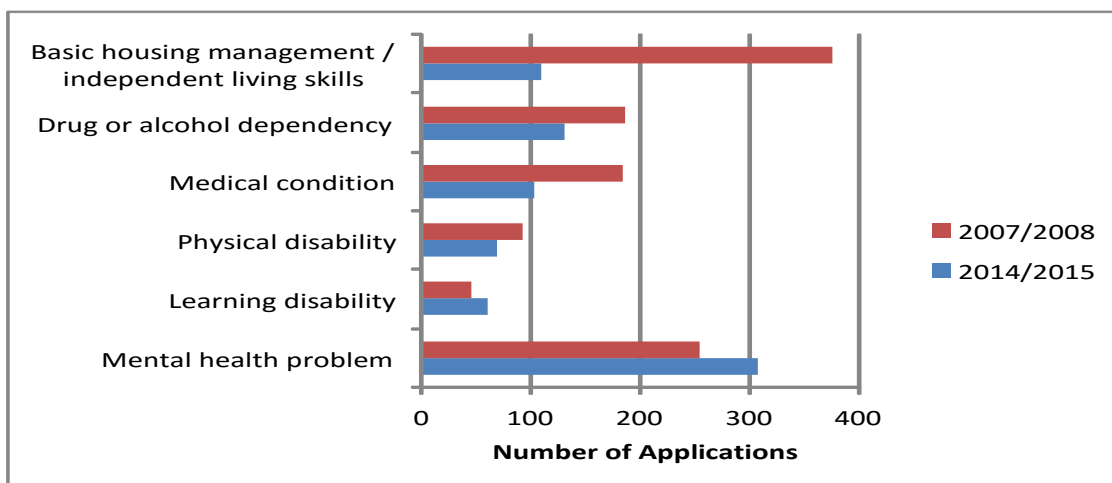- Information on the needs identified by clients at the point of making a homeless application to North Lanarkshire Council
- Needs identified by clients presenting at the Health and Homeless service in recent years and through an evaluation of the H&H service conducted in 2010

4.1 NLC Homeless applications

It is recognised that identifying the support needs of clients can be challenging if clients choose not to disclose these needs during the assessment process. 48% of all applicants identified a support need during the application process and of these 23% had multiple needs.

Figure 2 shows the needs identified by clients at the point of application. Support needs for mental health problems and learning difficulties have increased quite considerably since 2007/08 (20.4% and 32.6% respectively), while support needs for all other categories have reduced. The largest reduction is in 'Basic housing management / independent living skills' which has reduced by 70.7%, with 375 applications identifying this need in 2007/08 and only 110 in 2014/15.

Figure 2 Support needs identified by clients

A number of clients with multiple, complex and enduring needs can have difficulty sustaining any form of accommodation despite support. North Lanarkshire Council are considering models such as Housing First and working collaboratively with partners to remove barriers to services and ensure a holistic response to the clients' needs.

It is worth noting that North Lanarkshire Council gather Prevention and Sustainability information which risk assesses the likelihood of tenancies being sustained. Data for 2014/15 shows 1500 people were assessed as high risk and 2227 medium risk. Of these almost 2000 subsequently went on to make a homeless application. This highlights an opportunity for more preventative intervention earlier in the process.

4.2 Health and homeless team data

In 2014/15 the Health and Homeless team received 466 referrals. The numbers referred to the service have increased by one third over the last 5 years. There is an equal distribution by gender for males and females. 30% of referrals were received for clients within the 0-15 year old age group and is probably due to the agreed pathway mentioned earlier whereby all families with children are referred to the service.

Referrals for 25-50 year olds remain consistent with previous years and account for more than half of all the referrals. The distribution across ethnic groups is similar to homeless applications with the majority of clients white Scottish (86%) and a disproportionately higher percentage of Polish (5%) than in the general population.

Clients are referred to the service from a range of agencies however data over the last three years has shown that over half of all referrals have come from Coatbridge and Airdrie at 48% and 13% respectively in 2014/15. Referrals from the North locality have increased over the period from 1% to 9% whilst referrals from Motherwell have fallen from 21% to 7%. For 2014/15, 12% of referrals were self referrals generated across all localities in North Lanarkshire. The remaining 11% of referrals were received from Wishaw and Bellshill Housing, SAMH and Blue Triangle.

The service records data on the reason for the referral to the service. The most frequently cited reasons for referral are mental health (25%), substance misuse (13%) and families that are affected by homelessness with a rise in the latter on the previous year to 37% of all referrals. Other reasons for referral include seeking registration with a General Practitioner (15%) and general physical health issues (8%) including foot care issues. A small number of clients are referred for flu vaccinations or as a result of domestic violence.

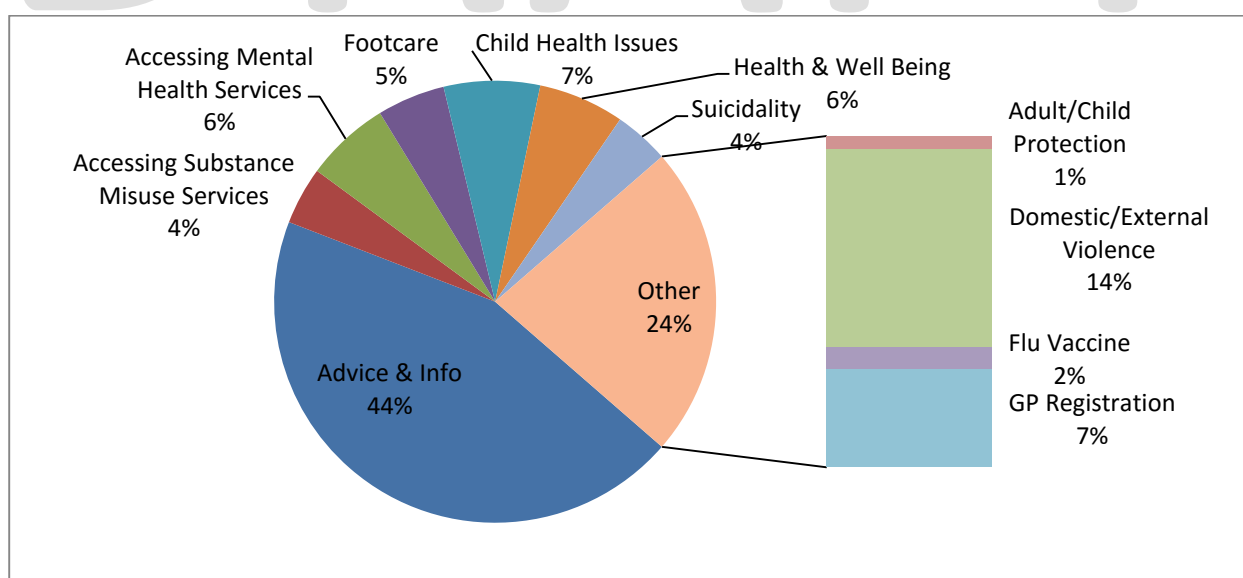**Figure 3 Health tasks identified**

Figure 3 outlines the range of tasks and interventions undertaken. Advice and information is given to everyone who receives a service. This may include simple advice and/or health promotion information in line with the health needs identified such as depression, anxiety, sleep, diet, exercise, child safety. All adults assessed by the service will receive a Brief
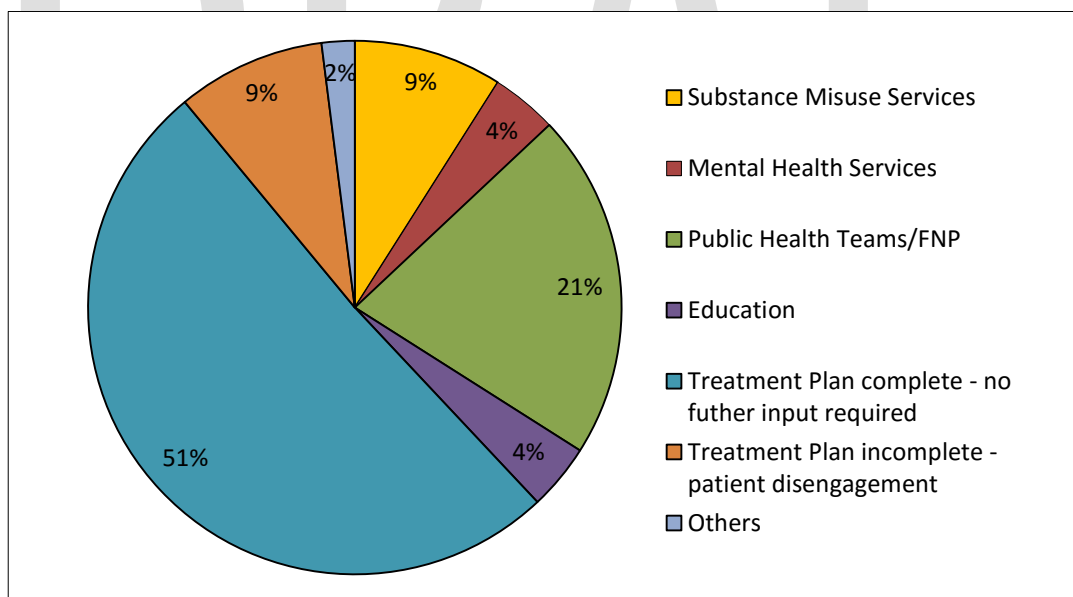
Intervention for Alcohol discussion and Routine Enquiry For Domestic and Childhood Sexual Abuse.

Clients referred onto Mental Health Teams are cases of a severe and enduring nature as staff within the Health and Homelessness team will use an early intervention approach to support patients referred with mild to moderate mental health issues using a range of therapies. The current reporting does not capture occasions where staff reconnect individuals to services that they have previously disengaged from.

Children's Health Issues and Health & Wellbeing are recorded when families present as homeless and are either connected with local services or a Wellbeing assessment is carried out.

The service records discharge outcomes for all those who are referred to the service as outlined in Figure 4. The percentage of clients who have remained with the service until their treatment is complete has increased in recent years with just over half of all clients now falling in to this category. Referrals to public health nursing teams have fallen but are nevertheless a discharge outcome for approximately one fifth of all clients. Positively, the number of clients who either don't engage with the service or disengage during treatment have fallen over the last three years from 16% to 9%. Referrals to mental health or substance misuse services have remained low at 9% and 4% respectively.

Figure 4 Discharge Outcomes 2014/15

Legend:
- Substance Misuse Services
- Mental Health Services
- Public Health Teams/FNP
- Education
- Treatment Plan complete - no futher input required
- Treatment Plan incomplete - patient disengagement
- Others

5.0   Qualitative research with key stakeholders

Two focus groups were undertaken in November 2015 to ascertain the views of key staff working with the client group. The first focus group included the seven staff members of the NHS Health and Homelessness team and the second focus group consisted a mix of ten staff from North Lanarkshire Council Housing Department, other Housing providers and third sector agencies.

Unfortunately due to the deadline for this work to be completed there was not sufficient time to also seek the views of clients as this would have required ethical approval however this should be considered in the future.

A number of key themes have emerged, as summarised below.

- The Lanarkshire homeless population experiences similar health needs to people who are homeless in other areas in Scotland with mental health and substance misuse key issues. Poor overall physical health and lack of self care were also highlighted often leading to use of emergency care services.

- Health services in Lanarkshire remain less accessible for homeless people due to a number of barriers. Some of these are linked to the nature of the individual's circumstances whilst others relate to how services are provided. In terms of the former, lack of a permanent address, chaotic life circumstances and difficulties making appointments were noted as key issues. In terms of service providers, barriers highlighted included a lack of consideration of the wider circumstances of these clients and inflexible service models. The issue of ensuring there is provision of emergency care, out with Accident and Emergency, was deemed a priority.

- Particular issues were noted in accessing General Practitioner services. It was reported that in some areas GP appointments had to be made by phone and could not be made face to face within the surgery. People who are homeless may be less likely to have the means by which to utilise phone based systems. The transient nature of this population has an impact on their ability to receive appointment letters and attend appointments. The geographical spread of townships and the fact that people may be re-located depending on accommodation availability was felt to be a particular issue for North Lanarkshire in terms of the impact on continuous access to primary health care services. Further, the lack of support within primary care for this client group often led to inappropriate use of Accident and Emergency services.

- Certain services were viewed as inaccessible for homeless people due to eligibility being based upon people being settled in an address. Others highlighted long waiting times for non-emergency services such as mental health services which means the person does not receive the support when it is needed most.

- Some focus group participants felt that communication between agencies supporting homeless clients need to improve. Discharge from acute services was highlighted as an area of concern with a perception that housing staff could play a more proactive role in care planning if they were involved in discussions and the care/crisis plan was shared. Further support from health services post discharge can be difficult to access and it would be better for the client if there was ongoing shared responsibility between agencies.

- A core issue underpinning many of the challenges and difficulties reported was the perception that negative attitudes still exist amongst health care professionals in relation to homeless people and that these act as barriers to equitable services being provided for homeless populations.

- A specific issue was highlighted in relation to GP registration for homeless people who have been incarcerated and subsequently discharged with a perception that clients have to re-register with a GP practice and can sometimes find this difficult.

- Current service delivery for this client group was perceived to be fragmented with more multi agency and coordinated approaches needed and sustained over time.

- The need for better sharing of relevant patient information (e.g. change of address) between health and housing was identified as an area for improvement and it was recognised that electronic data sharing between agencies would be particularly useful.

- Overall there was a view that the health needs of people who are homeless have not been given sufficient priority in planning and delivery of services and it was suggested that Homelessness champions within agencies would be beneficial to ensure the needs of the population are better reflected in strategic and operational health and social care planning.

6.0 HLI and ISD data linkage exercise

In order to further consider the needs of the client group an exercise was undertaken to link client data from homeless (HL1) applications made to North Lanarkshire Council between April 2014 and March 2015 to information held on NHS National Services Scotland datasets. This work built upon an exercise which was developed by Public Health in NHS Fife to review the use of health care services by people experiencing homelessness. Locally, this work was taken forward under the Health and Social Care Partnership Joint Strategic Needs Assessment programme and was limited to existing national data sets. Subject to information governance approval there is potential in the future to match the HL1 data to NHS Lanarkshire internal data sets such as MiDIS.

As this exercise required access to person identifiable data, information governance approved was sought and given by NHS Lanarkshire Director of Public Health and Health Policy as Caldicott Guardian. All HL1 applicants were contacted by letter to inform them their data was to be shared and to afford them the opportunity to opt out of the process. 30 people requested their information was not shared for this purpose and these clients were excluded from the analysis.

6.1 Methodology

The HL1 file was seeded with the CHI (NHS unique patient identifier) using a probability matching algorithm. The fields used were: *Surname, Forename, Date of birth, Gender* and *Postcode*. This process is 98% accurate.

The HL1 applicants were then compared to the rest of the Lanarkshire population.

The HL1 cohort is the list of homeless applicants (main applicant only) who presented to North Lanarkshire Council during the period 1/4/14-31/3/15. The age range of this cohort at the date of application is 16-86 years and there are 1,856 people in this cohort with an age range between 16-86 years.

The North Lanarkshire cohort consists of the population of North Lanarkshire, aged 16-86, **excluding** the HL1 cohort.

The HL1 cohort was linked to the following datasets:

- Age, gender and area of last known address
- Mental health
- Accident and Emergency
- Outpatients
- Inpatients/day cases
- Obstetrics
- Prescribing
- Dental

Below provides a summary of the findings of the linkage exercise for each dataset. The full report is available upon request.

6.1 Age, Gender and area of last known address

The age range of the HL1 cohort was 16-86 years within one third of the population in the 20-29 age range and the majority of applicants between 20-50 years of age.

It is important to note that the cohort only contained the main applicant as there is only one application made per family and no children are on the list. As a result the health needs of children who are homeless have not been assessed or included in this report.

There were more males than females in the HL1 dataset compared to the general population where 48% of the population are males.

As shown in Table 3, the North locality had the highest proportion of the HL1 population (20%); however this was lower than North Lanarkshire as a whole, where 25% of the population live in the North locality. Airdrie, Coatbridge and Motherwell all had a higher proportion of the HL1 cohort living in these localities when compared to the proportion of North Lanarkshire's population as a whole.

Table 3 Homeless applicants and NLC adult population by locality (2014-15)

	HL1	%	North Lanarkshire	%
Airdrie	331	18.6	54,531	16.1
Bellshill	230	12.9	43,567	12.9
Coatbridge	323	18.2	50,406	14.9
Motherwell	289	16.3	47,396	14.0
North	351	19.7	84,521	25.0
Wishaw	254	14.3	57,309	17.0
All localities	1,778*	100.0	337,730	100.0

*75 people could not be defined in to a locality due to either missing data or a postcode outwith the North Lanarkshire area

6.2   Accident and Emergency new and unplanned attendances

The following tables compare the HL1 cohort with the general population for A&E attendance by: age; gender; source of referral; multiple attendances; and, alcohol, drug and self harm related attendances. The latter must however be treated with caution as the field used to record diagnosis is only completed around 50% of the time and the actual injury caused by these may be recorded instead of what caused these injuries to occur i.e. if someone broke their arm because they were under the influence of alcohol, they may have only been recorded as having a broken arm as opposed to being under the influence of alcohol.

Table 4 and 5 show A&E attendance rates were three times higher in the HL1 cohort than the North Lanarkshire cohort in 2014/15 for all ages. Males in the HL1 cohort have much higher A&E attendance rates than females. Moreover, as shown in Table 6, the rate of the HL1 cohort that attended A&E three or more times in a year was five times higher than the North Lanarkshire cohort in 2014/15.

Table 4: A&E attendance rate per 1,000 population by age (2014/15)

Age	HL1	North Lanarkshire
<20	1160.0	360.2
20-29	1020.9	370.0
30-39	1157.4	316.3
40-49	936.7	283.1
50+	1085.2	347.5
All ages	1065.7	334.6

Table 5: A&E attendance rate per 1,000 population by gender (2014/15)

Gender	HL1	North Lanarkshire
Female	847.6	317.9
Males	1262.0	352.8

Table 6: Proportion of population attending A&E at least once in financial year and those with 3 or more attendances in one year in 2014/15

	HL1	% of population	North Lanarkshire	% of population
Number of people attending at least once in the year	791	42.6	58,108	21.6
Number of people attending 3+ times in one year	238	12.8	6,325	2.4

Figure 5 shows the proportion of A&E attendances in the HL1 cohort and the general population. 30% of the HL1 cohort were referred through '999 emergency services' compared to 22% of the general population. The HL1 cohort (3%) was also less likely to be referred by their GP when compared to the North Lanarkshire cohort (10%). This is not surprising given the issues highlighted with regards to access to primary care services for people who are homeless.

Figure 5: Distribution of A & E attendances by source of referral (2014/15)
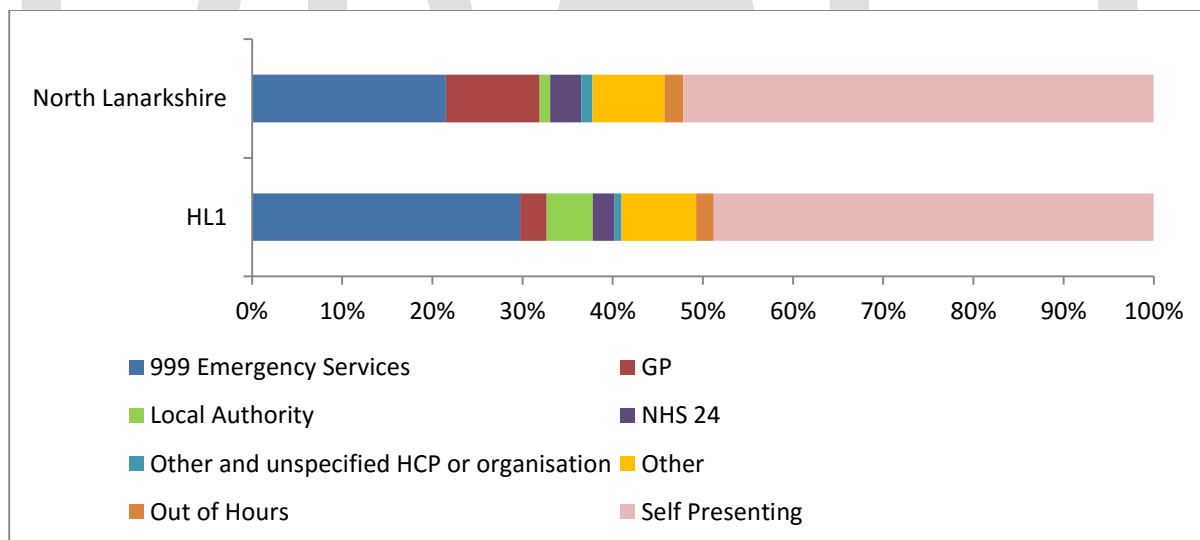

Table 7 outlines the A&E attendances due self harm (see *Appendix A* for a breakdown of IcD10 codes searched) for both cohorts. The rate per 1,000 population of recorded self-harm related A&E attendances was 20 times higher in the HL1 cohort than in the North Lanarkshire cohort. This is very concerning and may reflect the higher incidence of suicide within this population noted in the literature.

Table 7: Self harm related A&E attendances per 1000 population in 2014/15

	HL1	North Lanarkshire
Self harm	48.0	2.4

6.3 Hospital admissions

The following tables compare the HL1 Cohort with the North Lanarkshire population for rate of emergency hospital admissions per 1000 population, those that had three or more admissions during 2014/15, and admissions for alcohol, drugs and self harm.

Table 8 shows the rate of admissions for the HL1 cohort (all ages) was approximately double the rate of the North Lanarkshire cohort and was more than three times higher in the under 20 year olds and the 30-50 year olds. The rate of multiple (3+) admissions within a single year for the HL1 cohort was nearly three times higher for all age bands compared to the North Lanarkshire cohort and was even greater in the younger age groups.

Table 8: Emergency Admissions rate per 1000 population in 2014/15

Age	Admissions per 1000 population		Multiple Admissions (3+) per 1000 population	
	HL1	North Lanarkshire	HL1	North Lanarkshire
<20	213.3	55.2	22.2	2.6
20-29	202.6	69.9	17.7	3.8
30-39	274.5	75.6	34.0	3.6
40-49	297.5	88.4	28.5	4.8
50+	439.5	212.0	53.8	17.0
All ages	266.7	135.6	28.6	9.7

In terms of reasons for admission the rate of alcohol, drug misuse and self harm related admissions (see *Appendix A* for a breakdown of IcD10 codes searched) for the HL1 cohort was significantly higher for all ages compared to the North Lanarkshire population. Alcohol admissions were over seven times higher overall in the HL1 cohort and increased with age. Drug misuse admissions were nearly eighteen fold more prevalent. Self harm was twenty three times more prevalent for the HL1 cohort and highest in the <20 age band.

Table 9: Rate of alcohol, drug misuse and self harm admissions per 1000 population in 2014/15

Age	HL1			North Lanarkshire		
	Alcohol	Drugs	Self harm	Alcohol	Drugs	Self harm
<20	13.3	13.3	66.7	2.0	0.9	3.9
20-29	43.4	19.3	45.0	3.9	1.1	3.2
30-39	78.7	31.9	61.7	8.1	2.6	3.5
40-49	107.6	9.5	47.5	12.5	1.3	3.1
50+	125.6	0.0	40.4	10.4	0.3	0.9
All ages	69.5	17.8	51.7	9.0	1.0	2.2

6.4 Psychiatric admissions

Table 10 compares the psychiatric inpatients and day cases admitted and discharged from mental health wards.

The data shows the psychiatric admission rate in the HL1 cohort is just over 10 times the rate in the North Lanarkshire cohort. The 50+ age band has the highest rate of psychiatric admissions in the HL1 cohort with 62.8 admissions per 1,000 population in 2014/15, this compares to 3.7 in the North Lanarkshire cohort.

Table 10: Psychiatric admissions per 1000 population in 2014/15

Age	HL1	North Lanarkshire
<20	13.3	2.4
20-29	30.6	2.5
30-39	42.6	4.3
40-49	31.7	3.9
50+	62.8	3.7
All ages	35.6	3.5

6.5 Outpatient appointments

New outpatient appointments and Did Not Attends (DNA's) were compared between the two cohorts for all clinics, with the exception of GU medicine and A & E.

Comparison for new outpatient appointments revealed that the rate of new outpatient appointments per 1000 population in the male HL1 cohort was only slightly higher than the North Lanarkshire's population at 327.5 compared to 289.5 however for females the difference was large with 566.6 per 1,000 population in the HL1 cohort and 405.7 in North Lanarkshire's cohort. This may reflect a higher level of health needs in the HL1 cohort.

Over one third of new outpatient appointments were not attended (DNA) by those in the HL1 cohort (35%), approximately three times higher than the percentage of appointments not attended by the wider North Lanarkshire's cohort (11%). 44% of appointments for those aged 30-39 in the HL1 cohort were not attended.

Further interrogation of the data showed males in the HL1 cohort were more likely to miss appointments than females at 42.5% compared to 30.3%. These compared to 12.4% and 10.4% in the North Lanarkshire population respectively.

The higher proportion of missed appointments within the HL1 cohort may reflect the transient nature of their living arrangements and lack of security of address.

Table 11: New outpatient appointments rate per 1000 by age and % DNA in 2014/15

Age	HL1	%DNA	North Lanarkshire	%DNA
<20	355.6	36.3%	197.6	16.5%
20-29	397.1	35.2%	279.1	19.0%
30-39	493.6	44.0%	309.9	16.0%
40-49	468.4	29.1%	312.6	12.3%
50+	497.8	23.4%	426.8	7.4%
All ages	440.7	35.1%	350.0	11.2%

6.6 Prescribing

Drawing on the knowledge and experience of the Health and Homelessness service the prescribing rates were looked at for the drugs most likely to be prescribed within the community for people who are homeless.

The following five categories of drugs were considered: Substitute prescribing, Benzodiazepines, Opiates, Anti-epileptic and Anti-depressants (*Appendix B* outlines which drugs were used in each category).

Table 12 Patients prescribed drugs, rate per 1000 population in 2014/15

	HL1	North Lanarkshire
Substitute prescribing	83.5	6.1
Benzodiazepines	127.7	54.1
Opiates	154.6	155.2
Anti-epileptic	36.6	29.5
Antidepressants	201.0	63.8

The rate per 1,000 population of the HL1 cohort being prescribed drugs under the substitute prescribing group was 13 times higher than the North Lanarkshire cohort. The rate of the HL1 cohort being prescribed drugs under the anti-depressants group was 3 times higher than the rate in the North Lanarkshire cohort.

6.7 Obstetrics

The rates of live births and the obstetric admission rates were compared between the two cohorts. In addition, tobacco use (this is self reported at the booking appointment) and drug misuse by pregnant women were compared between the two cohorts.

Table 13 shows the obstetric admission rate and live birth rate for the HL1 population in 2014/15 was higher than for the North Lanarkshire cohort. In the <20 age band, this difference increases to over four times the North Lanarkshire cohort's rate.

Table 13 Rate of live births and obstetric admissions per 1,000 population in 2014/15

	HL1		North Lanarkshire	
Age	Live births	Obstetric admissions	Live births	Obstetric admissions
<20	110.2	354.3	20.4	82.8
20-29	121.3	455.7	78.8	275.6
30-39	65.4	345.8	72.4	221.3
40-49	0.0	0.0	9.3	31.4
All ages	91.4	362.9	52.9	175.6

Table 14 outlines that those in the HL1 cohort were more likely to be smokers at the time of their 12-14 week antenatal appointment. Aggregated data shows 103.1 per 1000 live births in the HL1 population had drug misuse issues recorded compared to only 6.7 per 1000 live births in the wider population at the same appointment.

Table 14 Smoking and drug misuse in pregnancy and drug misuse per 1,000 live births in 2014/15

	HL1	North Lanarkshire
Current smoker (as recorded at booking appointment)	51%	19%
Maternities recording drug misuse (three year aggregated data from 2012/13-2014/15)	103.1	6.7

6.8   Dental

Dental registration were compared between the two cohorts however it should be noted that this data is based on a snapshot drawn at different points as North Lanarkshire data is available annually and was drawn in March 2015 whilst the HL1 cohort was specifically drawn for this analysis on the 8th November 2015. Information on participation rates are only published at Health Board and not Council level thus the Health Board area rate has been used as the comparator in this instance.

Table 15 Dental registration

	HL1	North Lanarkshire	Lanarkshire Health Board
Registered with dentist	82.2%	89.9%	89.9%
Participated in last 24 months	53.9%	Not available	67%

Eighty two per cent of the HL1 cohort was registered with an NHS dentist as at 8 November 2015. This compares with 90% of North Lanarkshire's population being registered as at 31 March 2015. Fifty four per cent of the HL1 cohort had attended their dentist in the previous 2 years, this is compared to 67% of the Lanarkshire Health Board cohort.

Conclusions and Recommendations

Homelessness in North Lanarkshire

Homeless people are a key vulnerable group and experience health inequalities with higher morbidity and mortality than the rest of the population. Tackling and preventing homelessness will therefore contribute to reducing health inequalities. Community planning partners have a key role in improving the health and wellbeing of homeless people and in preventing homelessness.

Since 2013 all unintentionally homeless households are entitled to settled accommodation and there are a range of support services available for people experiencing homelessness in North Lanarkshire. Housing support services and income maximisation services are delivered through locality offices and the Council also commission support services for young carers, adults and prisoners from the third sector.

In line with national guidance housing needs should be assessed holistically using an approach known as Housing Options and national data suggests this model is having a positive impact on numbers presenting as homeless across Scotland and within North Lanarkshire.

Homeless applications have halved over the last decade in North Lanarkshire however the rate of decline has recently slowed and this may in part be due to the reduced number of lets in the social sector and also related to the impact of welfare reforms. Reduced lets, and a mismatch of suitable lets available to meet clients needs, has also led to an increase in the length of time people remain homeless. Actions are being taken forward under the new draft Local Housing Strategy (2016-21) to address these demand issues, particularly for temporary accommodation.

Almost two thirds of homeless applicants are aged 26-59 and just over half are male. Single people represent the largest group with one parent families the next largest cohort. Approximately one third of applications involved children however it should be noted that this group has seen the largest decline in recent years. Young people under 25 are disproportionately represented making up 37% of all applications despite representing only 12.5% of the overall North Lanarkshire population. There is also some evidence that those from European countries, specifically Poland, may also be disproportionately affected by homelessness, relative to their population.

Reasons given by clients for homelessness have remained consistent over the years with the most common being that family or friends were not longer able to accommodate them or relationship breakdown.

During the process of making a homeless application a small number of clients lose contact with Housing services and this is of concern particularly with regards to young people who may be particularly vulnerable.

3.5% of homeless applications made in 2014/15 were repeat applications and this figure has not changed in recent years. In the same year 84% of tenancies provided were sustained for at least 12 months. This suggests there may be a small cohort of clients who would particularly benefit from a more intensive supported approach. A new model called 'Housing First' is being developed in some areas of Scotland which puts the need for stable housing before addressing any wider social and health needs. This model works intensively with clients to support them to remain in their tenancy.

Health and Homelessness

Research evidence clearly shows that people experiencing homelessness have higher levels of mortality and morbidity from a range of causes with substance misuse and mental ill health often primary factors. The social determinants of those affected by homelessness contribute to their poor health status and needs with poverty, childhood trauma and neglect common. Research has shown homelessness is both a cause and consequence of poor health and wellbeing with many people presenting as homeless after prolonged contact with services.

Research also shows children who are homeless are a particularly vulnerable group as the drivers of homelessness can affect children's health and wellbeing leading to developmental delays and acute and chronic physical and mental health problems. Young care leavers are also known to experience poorer health outcomes. A multi agency approach is required for these groups to try and break the cycle that will lead to them becoming homeless as adults. Some progress appears to have been made in this area with a defined pathway in place between Housing and Childrens Services and an increase in referrals of children and families to the health and homeless service.

It is worth noting that not all those who present as homeless will have significant health needs as some will experience homelessness only once and for a short period of time however those who experience homelessness repeatedly or intermittently are more likely to have multiple health needs. Profiling work by NLC suggests approximately 47% of all applicants have support needs however this data only reflects the main applicant and does not include the needs of their families so it is likely there are further needs which go under-reported through current systems.

The NHS Lanarkshire Health and Homelessness service was developed in 2000 to provide a dedicated response to health care issues for homeless households. The service aims to ensure immediate access to healthcare assessment and treatment and support client's integration into mainstream services where required. The service has protocols with Housing and Public Health nursing to ensure all families making a homeless application get immediately referred to the service.

Local data available through Housing Services, the Health and Homelessness team and the data linkage exercise suggest the health needs of people who are homeless in North Lanarkshire reflect those reported in the literature.

Housing assessment data suggests approximately a quarter of applicants have support needs with mental health, learning disabilities, substance misuse and medical conditions often cited. Mental health issues have increased in recent years and were cited by approximately one fifth of applicants in 2014/15.

This data is supported by the referrals made to the Health and Homeless team over the last year with one quarter of all referrals made for support with mental health issues. Substance misuse, physical health issues including foot care, and issues relating to access, specifically registration with a GP, were also frequently cited. In 2014/15 the service was able to support just over half of all clients until their treatment was complete and the remainder were referred on to other services. Nine per cent of clients disengaged before their treatment was complete. It is worth noting that the referrals to the Health and Homelessness service varied quite considerably by locality and do not reflect the proportion of HL1 applications made in each area.

The findings of the data linkage exercise have been particularly useful in providing insight in to the needs of the homeless population as it clearly demonstrates the significantly poorer health burden experienced by this vulnerable population in comparison to the wider population, particularly in relation to mental health and substance misuse.

The linked data showed the psychiatric admission rate in the HL1 cohort was over 10 times the rate in the North Lanarkshire cohort and the rate per 1,000 population of recorded self-harm related A&E attendances was 20 times higher in the HL1 cohort than in the North Lanarkshire cohort.

In terms of reasons for admissions the rate of alcohol, drug and self harm related admissions for the HL1 cohort is significantly higher for all ages compared to the North Lanarkshire population. Alcohol admissions increase with age and the rate of self harm related admissions for the HL1 cohort is highest in the <20 age band. These differences are also reflected in the prescribing data with the rate per 1,000 population of the HL1 cohort on substitute prescribing 14 times higher than the North Lanarkshire population whilst the rate being prescribed antidepressants was 3 times higher in the HL1 cohort than in the North Lanarkshire cohort.

Substance misuse were also a key factor in the obstetrics data which showed the HL1 cohort were more likely to be smokers at the time of their 12 week antenatal appointment and just over 103.1 per 1000 in the HL1 population had recorded drug misuse issues recorded at the same appointment compared to only 6.7 per 1000 in the wider population. The obstetrics admission rate and live birth rate for the HL1 population in 2014/15 was higher than for the North Lanarkshire cohort and increased to four times the rate for those under 20 years of age.

People who are homeless or at risk of homelessness often experience barriers to accessing services which can be inflexible to their needs and circumstances. This was supported by the qualitative research undertaken locally with stakeholders who noted issues such as lack of a permanent address, difficulty making and keeping appointments, and inflexible service models key barriers to accessibility. This was also supported by the linked data which showed that the proportion of new outpatient appointments that do not attend was three times higher in the HL1 cohort (35%) than North Lanarkshire's cohort (11%) with males more likely to DNA than females.

Further, in line with the evidence outlined in the literature, local stakeholders suggested a core issue underpinning many of the barriers faced by people who are homeless are the perceived negative attitudes of staff, particularly within primary care.

Particular issues were noted around access to services, particularly primary care services and stakeholders felt this may lead to inappropriate use of Accident and Emergency services and clients presenting with health issues at a more advanced stage.

This was substantiated by evidence from the data linkage exercise which showed a much higher use of emergency services by people who are experiencing homelessness. Those in the HL1 cohort were five times more likely to have visited Accident and Emergency three or more times in the last year with males more likely to present than females. Those in the HL1 cohort were also nearly three times more likely to have had three or more emergency admissions to hospital. The issue of ensuring provision of emergency care for this client group is therefore highlighted as a key priority.

Local stakeholders reported services seem quite fragmented and highlighted the need to have a more holistic joined up approach which is sustained over time. It was recognised communication between different partners involved could be improved particularly around key transitional points for clients such as discharge from hospital or prison.

Homelessness is often the end product of a long period of severe health and social inequality and collective action is therefore required across all social determinants with opportunities maximised to embed homelessness prevention into upstream programmes of work. Stakeholders suggested more priority to homelessness needs to be given within strategic planning and consideration should be given to Homelessness champions to ensure the needs of this vulnerable group are better reflected in strategic and operational health and social care planning.

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Summary of findings

Review of health and homelessness literature and policy

- *People who are homeless are a very vulnerable group and experience health inequalities with higher morbidity and mortality than the rest of the population.*

- *The homeless population is not a homogenous group and people experiencing homelessness do so for a variety of complex reasons*

- *The life circumstances of many affected by homelessness contribute to their poor health status and high health and social care needs.*

- *For those with the most complex needs homelessness is often the result of deep social exclusion and these clients may benefit from an intensive case management approach.*

- *Homelessness is both a cause and consequence of poor health and wellbeing*

- *Children and young people who are homeless are a particularly vulnerable group*

- *Strong national and local policy imperative has resulted in a significant reduction in the numbers of people affected by homelessness however there is a need for a more integrated approach through community planning to prevent and mitigate homelessness in the future.*

Profile of people who are homeless in North Lanarkshire

- *Homeless applications have halved over the last decade in part due to the preventative approaches taken through the Housing Options model.*

- *Almost two thirds of homeless applicants are aged 26-59 and just over half are male.*

- *Single people represent the largest group with one parent families the next largest cohort.*

- *One third of applications involve children and young people.*

- *Under 25's are disproportionately affected by homelessness.*

- *The average length of time people remain homeless has increased to 30 weeks in recent years.*

- *Hidden or concealed homelessness is difficult to quantify however is known to be higher in areas of deprivation.*

- *The most common reason given for homelessness was that family or friends were no longer able to accommodate them or relationship breakdown.*

- *Approximately 3.5% of clients make repeat homeless applications within 12 months.*

Service provision for people who are homeless in North Lanarkshire

- *Both statutory and third sector support services are available for people experiencing homelessness in North Lanarkshire, either provided by or commissioned by Housing Services. There are a range of temporary and supported accommodation options available however demand outstrips supply and there is a mismatch between needs and accommodation available. This issue is being addressed through actions in the Local Housing Strategy 2016-21[4].*

- *The NHS Lanarkshire Health and Homelessness service provides a dedicated response to healthcare issues for homeless households and supports integration in to mainstream services. Referrals to the service vary considerably across localities.*

- *The range of health and social care services that are available to all parts of the community are also available to the homeless population; however there are challenges in terms of knowledge of pathways to services, access, ability to respond to the specific needs and coordination of support.*

Local service data on the health needs of people who are homeless

- *Almost half of all homeless applicants identify they have support needs, of which 23% have multiple needs.*

- *Support needs for mental health and learning disabilities have increased in recent years.*

- *Through the Prevention and Sustainability information gathered by NLC there is an opportunity for multi-agency intervention earlier to reduce the risk of tenancies being lost.*

- *A small number of clients with multiple and complex needs can have difficulty sustaining accommodation and may require a more intensive case management approach.*

- *One quarter of referrals to the Health and Homeless team were for support with mental health issues, substance misuse, physical health issues and issues relating to accessing services were other reasons for referral.*

- *Referrals to the Health and Homeless team vary considerable by locality and are not proportionate to the number of homeless applications (HL1) in each locality.*

Qualitative research with key stakeholders

- *People who are homeless often experience barriers to accessing services due to services being inflexible to their needs and circumstances and negative attitudes of staff towards this client group.*

- *There are particularly issues with regards to access to GP services and this is perceived to lead to inappropriate use of A&E services.*

- *Communication and information sharing between services and the need for better understanding of how services can be accessed was noted particularly for discharge from acute services and prison.*

- *Services for people who are homeless are perceived to be fragmented and required to be better coordinated, sustained over time and given more priority than at present.*

HL1 and NHS Information Services Division data linkage exercise

- *Linking homeless application data with health service data demonstrates the significantly poorer health burden experienced by many people who are homeless, relative to the wider population, particular in relation to mental health and substance misuse.*

- *The psychiatric admission rate in the HL1 cohort was over 10 times the rate in the NL cohort and A&E attendances due to self harm were 20 times higher.*

- *Those in the HL1 cohort were five times more likely to have visited A&E three times or more in the last financial year.*

- *The HL1 cohort were nearly twice as likely to have had an emergency admission in the last financial year, and the rate of 3+ emergency admissions in one year is nearly three times higher in the HL1 cohort and is even greater in the 20-29 age band.*

- *Hospital admissions for alcohol, drugs and self harm are significantly higher in the HL1 population. Alcohol admissions are over 7 times higher overall and increase with age. Drug admissions are nearly 18 fold more prevalent and self harm is 23 times more prevalent and are highest in the <20 age band.*

- *Substitute prescribing was 13 times higher in the HL1 cohort and antidepressant prescribing was 3 times higher.*

- *Those in the HL1 population were 3 times more likely to not attend outpatient appointments.*

- *Women under 20 in the HL1 Cohort were 5 times more likely to give birth when compared to all women under 20 in North Lanarkshire.*

Conclusions

- *People experiencing homelessness are a key vulnerable group and homelessness is often the end product of a long period of severe health and social inequality. Data available locally demonstrates the significantly poorer health burden experienced by this vulnerable population, particularly in relation to mental health and substance misuse.*

- *The social determinants of those affected by homelessness contribute to their poor health status and needs with poverty, childhood trauma and neglect common. Not all those who present as homeless will have significant health needs as some will*

experience homelessness only once however those who experience homelessness repeatedly or intermittently are more likely to have multiple health needs.

- *Research shows people who are homeless or at risk of homelessness often experience barriers to accessing services. Locally, stakeholders noted issues such as lack of a permanent address, difficulty making and keeping appointments, and inflexible service models as barriers to accessibility. This was supported by the high proportion of missed outpatient appointments by those who are homeless.*

- *Particular issues were noted for this client group from stakeholders and the literature in terms of access to primary care services, inappropriate use of Accident and Emergency services and presenting to services later once conditions are more advanced. This was substantiated by the data which showed a much higher use of emergency services by people who are experiencing homelessness.*

- *In line with what is reported in the literature, perceived negative attitudes of staff locally were thought to underpinning some of the barriers faced by people experiencing homelessness.*

- *A more proactive multi-agency approach has the potential to not only improve outcomes for individuals and families but also improve service efficiency and effectiveness.*

Recommendations

- *The stark physical and mental health inequalities experienced by many people who present as homeless are unacceptable. Through Community Planning and the integration of Health and Social Care priority should be given to upstream approaches which tackle wider life circumstances and to better support those with mental health and substance misuse issues as early as possible in order to reduce these health inequalities and reduce the number of people presenting as homeless.*

- *A Health and Homelessness multiagency outcome focused action plan should be developed and implemented with accountability to North Lanarkshire Partnership. The data gathered for this HNA provides a baseline for measuring progress and relevant indicators should be incorporated in to the Health and Social Care Joint Strategic Needs Assessment dataset to allow progress to be measured over time. A more proactive multi agency approach has the potential to not only improve outcomes for individuals and families but also improve service efficiency and effectiveness.*

- *All health and social care assessments should include questions on housing provision and financial security in order to ensure basic needs are being met and to identify and mitigate any risks to future security. Community based staff should be trained to identify signs that clients are at risk of losing their accommodation.*

- *For those experiencing homelessness there is a need for better joined up multi agency working with all services taking responsibility to support this vulnerable client group, particularly at transitional points and as early as possible in the process. Housing currently appears to have sole responsibility.*

- *Better data sharing and tagging of records between agencies may help facilitate an more integrated approach and there is also a need to consider the health needs of all members of a couple or family presenting as homeless.*

- *For clients with more complex needs, input from all services need to be sustained over time. The potential for an intensive case management support model, such as Housing First, could be considered for the small cohort of clients who have high needs and have difficulty maintaining a tenancy.*

- *All services providing care and support should be more responsive and flexible to the particular needs of people experiencing homelessness. Workforce development focusing on attitudes and values using rights based approaches and the emerging evidence around psychologically informed services should be considered to improve service response. Consideration should also be given to how those who disengage with services can be better supported through proactive engagement, review and distress/crisis management planning.*

- *The provision of 24 hour emergency care for people who are homeless should be reviewed with particular consideration given to improving access to primary care emergency services. Further analysis should also be undertaken to identify those who are accessing emergency services most in order to look at how these clients can be better supported.*

- *The high incidence of self harm within the younger homeless population should be explored and plans put in place to better identify clients at risk of self harm earlier and to reduce repeated self harming behaviour, supported through the Improving Responses to Distress in Lanarkshire Working Group.*

- *There is a need to review support around mental health and substance misuse for those that are homeless and living in temporary or supported accommodation with a view to intervening as early as possible in the client journey and ensuring out of hours access to support is available.*

- *Extension of the Joint Strategic Needs Assessment (JSNA) programme to other data sets should be considered to allow the outcomes of referrals from the Health and Homelessness team to other services (e.g. mental health and substance misuse services) to be reported in order to review client outcomes and further areas for improvement. Uptake of preventative services such as screening by people experiencing homelessness should also be reviewed.*

- *The JSNA programme should also be extended to consider the financial costs associated with the current health and social care response for this client group and the benefits that could be realised through earlier intervention approaches.*

- *Children within families who are homeless are a particularly vulnerable group. Whilst no data relating to children was included in this review given the vulnerability of this group it would be useful to consider what data is available and to audit the pathways in place between Housing and Health in order to identify any areas for improvement.*

- *Given the variance in referrals to the Health and Homelessness team across localities there should be further exploration to determine why some areas are less likely to refer and actions taken to improve referrals from these areas.*

- *The issues of clients moving locality to access temporary accommodation need to be reviewed in terms of the potentially detrimental impact of relocation on clients and their families and to ensure continued access to primary care services.*

- *Young pregnant women who present as homeless appear to be a key vulnerable group within the homeless population and further work may be required to better support these clients during pregnancy.*

- *It was not possible to include the views of service users in this assessment however opportunities for consulting with users should be built in to future service reviews and planning processes in order to ensure service developments meet needs.*

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Appendices

Appendix A

The following ICD10 codes sere used to find admissions related to drugs, alcohol and self harm:

Diagnosis	ICD10 codes used
Alcohol related admission	'F10','K70','X45','X65','Y15','Y90','Y91' 'E244','E512','G312','G621','G721','I426','K292','K860', 'O354','P043','Q860','T510','T511','T519','Y573','R780' 'Z502','Z714','Z721','K852'
Drug Misuse	F11','F12','F13','F14','F15','F16','F18','F19
Self Harm	X60-X84

Appendix B

1. Drug groups were selected based on the following items:

1. Substitute prescribing	Approved name: Methadone Hydrochloride Prescribable item names: Suboxone, Antabuse
2. Benzodiazepines	Approved names: Diazepam, Chlordiazepoxide
3. Opiates	Approved names: Tramadol Hydrochloride, Paracetomol with Tramadol Hydrochloride, Co-Codamol (30mg/500mg formulations only)
4. Anti-epileptic	Approved name: Gabapentin
5. Antidepressants	Approved names: Mirtazapine, Fluoxetine

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