North Lanarkshire Health and Social Care Partnership

Health and homelessness in North Lanarkshire

A rapid health needs assessment

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Overview

- Review of literature
- Service provision and local service data
- Focus groups with stakeholders
- NLC homeless applications and NHS Information Services Division data linking exercise
- Key conclusions and recommendations

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What does the homelessness literature tell us?

- Stark health inequalities
  - Average age of death for a homeless male is 47 compared to 77 in the general population
- High levels of morbidity
  - Substance misuse, poor mental health, smoking, COPD, infectious diseases, musculoskeletal disorders, skin problems, poor nutrition, dental decay
- Poor life circumstances
  - Poverty, relationship breakdown, domestic violence, social isolation, childhood trauma, multiple exclusion homelessness, hopelessness
- Homelessness as cause and consequence of poor health and wellbeing

NOT JUST A HOUSING ISSUE

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Who is experiencing homelessness locally?

- Homeless applications in NLC have halved over the last decade
- Two thirds of applicants are aged 26-59 and under 25's are disproportionately affected
- Just over half are male
- Single people the largest group and one parent families the next largest cohort
- One third of applications involve children and young people
- Most common reason for homelessness was that family/friends were no longer able to accommodate them or relationship breakdown

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What services are available locally?

- Housing support and advice services through locality offices and third sector commissioned services
  - Barnardo's, Simon Community, Blue Triangle housing Association, Citizens Advice Bureaux
- Temporary and supported accommodation
  - Demand outstrips supply and actions being taken to address this through the Local Housing Strategy
- The NHS Lanarkshire Health and Homelessness service
  - Provides an immediate response to healthcare issues for homeless households and supports integration in to mainstream services.
  - Referrals to the service vary considerably across localities
  - Evaluated in 2010

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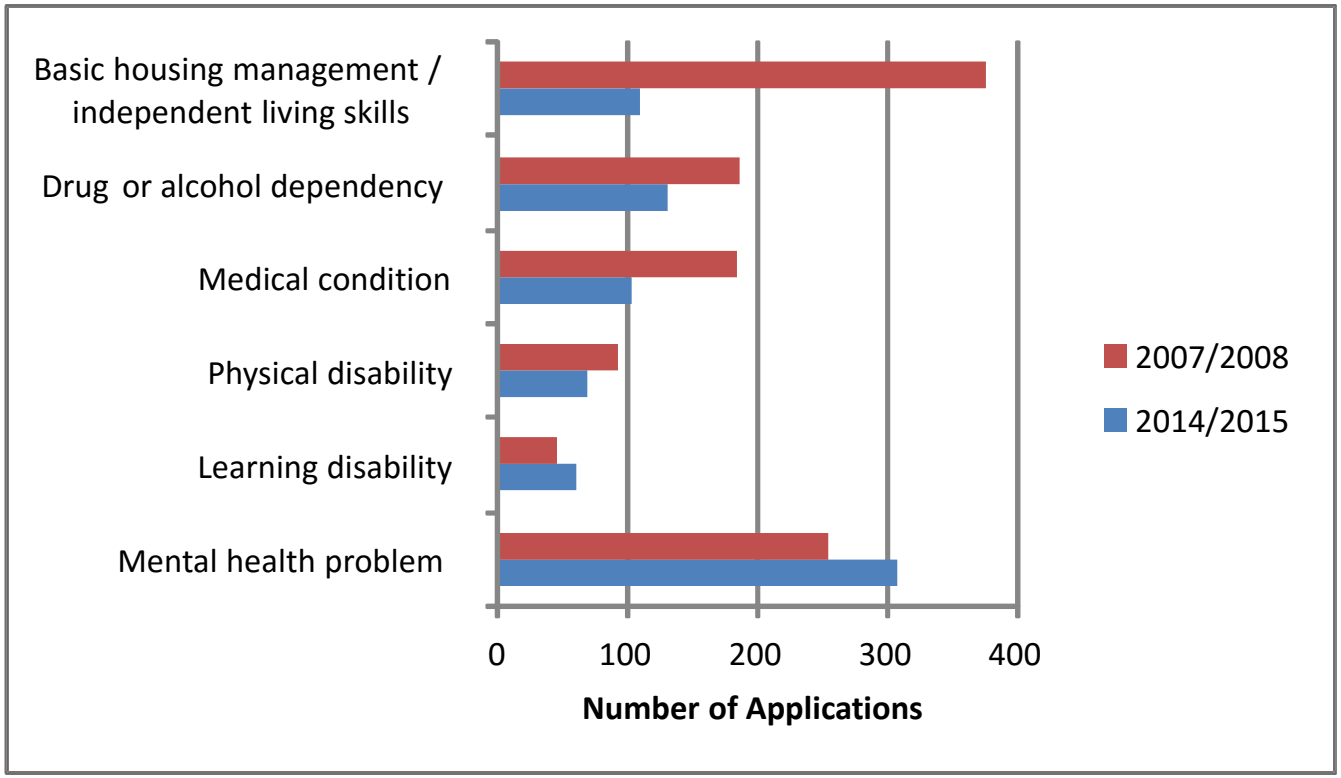
NLC Housing data: Support needs identified by clients



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Prevention and Sustainability information

- Risk assesses the likelihood of tenancies being sustained
- 2014/15 data showed:
  - 1500 assessed as high risk
  - 2227 assessed as medium risk
  - 2000 went on to make a homeless application

WHAT ARE THE OPPORTUNITIES FOR PREVENTATIVE INTERVENTIONS TO REDUCING RISK OF TENANCIES BEING LOST?

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Health and homeless service data

- In 2014/15 466 referrals were received to the service
- Numbers referred to the service have increased by one third over last 5 years
- One quarter of referrals to the Health and Homeless team were for support with mental health issues, addictions, physical health issues and issues relating to accessing services were other reasons for referral.
- 30% of referrals were for children
- Referrals to the Health and Homeless team vary considerable by locality and are not proportionate to HL1 applications.

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Focus group findings

- People who are homeless often experience barriers 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.

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Data linkage exercise

- Compared HL1 applicants to the rest of the Lanarkshire population.
- 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

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Data linkage: A & E attendance

- Compared to NLC adult population HL1 cohort attendances were:
  - 3 x higher overall
  - 5 x higher for 3+ attendances in 12 months
  - Males in HL1 cohort higher rates than females
  - Higher % referred through 999
  - Lower % referred through GP
  - 20 x higher reported self harm

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Data linkage: Admissions

- Compared to NLC population the HL1 cohort had:
  - Double the rate of admissions
  - 3 x higher rate of multiple admissions

- Reasons for admission
  - Alcohol 7 x higher for HL1 cohort
  - Drug misuse 18 x higher for HL1 cohort
  - Self harm 23 x higher for HL1 cohort

- Psychiatric admissions
  - 10 x higher for the HL1 cohort

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Data linkage: Outpatient DNA's

- New outpatient appointments that were not attended
- HL1 cohort: 35%
- NLC population: 11%

May reflect transient nature of living arrangements

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Data linkage: Prescribing

- Rate per 1000 of the HL1 cohort prescribed drugs in the substitute prescribing group was 13 x higher than the NLC adult population

- Rate per 1000 of the HL1 cohort prescribed antidepressants was 3 x higher than the NLC adult population

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Data linkage: Obstetrics

- Obstetric admission rate and live birth rate higher for HL1 cohort
- In the under 20 age group this difference is four fold
- 51% of HL1 pregnant women smoked compared to 19% in the wider population
- Drug misuse recorded for 103.1 per 1000 live births in the HL1 cohort compared to only 6.7 per 1000 live births in the wider population

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

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

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Recommendations (1)

- Priority should be given to upstream approaches which tackle wider life circumstances and to better support those with mental health and addiction issues as early as possible
- For those experiencing homelessness there is a need for better joined up multi agency working, particularly at transitional points and as early as possible in the process.
- 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 the homeless population.

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Recommendations (2)

- 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.
- Plans should be put in place to reduce the high incidence of self harm within the younger homeless population.
- Extend the Joint Strategic Needs Assessment programme to other data sets should be considered
- There should be further exploration to determine why some areas are less likely to refer to the Health and Homelessness team 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 in terms of access to health services.
- 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.