Health and homelessness

NHS Health Scotland is a national Health Board working with and through public, private and third sector organisations to reduce health inequalities and improve health. We are committed to working with others and we provide a range of services to help our stakeholders take the action required to reduce health inequalities and improve health.

Key messages

- A secure nurturing environment is a key component of wellbeing for individuals, families and children.
- Being homeless is much more than just being out on the street. Only a small proportion of homeless people sleep rough.
- All those assessed as being unintentionally homeless in Scotland are entitled to settled accommodation and the main reasons for homelessness include relationship breakdown and being asked to leave the home.
- Around 10,000 homeless households are in temporary accommodation in Scotland, mainly waiting for appropriate settled accommodation. Others may stay on friends' floors or with family, sometimes in precarious arrangements.
- Homelessness can happen to anyone at any stage in their life and often appears very late, following contact with non-housing services such as mental health, substance misuse and criminal justice.
- While many people who are homeless or at risk of homelessness have significant complex needs, it is important to recognise that many don't. When people first become homeless, providing the right help, or access to the right resources (work, housing, income or access to specialist support), would allow them to quickly exit homelessness and continue with their lives.
- Every opportunity must be taken for its prevention by better understanding the routes and key transition points into and out of homelessness.

Key actions

- Health services (especially primary care) and other frontline services can play a powerful role in early detection and prevention of homelessness. Those responsible for training and developing the workforce should give support to those who need it (e.g. GPs, health visitors, housing officers) to identify routes and early risk factors that can lead into homelessness and provide opportunities to intervene.
- Those providing homelessness-related services (e.g. NHS, local authorities, local housing associations) should plan for, commission and implement evidence-based models of delivery and care, including 'psychologically informed services' and 'Housing First' (see p. 6).
- The public, private and third sectors should maximise the connections between housing, health (including oral health) and social care to ensure those individuals and families affected by homelessness are supported by all necessary agencies in new and evidence-informed ways. Connections should include referral pathways, prevention protocols and partnership working where possible.

What is this briefing about?

This is the sixth in a series of inequality briefings. It focuses on the issues around health and homelessness. It addresses the impact that homelessness can have on health and wellbeing and suggests opportunities for early intervention to prevent it. The intent is that this work becomes a systemwide movement to 'restore a public health response to homelessness in Scotland'. It is based on work undertaken on behalf of the Scottish Public Health Network (ScotPHN).[1]

What are health inequalities?

Health inequalities are the unfair and avoidable differences in people's health across social groups and between different population groups.

They represent thousands of unnecessary premature deaths every year in Scotland. For example, for men in the most deprived areas, health inequalities mean nearly 25 fewer years spent in 'good health' than men in the least deprived areas. This is 22 years for women.

Health inequalities are caused, in part, by inequalities in income, power and wealth across the population. The first briefing[2] in this series provides more information on health inequalities and the broad range of actions that can be taken to reduce them.

The scale of the problem in Scotland

Official Scottish Government data show that **34,662** homeless applications were made in Scotland in 2015–2016 and of these **28,226** were assessed as being homeless. A Scottish Government report[3] states: 'Being homeless doesn't mean not having a roof over your head or being out on the street. Only a tiny proportion of homeless people sleep rough. Many stay on friends' floors or with family, sometimes in precarious arrangements. Under the Housing (Scotland) Act 1987, a person should be treated as homeless even if they have accommodation, if it would not be reasonable for the person to continue to stay there'. This includes if the person would not be safe if they continued to stay there, they do not have a lease or title to the property and if it is insecure.

The average age of death for a homeless person is

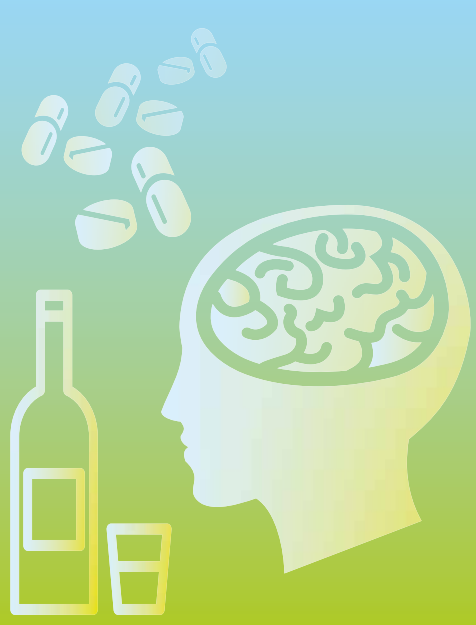
47 for males

43 for females[4]

Homeless people, and in particular those who sleep rough, have a much higher risk of death (from a range of causes) than the general population.[5] Many of the health conditions that homeless people develop in their 40s and 50s are more commonly seen in people who are decades older.[6]

Violence, such as injuries and assaults, are also a threat to the physical and mental health of homeless people.[7,8] Depression and suicide are higher among homeless people than the general population. Mental ill health can be both a cause and a consequence of homelessness, as are alcohol and drug abuse.[9,10] There is also a complex relationship between homelessness and offending. Those who have spent time in prison are more likely to experience homelessness, however, those who do not have stable accommodation are at higher risk of (re)offending.[11]

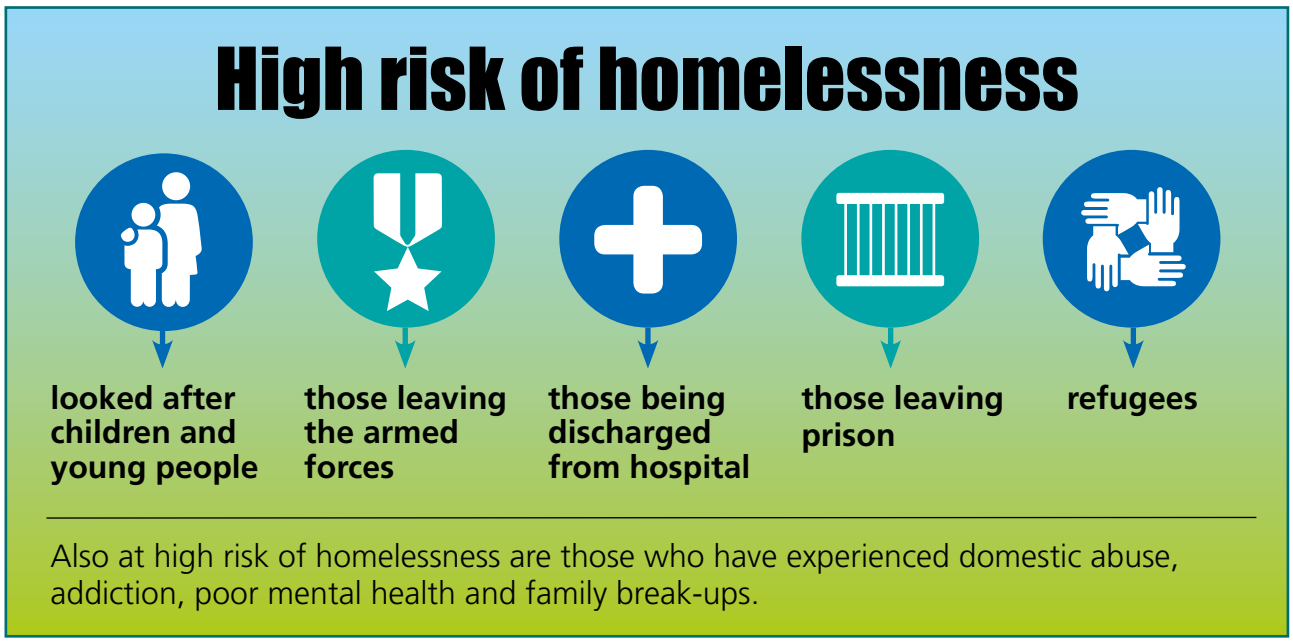
The most common health needs of homeless people relate to mental ill health, alcohol abuse and illicit drug use, and dual diagnosis is frequent.[8,12]



Homelessness also has a negative impact on children's health and wellbeing. While children rarely sleep rough in the UK, homeless children in temporary accommodation still have higher rates of acute and chronic health problems than low-income children with homes.[13]

A child's development can be damaged and delayed by disruptions to important relationships and the failure to establish or maintain a familiar environment.[14] Most street homeless people experienced homelessness as a child, along with school or family problems. This indicates the need to support families experiencing homelessness to avoid and break such patterns.[15,16] Homeless children are therefore a particularly vulnerable group and unstable accommodation can result in difficulties for homeless families in accessing services.[17]

The Scottish Government's and Convention of Scottish Local Authorities' (COSLA's) guidance on the prevention of homelessness recognises poor health as a trigger for homelessness.[18] It found that there are particular groups of the population with health and support needs who may be at high risk of homelessness at critical transition points.



Homelessness and complex needs

Many people who are homeless often have multiple, complex support needs which overlap and make the problem worse (e.g. drugs, alcohol, mental health, learning difficulties and physical health problems). As services tend focus on single 'issues', this group struggles to access the mainstream service offer.

Research shows that early childhood trauma can often be at the root of 'multiple exclusion homelessness',* highlighting the need to recognise this as an early sign of potential future homelessness.

* Multiple exclusion homelessness is an extreme form of social exclusion and inequality; the visible tip of a much larger iceberg of complex disadvantage below the waterline. It is often linked to substance misuse, institutional care (e.g. prison), domestic abuse, adverse childhood experiences and/or involvement in 'street culture' activities (e.g. begging and street drinking).

People who have a history of severe childhood adversity, such as neglect, and those who are chronically homeless, may behave in ways that mainstream services and staff can find challenging. Those providing care can respond to such behaviour in ways that maintain exclusion, such as discharging a person because they are not using the service in a way that is expected. It is this complex relationship with care/authority figures and the way services respond that can maintain exclusion, despite the best intentions from services. Developing trusting relationships and managing emotions can be difficult for those who have experienced complex adversity in their lives. 'Psychologically informed' services or environments are intended to help staff and services understand where these challenging behaviours are coming from, allowing staff to work more creatively and constructively with people.[19]

It has long been recognised that for many, homelessness is not only a housing issue. Providing a roof is sometimes not enough to enable someone to stay in accommodation. The right support is crucial. Without the right support, accommodation can break down, leading to cycles of repeat homelessness.

As well as the financial costs, through the disproportionate use of certain public services, there are also significant social costs for the individual's family and children.

Homelessness often happens very late, following contact with non-housing services such as mental health, substance misuse and criminal justice. This highlights that there are critical points in a person's journey into multiple exclusion homelessness. Therefore, there are opportunities for services such as mental health and substance misuse to contribute to the prevention of homelessness.

What's the solution?

Health services need to respond with earlier detection of 'at-risk' individuals and families, and identify appropriate prevention pathways.

Housing and health professionals should engage with schools, educational establishments and early years services.

Working with these services can raise awareness and help to share effective practice in identifying those at risk of homelessness.[20]

In addition, homeless people and those at risk come into routine and regular contact with hospitals, therefore, hospital admission and discharge are good opportunities to get involved. Much good work is already happening in this area which could be built on.[21,22]

The current change to the role of a school nurse provides a timely opportunity to make homelessness prevention part of the school nursing service. The Scottish Government has also made it clear that improving social justice, tackling the educational attainment gap and establishing the critical role of a stable home in improving children's wellbeing and life chances are core priorities. These could have a significant impact on homelessness in Scotland.

Housing First

Housing First (a model that initially provides a relatively secure tenancy, and then combines that with supportive treatment services in the areas of mental and physical health, substance abuse, education and employment) is one 'housing option' that delivers more effective outcomes for those with the most complex needs and who have previously experienced difficulties in sustaining tenancies.[23,24]

Evaluations from the approach in Glasgow and Renfrewshire support international evidence[25] that it provides the best model to resolve homelessness in around 80% of those with complex needs.[26]

By providing a stable home for people to build their lives from, along with support that 'sticks' with the person, those with the most complex needs are being supported to overcome cycles of homelessness. Peer support workers are also important in helping homeless people to get support.

Housing, health and social care

Housing has an important part to play in the outcomes that Health and Social Care Partnerships are working towards, however, most areas of housing, including homelessness services, may not be within the scope of the partnerships that are currently forming. While these partnerships cannot provide all of the required services, the services that they do provide can be agreed on an individual basis. For example, Glasgow City Council have chosen to include homelessness within the remit of the Health and Social Care Partnership. This provides the opportunity to include homelessness as part of frontline health and social care services.

There remains an opportunity through integration to maximise the connections between housing, health and social care to ensure those individuals and families affected by homelessness are supported by all necessary agencies in new and evidence-informed person-centred pathways.

Actions to raise awareness of health and homelessness connections

- The Homelessness Prevention and Strategy Group, chaired by COSLA, now has a health representative on the group. Health is a part of their work plan, with support from a designated Directors of Public Health Champion.
- There is now a national one-off exercise to link council homelessness data (HL1 and PREVENT 1) with NHS data. This will create a national picture of healthcare access and outcomes by the 'identified' homeless sector. These data can be used to better inform actions, policies and service design to prevent homelessness in Scotland.
- There is agreement that housing and homelessness data will be included in the data collected to support health and social care integration through the Health and Social Care Data Integration and Intelligence Project (HSCDIIP).
- Health is now invited to help shape the relevant sections (including one specifically on health matters) for a new training toolkit to be commissioned by the Housing Options Hubs and used as part of the 'preventative' housing options approach being taken across Scotland.
- Housing will be included in the forthcoming Scottish Government framework for health and justice for offenders in the community.
- The NHS-hosted Health and Homelessness Group has been refocused to support implementation of the recommendations in the report *Restoring the Public Health Response to Homelessness.*[1]
- Homelessness has been included in the new Chief Medical Officer letter issued to NHS Boards in October 2015 for reporting requirements on the Health Promoting Health Service (HPHS).
- Work is underway to support the Faculty for Homeless and Inclusion Health in Scotland. The faculty is an independent, multidisciplinary body focused on improving the health care of homeless and other multiply excluded people. It is a membership organisation for people involved in health care for homeless people and other excluded groups such as gypsy/travellers, vulnerable migrants and sex workers.
- NHS Health Scotland has supported events to promote the key messages in the report *Restoring the Public Health Response to Homelessness in Scotland*[1] and to bring various sectors together to share practice and learning. This included an event focused on remote and rural homelessness issues.
- A national partners group has been formed to bring together a range of organisations and agencies that have the potential to support Health and Social Care Partnerships achieve their outcomes. This partnership has identified a wide range of existing and potential areas of support such as the testing of new models of multidisciplinary working, encouraging, enabling and supporting the use of evidence and data, and workforce training and development. NHS Health Scotland is a member of this group and will be using it as a means of progressing homelessness within the context of health and social care integration.

1. Hetherington K, Hamlet N. Restoring the Public Health response to Homelessness in Scotland. ScotPHN; 2015. www.scotphn.net/wp-content/uploads/2015/10/Restoring-the-Public-Health-response-to-Homelessness-in-Scotland-May-2015.pdf.
2. NHS Health Scotland. Health Inequalities: What are They? How do we Reduce Them? Edinburgh: NHS Health Scotland.
3. Scottish Government. *Homelessness and keeping your home*. www.gov.scot/Topics/Built-Environment/Housing/homeless
4. Thomas B. Homelessness kills: an analysis of the mortality of homeless people in early 21st century England. Crisis; 2012.
5. Morrison D. Homelessness as an independent risk factor for mortality: results from a retrospective cohort study. *International Journal of Epidemiology* 2009;38(3):877–83.
6. Crisis. Homelessness: A Silent Killer – A Research Briefing on Mortality amongst Homeless People. London: Crisis. 2011.
7. Hwang S. Homelessness and health. *Canadian Medical Association Journal* 2001;164(1): 229–33.
8. Fazel S, Geddes JR, Kushel M. The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. *Lancet* 2014;384:1529–40.
9. Wang SW, Burns T. Health interventions for people who are homeless. *Lancet* 2014;(384):1541–1547.
10. Edidin JP, Ganim Z, Hunter SJ, Karnik NS. Mental and physical health of homeless youth: a literature review. *Child Psychiatry and Human Development* 2013;43:354–375.
11. Dore E. Insights: prison leavers and homelessness. Glasgow: IRISS. 2005.
12. Wright N, Tompkins C. How can health services effectively meet the health needs of homeless people? *British Journal of General Practice* 2006;56(525):286–293.
13. Briggs MA. Providing care for children and adolescents facing homelessness and housing insecurity. *Paediatrics* 2013;131:1206.
14. Kirkman M, Keys D, Bodzak D, Turner A. Are we moving again this week? Children's experience of homelessness in Victoria, Australia. *Social Science and Medicine* 2010;70(7):994–1001.
15. McDonagh T. Tackling homelessness and exclusion: understanding complex lives. York: Joseph Rowntree Foundation; 2011.
16. Fitzpatrick S, Bramley G, Johnsen S. Multiple exclusion homelessness in the UK: an overview of findings – Briefing paper no. 1. Edinburgh: Heriot-Watt University; 2012.
17. Homeless children and families in Edinburgh. Business Case proposal by Dr Joy Rafferty, Health Inequalities Fellow, South East Scotland; 2013 (unpublished).
18. Scottish Government. *Prevention of homelessness guidance*. www.gov.scot/Publications/2009/06/08140713/14
19. Department for Communities and Local Government. Psychologically Informed Services for Homeless People: Good Practice Guide; 2012.
20. Homeless Link Preventing homelessness to improve health and wellbeing, London: Homeless Link; 2015.
21. Inclusion health, St. Mungos, homeless link. Improving Hospital Admission and Dischargers for people who are homeless; 2012.
22. St Mungo's. Welcome Focus on Homeless Hospital Discharge; 2015. www.mungos.org/press_office/2332_welcome-focus-on-homeless-hospital-discharge
23. Pleace N. Consumer choice in Housing First. Reponses to "Discourse of consumer choice". Centre for Housing Policy, University of York, UK and the European Observatory on Homelessness; 2013.
24. Pleace N. Ambiguities, Limits and risks of Housing First from a European perspective. *European Journal of Homelessness* 2011;5(2):113–127.
25. Busch-Geertsema V. Housing First Europe Final Report. Brussels; Housing First Europe; 2013.
26. Johnsen S. Turning point Scotland's housing first project evaluation – final report. Edinburgh: Heriot-Watt University; 2013.

Collaboration with NHS Health Scotland

For further information, to join the mailing list for future Inequality Briefings in the series or to discuss working in partnership with NHS Health Scotland, contact:

Senior Communications and Engagement Officer (Public Affairs)
nicholas.hay@nhs.net
07500 854575