Health and social care
Introductory briefing for Prevention Review Group

Summary

Households with experience of homelessness make up the majority of users of certain healthcare services. While the majority of homeless households do not have additional support needs, rates of mental ill health, drug or alcohol use are much higher than comparison populations. Death rates are also much higher. Children from homeless households have higher rates of a range of physical, emotional and behavioural risk factors, and housing has been a factor in a number of significant case reviews.

Homeless people can face a range of barriers accessing health and social care services. However people often access health and social care services immediately prior to becoming homelessness, and this could provide opportunities to provide assistance at an early stage and prevent people's housing, health and social care needs deteriorating. Earlier intervention may also facilitate the implementation of existing frameworks for health and social care, as well as providing financial benefits to services over time.

Support needs of homeless households

At least 8% of the Scottish population (as at 30 June 2015) have experienced homelessness at some point in their lives. Of these, 29% of men and 26% of women had experienced more than one episode of homelessness[1].

29,900 households were assessed as homeless or threatened with homelessness by local authorities in 2018.19. Over the past 5 years, the support needs of homeless applicants have increased, from 34% of all homelessness applicants to 49% in 2018/19[2]. In 2018/19:

- 25% of homelessness applicants had mental health problems
- 3% had learning disabilities
- 5% had a physical disability
- 10% had a medical condition
- 11% had a drug or alcohol dependency

The proportion of people with support needs has risen across all categories over the last five years, except for drug or alcohol dependency which has stayed static. In particular, the proportion of homeless applicants with mental health problems has increased from 13% of all homeless applicants to 25% in the past five years.

Mental health was recorded as a contributing factor to being unable to maintain housing for 25% (6,031) of households in 2018/19. Drug or alcohol dependency contributed in 13% (3,193) cases, and physical health reasons in 10% (2,340) applications. Unmet needs for support from housing, social work or health services were a contributing reason for failing to maintain accommodation in 1,454 (6%) of applications.

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[1] Waugh et al (2018) Health and homelessness in Scotland. Homelessness is defined as receiving homelessness support from their local authority.

[2] Scottish Government (2019) Homelessness in Scotland 2018/19

22% of female homelessness applicants are homeless as a result of a violent or abusive relationship. Women were also more likely than men to have support needs overall, and more likely to have mental health problems[3].

Around 5,700 people in Scotland experience a combination of offending, substance misuse and homelessness within one year in Scotland, while another 28,800 experience a combination of two of these disadvantages[4].

263 households made homeless applications on discharge from hospital in 2018/19, and 1,034 households made applications from supported accommodation. 51 applications were made from children's residential accommodation (i.e. looked after young people)[5].

Use of health services by homeless people compared to other populations

A recent study matched records of 1.3 million people in Scotland over a 15 year period, comparing people who had ever been homelessness (defined as being assessed as homeless by a local authority) with equivalent populations in the 20% most and least deprived communities[6].

- The majority (51%) of people with experience of homelessness had no evidence of health conditions relating to drugs, alcohol or mental health. However, this was a much lower proportion than in either of the two control groups. For example 74% had not experience of these health conditions in the most deprived 20% control group.
- There was evidence of drug and/or alcohol-related interactions for 19% of people who had been homeless. This is five times the rate for those in the 20% most deprived cohort. Of these, the vast majority (94%) also had evidence of mental health issues.
- 6% of homelessness-experienced people had evidence of all three of the following conditions – a mental health condition, a drug-related condition and an alcohol-related condition – although not necessarily at the same time. This was much higher than in the control groups and the figure was markedly higher for those experiencing repeat homelessness (11.4%)

In comparison with people from the most and least deprived communities, people who have ever been homeless account for the majority of attendances at health services:

- 55% of A&E attendances (1.16 million attendances out of 2.12 million). This is nearly twice the rate of those from the 20% most deprived communities
- 52% of Acute Hospital Admissions
- 49% of Outpatient Appointments
- 66% of Dispensed Prescriptions, 2.5 times the rate of people in the 20% most deprived communities. The differences in rates was much more pronounced for Alcohol related and Opioid related (3.9 and 6.4 times higher) prescriptions.
- 80% of Admissions to Mental Health Specialities (80,000 out of 100,000), 4.9 times the rate of people in the most deprived communities

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[3] Scottish Government (2019) Homelessness in Scotland: 2018/19 - Equalities Breakdown
[4] Bramley et al. (2019) Hard Edges Scotland: New conversations about severe and multiple disadvantage
[5] Scottish Government (2019) Homelessness in Scotland 2018/19
[6] Waugh et al (2018) Health and homelessness in Scotland.

- 90% of Initial Assessments at Drug Treatment Services, 10 times higher than the most deprived cohort

Increased interactions with health services preceded people becoming homeless and a peak in interactions with health services was seen around the time of the first homelessness assessment.

Death rates among the homeless population

Over the course of the 15 years of the study comparing different population groups, 60% of the deaths were among the cohort of people who had ever been homeless, despite making up only a third of the people in the study. The death rate in the ever homeless cohort was 2 times higher than the cohort of the most deprived communities, and over 5 times the rate of those from the least deprived communities.

A recent study of nearly 4,000 homeless hospital admissions in England found that the median age of death was 51.6 years, and 30% of homeless deaths were due to causes amenable to timely and effective health care[7]. It also highlights the need for a much broader focus on homelessness prevention and support that is encompassing of physical health and long-term condition management, especially for more common conditions such as cardiovascular disease.

Use of health services by children in homeless households

A study in North Lanarkshire[8] has found that children in households with an open homelessness application showed:

- Twice the rate of CAMHS referrals compared to the wider population (72 per 1,000 population compared to a council average of 35 per 1,000)
- A much lower rate of teenage booster vaccine uptake, 45% compared to 73%
- 2.5 times greater likelihood not to attend a new outpatient appointment
- Higher rates of concerns in the 27-30 month child health review (31% compared to 18.5% in the general population). 17.5% of children in homeless households had emotional and behavioural concerns identified, compared to 7% in the wider population
- Higher rates of asthma prescriptions
- A 57% increased likelihood of having had a tooth extracted in the 5-11 year age band

Housing and significant case reviews

An analysis of significant case reviews carried out in Scotland in 2012[9] shows that housing issues were recorded in over half of cases, and "many families had experienced multiple moves and periods of homelessness". Failure to meet housing needs or to

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[7] Aldridge et al (2019) Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England

[8] Campbell R (2019) A Health Needs Assessment of children experiencing homelessness in Lanarkshire. NHS Lanarkshire

[9] Vincent, S, Petch A (2012) Audit and Analysis of Significant Case Reviews https://www.celcis.org/files/4415/4445/2689/Audit_and_Analysis_of_Significant_Case_Reviews_Sharon_Vincent_2012.pdf

identify teenagers with housing needs as vulnerable young people rather than homeless adults was highlighted as a key risk factor in another review of significant case reviews in 2015[10].

Access to health and social care services

Much of the evidence around use of and access to health and social care services by homeless people focuses on health rather than social care services. Anecdotally there are significant barriers to accessing social care support for homeless people. Some homeless services report that when people come to their service it can be following a number of missed opportunities to prevent needs escalating and people losing their housing, often because people do not meet the high thresholds for social care and other services. The housing stakeholder group highlighted mental health, learning disability and autism as some of the areas where this can occur.

A 2017 report form the Mental Welfare Commission[11] found many of the homeless people it spoke to had significant mental ill health. Some were able to access the care and treatment they needed, but others were not. Homelessness services did not have direct referral routes to psychiatric or psychological services. There could be barriers to registering with GPs, but often this was the only route for referrals to specialist services. The report made useful recommendations around access to services, planning for the needs of homeless people, ensuring support for people with mental health and substance misuse needs, and continuity of healthcare for prison leavers at risk of homelessness.

Research on the implementation of the Homelessness Reduction Act in England[12] shows that people who were homeless or at risk of homelessness and approached their local authority Housing Options services for assistance are often also accessing health and social care services before they experienced their homelessness episode:

- Nearly a third (32%) were accessing their GP
- 14% were accessing hospital support
- 15% were accessing mental health services
- 5% were accessing drug and alcohol services
- 11% were accessing social services support

Of these services, drug and alcohol, mental health and social services were most likely to advise people to go to Housing Options services for housing support, with GPs only doing so in 31% of cases. Under the Act, there is a duty on certain public bodies to refer people to the local authority where there is a risk of homelessness. This includes social service authorities (both adult and children's), emergency departments, urgent treatment centres, hospitals in their function of providing inpatient care. Early findings from the

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[10] Care Inspectorate (2015) Learning From Significant Case Reviews in Scotland: A retrospective review of relevant reports completed in the period between 1 April 2012 and 31 March 2015 https://www.safershetland.com/assets/files/Learning%20from%20Significant%20Case%20Reviews%20in%20Scotland%202012%20-%202015.pdf

[11] Mental Welfare Commission for Scotland (2017) Themed visits to homeless people with mental ill health

[12] Crisis evidence for the Communities and Local Government Select Committee Inquiry: One year on since the introduction of the Homelessness Reduction Act: https://www.parliament.uk/documents/commons-committees/communities-and-local-government/Crisis-written-evidence-HRA-one-year-on.pdf

research suggest that there are more opportunities to intervene to prevent homelessness by health and social care services than are currently taking place in the English context.

Cost benefits

Crisis's research *Better than Cure* estimated that the costs of preventative services that would help stop someone entering homelessness would cost on average £2,263 per person. They also estimated that there would be a 24% fall in NHS service use if someone's homelessness was prevented. The research also highlighted that many of the respondents said that support with mental health and drug/ alcohol issues would have helped some people prevent their homelessness.[13]

Current regulatory framework for health and social care

Under the Public Bodies (Joint Working) (Scotland) Act 2014, Scottish ministers may prescribe national outcomes for health and wellbeing. Health and Social Care Integration Authorities must have regard to these. These are backed by Health and Social Care Integration Indicators[14], which include the following of potential relevance to people at risk of homelessness:

1. Percentage of adults able to look after their health very well or quite well

2. Percentage of adults supported at home who agree that they are supported to live as independently as possible

3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided

4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated

7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life

9. Percentage of adults supported at home who agree they felt safe

Potential areas for duties on health and social care bodies

Research for the Homelessness Monitor Scotland 2019[15] found that only 8 out of 28 local authorities surveyed said that their local Health and Social Care Partnership helps them prevent homelessness.

> "…it's a failure of services, whether health or social work, to pick up the harm that's been done to that person at the time…and there's so many different opportunities to pick that up, until the person hits the homeless service. At that point in time, what they do need is somewhere to stay, but what's brought them there has been a series of trauma, and other incidents, that's had a detrimental effect on their mental health and wellbeing…"
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> (Independent key informant, 2018)

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[13] Pleace, N. & Culhane, D.P. (2016) Better than Cure? Testing the case for Enhancing Prevention of Single Homelessness in England. London: Crisis

[14] Scottish Government (2015) Core Suite of Integration Indicators https://www2.gov.scot/Resource/0047/00473516.pdf

[15] Fitzpatrick S et al (2019) Homelessness Monitor Scotland

Improving understanding of homelessness, prevention triggers and referral pathways from Health and Social Care colleagues is mentioned in around half of local authority Rapid Rehousing Transition Plans.

There are a number of areas where legal duties on health and social care bodies could assist in the prevention of homelessness. Some areas that have already come up in discussions include:

- Duty on health and social bodies (Integrated Joint Boards?) to prevent homelessness
- Duty to carry out a health needs assessment and provide relevant support in relation to a person at risk of homelessness if requested by the local authority
- Duty on individual health and social care bodies to refer individuals or households to the local authority where there is a perceived risk of homelessness

Appendix: Functions delegated to the Health and Social Care Partnership

Health services that *must* be delegated:

- A&E
- Unplanned inpatients
- Care of older people
- District nursing
- Health visiting
- Clinical psychology
- Mental health
- Learning disabilities
- Addictions services
- Allied Health Professionals (occupational therapists, physiotherapists, psychologists etc)
- GP Out of Hours
- General medical services

Local authority services that *must* be delegated:

- Social work for adults and older people
- Services and support for adults with physical and learning disabilities
- Mental health
- Drug and alcohol services
- Carers support
- Community care assessment teams
- Support services
- Care home services
- Day services
- Occupational therapy
- Reablement, telecare
- Housing support, housing adaptations

Other functions may be delegated through local agreement