Local Government and Communities Committee

Homelessness

Submission from NHS Health Scotland

About Us

NHS Health Scotland is a national Health Board working with public, private and third sectors to reduce health inequalities and improve health.

Our corporate strategy, A Fairer Healthier Scotland, sets out our vision of a Scotland in which all of our people and communities have a fairer share of the opportunities, resources and confidence to live longer, healthier lives.

Our mission is to reduce health inequalities and improve health. To do this we influence policy and practice, informed by evidence, and promote action across public services to deliver greater equality and improved health for all in Scotland.

Key Messages:

- Health services (especially primary care, mental health and substance use services) and other frontline services such as justice can play a powerful role in early detection and prevention of homelessness.

- 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’, recognising that many of those experiencing repeated homelessness have experienced both adult and childhood trauma and adversity.

- 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.

Housing Options and Homelessness Prevention

How effective is the relationship between all the relevant agencies, including the health sector, and charities working on homelessness prevention?

Given what we know about the causes of homelessness, the health of homeless people and the contact with health and social care services that some people have prior to a homelessness presentation at a local authority, the prevention of homelessness cannot be led by housing alone.1 The NHS and partners can contribute greatly through early intervention and prevention activity. In particular, services such as primary care, mental health and substance use services can
contribute to the prevention of homelessness by identifying those who are at risk and signposting or supporting access to welfare and housing advice, including that provided by the third sector. In addition, homeless people and those at risk come into routine and regular contact with hospitals; therefore, contacts made in A&E or during hospital admission and discharge are good opportunities for intervention and referral. Much good work is already happening in this area which can be built on.

At a more strategic level, there are many examples of effective relationships and close partnership working across and between sectors in Scotland. NHS Health Scotland hosts the National Health and Homelessness Group, which includes representation from national and local government; the health sector, including public health, primary care, oral health and psychology; housing; welfare; academia; and homelessness charities. This group was established to support implementation of the opportunities identified in the Scot PHN report, ‘Restoring the public health response to homelessness in Scotland’ and continues to identify new opportunities for homelessness prevention as well as its mitigation.

NHS Health Scotland also supports the Scottish branch of the Faculty for Homeless and Inclusion Health which is a network of people from a range of backgrounds and sectors, including people with experience of homelessness, which is focused on improving the health care of homeless and other multiply excluded people such as Gypsy/Travellers, vulnerable migrants and people at risk of or involved in prostitution.

NHS Health Scotland has a Shared Agreement with Shelter Scotland in order to progress shared aims in relation to both housing and homelessness. The health sector is represented on the multidisciplinary Homelessness Prevention and Strategy Group, which is jointly chaired by COSLA and the Minister for Housing and Local Communities. Strategic health input is also present by representation on the Joint Housing Policy and Delivery Group (JHPDG) and both of its current task groups.

There has been excellent partnership work taking place between the Scottish Prison Service (SPS), Shelter Scotland and the Chartered Institute of Housing to develop standards for SPS to ensure no prisoner is released into homelessness. These are due for publication in 2017 and offer a powerful stimulus to positively address the interplay between justice and homelessness. Similarly the establishment of Throughcare Support Officers (TSOs) in SPS establishments is a welcome and positive contribution to both homelessness prevention and reduction of re-offending. The Community Justice (Scotland) Act 2016 and the newly formed national agency, Community Justice Scotland, provide further opportunities to strengthen links between justice, housing strategy and the universal health and social care services that people in contact with justice services need.
Multiple and Complex Needs

What more could be done to ensure that the needs of homeless people with multiple and complex needs are adequately supported? Are there examples of good practice?

Many people who are homeless have multiple, complex support needs which overlap (e.g. drugs, alcohol, mental health, learning difficulties and physical health problems, as well as involvement with the justice system).\(^3\) As health services tend focus on single ‘issues’, this group struggles to access the mainstream service offer. Patients with so called ‘dual diagnosis’ (mental health and substance use issues) can all too easily fall between current condition-led services. The call for true ‘person-centred care’ is nowhere more needed than in the case of the multiply excluded homeless community with dual or indeed tri-morbidity (mental health, substance use and physical health problems). ‘One-stop shop’ arrangements do exist but mostly in the voluntary sector and these are often underfunded and challenged by the condition-specific funding they receive from commissioners who are characteristically siloed in traditional service approaches (such as mental health, alcohol, problematic substance use etc.).

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 to understand where these challenging behaviours are coming from, allowing staff to work more creatively and constructively with people.\(^4\)

Embedding the application of ‘psychologically informed’ service design and delivery is a core element of the work of the national Health and Homelessness Group. Already a number of third sector organisations (such as Y-People, Rowan Alba and Blue Triangle) apply this approach with excellent results. Public services have yet to fully embrace this evidence-based formulation. ‘Psychologically informed’ service commissioning is required in Scotland as the providers of front line services struggle to align the process-based demands of commissioners (usually NHS, Health and Social Care Partnership or local authority) with the outcome-based approach of psychologically informed delivery of services.

What scope is there for improved joint working with all agencies and groups supporting those with multiple and complex needs, which would also include the health sector?

The health sector plays a key role in tackling health inequalities and in meeting the needs of people with multiple and complex needs, including homeless people. Public health in particular is well placed to orchestrate the partnerships required. There has
been considerable development in terms of public health engagement and networking at national and local levels over the past two years arising from the ScotPHN report mentioned above. This has led to progress in data sharing between housing services and NHS secondary care and a national piece of work to examine the health impacts of homelessness and health due to be concluded in 2017.\(^5\) Local homelessness health needs assessments are also under way in a number of local authorities and their partnering Health Boards. Going forward the challenge is to embed emergent best practice across all Health Boards, primarily by proactive engagement of health in the network of Scottish Government Housing Options Hubs. This has been identified as a priority for the national Health and Homelessness Group, and approaches have already been made to some of the hubs to start to establish relationships. NHS Health Scotland is also a partner in the development of training materials for the Housing Options Hubs Training Toolkit and is considering the potential for material on housing and homelessness to be incorporated into core health inequalities training for NHS staff.

Housing can be seen as a bedrock requirement for wellbeing across the life course, thus lack of housing and housing insecurity underpins much of the adversity that leads to social disadvantage, poor health and exclusion. It will be important for strong housing (including homelessness) expertise to be embedded in the new Scottish Public Health body.

Health and Social Care Partnerships will be central to the development of Local Outcome Improvement Plans (LOIPs) in meeting the needs of the homeless community. The link between housing and Integration Joint Boards currently lies in the Housing Contribution Statements which are very variable in quality at present. There is a pressing need for housing to be more fully recognised as an essential partner alongside health to create local housing provision and support which generates wellbeing and mitigates the risk of homelessness.

**How can access to general health services, including preventative health services, be improved for homeless people?**

Many of the thresholds to access support services are sub-optimal and offered too late to have an impact or to prevent homelessness. Much of current innovative practice is small scale, piloted or short term. Local planning and integrated models are necessary to achieve sustainable future models of homelessness prevention.

There needs to be a recognition of the bi-directional causality between housing insecurity and wellbeing – poor (or lack of) housing leads to poor health and poor health leads to levels of exclusion which can include homelessness. Thus a close relationship between GP clusters and local housing options and homelessness services are necessary. Housing options staff are ideally placed to detect health issues and a speedy, seamless referral process (ideally using ‘experts by experience’, mentors or advocates) from a housing interview to mental health, addiction and primary care services is needed. Similarly in primary care, there is need for recognition that prompt management of housing insecurity is a component of treatment and a key form of social prescribing. Where population density merits it, the establishment of a dedicated primary care service (nursing or GP-led) for the
multiply excluded homeless is a robust mechanism for the provision of a multi-
professional team to care for the health needs of the homeless.

**What role could the ‘housing first’ model play in improving outcomes for homeless people with multiple and complex needs?**

The recent ScotPHN report, ‘Foundations for Wellbeing’, demonstrates that good housing, encompassing not only the physical dwelling but also household circumstances, neighbourhood conditions, and the community in which homes are set, is an essential pre-requisite for human wellbeing. Adequate housing is also recognised in the Universal Declaration of Human Rights as a fundamental part of the right to an adequate standard of living. As well as providing protection from physical and psychosocial hazards, housing is central to many other determinants of our health, such as education, employment, social relationships, and environmental sustainability.

Because ‘housing first’ provides a relatively secure tenancy, and combines that with supportive treatment services in the areas of mental and physical health, substance use, education and employment, it delivers more effective outcomes for those with the most complex needs and who have previously experienced difficulties in sustaining tenancies. Evaluations from the approach in Glasgow and Renfrewshire support international evidence that it provides the best model to resolve homelessness in around 80% of those with complex needs. 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 can be supported to overcome cycles of homelessness. From a health perspective, Local Authorities and commissioners should be actively pursuing ‘housing first’ as a component of their housing portfolio for the most complex individuals.

**Other**

**What are the reasons behind why people become homeless?**

Relationship breakdown is a major factor, thus seeking preventative approaches to family or other relational breakdowns is key to the long term prevention of homelessness. Homelessness is often a late marker of a history of adverse childhood experiences (ACEs), care experiences, involvement in the justice system, mental health problems, abuse, violence and harmful substance use. The current focus on positive parenting, and support in the early years, is a key aspect of homelessness prevention. Also the rising awareness of ACEs and their impact across the life course is a welcome mechanism which will, from a psychologically informed perspective, help address one of the core underpinning causes of homelessness. NHS Health Scotland has established a Scottish Adverse Childhood Experiences (ACEs) Hub, to raise awareness of the impact of childhood adversity on later health and wellbeing and identify actions to both prevent and respond to ACEs. NHS Health Scotland is working closely with a range of partners to generate action on ACEs, including with Scottish Government.

Clearly the lack of social and affordable housing must also be addressed, alongside the critical impact of welfare reform on both individuals and the mechanisms by
which local authorities fund their temporary housing portfolios. There are also opportunities for prevention and intervention around the key transition points when at-risk individuals can become homeless. These can be summarised as points of ‘leaving’ or ‘losing’. Risks are high when leaving care as a child, leaving home following relational breakdown or leaving an institution such as prison, hospital or the military. Loss following a bereavement, a job, a relationship or a mental illness can also precipitate homelessness. By targeting prevention at these critical transition points, individuals at highest risk can be helped to navigate such times.

Are there any problems with people accessing their housing and homelessness rights? If yes, how can access be improved?

A human rights based approach recognises access to services as a fundamental aspect of the right to health.\textsuperscript{13} Using tools such as Health Inequalities Impact Assessment, which includes equality and human rights impact assessment, when planning or redesigning services can help planners and providers to assess the accessibility and acceptability of services to all users, including those who are homeless or otherwise marginalised. As discussed above, using ‘psychologically informed’ approaches which recognise the trauma people may have experienced is likely to improve the accessibility of, and people’s engagement with, services.

There is a need for further training for health and social care staff on the rights and entitlements of people who are homeless. For example, issues remain around prompt GP registration and the requirement for primary care to gate-keep access to community mental health, alcohol or substance use services. Recent NICE guidelines on transitions of people with mental health problems between hospital and the community\textsuperscript{14} and the Equalities and Human Rights Committee report Hidden Lives – New Beginnings\textsuperscript{15} identify cross-cutting issues pertinent to this agenda and examples of best practice.

The role of ‘experts by experience’ or peer supporters, and of advocacy, is also central to improving access to housing and homelessness rights.

Are there any other issues relating to homelessness which you wish to bring to the attention of the Committee?

Taking a strategic cross-sectoral approach to homelessness prevention requires adoption of the principles clearly laid out in the Commission on Housing and Wellbeing’s report ‘A blueprint for Scotland’s future’.\textsuperscript{16} Housing policy and practice in Scotland underpins wellbeing and health across the life course and as such acts as a potent driver alongside poverty alleviation to prevent ill-health and reduce social and health inequality. The role of Community Planning and the development of LOIPs together with a much stronger engagement of IJBs with housing (and homelessness) services are opportunities not to be missed.

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References


7. 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


