Local Government and Communities Committee

Homelessness

Submission from NHS Greater Glasgow and Clyde Directorate of Public Health

Please find below a partial response to the call for evidence on homelessness on behalf of Public Health in NHSGGC.

1. Multiple and Complex Needs

Q. 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?

Tackling homelessness for people with multiple and complex needs requires an understanding into the multiple pathways into homelessness. The pathways into homelessness and experiences of homeless people with multiple support needs were illuminated by the Economic and Social Research Council (ESRC) funded research into Multiple Exclusion Homelessness (MEH) in the UK\(^1\). This study has informed a more sophisticated understanding of ‘deep social exclusion’ in order to inform better responses to people with multiple and complex needs. For the purposes of the research, MEH was defined as experience of homelessness plus either institutional care, substance misuse, or street culture activities (begging, street drinking, ‘survival’ shoplifting or sex work).

The research recognised that this multiple needs group is particularly costly both to the individuals affected and society as a whole as a result of the range of interventions made by multiple agencies. Additionally, attempts to successfully address people’s needs have most often been made by a single agency viewing ‘problems’ through their own specific lens (e.g. criminal justice, addictions).

The research identified 5 statistically robust clusters of pathways into homelessness and associated forms of severe and multiple disadvantage which can be used by policy makers and practitioners to target interventions. These clusters are:

- Mainly Homelessness;
- Homelessness and Mental Health;
- Homelessness, Mental Health and Victimisation;
- Homelessness and Street Drinking;
- Homelessness, Problematic Use of Drugs and High Complexity.

\(^1\) Joseph Rowntree Trust. Tackling homelessness and exclusion: Understanding complex lives. September 2011
Furthermore, the research was able to identify the sequencing of MEH experiences, allowing the median age of experiences to be reported. This sequencing indicated that:

- Leaving home or care, and first experience of substance misuse tended to occur in mid-to-late teens, as did prostitution;
- First experiences of sofa-surfing, survival shoplifting, being a victim of violent crime, prison, anxiety and depression, and injecting drug use tended to occur in very early 20s;
- Homelessness experiences (except sofa surfing) tended to be reported as first having happened in mid-to-late 20s - as was first experiences of begging, being admitted to hospital with a mental health problem and adverse life events such as redundancy, eviction and bankruptcy;
- Experience of divorce, repossession and death of a partner tended to happen at a higher median age.

Due to a combination of structural and social issues, there is evidence of multiple exclusion being higher than average for single men and of additional challenges faced by groups such as refugees and asylum seekers; people who are destitute and unable to claim welfare support; the Roma community who are subject to overcrowding and exploitation by private landlords; and ex-prisoners leaving prison with no accommodation options who are transitioning into mainstream housing and welfare provision.

The evidence from the MEH study and others indicates that for many, homelessness is a late manifestation of adversity across the lifecourse. This means that preventing homelessness requires action by multiple agencies to prevent those forms of adversity, to mitigate their impact, and to support those affected - from primary care, addictions care and mental health within the NHS, to housing services, children's services, prisons, community justice, and the police. It also requires action in multiple policy spheres, from early years, employment, social security, housing, mental health and drugs, and criminal justice.

There is a useful analogy here with the medical concept of multi-morbidity, which refers to a situation in which a person has multiple long-term health conditions. Multi-morbidity is increasingly recognised as the rule rather than the exception, so we are having to re-think how we deliver health services, particularly in hospital settings, which have traditionally been highly specialised and set up to deal with a single organ system (such as cardiology, or respiratory medicine).

Similarly, people with multiple and complex needs also often experience a difficult journey through a fragmented system of different specialist services with different thresholds, criteria, cultures, and remits. This is particularly challenging for people
with multiple and complex needs, who may have difficulties with literacy and numeracy or with trusting individuals or organisations, or previous experiences of stigma or discrimination. Like multi-morbidity, addressing multiple and complex needs requires changes in traditional 'siloed' or ‘vertical’ models of service provision to ensure more integrated and holistic care, in order to maximise access, engagement, and positive outcomes for those individuals.

Evidence from a recent review by researchers at Heriot-Watt University identified a number of principles for such services:

- Personalisation, involving open-ended, persistent, flexible, and co-ordinated support
- Deinstitutionalisation (i.e. mainstream housing as the default option, rather than separate institutions)
- Reintegration, through employment and other activities
- Asset-based, focusing on an individual’s strengths and potential
- Poverty-informed, dealing directly with financial and material hardship

To this, we would highlight the value of ‘psychologically-informed environments’ that reflect the difficulties people with multiple and complex needs can have in accessing services and developing relationships with care/authority figures. These difficulties are often rooted in adverse childhood experiences.

There is great potential to use health and social care integration as an opportunity to improve joint working between services. In Glasgow City, homelessness has been included in health and social care integration to this end.

In order to improve services and outcomes, people with lived experience of multiple and complex needs (also known as ‘experts by experience’) should be closely involved in the planning, design, and delivery of services. There are a number of successful examples in this regard, such as Glasgow Homeless Network’s peer support and advocacy network and the work of the UK charity Pathway.

**Q. 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?**

This is partly addressed by our response to the above: we believe that joint working across agencies, groups, and policy areas is crucial to addressing the issue of multiple and complex needs. This work should encompass:

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Examples of services at the top tier would include Housing First initiatives and psychologically-informed integrated services for people with multiple and complex needs. Local examples in NHSGGC include the plans underway in Glasgow City HSCP for a multi-agency hub to support homeless people in the city centre, and the Tomorrow’s Women project for female offenders.

Examples of services at the middle tier would include intensive support for people at high-risk transition points, such as people leaving prison, the armed forces, or local authority care, or other life events, such as bereavement, job loss, or mental illness. Other examples include routine enquiry about relevant life circumstances – such as housing and homelessness – in healthcare settings, with appropriate follow-up support and signposting.

Examples of activity at the bottom tier would include national policies on early years, housing supply, and social security, as well as local activity through Community Planning and Health and Social Care Partnerships.

Data linkage between different services can help inform multi-agency working. Locally, NHSGGC is undertaking a data linkage project to bring together data from homelessness services and the NHS, to understand health outcomes among people with multiple and complex needs. We would be happy to share the findings of this exercise as they become available.

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

In general terms, principles for improving access to general and preventative health services for homeless people include:

- An awareness among health professionals and practitioners of multiple exclusion and how to apply the principles of inequalities-sensitive practice
- Person-centred and asset-based approaches, without stigma or discrimination
- Strong relationships between healthcare, housing, and homelessness services, e.g. through link workers and social prescribing in primary care; liaison teams in secondary care; and Housing Options hubs
• Application of the principle of ‘proportionate universalism’, whereby services are provided on a universal basis, but the intensity of provision is proportionate to need. In this instance, this might include specialist services able to provide flexible appointments (such as Hunter Street in NHSGGC); outreach services; or additional support from case workers or peer advocates
• Involvement of service users and people with lived experience in the design and delivery of services
• Robust Equality Impact Assessment processes which consider the needs of marginalised groups, including homeless people. This has been a particular focus of work in NHSGGC.
• Ensuring people can access support for other issues which often take priority over preventative healthcare, such as immediate housing need, income and benefits, mental ill-health and addiction.

Actions likely to improve access to general health services for homeless people may also improve access for other population groups who experience difficulties in this regard (e.g. migrants and refugees, or Gypsy/Travellers).
People who are homeless have high rates of preventable ill-health, resulting in high rates of A&E attendances and unplanned hospital admissions. They also have longer durations of stay once admitted, largely due to the severity of their conditions. Improving access to primary healthcare and preventative interventions is therefore likely to be highly cost-effective and a worthwhile form of preventative spend.

2. Other

Changes to the benefits system over the past few years have negatively impacted on the lives of homeless people, and will continue to do so. Below are some areas we considered for a report in 2016 in relation to welfare reform and homelessness, including some early evidence of the impacts.

Universal Credit

The introduction of Universal Credit (UC) represents the biggest change in the benefits system in years and full-service roll out is underway. The risk UC posed to homelessness accommodation providers has largely been addressed through exemptions for rent being included in UC where a person is residing within ‘specified’ supported and/or temporary accommodation. However the move to UC will continue to pose challenges for homeless people who may have limited budgeting skill or be at risk of financial abuse or theft, as well as people on low incomes in receipt of in work benefits.

4 Universal Credit will allow for exceptions to the monthly payment so that claimants can receive their money more frequently, but these will be at discretion of DWP.
Impact of benefit sanctions, financial hardship and debt

The Real Life Reform Report\(^5\) tracking the impact of welfare reform on up to 100 households stated that nearly half of UK’s social housing tenants have no money left after bills are paid or are accruing debt as a result of government sanctions. Moreover emerging themes from this study indicate the highest cause of debt is rent arrears for both employed and unemployed people. The report states that:

‘for those who are employed and in debt, the highest debt is rent with 73% in arrears, followed by 53% in debt to household bills and 27% to both credit cards and catalogues. For unemployed households, 51% are in rent arrears, The main debt areas for unemployed households are 46% household bills, 41% to the bank and 24% in debt to credit cards and catalogue companies.’

This suggests a hidden time bomb of homelessness if such rent arrears are typical of low income households across the UK and if they result in evictions.

In the same study 86% of all respondents felt that Welfare Reform was having a negative impact on their health and well-being.

Income inequality and unemployment already characterise homelessness. Research in England\(^6\) reports that benefit sanctions introduced under welfare reform measures are disproportionately affecting individuals who are unemployed or receiving disability living allowances (now PIP) and have experienced homelessness, for example:

- 31% of homeless people on Jobseekers Allowance (JSA) have been sanctioned, compared to just 3% of typical claimants;
- Nearly a third of services report homeless people being sanctioned while facing poor mental health, learning difficulties or substance misuse problems;
- The majority of workers report clients being pushed into debt, food poverty and survival crime.

The report concludes that sanctions are not motivating homeless people back into work but putting many into severe hardship and further disengaging them from progressing to employment. This suggests welfare reform presents additional challenges for the NHS and its partners to deliver employability measures aimed at closing the health inequalities gap.

Young single people are also experiencing disproportionately high levels of


sanctions with DWP research reporting that almost 60% of <25 year olds on JSA have had their benefits sanctioned. Proposals to limit housing benefit for under 25s will reduce support options even further.

The majority of respondents (55 providers of food aid) interviewed in a Scottish Government sponsored study\(^7\) believed that the recent rise in demand for food parcels and cooked meals, pointed at the changes to the benefit system. The ‘bedroom tax’, benefit sanctions and benefit transfers resulting in payment ‘gaps’ were thought to be the main three reasons for clients not having enough income to buy food. Some also spoke of their clients being forced to use food aid because of not having enough working hours (or having lost overtime).

Whilst the full impact of welfare reform on homelessness is yet to be evidenced it is clearly already impacting adversely on a number of common risk factors for homelessness. The health impact was summed up in a report by the North East Think Tank (May 2014)\(^8\) as:

‘It is perhaps too early to assess the health implications of welfare reform, but adverse consequences for physical and mental health could result from: poorer housing conditions, decreased housing security, social isolation, the increased stigmatisation of benefit claimants, a fall in real and disposable incomes, a rise in personal debt and increased food and fuel poverty. Reports of increased levels of anxiety, worry and depression among social housing tenants and homeless people as a result of financial hardship are common. Housing providers are giving staff additional training on how to deal with distressed tenants. Organisations report the impacts of sanctions and accessing food banks on emotional wellbeing to be a key feature of discussions with tenants and clients’.

\(^7\) An Overview of Food Aid Provision in Scotland, Scottish Government, December 2013

\(^8\) Welfare reform in the North East and its impact on Single Homelessness, Association of North East Councils, September 2013