Health and Homelessness Study for North Lincolnshire

A report on a qualitative study examining the views and experience of homeless people aged 16 years and over in accessing services in North Lincolnshire.

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1. Introduction

Recent National Health Service reforms have given Local Authorities and local health structures greater responsibility for assessing local need and commissioning services. Such times of change provide new opportunities to ensure homeless people’s needs are included in local planning, and acted upon in local health services. New commissioning responsibilities for GP-led consortia; Joint Strategic Needs Assessments (JSNA); and Health and Wellbeing Strategies undertaken by Health and Wellbeing Boards, sit alongside ongoing work within North Lincolnshire’s homelessness services as they develop effective responses to the needs of their clients.

In 2010 Homeless Link, funded by the Department of Health Third Sector Investment programme, developed a Health Needs Audit Toolkit for local providers and partners to gather information about the health of people who are homeless in a local area. Aspects of this audit toolkit have been incorporated into this study.

The audit of 900 homeless people in 11 areas across the UK found that 73% of clients admitted to hospital received no help with their housing before they were discharged; that in a 12 month period an estimated 7% of the general population will have an inpatient hospital stay compared to 31% of homeless people; that 77% of homeless people smoke and 8 out of 10 have one or more physical health need, with 7 out of 10 having one or more mental health need. Of the pilot areas, the nearest to North Lincolnshire geographically, was in Leeds.

The national audit results demonstrate that homeless people are often excluded from routine health assessments yet can experience the poorest health in a local community. This Health and Homelessness Study was commissioned to provide a robust evidence base about the health needs of homeless people in North Lincolnshire and their experiences in accessing services.

The study is intended to build upon the findings of The North Lincolnshire Place of Change Feasibility Study; Needs Analysis Report commissioned by North Lincolnshire Council in 2011 and undertaken by Framework. The feasibility study provides local agencies with baseline information on the numbers and accommodation needs of homeless people with additional complex needs in North Lincolnshire. This information was used to inform the recently successful ‘Place of Change’ bid to develop a 20 bed facility with onsite training in Scunthorpe.

This study intends to develop the baseline information in the ‘Framework’ study by researching health needs and provision in the North Lincolnshire area, including clients’ and other stakeholders’ experiences of services in the area. This information will be used to inform the development of the ‘Place of Change’ project and the

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1 The Health & Wellbeing of People Who Are Homeless: Evidence from a National Audit - Homeless Link, September 2010
planning and commissioning of other relevant services, including universal and specialist services provided by partner agencies.

2. Brief
To complete a qualitative study via a range of methods including survey, in-depth interviews and focus groups with people and organisations based in North Lincolnshire, to:

- increase evidence available about the experience of homeless people in accessing services within North Lincolnshire in respect of their health and well-being.
- assess opportunities for joint working of services for the homeless in North Lincolnshire
- determine what services should be delivered from the proposed 20 bed facility for the homeless in North Lincolnshire

3. Methodology
The study was conducted in two tranches. The first investigated the views and experience of Service-Providers and key stakeholders, whilst the second included service-users. The service-user aspect of this study required an ethical opinion prior to approval to proceed.

3.1. Ethics Approval
An application was made to the NHS Health Research Authority (Research Ethics Committee for Yorkshire and the Humber) in readiness for its meeting on 29th March 2012. The committee considered the application and provided a provisional opinion requesting further information and clarification on 3rd April 2012. The requested clarification was provided and a favourable ethical opinion to proceed was given on 14th May 2012. NHS North Lincolnshire Research Governance approval to proceed was confirmed on 12th June 2012.

This process took just under three months, which delayed the start of service-user involvement in this study and created a considerable interval between requesting support from Service-Providers to recruit service-users for the study and start of their involvement.

In developing the application for submission to the Research Ethics Committee, NHS Health Research Authority guidance was followed on developing the study methodology. It was expected that at least two weeks’ notice was given for potential participants to consider whether they wished to be involved. Whilst this was adhered to in undertaking the study, it created substantial difficulties and delays, as
participants’ circumstances changed and there were difficulties experienced by this client group in making and keeping appointments.

3.2 Service-Providers
Service-Providers were contacted through the Homelessness Forum and were asked to complete a survey questionnaire by email.

Study commissioners and the Study Steering Group advised the researchers on appropriate people within the health services to include in this study and these contacts were engaged in one to one interviews. In addition, three Service-Provider Focus Groups were conducted, each with a separate theme to enable common issues for each category of service-user to be fully explored. The three themes for the Focus Groups were:

- Homeless Families
- Young and Single Homeless
- Rough Sleepers and those with Complex Needs

3.3 Service-users
Key workers in services which provide support or advice to people who are homeless or in fear of becoming homeless were provided with information about the study and asked to assist by promoting the study amongst their service-users to aid recruitment and providing suitable facilities for focus groups or one to one interviews to be conducted with service-users.

Information provided included:

- service-provider information sheet (Appendix 1)
- service-user information sheet (Appendix 2)
- service-user consent form (Appendix 3)
- recruitment flyer for display at service premises (Appendix 4)
- service-user survey tool (Appendix 5)

Most of these organisations have drop-in or timetabled sessions when they offer group or individual support and the interviewers liaised with key workers to agree the best times to visit their premises to undertake interviews and/or focus groups with their clients. Service-users were given at least two weeks to make their decision whether or not to participate. If potential participants required more time to make their decision, this was arranged.

In-depth interviews were conducted by one interviewer in a private room conducive to confidential interviews within the service premises. Service staff were made aware that an interview was being conducted and asked to make themselves available in case of any need for support or counselling.
Focus group discussions were held in a group room within the service premises. Service staff were made aware that a focus group was being conducted and again asked to make themselves available in case of any need for support or counselling.

The interviewer or focus group facilitator explained the purpose of the study and participants’ freedom to withdraw at any point without any negative consequences to them. The information sheet (Appendix 2) explained to participants that their name or other personal details would not be recorded in the survey or the Focus Group; that the findings in the study will be seen by local agencies but they will not be able to identify any individual; and that the information they provide would not affect any services they were already accessing. Participants were then asked if they had any questions and if they wished to proceed.

3.4 In-depth interviews with service-users
The in-depth interviews were conducted with service-users on a one-to-one basis using a pre-determined set of questions (service-user survey tool - Appendix 5). The questions were read out and answers recorded on the questionnaire by the interviewer. Participants were thanked for their time and provided with a £5 gift voucher by the interviewer as a goodwill gesture. 30 questionnaires were completed with service-users in this way. Questionnaire responses were entered onto a spreadsheet specifically designed for the purpose and analysed on a thematic basis. A detailed breakdown of responses from the cohort of 30 service users can be found in Appendix 8.

3.5 Focus group discussion with service-users
Five focus groups were conducted with service-users using a focus group topic guide to generate discussion within each group. Discussions were initiated by the facilitator and a record of the discussion was made by a note taker. Participants were thanked for their time and provided with a £5 gift voucher as a goodwill gesture. 20 service-users participated in these focus groups. Notes from the focus groups were analysed on a thematic basis to add detail to the survey tool analysis.

In both providers and service-users focus groups by way of introduction researchers shared information with participants from the Homeless Link National Audit and from ‘A Silent Killer’ - A research briefing on mortality amongst homeless people published by Crisis in December 2011, to initiate discussions.

3.6 Recording of participants’ responses
It is important to stress that this report reflects the views of people we have spoken to and their recollections of their experiences which are taken at face value. Where we have used quotation marks these accurately reflect the comments made, though not necessarily verbatim as the authors have used their discretion in adding punctuation and linguistic connectors in recording some statements, to clarify meaning in recording what was said.
The authors would like to record their deep gratitude to all those organisations and individuals who gave their valuable time and insight to developing and conducting this study.

4. Outcomes from Service-Provider Survey Interviews and Focus Groups

A total of 22 organisations returned completed Service-Provider Questionnaires, a detailed statistical analysis of responses to the survey questions can be found in Appendix 7. In addition five service-providers were engaged in follow-up interviews and 23 people attended three Service-Provider Focus Groups. Each Focus Group had a separate theme to enable common issues for each category of service-user to be fully explored. The three themes for the Focus Groups were:

- Homeless Families
- Young and Single Homeless
- Rough Sleepers and those with Complex Needs

4.1 Access to services

The 22 organisations responding to the Service-Provider Survey reported that they saw 446 clients on an average day between them; an average of 20 service-users each. It can be presumed that many of these clients are seen by several organisations, and some will see the same service-user several times during any day or week. The service-user element of this study records 30 service-users engaging with 16 Service-Providers a week; other than GPs, pharmacies, courts and prisons. A robust analysis of service effectiveness will be difficult to provide without personal identification of service-users, which could also identify the numbers of service-users who fall back into need after an organisation has provided a service – the revolving door clients.

86% of organisations responding reported that they pro-actively signpost or link clients to appropriate health services. What is not evident from this statistic is the capacity of health services to deal with this rate of referral, or clients’ take-up of such referral.

Access to health services was reported to be a problem across the board. Difficulties reported were as a result of clients’:

- not knowing that services were available;
- difficulties with this client group in making and keeping appointments;
- services not being available, and
- cost or difficulties in getting to the service

Providers also noted that eligibility criteria for some services rendered some clients as ineligible and this caused problems for those in need, who had nowhere else to turn.
“We support and signpost into health services, but a lot of clients don’t know what is available”
“They neglect health issues and appointments because being homeless takes priority”
“It’s a transient population - so not good at keeping appointments - especially around emotional well-being”
“Our staff don’t always have the time or information (about the client’s health needs), and not sure they would feel comfortable asking”
“I know someone who committed a crime just to get accepted by DIP”

Equitable Access Centre
It is apparent, having interviewed Service-Providers and service-users, that the Market Hill 8 to 8 service now located in the Ironstone Centre is considered to be a walk-in health centre. Clarification on this was provided during Service-Provider interviews. Commissioned by the NHS in 2009 to meet the need for extended hours and access, Market Hill 8 to 8 is an Equitable Access Centre, not a walk-in facility. There is a registered patient list, but unregistered patients are accepted and seen within four hours. Unregistered patients can pre-book, and approximately 100 to 160 walk-in or unregistered pre-booked patients are seen each week.

One reported concern of service-providers and service-users was the problem of those not registered with a GP, who had lived at several addresses or were of no fixed abode (NFA). Whilst it was reported to be difficult to access patient records for those who have moved from one health service to another, if a patient can provide a correct name and date of birth, it is possible to find their NHS number and track their records manually. NFAs are registered at the 8 to 8 by their last known address.

The Market Hill 8 to 8 service deals with a number of people at a later stage in their health needs, those who have been removed from other lists or are of NFA, and those with complex needs. The service undertakes a range of ‘chasing’ activities to cope with this group. To reduce the potential for missed appointments, the service now texts the patient to remind them and also texts at 6.30pm the night before.

The service tries to accommodate a range of specialist needs if provided with sufficient notice, for example providing health care to patients under Police escort.

4.2 Physical Health Services
Whilst there were no substantial concerns identified by the Service-Provider survey respondents around physical health services, the free text comments they provided describe a number of concerns, which are supported by the views expressed within the Service-Provider Focus Groups.

“They are at significant risk if homeless, vulnerable to health problems - physical and mental as well as risks of being in an unsafe environment”
Health and wellbeing issues for BME service-users threw up some specific problems around their children’s health. Housing workers reported that those with children born in the UK were usually well linked up with children’s health services. However, those whose children were born outside the UK were not so aware and often did not have vaccination or other health records for them.

There were examples of a good understanding of the needs of homeless people within the Shared Care service where GP’s provide clinical support for patients with support workers providing practical and preventative support for clients.

Providers said that they had seen the physical health needs of the client group deteriorating the longer they remained homeless or in unsuitable or uncertain accommodation. They acknowledged that this had a resource impact on health services and agreed that preventative work and engaging people before health issues became advanced was essential. However their knowledge of the client group, led them to concede that there were great difficulties to be overcome in providing services to people whose lives were chaotic, who could be uncooperative or unmotivated and whose priorities did not fit with early preventative approaches.

**Accident and Emergency Services**

It has been widely acknowledged by participants in this study that not having a home or living with uncertainty or the threat of losing your home, impacts negatively on an individual’s health. The high risk lifestyles associated with homelessness frequently result in crisis healthcare rather than preventative or routine care. The consequence is that many homeless people present to A&E rather than a GP.

Staff at Scunthorpe General Hospital’s A&E Department reported difficulties in managing the inappropriate use of health resources. Whilst there was evidently a great deal that the staff tried to do for this group beyond their immediate health needs, there were also frustrations expressed. Staff bring clothes in from home for those in need of clean clothes and toast is provided when staff have spare bread. However, this goodwill had been eroded by some patients who have preyed on other patients or who arrive with the expectation of being showered and provided with food and clean clothes.

It was acknowledged that this group tended not to use the services of GPs and so attended A&E for general health care, and there were incidents of people turning up to have simple healthcare needs met, such as dressings changed. Evidence of this was present in the service users research with one participant stating: “There’s been times when I’ve been there every day”.

**Discharge from Hospital**

The Department of Health states that all acute hospitals should have admission and discharge policies ensuring homeless people are identified on admission and linked into services on discharge. However, the Homeless Link audit found less than a third
(27%) of clients admitted to hospital had help with their housing before they were discharged.

A number of Service-Providers attending the focus groups had encountered clients who have been discharged from hospital with no accommodation to go to or to an address that does not exist:

- “We sometimes do get a call to say ‘we are discharging someone who has no home’. There’s supposed to be a protocol in place but it has dropped off”
- “Some are discharged to us, but some people aren’t honest when asked for their address. But it can depend on the staff in the hospital - some do some don’t”

Several Service-Providers reported that they had made attempts to engage with the local hospital to improve discharge arrangements for NFA (no fixed address) patients but had failed to improve the situation.

A recent report in a national newspaper highlighted the increase in discharge rates from hospitals between 11pm and 7am and this was reflected in comments from respondents:

- “Hospitals discharging in a very unplanned way, especially between the hours of 9pm and 6am”
- “We’ve had incidents where people have been discharged from hospital and arrived in their pyjamas from hospital with no warning”
- “We have an out of hours service and get at least one call a week around 3am from hospital discharging a patient”

Dental Health Services
Dental Health access and availability was reported as an issue by most respondents. Providers described accessing a dentist for their clients as ‘impossible’ and ‘a nightmare’:

- “It’s a big problem accessing dental care for clients - easy to register on a waiting list, but then they never hear nothing. We have never got a dentist through this system - it has to be an emergency”
- “A homeless client from Scunthorpe needing urgent dental care was told to go to a surgery in Westwoodside - he had no means of getting there”
- “Used to have mobile dental unit came to Scunthorpe from Grimsby once a month - really high uptake here but it stopped when the funding went. Now we can’t get access to dental care for clients”

4.3 Mental Health Services
Throughout all of the focus group discussions, there was consensus that mental health played a major part in the causes and continuation of homelessness.
“Mental health issues are evident in the majority of homeless people: the longer a person is homeless, the more their mental health deteriorates and the less able they are to resolve their difficulties”

A lack of information sharing, bureaucracy and poor communication with mental health services were described as key difficulties. Focus group respondents described their experiences of accessing mental health services on behalf of clients as frustrating and difficult. One accommodation provider experienced problems for a client who had been discharged from Great Oaks and described communicating with the service as like ‘hitting a brick wall’. However, this view was not supported by mental health Service-Providers who stated that good personal relationships had been established with housing and housing support services to ensure that they rarely had to discharge in-patients to bed and breakfast accommodation.

A problem identified by mental health workers was the lack of crisis beds, which had an impact on the average in-patient stay, pushing this to 15 nights.

One concern for providers of homelessness services was the lack of information available regarding the level of risk related to some potential clients. This impacted on any decisions around the safeguards to be put in place when placing a client in accommodation. Health practitioners felt that this could be managed effectively once written consent had been obtained from the potential client for the Service-Provider to request information as to the risks involved from their GP.

There was a view that rooms in supported accommodation for people with mental health issues were lying empty because clients would not be allowed in if they had any drug or alcohol issues. This was described as a ‘vicious cycle’ and there was general frustration with the perception that clients’ mental health issues could not be provided for whilst they were involved in drug or alcohol use. Providers felt that their clients’ mental health issues were an underlying factor in their drug and alcohol use. They understood that one criterion for accessing mental health services for clients who had problematic drug or alcohol use was that they had to evidence that they had been on a course of medication for a period of time. This, they felt, was most difficult for their clients as homeless people with complex needs tend to live chaotic lives and not manage their medication.

One provider of emergency accommodation gave an example of a mother of six who has alcohol issues and has. There was intervention from Adult Services, but the client was not motivated to change her behaviour and so is now back in the community and likely to lose her tenancy and re-enter services.

- “We have an issue with vulnerable people with complex needs having mental health issues that are undiagnosed”
- “Young people don’t have the life skills, are often frightened and don’t know what to do or how to handle situations. Mental ill health leads to low self-esteem and lack of confidence”
“If new and not known (to mental health services), they are asked ‘have you been to your GP?’ The GP will say go and see the Crisis Team and the Crisis Team say go and see your GP. It’s very frustrating and difficult to work through”

“Our clients don’t want to say they’re with drug and alcohol services (when dealing with mental health services) because they know it’ll make a difference to their treatment”

A reported difficulty for medical practitioners was in determining the motivation behind a patient with drug and/or alcohol problems, who requests medication for undiagnosed mental health issues.

Focus group respondents were especially concerned and confused by their experience of dealings with the Mental Health Crisis team. They were unclear about the point at which they should contact them on behalf of clients and concerned that they had clients who, to the best of their knowledge, were exhibiting signs of requiring immediate intervention:

“I’ve been told off by the Crisis Team for sending someone who I thought was in crisis. They know best - but it’s the support worker who is with that individual at the time’s view - should that not count for something?”

“They ask us how they (the clients) are feeling. Why don’t they give a layman’s description so we can do an assessment and then send them to the Crisis Team?”

“I had one resident who I had tried to access help for but the mental health team said ‘that’s just the way they are’. I can see them deteriorate as I see them every day but our opinion as support workers is not valued by Mental Health professionals - when you ring up you know they aren’t going to do anything”.

However, it was also acknowledged by respondents that the Crisis Team were extremely busy and they felt that the service was under-resourced.

4.4 Drug and Alcohol Services

The impact that drug and alcohol use had on client’s physical and mental health and wellbeing was identified by service providers as significant and problematic in relation to accessing appropriate services.

“Clients’ decline in physical health is usually brought on by Drug and alcohol use and poor mental health which are the main problems”

“I tried to do a referral - 17 phone calls - Adult Services, Learning Disabilities. Drugs and alcohol seems to stop everybody in their tracks and they don’t get help. They say alcohol is their problem, but we think their circumstances are causing the drinking - self-medicating”
“We see lots of underlying problems - like leg ulcers, and poor veinal access when trying to take blood for tests. But appointments get missed, so lots of physical problems from drug and alcohol use and rough sleeping just build up”.

4.5 Adult Services

A few focus group respondents expressed concern that they were not clear how or under what circumstances Adult Services should or could be involved in supporting their clients.

- “Those with learning difficulties have poor life skills. We had a client with LD and Social Services took months and months, nothing could be done as he didn’t tick any box, so we had to leave him”
- “As we are expected to do more with less, we are all prioritising - so there will always be people we prioritise. Adult Services have a whole team dealing with vulnerable adults, but I have no end of people who (they say) don’t meet their criteria”
- “Clients who can’t read or write so can’t cope - that is learning difficulties, but there is no help”

4.6 Sexual Health and Personal Safety

The sexual health and personal safety of clients was raised in the Young People and Single Homeless Focus Group. Young girls were seen to be particularly vulnerable - especially to exploitation, but it was also felt that young homeless people generally missed out on contraception and sexual health screening services:

- “We contact sexual health workers, but it’s not a lot of help as the clients have to go all the way up to hospital”
- “Young homeless people miss out on the opportunities for Chlamydia testing, because they don’t mix in the youth culture where the kits are available”
- “We can’t get free condoms now, we provide Chlamydia testing when they come to us. It would be better if we could have condoms in rather than tell people where to go to get them as there is a stigma”
- “Self harm is quite prevalent - young people especially, but it usually carries on throughout their lives”

4.7 Nutrition and Hygiene

A number of organisations provide food parcels or meals, although it was reported that there is a ‘three parcel limit’ at the Food Bank. When asked about their work with homeless people, the Food Bank, said that they did not feel they provided food parcels for homeless people as a basic kitchen was required to prepare the food they distributed. Aggregating the meal services provided by all services contacted, it is possible for a service-user to have four cooked meals in any week, however this does not include weekends. The Forge Project provides three meals a week as well as food parcels and reported that the recent increase in uptake of these was severely draining their resources. Another provider reported that the Food Bank was also experiencing
a recent surge in requests and was concerned about having sufficient supplies to meet this demand.

- “Clients who are underweight are a big problem”
- “I do meal plans with my clients, but if they are really bad we send them to the GP. I go shopping with them and show them what to buy and how to prepare a meal from it”

Personal hygiene was seen to deteriorate rapidly once a client had experienced more than a couple of weeks of homelessness. Whilst not seen as a great problem with younger clients - especially those who had recently left home or had experienced a period of ‘sofa surfing’ before becoming roofless, older clients who had experienced homelessness for some time or whose decline into homelessness had occurred over a longer period were reported as having a greater degree of poor personal hygiene and associated health problems.

The lack of any facility in North Lincolnshire for rough sleepers and the roofless to take a shower or wash their clothes and the impact this had on their health was highlighted both in the survey and the focus groups:

- “We see a lot of skin problems - sleep is also a problem”
- “If they’re roofless, there’s nowhere to access a shower and wash their clothes, there’s a huge gap. We see their hygiene dropping. At first homeless girls will trot off to the toilets every day (to have a wash), but they soon stop after a week or so.”
- “There are fewer services here to meet basic health and wellbeing needs. Rough sleepers spiral downwards quicker in this area. In other areas I’ve worked, I’ve seen them set up a community laundrette with a voucher system. They give them dressing gowns to sit in whilst they’re washing their clothes if all they have is what they’re wearing.”
- “There are fewer rough sleepers here but they deteriorate quicker. It’s a very hard road that they’re on. Hygiene goes first, then their health”

One provider reported that they frequently found families from BME backgrounds who expressed satisfaction with their home, even when it was often not suitable due to overcrowding - and these clients were often not on the radar for health. They reported examples of people sleeping in bathrooms due to overcrowding, but were not overly concerned, as they were among family and friends and not aware of the temporary nature of their accommodation.

4.8 Customer Care
There was a range of frustration and irritation expressed over what providers felt was poor and insensitive customer care towards their clients from some health professionals:
“A lot of clients ask me to accompany them, they say ‘The Dr doesn’t listen to me when I go on my own’”

“I had a client who was in casualty and they needed to take a blood sample. The nurse was having difficulty finding a vein and the Dr said ‘He’s a druggie - can’t he do it himself?’”

“I know of someone who was in dire straights before they went to hospital as they were reluctant to go because of a previous bad experience there”

“If someone shouts across the ward ‘I’ll bring your Methadone in a moment’, you’re not going to want to go again are you?”

One provider spoke of a client who had been admitted to hospital and was being moved to another hospital for further treatment. The client reported that he heard the doctor saying that he wanted the client out of the hospital as he didn’t like ‘that sort’ in his hospital.

4.9 Working relationships between Service Professionals

Providers stated that they felt their experience and professionalism in dealing with an often chaotic and sometimes uncooperative client group was seldom acknowledged by professionals from other services.

“GPs are a law unto themselves. They don’t look at us as professionals”

“People working regularly with these clients have a good knowledge of them. We should be seen as professionals and working together for the benefit of the client”

“There is a big barrier between health and these other services ‘we know best’ attitude from GPs and mental health services generally. This perhaps explains why it’s so hard to get decent working relationships with hospitals for example on discharges; we just don’t get the notice we should”

5. Outcomes from Service-user Engagement

5.1 Participant Profile

A total of 20 people took part in one of the five focus groups held in the community and 30 people participated in one-to-one interviews where the survey tool was used. The five focus groups were held in the community with a diverse range of participants including:

- Young people in supported accommodation
- Black and minority ethnic people
- Clients attending a community drop-in facility for homeless people
- Residents in temporary, emergency accommodation
- Clients of substance misuse services

Of all respondents; 39 were male and 11 were female. All of the one-to-one interview participants described themselves as White British. Of the 20 focus group
participants five were from BME communities - Polish (2 females), South East Asian (2 females) and Kurdish (1 male).

Of the 30 participants in one-to-one interviews; 8 were 25 years of age and under with 3 (all male) being aged 16-17 years. The largest proportion of respondents were from the 26-35 years age range followed by those aged 36-45 years, the oldest participant was a 60 year-old female. Half of respondents said they were currently working with offending services, 8 said they had left prison within the last 12 months with a further 5 having left more than 12 months ago. Two males said they had left Care Services (for young people) within the past five years with anecdotal evidence from several older respondents of a background in care as a child.

5.2 Current Housing Situation
Participants had a varied range of housing experiences. Most of those who took part stated that they were currently experiencing homelessness, several had repeated experiences of homelessness and several said that they were currently at risk of homelessness. There were examples of participants who were currently housed but under notice to quit or who said they had to leave who had previously been homeless within the last six months. This supports the anecdotal evidence from service providers in their focus groups that the lack of suitable accommodation in North Lincolnshire is ‘setting people up to fail’.

One focus group participant told us he had been homeless for three years and was currently living in a shed. He was quite comfortable there and went to a friend’s house on occasions for a shower. He did not want anyone else to find out the location of this shed as he had encountered problems in the past with people overrunning a rented flat he had previously which had resulted in his eviction.

5.3 Causes of homelessness
Interviewees gave a range of responses for leaving their last home this included relationship breakdown either with a partner or, in the case of many of the younger people, with their parents. Others stated that they had left their previous accommodation after being evicted because of either rent arrears or their own behaviour. Several participants in shared accommodation said they had left or needed to leave as it was either unsuitable due to overcrowding or the other residents were unsuitable to them and their circumstances, and one told us they had left for fear of their own safety.

Several participants had experience of rough sleeping, some of them periodically throughout their lives. One participant shared his reasons for becoming homeless - “It was my own choice to become homeless. I saw what I was putting my family through on drugs, so I moved out. I chose to sleep rough”

There was a view that rough sleeping was on the increase in Scunthorpe. One male had recently been released from prison - “There’s more rough sleepers now than last
time I was sleeping rough - it could be any number of things (causing the increase) - they come out of jail, nothing to do, back on the same old road - taking drugs to get you to sleep at night when you’re rough sleeping”

Focus groups discussed whether certain people were at greater risk of homelessness than others. Whilst there was little consensus on this issue, most responses identified poor relationships with parents for the young and that homelessness could happen to anyone:

- “I was more at risk than my sister because I don’t understand things as well because of my learning difficulties”
- “If you don’t have a good relationship with your parents”
- “No - happen to anyone at any time”
- “With this recession - it’s got no favourites, when it bites, it bites”

Focus group participants were asked if they thought where someone was living was important to prevent homelessness:

- “I just need a normal decent one bed flat. Beggars can’t be choosers but I don’t want to be in a really rough area because I don’t need to be around the wrong people”
- “It’s important you don’t get dragged down - fresh beginning rather than somewhere that is worse”
- “Need somewhere where it hasn’t had a violent history”
- “Ideally not on Frodingham Road although the house is ok”
- “Location is important”

Shared accommodation gave a lot of concerns, with many of the participants we spoke to complaining that the other people they were sharing with affected their ability to maintain a stable and positive lifestyle, especially with regard to substance misuse and offending. This is also reflected in the comments made by those who participated in the one-to-one interviews. If shared accommodation was inevitable, focus group participants felt that care should be given to making sure that vulnerable people were not placed in accommodation where other residents were still chaotic and unpredictable:

- “Need to balance people so they get on well together”
- “Age groups matter a lot”
- “Where you live matters if you’re in shared accommodation”.
- “Before I went into hospital I was going into shared houses, but I’m the sort who likes to keep to myself. It was no good - doors getting kicked in, people taking drugs”

5.4 Access & Awareness of homelessness services
Awareness of homelessness services amongst participants was high with most identifying the Housing Advice Team on Oswald Road as being their first point of call.
Some interviewees struggled to identify where they had first been to seek help with their housing situation, as they had been in and out of homelessness for so many years.

We asked participants to think about whether they could have sought help any earlier than they did and if that would have made any difference to their circumstances. Views were mixed, those who thought earlier requests for help would have benefitted them mainly identified prevention as a possible outcome of an earlier request for help:

- “If I’d known a lot beforehand I could still have my house”
- “I wouldn’t have been round drug users - from the homelessness it’s all spiralled - drugs, crime. Once in that mess it just carried on. Jail was a life saver - I didn’t have to think no more”
- “Situation I got into wouldn’t have got so bad”
- “Would not have been left with no place to sleep”
- “Get sorted better - less stress”

Participants identified a range of reasons as to why they did not seek help with their homelessness earlier than they did, and these can be grouped into the following themes:

Lack of awareness of services and or support

- “Didn’t know where to go - if you bollocked it up with HAT you’ve got nowhere else to go”
- “Didn’t know I was going to be made homeless”
- “...didn’t know about it and I was poorly - I had undiagnosed Schizophrenia. I was going to the Leisure Centre for a shower, I was sort of coping”
- “I didn’t know where they (services) was and being homeless - it’s hard to get things done when you don’t know where anything is”

Self-reliance

- “Tried to resolve problem with friend who shared house”
- “Tried to resolve problem myself but couldn’t in the end”
- “Am stubborn always been able to take care of myself”
- “I was working and managing my alcohol problems at the time - thought I could deal with it”

Belief that the problem would go away

- “I thought my Dad would cool down in time”
- “I assumed everything was ok as I had been in and told them (social landlord) my partner had left”
- “I was not aware of how desperately I would need a place”
- “Parents keep threatening to throw me out, but usually say I can stay a bit longer”
“My Mum was messing me about - she’d say “Stay with me” and then kick me out”

Fatalism

“I had some rent arrears with NLH - so I had limited options”

“I tried to get help but I’m a single male - I am bottom of the pile - I am not a priority”

Self-blame

“Me, just being a four-year old - addiction”

Several participants, particularly young people reported high levels of satisfaction with the help and advice they received from homelessness services.

Service users who took part in the individual interviews were asked to identify the services or support they had received over the preceding month from a list provided. Practical support with basic essentials such as a cooked meal, food parcel, clothing and/or bedding were the most used services. However, accessing support to deal with finance and advocacy in dealing with their situation was also high with service-users receiving help with filling in forms, help to sort out debts and benefits advice. Several interviewees said they had received advocacy support either having someone to make telephone calls on their behalf or being accompanied to a meeting or interview by someone in a supporting role. Participants recognised how valuable this support was to them:

Makes me feel better inside - xx (name of support worker) for example - I’ve never met anybody in my life who cares so much for people

“When I don’t come here I go hungry”

“I didn’t know this place existed ‘til the beginning of the year (when they became homeless). They have helped me - the staff let me use the computers so I can talk to my kids and that”

Comments from the service-user focus groups supported those of Service-Providers in relation to the lack of service and amenities for homeless people in North Lincolnshire.

“When I was homeless in Grimsby, I used to go to Cleethorpes Leisure Centre - got a ticket from DIP to go to the gym, but got a shower instead”

“In Grimsby there’s loads of places, you can get clothes washed - a lot more facilities - You can pick a food parcel up every 3 or 4 days”

Whereas in Scunthorpe things are more challenging:

“You can go to the Pods for a shower- but they’re not happy about it”

“Very hard because you haven’t got washing facilities all the time”
“When I don’t come here I go hungry” (Male rough sleeper talking about the Forge which provides hot meals three times per week).

“Every morning when I wake up I think ‘oh no, not again - another day of this’”

Of note was the compassion and empathy demonstrated by focus groups when sharing their experiences particularly towards the more vulnerable amongst them. They also shared a frustration with the lack of awareness and understanding of some of the services they accessed.

“There’s just been brief instalments of help for him when he needs constant help”

5.5 Frequency and Range of Services Accessed

As part of the study we wanted to try and get a picture of a ‘regular’ week’s experiences in accessing services for participants. A detailed breakdown of activity can be found in Appendix 5 and provides a starting point for services to consider outreach opportunities for health-related prevention and interventions.

Regular and in some cases daily appointments included collecting methadone from a pharmacy or chemist; and visits to substance misuse services as part of a treatment programme - often linked to offending services. Other ‘regular’ visits were the Forge for meals three days per week, New Life Church once a week, Time for Change (Westcliff) and the Recovery Café at the Junction. Other appointments included signing on at the Job Centre, YOT, probation service and GP/hospital outpatients.

Managing appointments was identified as especially challenging for people when they are experiencing homelessness:

“IT’S IMPOSSIBLE FOR A HOMELESS PERSON TO SAY WITH ANY GUARANTEE THAT THEY CAN MAKE AN APPOINTMENT - IN TWO WEEK’S TIME - HOW AM I GOING TO KEEP THAT IN MY HEAD WITH ALL THE STRESS?”

“How do you pick when you’re given two appointments at the same time?”

Many focus group participants spoke of having their benefit payments stopped - they used the word ‘sanctioned’ for missed appointments with the JobCentre. Participants were particularly unhappy with the treatment they received around their Benefit entitlements and claims, which they described as unsympathetic and inflexible:

“(Need) MORE TOLERANCE FOR MISSED APPOINTMENTS”

“They’re not trained for homeless people”

“DHSS - HALF OF THEM DON’T LISTEN TO YOU WHEN YOU’RE TRYING TO EXPLAIN. I WAS SANCTIONED FOR A MONTH WHEN IT WAS THEIR MISTAKE, BUT THEY WOULDN’T LISTEN TO ME. THEY HAVEN’T GOT A CLUE WHAT IT’S LIKE”
“I was sanctioned for 8 weeks with a two year-old - no Child Tax Credits or nothing”

“That bloke (focus group participants told of a homeless man who was recently hospitalised after being attacked in the street) - he was two nights in hospital, if he’s missed his JobCentre appointment it’ll take him 2 weeks to get it sorted, meanwhile he’s got no money”

“ESA - got to pay your way to Grimsby for an assessment. How do you get to Grimsby with two broken legs - so I was sanctioned”

“Stop being passed from pillar to post rather than go through 13 advisors before you get to the point”

5.6 Accessing Health Services

GP Services Of the cohort of 30 respondents 27 were registered with a GP, over two thirds had visited a GP in the last six months and almost half had seen their GP on 5 or more occasions over that period. Six respondents said they had been refused registration with a GP or dentist in the past 12 months.

Dental Services were described by most participants as being difficult to access and only 3 respondents said they were registered with a dentist.

Several respondents when asked if they were registered with a dentist became very self-conscious about the condition of their teeth and would say ‘No, but I need a dentist’, ‘I have been trying to get one’. Respondents with a history of drug and alcohol misuse were particularly aware of their poor dental health and one commented on how the condition of their teeth impacted on their self-esteem. Participants did report that they had found it easy to access emergency dental treatment but they had not been able to register with a Dentist for routine dental health services. One participant stated he had accessed emergency dental treatment but had not gone back for the follow-up treatment recommended as ‘It was going to cost me £300’.

Accident and Emergency Services had been accessed in the last six months by 14 of the cohort of 30 service-user who were interviewed. Visits to A and E were reported to be as a result of accidents, assaults, self-harm, drug, alcohol, mental or physical health problems. Interviewees who reported attending A and E as a result of an accident included: ‘being knocked down by a car’; ‘knocked off a bicycle’; ‘an accident at work’ and cuts sustained as a result of a fall. One participant involved in an assault said he had been stabbed in the foot. One male said he had rung the Mental Health Crisis Team to tell them he was going to kill someone, he said the Crisis Team then informed the Police who took him to A and E.

Focus group participants also shared their experiences of visiting A and E:
“I was there twice last week - not admitted - think they wanted to, but I was off - doing me other things”

“I’ve been loads of times. Got proper health problems - used to do drugs, my hearts a bit fucked”

“I went to A and E - frustrated because the windows kept getting smashed (at the supported accommodation) so I punched the wall”

**Hospital Stays**

Some participants had been admitted to hospital in the last six months - one had been admitted as a result of alcohol use and had stayed for 11 nights - his treatment had included a blood transfusion and he had been seriously ill. Two participants told us that staff in the hospital had ensured they had somewhere suitable to go when they were discharged, another two participants said the hospital did not ensure they had anywhere suitable to go on discharge - and one of these reported he was given little notice of his discharge and told by hospital staff who were aware he was homeless that they intended to get him a taxi to the Housing Advice Team on Oswald Road.

Some participants reported bad experiences whilst attending hospital and indicated that these experiences had put them off going back there for follow-up appointments.

**5.7 Health and Wellbeing**

**5.7.1 Physical and Mental Health problems**

The 30 individuals interviewed were asked ‘Do you experience any physical health problems?’ to which 14 said they did and of those 11 said they were currently receiving support or treatment to help them with a physical health problem. One respondent commented on how their homelessness impacted on their long term health condition - “My asthma gets worse when I’m living in tents and that”; and one on how their mental health problems impact on their physical health - “When I get stressed I break out in sores”.

Twelve of those interviewed reported themselves as having a disability. Of those; five described the disability as mental health related and four cited mobility problems - one respondent reported persistent leg pain and impeded mobility as a result of a past stab wound.

Individuals interviewed were asked ‘Do you experience any mental health problems?’ to which 14 said that they did and 8 said that they were receiving support for their mental health problems. Several of these participants and those taking part in focus group said that as well as having mental health problems that they also used drugs and/or alcohol or were recovering from a drug and/or alcohol problem.

Participants also reported problems accessing help for their mental health problems:

- “Doctor won’t give me pills for depression because they are addictive and I have got an addictive personality”
“They (the doctor) just said I was depressed and that was it”
“I feel as though by the end of this weekend I won’t be here because the professional health people who can help me won’t help me - they’re just not bothered”

One participant told us that he had a history of mental health problems and had seriously self-harmed in the past. He was very frightened of what he might do to himself in the future but he felt that health and support services were failing him, seeing him as difficult rather than understanding his mental health needs.

There was consensus amongst all focus groups that the findings in relation to the prevalence of physical and mental health issues and substance misuse amongst homeless people as recorded in the Homeless Link National Audit were in keeping with their experiences:

- “Cos people have lived unstable lifestyles”
- “Extremely stressful - moving house is one of the most stressful things in life, so sofa-surfing is more stressful”
- “Living on the street and hand to mouth, you’re bound to crack in the end”

One female participant was a single parent made homeless after fleeing domestic violence. She said she had been extremely anxious and depressed, but said she dare not seek help for fear of any suggestion that she could not cope as a parent: “I daren’t go along those routes, I’m already fighting a custody battle for my daughter as it is”.

Views from the groups also supported those given by providers that health needs are often neglected by homeless people as being homeless and getting through each day is their priority and takes up all their efforts - “You’ve got other things on your mind when you’re homeless”; “Can’t look after your health when you’re homeless”.

Others recognised the need for them to stay healthy in order to cope with their homelessness - “For me it’s health, because you have to keep yourself going to be able to do stuff, but it’s harder”

5.7.2 Substance Misuse problems
A total of 20 of the cohort of 30 service users interviewed said they either took drugs or were recovering from a drug problem, and all of these said that they were receiving help for the problem. Knowledge of needle exchange schemes and advice or training on injecting safely was high.

When asked if they had a problem with alcohol, four respondents said they did but none of these said they were receiving any help for their problem. One participant who answered ‘no’ to this question said he had stopped drinking after a recent stay in hospital caused by excessive drinking.
Two of the four men who reported having an alcohol problem but who were not receiving any treatment for it, said that they also had a drug problem for which they were receiving help.

Focus group participants were of the view that drugs and alcohol were used by people experiencing homelessness as a coping strategy.

- “Once you get in that circle, can’t get out”
- “You seem to knock it back and it comforts”
- “It’s an escape - a way of forgetting it all”

5.7.3 Testing and vaccinations
Respondents with a history of engagement with offending services reported the highest incidence of take-up of a range of testing and vaccinations associated with high risk behaviours. Those in receipt of substance misuse services also had a noticeably high reporting rate of testing and vaccination.

5.7.4 Sexual Health
Awareness of sexual health services amongst those interviewed was high however, only one person (male) out of the 30 said that they had accessed family planning or sexual health services in the last 12 months. Several young people said that they had had received a sexual health check and indicated that these were the chlamydia checks that were accessible in the community.

5.7.5 Smoking
The majority of participants said that they smoked and they linked smoking with other coping mechanisms such as drugs and alcohol to relieve the stress of their homelessness. Some participants said they had been offered advice or help to stop smoking. One said he had been offered help to quit at the chemist when collecting his methadone and another said had an upcoming appointment to see a Health Trainer.

One interviewee said his GP had advised him to quit smoking and drinking due to having ulcers and other health issues, however, the Doctor did not give him information on how to do this - “not even a leaflet”.

Some participants said they had either cut down or stopped smoking on their own:

- “I have not seeked out help, but I have cut down ‘cos I am too lazy to roll them”
- “I quit 4 weeks ago with no help. I used to smoke weed since I was 12 and I have stopped - it used to make me paranoid - I feel so much better now - I didn't want to do anything before - I do now”.

5.7.6 Nutrition
Of the 30 people taking part in individual interviews 13 respondents said they did not, on average, eat at least two meals each day. Service-users participating in the focus groups also said they often did not eat on average at least two meals a day.

- “Yes, we eat one meal in about two days”
- “Lucky to get that in a week”
- “If it wasn’t for places like The Forge, I would sometimes go hungry”
- “A couple of years ago I didn’t hardly eat, especially when I was on the crack - I went down to 8 stone - I was 23 years old.”

Some older respondents with a history of drug and alcohol misuse said they found it difficult to eat very much in one go as they had problems with their digestion - “I eat a meal now and it knocks fuck out of me”.

5.7.7 Employment, training, education and volunteering.
Participation in employment, training, education or volunteering promotes social inclusion and provides opportunities for personal development. Of the cohort of 30 people participating in an individual interview five said they were currently in training or education, four that they were volunteering, one was working and three said they were accessing guidance around work or training (presumably by referral through the Job Centre). 18 respondents were not involved in any kind of employment, training, education or volunteering suggesting that their homelessness, and for many their health issues, are a major pre-occupation for them.

We asked people if they thought their health stopped them from being able to undertake any training, volunteering or employment, and 12 felt it did; 17 said they thought that their living circumstances stopped them being able to undertake any training, volunteering or employment that they wanted to. In particular respondents currently staying in supported accommodation said that employment was not an option for them if they wanted to stay in their current home:

- “Its £180 per week rent here - I would have to be on some job to pay that”
- “If I was working I could not afford to stay here”

5.8 Health & Wellbeing Support & Information

We asked participants to consider who helped them most with their health - most people stated they themselves, their family or friends helped them the most, others cited their GP, ‘staff at a housing/homeless project’ (notably the Forge) and their Drug Worker. These responses could indicate a preference for self-reliance and established relationships over using specialist services.

Interviewees were asked to describe what they felt had been the most help to them. Whilst several people cited the support they received from local voluntary sector organisations; “Moving to the Lighthouse and the prospect of getting my own place”, “The Forge”, “xx at the Forge - she tells us how it is, she is like a mother figure”,

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“Westcliff Drop-In”, others recognised the support they received from statutory and housing services:

- “This place (CarrGomm, Conway House) - without a shadow of a doubt - I would be in prison now if it wasn’t for this place. The house I was in before (private, shared) was flea-infested hovel”
- “Drs with methadone - Shared Care - DIP”
- “Help and support from ADDACTION”
- “YOT - they have done more for me in the last few weeks than others have done over 3 years. Got me in here (Lighthouse), and into college”
- “Going on Methadone programme has helped me a lot”
- “Having a home has helped me get clean”
- “Prison”

Some felt that no one had helped them or that they had helped themselves the most

- “No one, help myself”
- “Myself - taking time out to think about things”
- “My girlfriend. My own responsibility to make own decisions”

We asked participants ‘What would make it easier for you to take care of your health needs?  Responses can be grouped into the following themes:

**Support with substance misuse:**

- “I’m on Methadone now - it’s ok”
- “At the moment my health needs are being met - I am reducing Methadone and diazepam - I am going in the right direction”
- “If I could access the services I needed - I went to GP to get alcohol detox and was told to get out as he had ‘proper patients’ to see”
- “To completely stop drinking - I have cut down I used to drink 12-14 cans 10% strength a day. I know I have to cut down - got stomach and liver problems”

**Housing/shelter:**

- “Need my own place, my own space, I’m living out of a bag and bathing everywhere”
- “Yes get a roof over me head - shared house - get back to normality”
- “Somewhere stable to live - drugs - can only change if you want to”
- “Obviously - getting somewhere permanent to live and not sending me to the chemist every day”
- “Need to have somewhere safe to be so you can concentrate on getting healthy”
- “Knowing I had a place of my own”

**Nutrition:**

- “Regular meals - low energy, not eaten”
Improved Physical and Mental Health care:

- “Two blood clots in my leg for 6 years - would like them removed, keep asking - told me not going to do it”
- “Dental treatment - need to get up a few floors ‘cos I’ve been down on skid row and need to look better”
- “Having a dentist! Stop taking as much alcohol as I do and also the drugs”

Accessible Services and Support:

- “To get the proper help I need and to be able to get to appointments”
- “Places nearer and more of them”

5.9 Improving Outcomes for Homeless People

All of the study participants were asked to consider what could be improved to help people in their situation more. Key themes emerging were:

More accommodation and improved access to accommodation:

- “The amount of empty flats - people should be given a chance to move”
- “Empty flats - you have to bid for everything now”
- “Don't know - is help - down to individual - hard to get the finance to get a home (bond)”
- “More housing for homeless people if you have rent arrears you're buggered, can't afford the bond”
- “Something for homeless people at night”

Person-Centred Services:

- “A crisis point - for mental health where you don’t have to be registered, you can just go”
- “Sometimes they should stop and concentrate on you - rather than put you in a category. When I was offending and using crack, shoplifting, I was costing Scunthorpe a lot of money - I have made a lot of progress in the last 9 months”
- “More places to go to for help - only HAT and if screwed up with them nowhere else. If know people taking drugs they don't want to know”
- “Able to access services locally - bar lifted. Professional health people to understand and be bothered”
- “Dentists - the mobile unit no longer visits”
- “Just a bit more help and advice on stuff. A place where people can go and get proper advice on stuff”
➢ “Yes - should be more help, the council should do more, especially for people with animals”
➢ “Better training so they understand mental Health”
➢ “Regular food bank, donations of food
➢ If you have a problem at the weekend - nowhere to go, need 24/7 service”
➢ “More support - positive vibes to move on - just get stuck here - with older people - makes you wonder where’s your life come to”

Overcoming restrictions on eligibility for help:

➢ “Just because you are male and single doesn’t mean you are not a priority - It’s a lonely place being homeless, being on your own. If they had gone into my background they would have seen”
➢ “Go to commit a crime or top yourself, do daft things to get a roof over your head”

5.10 Service-user Priorities
Both one-to-one survey respondents and focus group participants were asked ‘If you were in charge of providing services to homeless people in North Lincolnshire, what three things would you do to make it a better service?’

Respondents generally wanted to see more accommodation, more opportunities and more flexible and person-centred services. Several ideas related to development of a hostel:

➢ “Shelter in Scunthorpe so people don’t live on streets”
➢ “Build a homeless shelter for everyone”
➢ “Set up a community place where they could stay and have hot water and wash your clothes, somewhere to eat”
➢ “A centre - where you can get hot meals”
➢ “Get a homeless hostel built - as big as possible”
➢ “More places where you can just turn up for a night if you need to”
➢ “Big hostel for homeless people at night - first come first served”
➢ “Make sure people have showers - brush their teeth”
➢ “Build a place where people can go and get meals and things - meals are important - a hub like they’re doing down Westcliff. Somewhere they can get out of the rain. Put them on the right track towards getting themselves sorted and into a home”
➢ “Put some money to get a place where homeless people could go every day to get a meal and somewhere to stay and help them get their own property instead of being out on the streets”
➢ “Have clothing available so once a week they can come in and get clothing and a food parcel for the weekend”
➢ “Build the biggest mansion ever for homeless people, cut into sections for different types of people - disabilities, anger management etc. Build it to the
best standards - different sections, but they all have to talk to each other, then unlimited food, water - 4 star hotel quality”

- “Derelict buildings, there’s a couple of empty pubs - put money into that and turn them into this place - open door policy, knock on door and try to accommodate everyone - no ticking boxes. If I couldn’t do that I’d get tents”
- “I’d sort somewhere for them to stay. Stick them in B and Bs once a week so they get a rest”.
- “Get them involved in decorating it”

Some participant’s felt that a hostel should do more than just meet people’s basic survival needs:

- “I’d put the money into courses that people could go on - Passport to Housing - paying bills etc, I thought that was brilliant”
- “Building people up, not just giving them a bed or a meal”
- “Giving them a foundation to fend for themselves”
- “Life-skills”
- “Make sure there is a safety-net, stop them falling….something to fill time. Need activities to go alongside a hostel - working, helping people”
- “I know people in that hostel (Grimsby), suits them - just going to die in there”
- “Whilst they’re in there - helping them get a job, ID and stuff”
- “Just basic things that people take for granted, things that they haven’t got”

Other comments were linked to policy regarding homelessness and housing:

- “Don’t judge on age - I can be responsible and mature - but not given chance cos 16 - can’t wait to get a flat - stuck on band 3.
- “Stop single males being bottom of the pile
- “Foreigners get priority - stop that”
- “Make (homeless people) them a priority”
- “Find everyone somewhere to live - stop knocking down/boarding up houses”
- “Use boarded up houses/do them up and could let as shared accommodation - row of houses on Gurnell Street - could solve homelessness now here. If not got the money to build new then let people in them - don’t leave them boarded up”

Other comments related to improving services:

- More one to one support for people
- Easier to access and treat people better
- Go out and check on people to make sure they’re ok and got no problems and get them to come to place where they can have a meal.
- Professional people to go out and find the homeless and help them - talk to them, counsel them and help where they can
- Help to get people private places without a guarantor or with animals.
- More help when people get into difficulty - before it’s too late
- Somewhere set up to talk to people
- Make it easier - give people a chance who have messed up before.

One respondent had very clear ideas on what was need “First - Acknowledge there is a homelessness problem in Scunthorpe, second - Commission a study into the seriousness of it and then - invest in it”

6. Impact of Welfare Reforms

The impact of the forthcoming changes to housing benefit and the introduction of a universal credit gave concern to all providers. The reforms will have a major impact on the economic well-being of the client groups engaged in this study. In brief these reforms can be described as follows:

Housing Benefit:
North Lincolnshire Homes currently try to plan their allocations around the long-term needs of clients. For example: they would try to allocate a single parent with two young children - a girl and a boy, in a three bed-roomed home as a sustainable housing solution for that family over the long term. However, the new rules on housing benefit will mean that they will have to allocate a two-bed-roomed property to that family until the children reach ten years of age, when they are no longer legally able to share a bedroom, at which point the family will qualify for housing benefit to cover a three-bed-roomed property. The potential costs and impact on mental wellbeing for that family in having to uproot and move, was raised.

Single Room Rate:
The forthcoming change in the single room rate of housing benefit which is currently for under 25 year-olds, but will soon change to cover those under 35 years of age, was expected to have a substantial impact on the number of single homeless - those who are currently over 25 but not yet 35 years of age, single, living in accommodation with more than one room and in receipt of housing benefit will, under the new system, only receive the single room rate of financial support, regardless of rent paid.

Council Tax Benefit
People of working age in receipt of Council Tax Benefit in North Lincolnshire, will see a reduction of approximately 23% in the amount of support they will receive from April 2013.

Universal Credit
A system of single monthly payments will be launched in 2013 replacing:
- income-based Jobseeker’s Allowance
- income-related Employment and Support Allowance
- Income Support
- Child Tax Credits
• Working Tax Credits
• Housing Benefit.

Moving to a system of monthly payments could cause hardship for those on the lowest incomes, who are unfamiliar with managing their finances over an extended period and there are fears that money will run out before the month is up, pushing clients into arrears and debt and placing them at higher risk of exploitation by illegal and high interest money lenders.

One participant with mental health and substance misuse problems told us he had accumulated rent arrears, had fines to pay and was unable to pay utility bills. He takes out weekly loans of £87 from a High Street money lending outfit and re-pays £119 the following week from his benefits only to then take out another loan of £87 with the same company.

Many of these welfare reforms will increase the difference between what is received in benefits by claimants and what is due to be paid in rent and Council Tax - this difference is referred to as ‘top-up’ and must be found from a claimants’ income, placing increased pressure on their ability to cover basic food and utilities costs. This pressure will impact on all those providing services to low income groups and will have severe implications for those serving the homeless and those in fear of homelessness.

7. Key Findings

Study objective - increase the evidence available about the experience of homeless people in accessing services within North Lincolnshire in respect of their health and well-being.

Between July and September 2012; 50 people with experience of homelessness took part in this study, 30 of these were interviewed individually and the remaining 20 took part in focus group discussions.

❖ Whilst almost all those interviewed were permanently registered with a GP; few were registered with a dentist.
❖ Most respondents had visited a GP at least once in the past six months and nearly half had visited a GP more than 5 times in that period.
❖ There was a high rate of substance misuse, with over half reporting that they were accessing substance misuse services
❖ Whilst there was a high level of awareness of sexual health services and their location, less than a handful had accessed family planning or sexual health services in the last 12 months.
❖ Frequent use of emergency health services was evident, with almost half of interviewees reporting that they had visited A&E in the last six months.
Inappropriate use of emergency health services was reported by health professionals, however those interviewed reported use of these services as a result of non-domestic violence and self-harm.

Service-users and service providers provided anecdotal evidence of poor customer care in hospital resulting in a reluctance to access the service by homeless people.

Physical and Mental Health

Interviewees reported a high incidence of physical health problems with nearly half stating that they experienced poor physical health, and slightly less saying that they had a disability of some form.

A high incidence of poor mental health with almost half of respondents in the study reporting that they experienced mental health problems and over three quarters of these reporting that they also had a drug and/or alcohol problem.

Well Being

Almost three-quarters of respondents said they either took drugs or were recovering from a drug problem.

The majority of respondents said they knew about a needle exchange scheme they could access with slightly less saying they knew about advice or training on injecting safely.

There was a lower incidence of alcohol problems with only a handful saying they had a problem with alcohol.

Almost half of all respondents said they did not, on average, eat at least two meals each day.

Most of the participants said they smoked but few said they had been offered any information or support to quit.

These findings confirm that homeless people do experience poorer health in North Lincolnshire, and are more likely to access acute services.

Of the organisations that supported homeless people over two-thirds of them said that they pro-actively signposted or linked clients to appropriate health services. What was not evident from this statistic is the capacity of health services to deal with this rate of referral, or clients’ take-up of such referrals.

Providers said that they had seen the physical health needs of the client group deteriorating the longer they remained homeless or in unsuitable or uncertain accommodation. They acknowledged that this had a resource impact on health services and agreed that preventative work and engaging people before health issues became advanced was essential. However their knowledge of the client group, led them to concede that there were great difficulties to be overcome in providing services to people whose lives were chaotic, who could be uncooperative or unmotivated and whose priorities did not fit with early preventative approaches. This
is supported by anecdotal evidence from service-user focus groups who suggested that the failure of some services to meet homeless people’s needs was detrimental to their physical and mental health.

The lack of services and amenities for homeless people in North Lincolnshire was identified by both service-user and providers as impacting on health and wellbeing. A number of voluntary organisations provide food parcels or meals and it is possible for a service-user to access four cooked meals in any week, however this does not include weekends. Rough sleepers and the roofless struggle to look after their personal hygiene as there are no facilities locally where then can have a shower or wash their clothes. The impact this had on their health was highlighted both in the survey and the focus groups with anecdotal evidence that rough sleepers deteriorate quicker here than in other areas due to the lack services and amenities.

The anecdotal evidence shared with researchers by all participants, highlights a concern that homeless people are reluctant to access some services as they feel they are not taken seriously, or are treated shoddily or after a previous bad experience of these services. This can lead to a reliance on other services where the clients are comfortable which may not have the resources or the capacity to meet their needs.

**Study Objective - assess opportunities for joint working of services for the homeless in North Lincolnshire**

It was evident from discussions with service-providers that where joint working is established it is beneficial to clients. Where existing arrangements for joint working and referral broke down, was due to a lack of clarity around other service providers’ roles, working practices and service constraints. Participants in service provider interviews and focus group discussions were able to identify a number of ways to enhance their knowledge and understanding of each other.

Where joint working appears to work well is within the substance misuse and offending services, where health professionals work within the same premises as, and alongside substance misuse and offending services staff. Whilst housing and homelessness professionals do not work alongside substance misuse and offending services, there does appear to be a reasonably good understanding between these services. It could be argued that within substance misuse and offending services a wider spectrum of the clients’ needs are considered.

Only half of the service-users interviewed had received information about local health services they could use from the service-providers they visited. Having visited most of these premises, the authors can confirm that leaflets and posters about health and health services are available in many of them. It is apparent from the service-user interviews and discussions that this client group is particularly hard to reach and is generally not pro-active about their health. A more robust means of communicating information about local health services is required.
Service users were well informed about local sexual health services but except for a few individuals, they did not take them up, therefore information alone will not increase the appropriate use of local health services. Making sexual health checks available at locations where this client group has already been engaged would appear to be an effective method of ensuring that the messages are delivered.

There is considerable anxiety amongst providers around the issue of mental health when combined with drug or alcohol misuse. A better understanding of how mental health services work around drug and alcohol issues would be helpful and could go some way to improving relationships between services.

Westcliff Drop-In Centre (WDIC) is a community organisation which has successfully responded to the needs of a group of local residents, many of whom are or have been homeless and have substance misuse issues. With funding, WDIC have established the “Time for Change” project, which provides a worker to engage with this group. Tea, toast and a chat sessions are available on a regular basis and a Nurse attends weekly to change dressings and advise on health issues. Advocacy, advice and support are available and many service-users referred extremely positively to this facility during interviews and in focus group discussions.

**Study Objective - determine what services should be delivered from the proposed 20 bed facility for the homeless in North Lincolnshire**

**Homelessness in North Lincolnshire**

Both service-users and providers recognised the gap in provision for homeless people and the need for a hostel. Service users wanted to see this hostel provide easy access and a safe, warm place to sleep, nutrition, bathing and laundry facilities. Access to bathing and laundry facilities for homeless people was identified as a means to prevent deterioration of physical and mental well-being. Participants wanted to see the Place of Change provide practical help to support clients with basic skills to function in the community such as help to sort out benefits, identification documents and debt. Service-users also recognised the need for clients to progress out of homelessness and wanted the facility to provide opportunities for personal development in life skills such as cooking, budgeting and managing a tenancy.

It is clear from the findings in this study that homeless people accessing the new facility will have significant health needs. In order to stem the flow of homeless people accessing acute services a holistic, preventative approach to health and wellbeing must be integral to the case management of each resident. There are examples of effective practice in North Lincolnshire where clinicians and support workers link together in the community to meet client needs for commissioners to consider when determining health service provision at the Place of Change.

8 Recommendations
Directory of Services
A directory of health and homelessness services to enable providers to better navigate the services that are available; this would include a clear description of the service, times and location available with contact details and would list any criteria for accessing the service.

Service Standards
A better awareness of the service standards that organisations work to, would raise awareness of what each service could expect from another and would support providers in being more effective in referring clients.

Understanding Mental Health
Mental Health First Aid Training to be made available to all homelessness service providers and to include a ‘lay person’s’ checklist to enable providers to identify at what point they should contact the Crisis Team and mental health services on behalf of their clients. This would enable non-specialist staff to gain confidence in referring appropriately around these issues and managing clients who give concern but who are not eligible for referral to mental health services.

Key Meetings
Attendance by key health professionals at the inter-agency forums and meetings for providers of services for homeless people is seen as key to building relationships and a better understanding between services. This could raise awareness amongst health professionals of the needs of the homeless and those in fear of homelessness and build mutual respect between the professionals involved.

Hospital discharge
Homeless, vulnerable people are on occasions being discharged from hospital and directed to homelessness services without prior notice. This results in poorer outcomes for clients and has the potential to put people at risk of re-entering acute services as they so not have the means to effective recuperation from their stay in hospital. An agreed protocol which identifies NFA patients upon admission and notifies the appropriate homelessness service needs to be developed and implemented in order safeguard these patients.

Community Involvement
Homeless people access a number of services to help them deal with their homelessness. There are a number of voluntary sector organisations that have successfully engaged with this often difficult client group and developed positive relationships with them. Also there are a number of effective service-user led support groups in North Lincolnshire. Both of these are assets; they have considerable expertise, knowledge and understanding of homelessness which needs to be harnessed by commissioners when planning future services.

9 Conclusions
It has been evident throughout the course of this study that a wide range of services are provided to the homeless or those in fear of homelessness in North Lincolnshire. What is also evident is that these services provide valuable and often life-changing support to an extremely vulnerable and frequently difficult to serve client group. Services could be described as those aiming to meet the material needs of clients and those focussed on their health needs. Where intermediaries between these services exist such as with substance misuse and offending services and the Time for Change project, service-user satisfaction and positive outcomes are in greater evidence. This one-stop, person-centred, clear referral and outcome-focused approach to health and homelessness needs has the potential to not only improve health and well-being but also reduce the impact on acute services. However this cannot succeed, without the full support of all services that engage with homeless people and a genuine commitment to partnership working.

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