

Improving the health of homeless people in the isle of man

NEW EVIDENCE ABOUT THE HEALTH NEEDS

OF PEOPLE WHO ARE HOMELESS

Background – Context and Methodology

The definition of homelessness comprises not only those who are rough sleeping but also those who are sofa surfing, in insecure, unsuitable or temporary accommodation. Unlike the UK the Isle of Man has no legislative or statutory framework for assessing or responding to homelessness.

Throughout the calendar year of 2015 Adult Community Nursing Services and Graih undertook an audit of homeless people’s health. This audit provides new evidence about the complex health needs homeless people experience and their usage of local health services.

The audit was a sample of 55 single individuals between the ages of 18 and 65 who were accessing either Graih or the Vulnerable Adult Health Visitor service. The audit was kept to these two services to avoid double-counting. It involved going through a short questionnaire with willing respondents (often those who had progressed past a ‘crisis’ stage as it’s hard to undertake a questionnaire living under a tarpaulin!). This data was then collated by Community Health.

It is important to note that this is a small snapshot from frontline services and not a comprehensive survey. However, the sample size was comparable to some similar audits undertaken with the same toolkit in the UK. To give some idea of reference, in 2015 Graih had contact with 150 different individuals. Total numbers of those homeless on the island are suspected to be much higher.

The audit was undertaken as there is little existing data about what health problems homeless people have. There has been no comparable research done in the Isle of Man into the needs of the homeless population and it has historically been an unaddressed sector of society. This makes it difficult to represent their needs at a strategic and commissioning level and make informed decisions about how services might be improved. Any improvements need to be underpinned by a better understanding of the health needs which exist.

We used a free toolkit available from Homeless link, launched in 2010, piloted in 9 UK sites and since used in over 28 different authorities (August 2015). Further information about the toolkit can be found at www.homeless.org.uk/our-work/resources/homeless-health-needs-audit

This document outlines the strategic context behind why it is important for the Department of Health and Social Care to use this new evidence to improve the way health services are accessed and delivered to this group of our local population, drawing on a range of UK-based research. It includes a snapshot of some of the findings from the Manx audit. More comprehensive analysis is available and we have also developed a presentation that can be presented to staff, politicians and community groups.

Why should we address the health of homeless people?

1. Homeless people experience poorer health than the general population

Homeless people are one of the groups most excluded from health services and they often have the highest level of health need. Often these go undiagnosed or untreated – and without good health, achieving other outcomes such stable accommodation and securing employment can be difficult.

Our audit data suggests around 96% of homeless people have one or more physical health needs, and 58% homeless people have a diagnosed mental health problem. 94% reported some form of mental health problem. In contrast, UK figures stood at 41% for long-term physical health problems and 45% for diagnosed or undiagnosed mental health problems.

This immediately suggests that the Isle of Man has quite a different sort of homelessness problem than the UK. We have a less transient population whose needs have likely to have been going on for a long time.

These findings are supported by a substantial body of evidence on the acute needs of homeless people. A publication by the UK Department of Health (DH) and the Cabinet Office brings together analysis about the health needs of socially excluded people, including those who are homeless. It highlights the complexity of health needs experienced by this group, which include:

* The average age of death was estimated at around 40-44
* 50-75% rough sleepers have mental health disorders such as anxiety disorders, depression, dementia and psychosis
* Physical health needs are experienced at a rate higher than the general population – for example rates of chronic chest and breathing problems are 3 times more common, and rough sleepers experience TB at 200 times that of the known rate among the general population.

Our audit showed that these trends are also true of our population. The data reveals:

* 96% of our clients had at least one physical health need, some of these include 17% Diabetic, 13% Epilepsy, 62% experience joint aches/ problems with bones and muscles, 47% experience palpitations/chest pain/breathing problems, 66% of our clients experience dental problems, 60% experience eye problems and difficulty seeing, 38% experience problems with their feet. 92% of our clients reported to have experienced their physical health problem for 12months+.
* 58% of our clients report one or more diagnosed mental health problem. A further 36% of our clients believe to have an undiagnosed mental health problem

In addition to high levels of need, homeless people experience barriers to accessing services. The UK’s report ‘Inclusion Health’ highlights some of the reasons for this:

* Unwillingness of some GPs to register homeless people and provide flexible services
* Discrimination and stigmatisation by health staff. This can be compounded by poor levels of training or awareness about homeless people’s needs.
* Some services are unwilling or unable to work with homeless people’s complexity of need; and referral and discharge policies are not always adequate.
* Homeless people’s own unwillingness or lack of confidence in navigating health services and accessing them when they need them.

A great positive of our audit findings was the access to some mainstream services. 93% were registered with a GP (higher than the UK), with 49% having visited a dentist in the last 6 months (again higher than the UK).

This highlights the excellent work being done, often in partnership with Vulnerable Adult Health Visitor. The Special Care Dentist Team, Podiatry and Social Care are among services that are forging flexible pathways into care and reaching some of the most vulnerable.

There is evidence of good practice that can be built on and this leaves the island in a strong position to address the needs of homeless people. The fact that most of the people in our audit were in contact with some services suggests that it may be more of a case that systems need ‘tweaking’ rather than further specialist services being created.

Some client comments about ‘what works well’:

“MOTIV8 works well. Geddyn Reesht and Griag Court are a big help”

“Mandy Davies is excellent, I can’t praise her enough. Dentist was also good at Community Health Centre.”

“Victim Support and police have been good. Mandy Davies and Maz are very good Graih and the volunteers are good”

“Venting stress by talking to people. Community Nurse Drop In’s”

“Next Step and Community Mental Health are good. Saturday opening is good and should continue”

“The help I get from David Gray House”

“GP’s and Hospital. My medidose box for medication is good.”

“People like Mandy who listen. Mandy got me seen by a neurologist”

“Easily accessible services where staff are accommodating and friendly and treat you as an individual e.g. Graih”

“I’ve recently had excellent support from Geddyn Reesht and my mental health has improved”

“A GP who listens and understands, seeing the same GP avoiding repeating background. Health Visitor has helped navigate services”

“Graih’s drop in is a big help. I’d be stuck without it”

However, our audit also found some evidence of these trends suggesting barriers to care:

* 58% of the clients admitted to hospital had not been helped with their housing before being discharged from hospital care.
* 19% of clients advised they don’t get support or help when it comes to their physical health. 45% of clients advised they don’t get support or help when it comes to their mental health.
* Client comments describing problems accessing services:

“I was neglected by GP, left bleeding for 6 hours, then when I was seen I was taken straight to hospital”.

“A lot of my problems were not diagnosed years ago by doctors. They did not listen or care so I isolated myself. I had a long period where isolation and struggling with mental health stopped me from accessing services”.

“People shouldn’t judge me”.

“Mental Health waiting times. Statutory services are all about lists”.

“GP’s/Hospital could be more patient and understanding and not jump to conclusions”.

“Make it easier to get help – Thank you for asking”.

“Shorter waiting lists e.g. Psychology - I needed help earlier”.

“DAT could be better – Better communication and more frequent appointments. Also left in hospital bed unable to go to toilet and had to wet myself. It was good they washed my clothes”.

“Having somebody to help when I have a problem, more information on what help is available”

“A lot of stigma from services because of my past, leading to lack of access to help I need”.

“I didn’t know what was available until Mandy told me. Hospital could have helped me like Mandy but I wasn’t offered the help for bereavement, dentist, benefits, smoking cessation etc.

2. Homeless people’s poor health places disproportionate costs on our communities

Poor health has a detrimental cost on the individual.

This places a huge financial burden on our health services. Research by the UK’s Chief Analyst at the Department of Heath places this cost at £85.6m per year. This breaks down as:

* £76.2m of Inpatient services, likely to be a minimum estimate because it is based on inpatient care funded under Payment by Results
* £5m A&E costs, not including ambulance services. It is estimated homeless people have A&E attendance rates of 5 times as much as the general population
* Hospital usage overall was found to be 4 times that of the general population. For inpatient costs (the bulk of usage for this client group) this rises to 8 times more per person.

The same research found that homeless people have an average length of stay in hospital

3 times as long as the general population. This was due to the severity of the health needs they presented with.

Previous research has suggested that many homeless people use A&E for a pre-existing condition which had reached the point of emergency attention. The above research clearly shows the disproportionate usage of hospital services by homeless people and highlights the need to explore more cost efficient ways to provide appropriate health care at a primary care level which could better address these health need before they reach crisis point.

Our audit showed that homeless people frequently use hospital services.

* 51% of homeless people had used A&E at least once in the past 6 months. Several clients had been regularly, with 17 clients attending 1-2 times, 6 clients attending 3-5 times and 5 clients attending 5+ times
* 42% clients had used an ambulance during the past 6 months.
* 47% had been admitted to hospital. The average length of stay was 10 days.
* The main reasons for accessing A&E were self-harm, seizure/fitting, breathing problems/chest pain, result of an accident.

3. Local commitment and responsibility to tackle the health of excluded people

Although every area should assess the needs of their local population, the needs of the ‘hard to reach’ are not always adequately included.

Our audit highlighted mental health as an area where more targeted support might be required

* 58% of our clients report one or more diagnosed mental health problem. A further 36% of our clients believe to have an undiagnosed mental health problem
* 44% of our diagnosed and undiagnosed clients with mental health problems self-medicate to help them cope.
* The most common diagnosed and undiagnosed mental health needs are depression (94%), anxiety (87%), panic attacks (54%), suicidal thoughts (52%), self-harm (37%), anger issues/ violent towards others (44%), post-traumatic stress disorder (10%)
* A significant number of homeless people reported that they needed more support to help them address their mental health. Counselling, psychological therapies and practical support to help with day to day life were identified as services which clients would find particularly helpful.

Our audit also identified the problems with accommodation on the island.

Here are some comments about where people are living:

“Living in almost derelict house with holes in roof and rain coming down the stairs”

“Very substandard flat, windows broken, no hot water, damp……”

“Boarding House – no cooking or laundry facilities”

We found that many in our audit had spent time, sometimes years, rough sleeping. The lack of minimum standards in the boarding houses on the island leaves vulnerable people open to abusive practices by unscrupulous landlords. It should be pointed out that many of these tenancies are maintained through the Benefit system – essentially the public purse is subsidising atrocious living conditions that exacerbate the already complex needs of the most vulnerable.

Add further

* Good public health is strongly linked to wider determinants of health such as housing. Homeless people disproportionately experience many of the health and well-being needs included in the realm of public health (e.g. poor nutrition, high rates of smoking and alcohol use, poor access to screening). For example the Homeless Health Needs Audit showed that:
* On average 56% of our clients do not have 2 meals a day
* 69% of our clients do not eat fruit and veg and 0% of clients eat 5+ pieces of fruit and veg per day
* Only 42% of our clients carryout 30 minutes exercise twice a week. 59% of those that don’t exercise would like to.
* 78% of our clients smoke. 19% were offered advice or help to stop smoking which they took up, 53% were offered advice however they did not take this up, 26% have not received any advice or help to stop smoking
* 53% of our clients that smoke would like to stop smoking
* 25% of our clients drink alcohol on a daily basis
* 67% of our clients have not been vaccinated against Hep A, 29% were unsure. 65% of our clients have not been vaccinated against Hep B, 25% were unsure
* 76% of our clients have not received the flu vaccine within the last 12 months

**Reasons to celebrate**

The audit is itself the product of a pioneering partnership between the statutory sector and the third sector (in this case, the Vulnerable Adult Health Visitor, Community Health and Graih). It is exactly this sort of holistic working that is needed to better serve the needs of the homeless people on the Isle of Man.

The Isle of Man compared favourably with the UK on several counts, including access to mainstream services such as GP registration, Special Care Dentist Team, Podiatry and Social Care. There were also lower rates of substance misuse than UK counterparts. A wide range of services were praised by respondents, including GPs, the Police, Victim Support, Geddyn Reesht and Next Step. This strongly suggests that there are areas of good practice within most services that can be built on.

Progress with the audit

It is clear that the Isle of Man does not need specialist ‘homeless’ services that are familiar in urban centres in the UK. We do operate in a different context and we have the opportunity to continue to build on the good work done to ensure that holistic, flexible services are developed that will meet the needs of the homeless population.

Of particular note for action were the three areas of:

1. Legislation to ensure minimum standards in the island’s boarding houses and an improvement in the accommodation for the most vulnerable.
2. Better access to community mental health services and resources.
3. More supported accommodation on the island for people needing extra support to maintain and improve stability and wellbeing.

While statutory services and legislation can play a large part tackling these priorities there is a vital role for the third sector and the wider community to play. At the very least this research provides a starting point and data to begin to raise the profile of homelessness on the island and ensure that the homeless population are included in service development and provision.

The audit was undertaken in the belief that a range of agencies in the Isle of Man will benefit from a better understanding of the health needs which exist among our homeless population. It has provided new evidence to inform local strategic processes as well as service development among the voluntary sector and healthcare providers. It provides valuable intelligence to improve joint working; encourage more responsive health services and opportunities to make the best of resources in the Isle of Man.

One immediate outcome of the audit process has been the idea of a ‘Homelessness Partnership Board’ that would look at the results of the research in more depth and seek to diffuse the findings throughout statutory and third sector services. Community Health is currently exploring a way forward with this.

To find out more about the results or to book a presentation please contact:

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