Single Homeless Adults in Derby: A Health Needs Assessment

Executive Summary

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i. Rationale

People who are homeless experience poorer health and wellbeing than the general population. It is not uncommon for people who are homeless for the longer term to have multiple morbidities. Those who experience homelessness from young adulthood are particularly at risk [1]. In particular, the single adult homeless population are vulnerable, have very high health needs and are hard to reach through mainstream services [2]. Those who are homeless experience very significant health inequalities, compared to the general population. One estimate puts the mean age of death of homeless people at 32 years lower than that of the general population [1].

The mean age of death for rough sleepers was 30 years younger than the general population (44 years for men and 42 years for women). Life expectancy worsened with increased acuity of housing need. Leading causes of death included drugs, alcohol, cardiovascular disease, cancer, respiratory disease, suicide, infections, and injuries. Many of these were amenable to healthcare

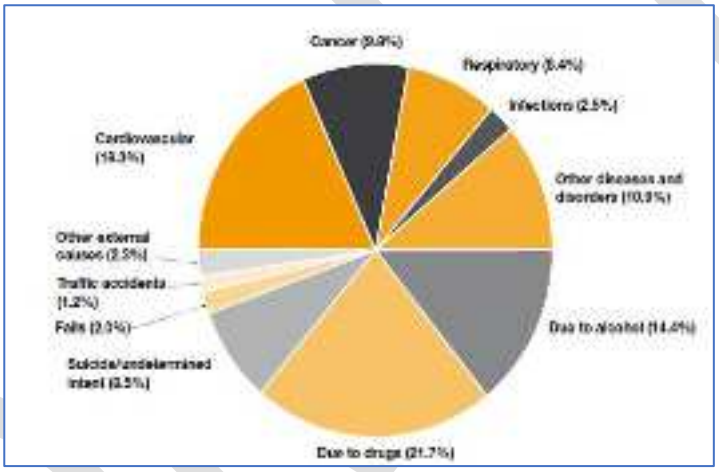

Figure 1: Causes of death for people experiencing homelessness in England (2001-2009)

(Source: Thomas [29])

The aim of this needs assessment was to identify the health needs of single people aged 16 to 65 who are currently homeless or living in temporary, supported accommodation in Derby, to identify gaps in current service provision and make recommendations for changes to meet their needs, improve health and reduce health inequalities. To achieve this aim, the following objectives were met:

1. To outline the epidemiology of homelessness in Derby City,
2. To review the current evidence of what works to meet these needs
3. To identify patterns of local healthcare use, to include strengths, gaps and inequities in services and make recommendations to address these

4. To identify any future work required to optimise health outcomes and reduce health inequalities for this population group

ii. Key Findings

In 2020/21, 825 single adults sought support from Derby City Council due to homelessness. Approximately 150 of these were rough sleepers or used hostels and night shelters. This population was younger than the general population and predominantly male.

The homeless population was part of wider inclusion health population, many of whom are at a high risk of homelessness at some point in their life and who have complex needs that require more specialised and personalised approaches to care.

There were large inequalities in health between those who experienced homelessness sand the general population of Derby. Those who experienced homelessness had significantly worse health. Health was poorest where the acuity of housing need was greatest. They were more likely to have multiple and complex health and care needs, multi-morbidity and long-term conditions. They were also more likely to have concurrent substance or alcohol dependency and mental ill health. In addition to healthcare support, many also required support with social care and end of life care.

Adverse childhood experiences of abuse and neglect were associated with a higher risk of homelessness in adult life. Many of the single adults who were experiencing homeless had been in care as children.

While there were fewer single women who experienced homelessness, they were more likely to have experienced domestic and sexual violence and to have more complex health and support needs (e.g., sexual, and reproductive health).

43 individuals from a cohort of 150 who were assessed at the start of the pandemic were identified to have extremely complex needs. 20 of these were also in the most unstable accommodation. Multi-agency interventions, which focused on this cohort had the potential to not only address health and social needs but also to increase independence and improve their longer-term housing situation.

While clinical expertise and evidence-based intervention programmes were important for working with people who are homeless, the model of care and approach to the design and delivery of services was also critical.

In Derby, the paramedic service played a critical role in navigating within and between health services, providing an informal single point of contact for services and service users, providing expertise by experience, and developing trusted personal relationships with people who experienced homelessness. At the time of writing, a business case had been approved for long term funding and additional support for this service.

This needs assessment has taken an exploratory approach to using routine housing data as a way of characterising the health needs of those who are experiencing homelessness. Support needs are recorded for all who approach Derby Homes for homelessness support, regardless of whether they have approached healthcare providers.

Qualitative insight has been provided by local housing, social care and healthcare informants about the service landscape and the challenges and opportunities to provide support to those who experienced homelessness.

There was limited access to data available for healthcare activity or costs in primary care, mental health services and drug and alcohol treatment services to inform this needs assessment. Data was not available to show the association between acuity of housing need and the successful completion of drug or alcohol treatment services.

iii. Recommendations

Recommendations for all sectors

1. Advocate for the health and care needs of people experiencing homelessness and the health inequalities, which exist for this population.
2. Review and incorporate the recommendations of NICE Guidelines NG214 to develop an integrated approach to health and social care to meet the health needs of people who are experiencing homelessness.
3. Improve referral pathways between services, including healthcare, social care, housing, welfare, and employment, including the adoption of a “no wrong door” approach.
4. Raise awareness of and increase use of the Duty to Refer to housing support, which exists for health and care agencies under the Homelessness Reduction Act 2017.
5. Build in flexibility into service access where possible, for example around the appointments system, which recognises that many people experiencing homelessness have chaotic lives and might struggle to comply with a rigid system.
6. Improve and formalise the arrangements for data sharing and information governance between agencies.
7. Use peer support and experts by experience in the design and evaluation of health and care services.
8. Workforce training and development, to improving understand about homelessness and the challenges that those who this population face, including a trauma informed approach to services and create psychologically informed environments.
9. Development of resources about the rights of people who are experiencing homelessness to access health and social care services.
10. Identification of opportunities for health and social care services to lengthen the contact time during consultations for people who are experiencing homelessness.

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