

Health & Homelessness Remarks, 17 March 2009

Disclaimer

While I am a part-time Consultant in Public Health Medicine with Highland Health Board, these views are my own professional opinion, and do not represent the views of Highland Health Board, nor of the NHS.

Outline

I intend to say a little about the wider context in which the issue of Homelessness & Health sits, then consider the findings of a particular piece of research, then consider the implications of them for Homeless people; and the wider implications of the research findings.

Wider Context

1). Dealing with helping those who are Homeless, or threatened with Homelessness, requires **an adequate availability of a variety of warm, affordable, appropriate stock**; which we haven't got, and don't look like getting within a useful time-frame.

This may accentuate the trend to only get access now to Social Housing if one is already accepted as Homeless; which may well produce public unrest and political discomfort.

The "appropriate stock" issue is very important. Those of you lucky enough to be as old as I, may remember the great Tom Lehrer singing about "Little boxes, little boxes, and they're all made out of ticky-tacky, and they all look just the same". We Brits now have the incredible distinction of being the country in Europe (28 or 29 or whatever) which is building **the SMALLEST new-builds** --- by a long way.

2). Given the Demographic Imperative, I can foresee a time when, like the NHS had Geriatric Bed-Blocking, we will have **Geriatric Home-Blocking** on a big scale. This will consist of, largely, little old ladies in 3 to 5+ roomed homes, which, of course, represents to them not only their home, but the capital to bequeath to their off-spring; or they have tenancies for life.

Research

In the former Argyll & Clyde Health Board, covering Argyll & Bute, Inverclyde, Renfrewshire and parts of East Renfrewshire and West Dunbartonshire, a structured interview, administered by trained interviewers, lasting 45 minutes, was done on **119 Homeless subjects**. Each individual was recruited in sequence of presentation, but we put a grid in place to make sure we had a geographically representative sample from across the area.

The results were analysed to reveal what other problems, besides being Homeless these families or individuals were experiencing, and the results were produced in a glossy Report. My then Chief told me that I'd be launching this, at a public 'do' in Helensburgh, which was about two years after I'd last looked at the results in detail. So, to refresh my memory, the night before take-off I skimmed through the Report, which was full of tables of what percentage of

Homeless people had Mental Health issues; Addictions; Physical disease; Dependent Children; etc.

To my horror, adding up the percentages in my head, I realised that they totalled about 350%

Putting my tongue firmly in my cheek, I went ahead with the launch, but afterwards I asked the statisticians whether they still had the original data, which they did. So I asked them to reanalyse those data along the lines of what proportion of the sample had no problems other than Homelessness; what proportion had one other; two other, and so on, problems.

The results are not a surprise to anyone experienced in this field of work, but were nevertheless arresting in the starkness of the picture presented.

Results

Only **one** of the sample (>1%) had no other problems. **Seventy-six per cent** had **two, three, or four** other problems. **One** individual had **nine** other problems.

Implications

1). First, for me:

As an Epidemiologist, I learnt an humbling lesson, in that when analysing characteristics of people who have multiple and complex needs, one needs to find a way of presenting the data which highlights the true complexity of the peoples' problems. In any given case, in a book or paper, simply add up all the percentages of single conditions. If it comes to more than 100%, the authors have fallen into the same elephant trap which nearly caught me out.

2). For the Homeless, and others experiencing Multiple and Complex Needs:

It is serious because focussing on specific conditions leads to a temptation to believe that good has been done when one such problem is solved. The reality is that putting a roof over someone's head who is Homeless, in 99+% of cases, does very little to improve their lot. They require assistance to solve all their problems, timeously and sequentially.

Tables of percentages of single issues do not make much impact on policy makers and funders, either.

3). Wider implications for Service Provision:

All those who have Multiple and Complex Needs are faced by Statutory Services and, to an extent, Voluntary Services which are Single-issue Specialist Services. These 'silo-ised services' discriminate, institutionally, because we leave the individual to do a comprehensive self-'diagnosis' of their own care and support needs, and then find their own way through the maze which even

workers in the field may not fully understand. Nor do these services offer much in the way of 'sign-posting'.

There are large numbers of these groups in our Society. For instance, post Cancer treatment; Stroke; Arthritis; Mental health problems; sufferers of Domestic violence; ex-Prisoners; Addictions; leaving institutional 'looked-after' status, Prisons and Hospitals; the Elderly and the Very Elderly.

Those who are experiencing Homelessness, or are threatened with it, could become a paradigm. If we can get it right for them, we can use the same techniques to help large numbers of people. Those with Multiple and Complex Needs require Multiple and Complex solutions.

Services must become much better at evaluating those with multiple and complex needs, and then working together in partnership, including the individuals, to solve all the individual's problems sequentially and timeously.

Some say that the Single Shared Assessment is the way forward, but I don't really believe it. It is an apparently simple, obvious solution to a multiple and complex problem. I'll rehearse some reasons why it won't work in practice. Certainly we've been urged to use it for years now, and it still doesn't seem to be working. It's the old saying: - "In theory, theory and practice are the same, in practice, they're not". Multiple and Complex problems have, usually, multiple and complex solutions.

The rapidly approaching demographic time-bomb will require that we learn these lessons, or abandon the situation. I have a very personal interest in getting this right!

Using some time-limited money from the Scottish Executive to pilot projects for 'Unmet Need', and recognising that there may be merit in 'embedding' Nurses in Homeless Persons' Offices of the Councils, we tried the experiment. It seemed to work by enabling Nurses to act as expert advocates for people experiencing Homelessness, putting them in touch with the other agencies needed to start to solve their problems; on occasions, by physically taking individuals to appointments. While the experiment was running, the most ardently convinced of its merits were the Local Authority staff. One reason it may have been a success is that the 'power relation' with the Homeless Persons' Officers is out of kilter, in that people who are Homeless are, inevitably, looking to the Officers to get them something, whereas the Nurses were obviously wholly devoted to their interests.

Conclusion

I have touched on some of the wider issues which affect assisting people who are Homeless, including the quality and quantity of stock and the demographic changes rushing towards us. I've outlined a piece of research on the characteristics of Homeless people, and the implications of that for meeting their needs. And I've drawn some conclusions about the wider implications of these results for future Service provision.

D. Bell 17 March 2009