# HEALTH & HOMELESSNESS IN ABERDEEN CITY

## A report for the Scottish Health Council

**June 2007**
***(revised October 2007)***

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## *Acknowledgements*

The present study was commissioned and funded by the Scottish Health Council. We would like to acknowledge the interest and support provided by members of the Scottish Health Council, in particular Rosemary Hill, Development Manager and Fiona Wardell, Assessment and Feedback Manager.

Based mainly on a large-scale survey of homeless people, we would like to acknowledge the commitment and hard work of a large number of agencies in Aberdeen who helped administer the 'self-completion' questionnaires: Aberdeen City Mission, Aberdeen Cyrenians, Aberdeen Foyer, Aberdeen Welfare Rights, Albyn House Alcohol Support Ltd, Alcohol Advisory & Counselling Service (AACS) Alcohol Support Ltd, Benefits Advice, Citizens Advice Bureau (CAB), Drugs Action, NHS Grampian Family Planning Clinic (Square 13), NHS Grampian Department of Genitourinary Medicine, Grampian Women's Aid, Aberdeen City Council Homelessness Section, Instant Neighbour Charitable Trust, SACRO, Aberdeen City Council Social Work Services Duty Social Work Team, St Vincent de Paul Society and Victim Support Aberdeen.

The study combined methodologies. We would like to acknowledge the additional fieldwork support provided by Emma Christie, School of Applied Social Studies, who helped out with a focus group and transcription.

As part of the study a part-time summer scholarship was offered to an Honours year student in the School of Applied Social Studies. We would like to thank Andrea Allan for the work carried out.

As the project developed, Dr Leela Gautham, NHS Grampian, Bucksburn Medical Practice and Dr Linda-Leighton-Beck, Social Inclusion Manager, NHS Grampian offered helpful comment and provided aggregate data on assessments carried out on housing applicants applying under homeless legislation. We would like to thank them for their interest and willingness to share findings.

As ever, the study relied upon the support and flexibility of Bill Walker and his team at Graphics and Printing Services (The Gatehouse), The Robert Gordon University. We would like to thank them for their on-going professionalism.

Above all we would like to thank the homeless people who took part in the focus group discussions and completed questionnaires. Their willingness to become involved belies the difficulties they faced in doing so. Their cooperation was much appreciated.

The Research Team
June 2007

# EXECUTIVE SUMMARY

## 1. Background

According to the latest official figures, 1900 households presented themselves as homeless in Aberdeen City in the year 2005/2006 (Scottish Executive 2006).

The problems faced by homeless people in Aberdeen and elsewhere have already been documented in terms of inadequate housing, family and relationship breakdown, unemployment, multiple debt, reliance on benefits and low income. (Love, 1993, 1997, 2002; Spicker, Love, Strangward, McLaverty & Strachan, 2002). Such multiple and linked problems serve to marginalise homeless people relegating them to ways of life outside of mainstream society.

A corollary of such exclusion is the relatively high levels of poor health (both physical and mental) found among the homeless population. Hence, physical hardship, accidents, inadequate resources to practice personal hygiene, poor diet, stress, difficulty registering with a GP, a lack of preventative care, a lack of (suitable) health information and stigma combine to increase the rates of morbidity and mortality among homeless people.

## 2. Research

The study examined the health status and health behaviours of homeless people in Aberdeen. It sought to find out how well NHS services engage with homeless people in the city. The intention was to explore how patient and public involvement could be developed meaningfully to ensure that the views of homeless people are actively sought, listened to and acted upon. The definition of homelessness used corresponded to that used by the Homelessness Task Force (see Appendix A) and covered the statutory homeless and non statutory homeless (e.g. roofless, houseless, temporarily housed, those living in insecure accommodation etc.).

The research was thus guided by the following five research questions:

1. What are the individual needs of homeless people, including young homeless people, regarding healthcare and treatment?
2. How should NHS services ensure that homeless people's individual needs are identified respected and responded to?
3. What are the barriers (i.e. structural, policy or attitudinal) to homeless people, including young homeless people, being involved in decisions about their care and treatment?
4. How should NHS services engage with homeless people, including young homeless people, to capture their views and experiences of NHS services?
5. How should NHS services engage with homeless people, including young homeless people, to plan changes and improvements in services?

The study combined both qualitative and quantitative methods of investigation. A two-stage approach was adopted, involving the carrying out of two focus groups and a large-scale survey of c.100 homeless people.

Fieldwork was carried out between December 2006 and March 2007. 14 people (4 men and 10 women) took part in two separate focus groups in December 2006 and February 2007. In

March 2007, 24 agencies with front-line contact with homeless people made available 295 questionnaires. 118 completed questionnaires were returned.

## 3. Findings

*General Profile*

The study group comprised an uneven mix of males 60% (n=71) and females 39% (n=46), who ranged in age from 16 years to 81 years, with a mean average age of 36 years. 25% (n=29) of those surveyed were young people aged 24 years or less. Two-thirds of the participants were single - never married (66%, n=76), just under a third had been married or cohabited in the past (27%, n=45) while 4% (n=5) were currently married or cohabiting. Just under half of the study group had children (48%, n=56), most having two or more off-spring, although less than a fifth of parents shared a household with their children (21%, n=11). Only 7% (n=8) of participants were currently employed, with the remainder either unemployed (i.e. looking for work) (57%, n=64) or non-employed (i.e. not looking for work) (36%, n=41). The latter group included people unable to work through ill-health and disability.

*Health*

The vast majority of the homeless people surveyed assessed their own general health as 'less than good' (83%). In addition, three-fifths reported a long-term illness or disability (61%), often related to drug, alcohol or mental health problems, which was limiting in some way for most sufferers (80%).

To put the above findings in context, in the general population as a whole, according to the Scottish Health Survey 2003, only a quarter of people report their health as 'less than good'. Also, two-fifths of people generally report a long-term illness or disability (41% men, 42% women) which is limiting for around three-fifths of sufferers (Scottish Executive, 2005).

As such the findings from the present study suggest that homeless people in Aberdeen suffer disproportionate poor general health and long-term (and limiting) illness and disability, compared with people in the general population.

Asked about their experience of 20 commonly reported 'objective' diseases or conditions, respondents, on average, indicated experience of three such conditions at some stage in their lives, with over half reporting severe depression or nervous illness (54%), and just under half reported alcohol problems (47%).

Investigation into recent illness (i.e. the subjective experience of pain and discomfort) in the past month, suggested that almost all of the homeless people surveyed had been 'ill' during this time (86%), often with colds/flu or headaches.

Enquiries about street drug use found that around a third of those surveyed had used street drugs in the past month (33%), while a quarter of respondents had injected street drugs in the four weeks prior to the survey (22%).

Overall, two-fifths of those surveyed had injected street drugs at some time (41%) and a third of all respondents considered themselves to be problem drug users (32%).

*Use of Health Services*

89% of those surveyed had registered with a GP, a quarter through the 'homeless practice' at Marywell Street 40% of those surveyed had consulted with a GP in the two weeks prior to the survey.

To put these findings in context, the Scottish Health Survey 2003 found that in the population as a whole, 20% of women and 16% of men had consulted a doctor in the previous two weeks (Scottish Executive, 2005). Also, in the previous Scottish Health Survey in 1998 (Scottish Executive, 2000), it was found that amongst the population with acute sickness, the consultation rate with GPs rose to 45% for women and 34% for men. Accordingly, the findings from the present study suggest that homeless people make heavy use of GP services, in excess of people in the general population, a use which may imply disproportionately high levels of ill-health.

40% of those surveyed had made use of Accident & Emergency services in the past 12 months. More than half of those surveyed (56%) had used some kind of hospital based out-patient service (including emergency services) in the past 12 months.

To put the above findings in context, in the 2003 Scottish Health Survey, 35% of men and 37% of women were found to have made use of Accident & Emergency facilities and other hospital based day-patient services in the previous 12 months (Scottish Executive, 2005). As such the present study suggests that homeless people make greater use of hospital based out-patient services than people in the general population.

30% of those surveyed had spent at least one night in hospital as a patient in the past 12 months.

To put the above findings in context, in the 2003 Scottish Health Survey it was found that 9% of men and 13% of women had stayed in hospital for one night or more in the previous 12 months (Scottish Executive, 2005). Once again, the findings suggest that the health behaviours of homeless people differ from those of people in the general population and that homeless people make disproportionate use of in-patient hospital services.

Two-thirds of those surveyed (65%) had used health related services in the past six months.

*Experience of Health Services*

Access to NHS services was linked to the particular type of condition for which treatment was sought. The conditions most likely to allow easy access to treatment were accidents, physical illness, smoking and sexual health. Between three-fifths and three-quarters of homeless people requiring NHS services for these conditions were able to access treatment. By contrast homeless people's access to NHS mental health services and substance misuse services was more problematic.

There were clear sets of enabling factors as well as potential barriers to NHS service use. Amongst the enabling factors, reported by two-thirds or more of participants, were homeless people's own knowledge, experience and attitude to using NHS services, as well as the disposition of medical staff.

With respect to the potential barriers to service use, the most reported were waiting lists, peer pressure and the appointment systems in place. In addition, the financial costs of using services and the attitude of GP receptionists were highlighted.

With the exception of substance misuse services, homeless patients generally found a range of NHS services useful in meeting their health needs in the previous 12 months. GP services and hospital out-patient services were the most reported useful services, with three-quarters of homeless people regarding them in this way.

The three most reported improvements called for in NHS provision were shorter waiting lists, better appointment systems and having a permanent address. Almost half of the homeless people surveyed called for shorter waiting lists and two-fifths for better appointment systems. The quarter who called for a permanent address touched upon the reality that health cannot be divorced from wider social issues.

Few homeless people sought dedicated health services for homeless people only. The latter request, in line with national policy, testifies to the desire by homeless people themselves to be treated equally.

## 4. Policy Implications

Research does not make health or social policy. However alongside resources and the political will to use them, research can inform decisions at both the strategic and operational levels. The findings from the present study should be understood in this way.

The present study examined the health status and health behaviours of homeless people in Aberdeen. It sought to find out how well NHS services engage with homeless people in the city and to explore how patient and public involvement could be developed meaningfully to ensure that the views of homeless people are actively sought, listened to and acted upon.

It was the intention that the information gathered and understandings achieved would inform the work of the NHS locally with respect to how best to engage with 'hard to reach' and 'seldom heard' groups. As such, in keeping with 'Health and Homelessness Standard 4' and NHS Grampian's Health and Homeless Action Plan 2004 – 2007, the research sought to explicate the structural, policy and attitudinal factors which may undermine the health needs of homeless people in Aberdeen. In addition the research sought to inform the Scottish Health Council about how best to support NHS Grampian as it seeks to identify, understand and address these issues, through for example, the development of guidance and standards. What does the research imply ?

Firstly, the study found that homeless people suffered exaggerated levels of ill-health compared with people in the general population. Their general health is not as good and they suffer more long-term (and limiting) illness and disability. The latter is often related to drug, alcohol or mental health problems. **Accordingly, NHS Grampian should take account of such patterns of illness and disease in the planning and delivery of health services, the better to meet the requirements of a particularly needy group.**

Secondly and (consequently) the study found that homeless people made disproportionate use of NHS services. Compared with people in the general population, they consulted more with GPs, were more likely to attend Accident and Emergency services, made greater use of hospital out-patient services and were more likely to have been a patient in hospital overnight. **Accordingly, NHS Grampian should take account of such distinctive patterns of health service use in the planning and delivery of health services, the better to meet the requirements of a particularly needy group.**

Thirdly, the study found that homeless people's high levels of need and experience were, in general, met by an appropriate response from NHS services. As such the majority of homeless people surveyed felt that the NHS did meet their needs and wishes as patients. **Accordingly, NHS Grampian should build upon the high levels of satisfaction expressed by homeless people about NHS services to reinforce the valuable work done by staff.**

Fourthly the study found that homeless people's assessment of NHS healthcare however was both illness and service related. As such, treatments for accidents, physical illness, smoking and sexual health were more readily available than treatments for mental illness or substance misuse. **Accordingly, NHS Grampian should ensure that effective action is taken to improve services to homeless people where necessary. Attention should be focused, in particular, on providing additional mental health and substance misuse services.**

Fifthly, the study found clear sets of enabling factors as well as potential barriers to NHS service use. Amongst the enabling factors were homeless people's own knowledge, experience and attitude to using NHS services, as well as the disposition of medical staff. In short, the study found that the 'key' to homeless people's satisfaction with services lay in knowing which services were available, a good previous experience and confidence in an interested and caring staff. **Accordingly, NHS Grampian should publicise its services to homeless people, ensure that 'first contact' with services is positive and offer 'care' as well as treatment.**

Sixthly, with respect to the potential barriers to service use, amongst the most reported were waiting lists and the appointment systems in place. In addition, the financial costs of using services and the attitude of GP receptionists were highlighted. **Accordingly, NHS Grampian should look again at the organisation of both primary and secondary care services, with a view to developing better ways of managing queues. Alongside a reduction in waiting times, keeping patients informed about likely dates for treatment would be welcomed by homeless people. In addition, extra NHS dentists would promote greater equality amongst a needy and disadvantaged group of patients unable to access private and costly healthcare. Also, values training, as part of on-going CPD amongst support staff (e.g. GP receptionists), would make NHS services for homeless people more accessible.**

Finally, the study explored how the views and opinions of homeless people about the design and delivery of services could best be represented to NHS Grampian. Participants identified a number of ways through which their voices might be heard. Such ideas fell into two broad categories: self-advocacy and representation. With respect to the former, it was felt that homeless people themselves could make use of 'suggestion boxes' available in some surgeries and clinics. Also, it was felt that participation in independently commissioned research would be a powerful way of having their views heard. With respect to the representation, the use of staff from voluntary sector agencies to advocate on their behalf was considered an important way of being recognised by homeless people. **Accordingly, NHS Grampian should proactively seek the views and opinions of homeless people by supporting the use of patient feedback forms in surgeries and clinics and other places where homeless people gather (i.e. drop-in centres), commissioning independent research and facilitating the use of non NHS agencies as advocates for homeless people.**

# SECTION ONE: INTRODUCTION

## 1.1 Background

According to the latest official figures, 1900 households presented themselves as homeless in Aberdeen City in the year 2005/2006 (Scottish Executive 2006). More than three-quarters were from single person households (78%), with around 12% from single parent households, while the remainder of applications came from couples with and without children and other types of household. Just over half of all applications came from single men (52%) and more than a quarter came from single women (26%). Historically and around a third have come from young people aged 24 years or less (32%) (Scottish Executive 2001). As such, the problem of homelessness in Aberdeen City is defined, not least, by the high proportion of single person households and the youthfulness of its homeless population. Both of these local characteristics are in excess of national trends.

The problems faced by homeless people in Aberdeen and elsewhere have already been documented in terms of inadequate housing, family and relationship breakdown, unemployment, multiple debt, reliance on benefits and low income (Love, 1993, 1997, 2002; Spicker, Love, Strangward, McLaverty & Strachan, 2002). Such multiple and linked problems serve to marginalise homeless people relegating them to ways of life outside of mainstream society. A corollary of such exclusion is the relatively high levels of poor health (both physical and mental) found among the homeless population. Hence, physical hardship, accidents, inadequate resources to practice personal hygiene, poor diet, stress, difficulty registering with a GP, a lack of preventative care, a lack of (suitable) health information and stigma combine to increase the rates of morbidity and mortality among homeless people (Wood, Sclare & Love 2001; Love, 2002).

At a national level, the issuing of government guidance to NHS Boards and the appointment of a Health and Homelessness Co-ordinator in 2001 highlighted the seriousness of the problem and, at the same time, demonstrated the commitment of the Scottish Executive to tackling health inequalities and social exclusion among the homeless population. In partnership with relevant agencies and homeless people themselves, Health Boards were asked to develop Health and Homelessness Action Plans which would link with both Local Health Plans and, by 2003, with Local Authorities' Homelessness Strategies. Underpinning such activity would be evidence demonstrating the scale and composition of the homeless problem in each area, integral to which will be a 'comprehensive assessment of homeless people's health and health-care needs'.

Since 2003, the Health and Homelessness Steering Group has been charged with formally assessing the implementation of local Action Plans and in 2005, drew up a list of six Standards against which local NHS service providers could be judged with respect to their effectiveness in meeting the health needs of homeless people in their areas. Underpinning such an approach was an appreciation that little is known about how best to engage with such communities to ensure that health services are responsive to their needs.

## 1.2 Health and Homelessness in Aberdeen City

NHS Grampian (NHSG) has produced a Health and Homeless Action Plan 2004 – 2007 with five clear objectives[1], the fourth of which is *'to ensure appropriate access to health care*

[1] 1. increase understanding of and support for health and homelessness
2. ensure co-ordinated response to improve the health of homeless people
3. ensure the provision of relevant training
4. ensure appropriate access to health care services for homeless people
5. ensure health provision is integral to provision for homeless people (NSGH, Health & Homeless Action Plan 2004-2007)

*services for homeless people'*. Such an objective corresponds to 'Health and Homelessness Standard 4', which calls upon Health Boards to ensure that homeless people have '*equitable access to the full range of health services'*. In short, Health Boards are now required to monitor and evaluate the use and non-use of health services by homeless people to ensure that such provision is 'barrier free'. As such, the structural, policy and attitudinal factors which may undermine the health needs of homeless people, must to be identified, understood and addressed.

In a recent review of the effectiveness of healthcare delivery to homeless people in Scotland, England and elsewhere, concern was expressed, in particular, about the lack of evidence of young people's experiences and views in relation to health and use of health services (Quiglars & Pearce, 2003). Given the extent of the problem of youth homelessness generally in Aberdeen, the proposed research will seek to fill an important gap in knowledge locally about an emergent and needy group of homeless people. In sum, the research has sought to capture the 'voice' of a marginalised group of health service users and by doing so enable NHS Grampian and its partners to effectively engage with homeless people, in particular young homeless people, to better deliver healthcare.

## 1.3 Research Study

***Research Questions***

The present study examined the health status and health behaviours of homeless people in Aberdeen. It sought to find out how well NHS services engage with homeless people in the city and to explore how patient and public involvement could be developed meaningfully to ensure that the views of homeless people are actively sought, listened to and acted upon.

It was the intention that the information gathered and understandings achieved would inform the work of the NHS locally with respect to how best to engage with 'hard to reach' and 'seldom heard' groups. In addition, the research sought to inform the Scottish Health Council about how best to support this work, through for example, the development of guidance and standards. The definition of homelessness used corresponded to that used by the Homelessness Task Force and covered the statutory homeless and non statutory homeless (e.g. roofless, houseless, temporarily housed, those living in insecure accommodation etc.)

The research was thus guided by the following five research questions:

1. What are the individual needs of homeless people, including young homeless people, regarding healthcare and treatment?
2. How should NHS services ensure that homeless people's individual needs are identified respected and responded to?
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4. How should NHS services engage with homeless people, including young homeless people to capture their views and experiences of NHS services?
5. How should NHS services engage with homeless people, including young homeless people to plan changes and improvements in services?

***Process***

The present study combined both qualitative and quantitative methods of investigation. Accordingly, a two-stage approach was adopted, involving the carrying out of focus groups with homeless people in order to identify and understand relevant health beliefs and attitudes, followed by a large-scale survey of health status and behaviours of homeless people.

***Sample***

In the absence of an up-to-date and comprehensive register of homeless people in Aberdeen City from which to select a random sample for study, the research adopted a 'purposive' sampling approach, which is commonly used in the study of difficult to access populations. Accordingly, at stage one, using knowledge of the local homeless scene and agency contacts, two focus groups were organised and hosted comprising homeless men (n=4) and homeless women (n=10). The focus groups were carried out in December 2006 and February 2007.

At stage two, a large-scale survey was carried out with the intention of recruiting a 'convenience' sample of 100 homeless people. As such, 24 agencies known to have 'front-line' contact with homeless people in Aberdeen City were approached and invited to help administer a self-completion questionnaire to homeless clients who approached their services during the month of March 2007.

Based on agencies own assessments of the likelihood of homeless people using their services during the survey period, 295 questionnaires were made available. 15 agencies returned questionnaires on behalf of 118 homeless people (see table 1.1).

**Table 1.1 Participating Agencies**

| *Agencies Approached* | *Questionnaires requested* | *Questionnaires returned* |
|---|---|---|
| ***Aberdeen City Mission*** | n/a | - |
| ***Community Support Services (Aberdeen Cyrenians)*** | 50 | 4 |
| ***Aberdeen Foyer*** | 20 | 2 |
| ***Aberdeen Welfare Rights*** | 25 | - |
| ***Albyn House Alcohol Support Ltd*** | 5 | - |
| ***Alcohol Advisory & Counselling Service (AACS)*** | 10 | - |
| ***Alcohol Support Ltd*** | | |
| ***Benefits Advice*** | n/a | - |
| ***Citizens Advice Bureau (CAB)*** | n/a | - |
| ***Clifton Road Project (Aberdeen Cyrenians)*** | 10 | 4 |
| ***Craig House (Aberdeen Cyrenians)*** | 6 | 4 |
| ***Drugs Action*** | 15 | 12 |
| ***Family Planning Clinic (Square 13)*** | 10 | 1 |
| ***Fonthill Project (Aberdeen Cyrenians)*** | 5 | 4 |
| ***Department of Genitourinary Medicine*** | 10 | - |
| ***Grampian Racial Equality Council (GREC)*** | n/a | - |
| ***Grampian Women's Aid*** | 10 | 2 |

| | | |
|---|---|---|
| ***Homelessness Section – Aberdeen City Council*** | 50 | 11 |
| ***Instant Neighbour Charitable Trust*** | 20 | - |
| ***Jobcentre Plus*** | n/a | - |
| ***Margaret House (Aberdeen Cyrenians)*** | 12 | 6 |
| ***Marywell Healthcare Centre (Practice for the Homeless)*** | 25 | - |
| ***Rape & Sexual Abuse North East*** | n/a | - |
| ***SACRO (Supported Accommodation Services*** | 10 | 4 |
| ***Safe & Sound for Carefree Kids Project (Instant Neighbour Charitable Trust)*** | n/a | - |
| ***Salvation Army*** | n/a | - |
| ***Social Work Services Duty Social Work Team*** | 20 | 8 |
| ***St Vincent de Paul Society*** | n/a | - |
| ***Stopover Project (Aberdeen Cyrenians)*** | 12 | 4 |
| ***Summer Street Project (Aberdeen Cyrenians)*** | 50 | 41 |
| ***Victim Support*** | n/a | - |
| ***Voluntary Service Aberdeen*** | n/a | - |
| ***Wernham House (Aberdeen Cyrenians)*** | 17 | 10 |
| ***Other**** | - | 1 |
| *TOTAL* | | 118* |

*n/a = the agency was unable to participate in the study * one questionnaire was returned independently of agency*

***Research Instruments***

The focus groups were based upon two research instruments. Firstly participants were invited to complete a short proforma that sought to collect basic demographic data (i.e. age, sex, marital status) as well as information about homeless experience. Secondly, participants were led through a themed discussion that covered the following five topic areas: health needs, use of health services, barriers to service use, ways of improving services and listening to service users.

The survey was based on a semi-structured (self-completion) questionnaire divided into four main sections. Section A: *About You*, sought classifactory information and information about family background and work experience. Section B: *About Your Health*, explored the areas of general health, long-standing illness and disability, the incidence of disease (based on reported/treated conditions), the experience of illness (based on reported symptoms suffered) and drug use. Section C: *Use of Health Services*, examined registration with GPs, consultation with GPs, use of hospital based A & E and other 'out-patient' services, in-patient stays in hospital and the use of other health related services (including drug and mental health services). Section D: *Experience of NHS Health Services* examined ease of access to treatment for different types of condition, factors which more or less facilitated access to

treatment, usefulness of treatment and ways of improving treatment. Section E: *Homeless Experience*, sought information about the past and present housing experiences, including the experience of homelessness and sleeping rough.

The individual questionnaire items comprised a mix of questions designed for the present research, as well as standardised questions employed in studies of health elsewhere. The latter thus enabled comparisons to be made between the study group (i.e. homeless people in Aberdeen) and the wider population.

### 1.4 Outline of Report

The report is divided into six main sections. In Section One: Introduction, the background to the study is outlined, the research interests described and the methodology used in the study explained. In Section Two: The Study Group, a description of the sample of homeless people who took part in the study is offered in terms of their socio-demographic characteristics and homeless experience. In Section Three: Health, the general health of the study group is described and the experience of disease, illness and drugs is reported. In Section Four: Use of Health Services, the use of GP services, hospital based services and other health related services is examined. In Section Five: Experience of NHS Health Services, ease of access to treatment for different types of condition, factors which more or less facilitated access to treatment, usefulness of treatment and ways of improving treatment are reported on. Finally, in Section Six: Conclusion, an attempt is made to answer the research questions which guided the study. In addition, the policy implications which flow from the study are outlined.

***Additional technical note***

Throughout the report analyses were carried out according to three main characteristics; sex (men/women), age (young people aged 16 – 24 years/older people aged 25 years +) and drug status (self defined problem drug users/non-problem drug users including users of drugs and people who had never used drugs).

Where an association is indicated in the text (e.g. problem drug users are more likely than non-problem drug users to sleep rough) the results are based on the $X^2$ statistic with a P value of 0.05 or less.

Throughout the report percentages have been rounded up or down and may not add up to 100%. Also, the N within a table may vary depending up the response to the 'control' variable used.

# SECTION TWO : THE STUDY GROUP

## 2.1 Introduction

The present section offers a brief description of the homeless people who took part in the study in terms of their socio-demographic characteristics and homeless experience. To begin with participants are described in terms of their age, sex, marital status, off-spring and employment status. Thereafter, a description of the homeless experience of participants is offered with respect to their current accommodation, recent housing experiences, the move into homelessness itself and rough sleeping. In order to highlight significant differences within the study group, the findings are analysed by the key characteristics of sex, age (i.e. 24 years or less vs 25 years +) and drug status (i.e. self-assessed problem drug user vs non-problem drug user).

## 2.2 General Profile

In general, the study group comprised an uneven mix of males 60% (n=71) and females 39% (n=46), who ranged in age from 16 years to 81 years, with a mean average age of 36 years. 25% (n=29) of those surveyed were young people aged 24 years or less. Two-thirds of the participants were single - never married (66%, n=76), just under a third had been married or cohabited in the past (27%, n=45) while 4% (n=5) were currently married or cohabiting. Just under half of the study group had children (48%, n=56), most having two or more off-spring, although less than a fifth of parents shared a household with their children (21%, n=11). Only 7% (n=8) of participants were currently employed, with the remainder either unemployed (i.e. looking for work) (57%, n=64) or non-employed (i.e. not looking for work) (36%, n=41). The latter group included people unable to work through ill-health and disability.

Comparing attributes of the sample with known dimensions of the homeless population in Aberdeen, the study group is seen to be slightly older than the local homeless population (i.e. 33% of the homeless population locally are aged 24 years or less) and more likely to have been married or cohabited at some time (i.e. 79% of the local homeless population are single – never married). Women are under-represented in the sample.

Differences with the study group suggest that men were generally older than women, with the (mean) average age of each group being 38.6 years and 32 years, respectively. Also, with respect to age, young people under the age of 25 years, were more likely than older people to be single-never married, with 96% (n=27) being in this position. (see Table 2.2.1).

**Table 2.2.1 Marital Status**

| | *Single – Never Married* | *Married / Co-habit* | *Separated, Divorced, Widowed* | |
|---|---|---|---|---|
| | **%** | **%** | **%** | **N** |
| ***Sex*** | | | | |
| *Male* | **67** | **20** | **13** | **70** |
| *Female* | **64** | **9** | **27** | **44** |
| ***Age-Group*** | | | | |
| *16-24 years* | **96** | **-** | **4** | **28** |
| *25 years+* | **56** | **6** | **38** | **87** |
| ***Drug Status**** | | | | |
| *Problem* | **81** | **3** | **16** | **31** |
| *Not problem* | **58** | **5** | **37** | **77** |

**Drug status was based on self-assessment*

Finally, differences were noted within the sample with respect to age and employment status. As such, although the vast majority of all participants were not working currently, younger people (aged 24 years or less) were more likely than older people (aged 25 years +) to declare themselves 'unemployed' and looking for work, while older people were more likely to be out of the labour market through being 'non-employed' and not looking for work (see Table 2.2.2). The latter was indicative of poorer health.

**Table 2.2.2 Current Employment Status**

| | *Working* | *Unemployed* | *Non-employed* | |
|---|---|---|---|---|
| ***Age-Group*** | **%** | **%** | **%** | **N** |
| *16-24 years* | **15** | **74** | **11** | **27** |
| *25 years+* | **5** | **51** | **44** | **86** |
| *All* | **7** | **57** | **36** | **113** |

## 2.3 Homeless Experience

Enquiries were made about the housing backgrounds of participants. In particular, participants were asked about their current accommodation, recent housing experiences (in terms of the number of separate addresses lived at over the previous 12 months), their last settled homes and sleeping rough. The following was found.

When contacted, around a third of participants were living in hostel accommodation (32%, n=35), over a quarter were living in some type of mainstream housing, such as council, housing association or private rented accommodation (29%, n=31), a further quarter were living in a variety of less secure types of accommodation including living 'care of others', in Bed & Breakfast establishments and caravans (29%, n=31), while the remaining 11% (n=12) were sleeping rough. Just under a third of participants had been settled in their current accommodation for less than three months (n=32, 30%) (see Table 2.3.1). Asked further about how many separate addresses they had lived at in the previous 12 months, the study found that on average participants had lived at 2 separate addresses in the past year, although a quarter had lived at 4 or more addresses during this time (23%, n=22).

**Table 2.3.1 Current accommodation by length of stay**

| | *Length of stay* | | | |
|---|---|---|---|---|
| ***Accommodation*** | **Less than 3 months** | **3-11 months** | **1 year+** | |
| | **%** | **%** | **%** | **N** |
| *Hostel* | **40** | **23** | **37** | **35** |
| *Mainstream Housing** | **23** | **36** | **42** | **31** |
| *Other Accomm*** | **23** | **32** | **45** | **31** |
| *Sleep Rough* | **50** | **13** | **38** | **8** |

**'mainstream housing' refers to council, housing association and private rented accommodation*
*** 'other accomm' refers to living c/o others, B&B, caravan and other forms of insecure accommodation*

Differences within the sample with respect to current housing situation suggest that men were more likely than women to sleep rough, with 18% (n=12) of men doing so and no women. Also, young people were less settled than older people, with just under half of those aged 16-24 years being settled in their current housing situation for less than 3 months (46%, n=12), whilst half of those aged 25 years+ had been settled for a year or longer. No other systematic differences were found within the study group either with respect to the type of accommodation currently lived in or the length of stay in this accommodation.

Participants were asked about their last settled homes and when they had first become homeless. Also they were asked if they had ever slept rough since becoming homeless. The findings show that around a third of participants had moved into homelessness from social

rented housing (36%, n=37) or private rented accommodation (16%, n=16). The remainder had been living in either a hostel (18%, n=18) or some other type of accommodation at this stage in their housing careers (31%, n=32). Asked when they had become homeless, it was found that around a quarter had been homeless for less than 5 months (28%, n=23), just under half had been homeless for between 12 - 14 months (49%, n=41) while the remaining quarter had been homeless for between 15 months and 8 years (23%, n=19). Since becoming homeless more than half of the sample had slept rough at some time (59%, n=58).

Differences within the sample suggest that (self-assessed) non-problem drug users are more likely to have been homeless for longer than (self-assessed) problem drug users, with 29% (n=15) and 8% (n=2) respectively of each group reporting that they had been homeless for 3 ½ years or longer. By contrast, problem drug users were more likely to have slept rough since becoming homeless, with three-quarters reporting this to be the case (75%, n=21) compared with less than a half of non-problem drug users (49 %, n=32).

# SECTION THREE: HEALTH

## 3.1 Introduction

The present section reports on the health status of the homeless people surveyed. In particular it describes their present general health, their experience of long-standing illness and disability, their responses to a check-list of specified diseases or conditions, their disclosure of discomfort and suffering and their involvement in the use of street drugs. To begin with participants are described in terms of their self-assessed general health status. Thereafter the experience of long-standing illness and disability (including the nature of the illness or disability and its impact on their lives) is looked at. Next responses to a check-list of 20 common diseases or conditions are described. Following this, participants' disclosures of specific type of pain and discomfort are reported. Finally, participants' use of street drugs, including the incidence of drug injecting and self-assessed problem drug use are described. As previously, findings are analysed by the key characteristics of sex, age (i.e. 24 years or less vs 25 years +) and drug status (i.e. problem drug user vs non-problem drug user).

## 3.2 General Health and Long-standing Illness and Disability

Participants were asked to assess their own general health in terms of whether they considered it 'good', 'fairly good' or 'not good'[2]. Next they were asked if they suffered from any long-standing illness or disability and if so whether such conditions were mental health, alcohol or drug related. Finally they were asked about the impact of any long-standing illness or disability. In particular they were asked if they found such conditions limiting in any way. The following was found.

As Table 3.2.1 shows, only a small proportion of participants regarded their general health as 'good' (17%, n=20), half assessed their general health as 'fairly good' (50 %, n=58) and a third assessed their health as 'not good' (33%, n=39). In total therefore, 83% of the homeless people surveyed considered their own general health as 'less than good'.

Differences within the study group suggest that older homeless people are more likely than younger homeless people to assess their health as 'not good', with two-fifths of the former

[2] Self assessed health is generally accepted as a good indicator of wellbeing and correlates with diagnosed acute and chronic disease as well as being a good predictor of mortality (Scottish Executive, 2005).

group doing so (40%, n=36) compared with 11% (n=3) of the latter group. No other systematic differences were found.

To put the above findings in context, in the general population as a whole, according to the Scottish Health Survey 2003, three-quarters of people report their health as 'good' or 'very good' (74% men, 73% women), around a fifth as 'fair' (18% men, 19% women) and only 8% (of both sexes) as 'bad or very bad' (Scottish Executive, 2005). As such the study group as a whole and older homeless people in particular, would appear to suffer disproportionate poor general health.

**Table 3.2.1 Self-Assessed General Health**

| | *Good* | *Fairly Good* | *Not Good* | |
|---|---|---|---|---|
| | **%** | **%** | **%** | **N** |
| ***Sex*** | | | | |
| *Male* | **21** | **45** | **34** | **71** |
| *Female* | **9** | **58** | **33** | **45** |
| ***Age-Group*** | | | | |
| *16 – 24 yrs* | **25** | **64** | **11** | **28** |
| *25 yrs +* | **15** | **45** | **40** | **89** |
| ***Drug Status*** | | | | |
| *Problem* | **9** | **69** | **22** | **32** |
| *Not Problem* | **21** | **44** | **35** | **77** |
| ***All*** | **17** | **50** | **33** | **117** |

The study went on to examine the issue of long-standing illness and disability. Three-fifths of participants reported having such a condition (61%, n=102), with drug problems, mental health problems and alcohol problems the most reported conditions suffered (Table 3.2.2). In addition, a 15% of sufferers reported suffering some kind of long-term physical illness or disability only. With respect to the latter, a range of conditions was reported including heart disease, paralysis, joint problems (i.e. painful legs), back trouble, blindness, epilepsy, kidney disease, asthma, osteoporosis and a general lack of fitness.

**Table 3.2.2 Long-Standing Illness and Disability**

| | | *Total* |
|---|---|---|
| | **%** | **N** |
| ***Long-Standing Illness/ Disability*** | **60** | **69** |
| *Physical Only* | **15** | **69** |
| *Drug Related* | **39** | **69** |
| *Mental Health Related* | **41** | **69** |
| *Alcohol Related* | **39** | **69** |

The vast majority of those who suffered from a long-standing illness or disability indicated that such a condition was limiting in some way, with around 80% (n=56) of sufferers reporting this to be the case. The limitations of such conditions were mainly experienced in terms of physical mobility, problems accessing the labour market and social isolation. As such, participants explained *'I have manic depression and can't work'* (female, 27 years), *'I have a loss of motivation and fear being outside'* (female, 46 years), *'I can't work or mix with*

*people'* (female, 31 years) , *'I don't feel like going out because my legs hurt so much.'* (male, 56 years) and from a young woman who suffered from mental health, alcohol and drug problems, *'I can't work. I don't get benefits and I can't read.'*

Differences within the study group suggest that older people (aged 25 years +) were more likely than younger people (aged 16-24 years) to report a long-term (and limiting) illness, with 68% (n=59) and 36% (n=10) respectively of each group reporting this to be the case. Also, older people were more likely than younger people to report a long-term (and limiting) alcohol problem, with 29% (n=26) and 3% (n=1) respectively of each group indicating such a condition. In addition, self-reported non-problematic drug users (30%, n=23) were more likely than problematic drug users (6%, n=2) to report a long-term drink problem, while the opposite was the case for long-term drug problems, where more than half of problematic drug users defined their use as a long-term (and limiting) condition (53%, n=17).

To put the above findings in context, two-fifths of people generally report a long-term illness or disability (41% men, 42% women) which is limiting for around three-fifths of sufferers (Scottish Executive, 2005). As such the findings from the present study suggest, once again, that homeless people suffer higher levels of morbidity than people in the general population.

## 3.3 Disease

The study went on to examine a further dimension of health and ill-health among the homeless population. As such, participants were invited to indicate whether or not they had ever had any of 20 specified (and common) medical conditions and if so, whether or not such conditions had been treated. Conditions reported as 'untreated' were more likely to be self-diagnosed.

**Table 3.3.1 Diseases 'Treated' or 'Untreated'***

| **Conditions Suffered** | | |
|---|---|---|
| **Treated for Majority** | **Equally Treated/Untreated** | **Untreated for Majority** |
| ***Chronic Bronchitis*** | ***Hepatitis*** | ***Alcohol Problem*** |
| ***'Other' Chest Trouble*** | ***'Other' Liver Condition*** | ***Varicose Veins*** |
| ***Diabetes*** | | ***Rheumatics / Arthritis*** |
| ***Stomach Disorder*** | | |
| ***Piles or Haemorrhoids*** | | |
| ***Asthma*** | | |
| ***Heart Trouble*** | | |
| ***'Other' Cancer*** *(i.e. not lung cancer)* | | |
| ***Severe Depression/Nervous Illness*** | | |
| ***High Blood Pressure*** | | |
| ***Stroke*** | | |
| ***Migraine*** | | |
| ***Back Trouble*** | | |
| ***Epilepsy*** | | |

**Although asked about, no-one reported having lung cancer*

As Table 3.3.1 shows, 19 out of the 20 diseases enquired about had been experienced by the homeless people surveyed. 14 of the diseases had, for the majority of sufferers, been 'treated' in some way while three conditions had, for the majority, been left untreated. As such, in most cases, it would appear that participants were likely to be reporting on 'medically defined' disease and impairment.

More than three-fifths of those surveyed reported suffering from at least one of the (20) conditions asked about (85%, n=100). On average, participants reported suffering from three conditions, although more than a third of all participants reported suffering from five or more conditions at some time (36%, n=43). No systematic differences were found within the study group with respect to whether or not participants reported having any of the 20 conditions asked about. As such men were as likely as women, young people as likely as older people and problem drug users were as likely as non-problem drug users to report having a condition. However differences were found with respect to the number of conditions suffered. As such, older people (25 years+) were more likely than younger people (16-24 years) to have had more conditions, on average reporting 4 and 3 conditions respectively.

As Table 3.3.2 shows, the most reported condition experienced was severe depression or nervous illness, with more than half of the study group indicating that this was so (54%, n=51). In addition, just under half of participants reported experiencing an alcohol problem (47%) and three conditions were reported by around a third of participants; asthma (37%), back trouble (33%) and chest trouble (32%). Around a quarter suffered from some kind of stomach complaint or digestive disorder (27%). The prevalence of psychiatric illness and respiratory disease, in particular, echo findings from the medical assessments carried out in Aberdeen city for people applying for housing under homeless legislation (see Appendix B).

**Table 3.3.2 Disease**

| *Condition* | *%* | *Likely Sufferers* | | |
|---|---|---|---|---|
| | | **Sex** | **Age – Group** | **Drug Status** |
| *1. Severe Depression/ Nervous Illness* | **54** | **women** | | |
| *2. Alcohol Problem* | **47** | | | **non-prob** |
| *3. Asthma* | **37** | | | |
| *4. Back Trouble* | **34** | | | **prob** |
| *5. 'Other' Chest Trouble* | **32** | **women** | | |
| *6. Migraine* | **31** | **women** | | |
| *7. Stomach Disorder* | **27** | | | |
| *8. Piles or Haemorrhoids* | **20** | | | |
| *9. High Blood Pressure* | **19** | | | |
| *10. Hepatitis* | **19** | | | |
| *11. 'Other' Liver Trouble* | **19** | | | |
| *12. Epilepsy or fits* | **19** | | **older** | |
| *13. Chronic Bronchitis* | **19** | **women** | | |
| *14. Varicose Veins* | **17** | **women** | | |
| *15. Rheumatic Trouble/ Arthritis* | **16** | | **older** | **non-prob** |
| *16. Heart Trouble* | **15** | | | |
| *17. Diabetes* | **8** | | | |
| *18. 'Other' Cancer (i.e. not ling cancer)* | **6** | | | |
| *19. Stroke* | **6** | | | |
| *20. Lung Cancer* | **0** | | | |
| *N=* | **94** | | | |

*Key: Age – Group = 'older' (25 yrs +); Drug Status = 'prob', 'non-prob' (self-defined problem, non-problem drug user). The 'N' (number of participants) varied from 93 to 105 with 94 the mode average number of participants.*

Nine of the 19 conditions reported were experienced differentially within the study group, according to sex, age and drug using status; severe depression / nervous illness, alcohol problems, back trouble, 'other' chest trouble, migraine, epilepsy or fits, chronic bronchitis, varicose veins and rheumatic trouble / arthritis.

With respect to sex, women were more likely than men to report experiencing severe depression or nervous illness, with 69% (n=28) and 44% (n=28) of each group respectively doing so. Likewise women were more likely than men to experience chronic bronchitis (29%, n=10 and 13%, n=8 respectively) and other chest trouble (46%, n=15 and 25%, n=16 respectively). Further women were more likely than men to experience migraine (52%, n=17 and 21%, n=13 respectively) and varicose veins (36%, n=12 and 7%, n=4 respectively).

In terms of age, older people (aged 25 years+) were more likely than younger people (16-24 years) to report experiencing epilepsy or fits (21%, n=15 and 0% respectively) and rheumatic trouble or arthritis (23%, n=17 and 5%, n=1 respectively).

Finally, with respect to drug using status, non-problematic drug users were more likely than problematic drug users to report experiencing alcohol problems (51%, n=37 and 26%, n=7) and rheumatic trouble or arthritis (20%, n=13 and 0% respectively). By contrast, problematic drug users were more likely to report experiencing back trouble (50%, n=13 and 27%, n=18 respectively).

## 3.4 Illness

The study sought to examine the issue of illness within the sample of homeless people surveyed. Unlike the more objective, medically defined condition or pathology of 'disease', illness refers to the subjective experience of pain or discomfort. Often related, although not synonymous, disease and illness allow for a multi-dimensional understanding of health and ill-health.

**Table 3.4.1 Illness in Past Month**

| *Symptom* | *%* | *Likely Sufferers*[1] | | |
|---|---|---|---|---|
| | | **Sex** | **Age - Group** | **Drug Status** |
| *1. Cold/Flu* | **57** | | **younger** | |
| *2. Headache* | **55** | **women** | | **prob** |
| *3. Trouble with Teeth* | **52** | | | **prob** |
| *4. Painful Joints* | **45** | | | |
| *5. Bad Back* | **42** | | **older** | |
| *6. Palpitations/ Breathlessness* | **42** | | | |
| *7. Indigestion* | **38** | | | |
| *8. Problem with Skin* | **36** | | | |
| *9. Trouble with Periods/ Menopause*[2] | **33** | | | |
| *10. Trouble with Eyes* | **30** | **women** | | |
| *11. Trouble with Feet* | **29** | | | |
| *12. Trouble with Ears* | **19** | | | |
| *N =* | **103**[3] | | | |

*Key:1 = Age – Group = 'younger' (16 – 24 years); Drug Status = 'problem' (self-defined problem drug user); 2 = Question for women only. 3 = The 'N' (number of participants) varied across common variables from 94 to 103, with 103 the mode average number of participants.*

Participants were asked about their experience of 12 common illness symptoms over the previous month. The following was found.

Almost all participants reported experiencing illness symptoms in the previous month (86%, n=111). On average participants experienced four symptoms during this time. There were no systematic differences noted within the study group with respect to the number of illnesses experienced in the past month. As such men were as likely as women, young people as likely as older people and problem drug users were as likely as non-problem drug users to report having an illness.

Looking at the nature of the pain and discomfort experienced, table 3.4.1 shows that the most reported illness symptoms experienced in the previous month were cold/flu, headaches and trouble with teeth. More than half of participants had suffered from these conditions. In addition, two other illness symptoms were experienced by two-fifths or more of the study group; bad back (42%, n=43) and palpitations and breathlessness (42%, n=43).

Differences in the experience of illness were noted with respect to sex, age and drug using status. In terms of sex, the findings suggest that women were more likely than men to suffer from headaches (70%, n=26 and 46%, n=30 respectively) and trouble with their eyes (43%, n=15 and 22%, n=14 respectively). In terms of age, young people (16-24 years) were more likely than older people (aged 25 years+) to suffer from colds / flu (79%, n=19 and 51%, n=41 respectively), whilst older people were more likely than younger people to experience back pain (47%, n=38 and 23%, n=5 respectively). Finally, in terms of drug using status, self-reported non-problematic drug users were more likely than those who did not consider themselves to be problematic drug users to suffer headaches (69%, n=18 and 47%, n=33 respectively) and trouble with their teeth (74%, n=20 and 42%, n=30 respectively).

## 3.5 Drug Use

Enquiries into the health status of the homeless people surveyed closed by exploring the issue of street drug use. In particular, participants were asked about their recent drug use, injecting drugs and problem drug use. The following was found.

**Table 3.5.1 Use Street Drugs in Past Month**

| *Sex* | *%* | *N* | *Age – Group* | *%* | *N* | *Drug Status* | *%* | *N* |
|---|---|---|---|---|---|---|---|---|
| *Men* | **29** | **69** | **16 – 24 yrs** | **56** | **27** | **Problem** | **81** | **32** |
| *Women* | **41** | **44** | **25 yrs +** | **26** | **87** | **Not Problem** | **16** | **75** |

A third of the study group had used street drugs in the previous month (33%, n=38). Differences were noted within the study group in terms of who had used street drugs. As such young people were also more likely than older people to have used street drugs in the recent past, with more than a half (56%, n=15) of those aged 16 – 24 years using street drugs in the previous month compared with a quarter of those aged 25 years + (26%, n=23). Self-assessed problem drug users were also more likely to have used street drugs in the previous four weeks compared with non-problem drug users, with 81% (n=26) and 16% (n=12) respectively reporting this to be the case. No other systematic differences were found.

Asked further about the types of drugs they used, the findings show that there were three main ‘drugs of use’: Heroin, Crack and Cannabis (see table 3.5.2).

To put such findings in context, recent figures from the (sixth) Scottish Crime Survey 2003 (Scottish Executive, 2004), indicate that 5% of all 16 – 59 year olds had used street drugs in the last month, while 14% of 16 – 29 year olds had done so. In addition, amongst 'new' individuals approaching treatment services in connection with a drug problem (in Scotland and Grampian), Heroin is the clear main 'drug of use', with only a small minority accessing Crack (ISD NHS Scotland, 2006). As such the findings of the present study point towards a relatively high use of street drugs among homeless people. In addition, the homeless people surveyed appear to make greater use of Crack than might be expected.

**Table 3.5.2 Drugs of Use**

| Name of drug | Number |
|---|---|
| *Heroin* | **18** |
| *Crack* | **17** |
| *Cannabis* | **8** |
| *Valium* | **4** |
| *Cocaine / Coke* | **3** |
| *Benzodiazepines* | **1** |
| *Zimovane* | **1** |
| *Pollen* | **1** |
| *Other* | **1** |
| **Total responses** | **55** |

Participants were next asked if they had ever injected street drugs.

**Table 3.5.3 Injecting Drugs**

| | *Yes – Past Month* | *Yes – Not Past Month* | *All Injectors* | *Never Inject* | |
|---|---|---|---|---|---|
| | **%** | **%** | **%** | **%** | **N** |
| ***Sex*** | | | | | |
| *Male* | **19** | **15** | **34** | **66** | **62** |
| *Female* | **26** | **26** | **51** | **49** | **43** |
| ***Age – Group*** | | | | | |
| *16 – 24 yrs* | **23** | **19** | **42** | **58** | **26** |
| *25 yrs +* | **22** | **19** | **40** | **60** | **79** |
| ***Drug Status*** | | | | | |
| ***Problem*** | **57** | **27** | **83** | **17** | **30** |
| *Not Problem* | **9** | **16** | **24** | **76** | **71** |
| ***All*** | **22** | **19** | **41** | **59** | **109** |
| *Grampian** | ***52*** | ***27*** | ***79*** | ***21*** | ***882*** |
| *Scotland** | ***29*** | ***28*** | ***57*** | ***43*** | ***12,991*** |

**Source: Information Services Division (ISD) NHS Scotland (2006), Drug Misuse Statistics Scotland 2006*

As Table 3.5.3 shows around a fifth of the homeless people surveyed had injected street drugs in the previous month (22%, n=23), while two-fifths had injected street drugs at some point in their lives (41%, n=43). Differences within the study group suggest that, as expected, self-assessed problem drug users were more likely to be 'ever' injectors and 'recent' injectors of street drugs compared with non-problem drug users. No other systematic differences were found.

To put the findings in context once again, recent figures on drug misuse in Scotland (ISD NHS Scotland, 2006) indicate that in Scotland two-fifths of 'new' individuals approaching treatment services in connection with a drug problem have never injected drugs (43%), while in Grampian the corresponding figure is a fifth (21%). The homeless people surveyed who define themselves as problem drug users, are therefore more like their counterparts in Grampian than problem drug users elsewhere, reporting enhanced levels drug injecting. As such they are involved in greater levels of risk taking in the methods used to consume drugs.

Finally, participants were asked about problem drug use itself. In particular they were asked if they considered their use of street drugs to be a problem.

**Table 3.5.4 Problem Drug Use**

| | *%* |
|---|---|
| *Consider drug use a problem* | **29** |
| *Do not consider drug use a problem* | **41** |
| *Never use street drugs* | **30** |
| *Total* | **100** |
| *N=* | **109** |

As Table 3.5.4 shows more than a quarter of participants considered their use of street drugs to be problematic (29%, n=32) and just under third reported that they had never used street drugs (30%, n=33). Two-fifths of participants used drugs but did not consider such use to be problematic (41%, n=44). No systematic differences were found within the study group with respect to problem drug use. As such men were as likely as women, young people were as likely as older people to declare (or not) a problem with street drugs.

**Table 3.5.5 Problem and Non-Problem Drug Use (Key Concepts)**

| | *Problem Drug User* | *Non-Problem Drug User* |
|---|---|---|
| ***(A) Type of Drug Use*** | **Heroin**<br>**Crack**<br>**Cocaine**<br>**Diazepam**<br>**Cannabis**<br>**Poly-drug use**<br>**Drugs and alcohol**<br>**Injecting < week**<br>**Extended drug use** | **Only Cannabis use**<br>**Heroin**<br>**Crack**<br>**Valium**<br>**Poly-drug use**<br>**Past drug user**<br>**Methadone programme**<br>**Occasional drug use**<br>**Injecting < week** |
| ***(B) Effects of Drug Use*** | **Withdrawal**<br>**Dependency**<br>**Lack of control**<br>**Limits lifestyle**<br>**Unable to work**<br>**Failed detox**<br>**Difficulty accessing GP** | **Manage detox programme**<br>**Only use socially**<br>**Know when to stop**<br>**Extended period of being clean** |

Responses to an open-ended (follow-up) question on problem drug use illustrate the meaning of the labels 'problem' drug user and 'non-problem' drug user.

As Table 3.5.5 shows, participants conceptualised their drug status in two (related) ways; firstly in terms of their actual drug use (i.e. both the type of drug(s) used and the ways in which drugs were used) and secondly in terms of the effects of their use of drugs (i.e. its impact on their physical, mental and social well-being).

For those who regarded themselves as problem drug users, their problem drug use was defined in terms of the use of opiates (i.e. Heroin), benzodiazepines (e.g. Diazepam) and other drug types, including crack cocaine and cannabis. In addition, they were often polydrug users and (recent) drug injectors. Such use of drugs led to a range of difficulties, including the unpleasant experience of withdrawal symptoms, feelings of dependency and lack of control, failed attempts at detoxfication, unemployment and difficulty accessing GP services. The experience of a young man (aged 21 years) who had been homeless and unsettled for three years highlights some of the issues faced. A recent drug injector, he described his drug use thus, '*I'm on Heroin, a benzos user and sometimes white crack cocaine and cannabis.'* He went on to explain why he considered his drug use a problem, reporting '*.. it's a problem trying to get a doctor willing to take me on for a scrip.'*

For those who did not regard their drug use as problematic the distinction with problem drug users lay not in the actual drug use itself but in the claimed effects of (the types and methods of) their drug use. As such non-problem drug users used a similar range of drugs to problem drug users and included users of Heroin, benzodiazepines and crack cocaine, as well as cannabis. They were polydrug users and (recent) drug injectors. In addition, several were on Methadone (detoxification) programmes.

If however the drug profile (i.e. types and methods of drug use) of non-problem drug users overlapped that of self-assessed problem drug users, the impact of such involvement in drugs differentiated the two groups of drug users. Whilst the former group succumbed to multiple difficulties attendant upon their drug use, non-problem drug users claimed to be in control of their drug use. As such they variously claimed, *'I only use occasionally and I'm not dependent'* (female, 46 years), *'I don't have a drug problem. Just socially use them'* (female, 17 years) and *'I only use them now and again and mostly stick to my meth.'* (male, 36 years).

In sum, problem drug users differed from non-problem drug users only in the degree to which they felt able to control their use of drugs. Whether such management of their drug use was successful in the longer term was not explored.

# SECTION FOUR: USE OF HEALTH SERVICES

## 4.1 Introduction

The present section reports on the use of health services by the homeless people surveyed. As such it examines their use of primary and acute services and explores their use of health related services. To begin with, registration and use of GP services is looked at. Thereafter homeless people's use of Accident & Emergency services and other hospital based out-patient services is explored. In addition in-patient use is touched upon. Finally the use made of a range of health related services (including community based 'dedicated' nursing services, mental health services (CPN), specialist drug services and statutory and voluntary sector social work services) is documented.

## 4.2 Primary Care

Participants were asked firstly about registration with GP services and contact with GPs in the previous two weeks. As table 4.2.1 shows, 11% (n=13) of participants had not registered with a GP. Around a quarter had registered with the dedicated homeless GP practice at the Marywell Health Centre, Aberdeen, while the remainder had registered elsewhere.

**Table 4.2.1 Registration GP**

| *Type of registration* | *%* |
|---|---|
| *Not registered with GP* | **11** |
| *Register Marywell Health Centre Homeless Practice* | **23** |
| *Other GP* | **65** |
| *Marywell Health Centre & Other GP* | **1** |
| | **100** |
| *N* | ***114*** |

Asked about use of GP services in the two weeks prior to interview, the study found that two-fifths of the homeless people surveyed had done so (40%, n=45). Differences within the study group suggest that women were more likely than men to have consulted with a GP in the two weeks prior to the survey, with half of them doing so (50%, n=22) compared with around a third of men (32%, n=22). No other systematic differences were found.

To put these findings in context, the Scottish Health Survey 2003 found that in the population as a whole, 20% of women and 16% of men had consulted a doctor in the previous two weeks (Scottish Executive, 2005). Also, in the previous Scottish Health Survey in 1998 (Scottish Executive, 2000), it was found that amongst the population with acute sickness, the consultation rate with GPs rose to 45% for women and 34% for men. Accordingly, the findings from the present study suggest that homeless people make heavy use of GP services, in excess of people in the general population, a use which may imply disproportionately high levels of ill-health.

## 4.3 Secondary Care

The study moved on to examine participants use of hospital based Accident & Emergency services, other hospital based out-patient services and in-patient stays.

Participants were asked firstly if they had used hospital based Accident & Emergency services in the last 12 months.

**Table 4.3.1 Use of Accident & Emergency < 12 Months**

| | *%* |
|---|---|
| *Yes* | **40** |
| *No ** | **60** |
| | **100** |
| *N=* | **113** |

**'No' includes one respondent who was uncertain about whether or not he had used A & E.*

As Table 4.3.1 shows, two-fifths of the homeless people surveyed had made use of hospital based Accident & Emergency services in the previous year (40%, N=44). Differences within

the study group suggest that women were more likely than men to have used such facilities, with half having done so (50% n=22) compared with less than a third of men (30% n=21). No other systematic differences were found.

Participants were then asked about their use of other (i.e. non Accident & Emergency) hospital based out-patient services in the past 12 months.

**Table 4.3.2 Use of 'Other' Hospital Based Out-Patient Services < 12 Months**

| | % |
|---|---|
| *Yes* | **39** |
| *No ** | **61** |
| | **100** |
| *N=* | **113** |

** 'No' includes one respondent who was uncertain about whether or not he had used such services.*

As Table 4.3.2 shows, around two-fifths of the homeless people surveyed had used 'other' hospital based out-patient services in the previous 12 months (39%, n=44). Differences within the study group suggest that older homeless people (aged 25 years+) were more likely than younger homeless people to have used such services, with 47% (n=40) and 15% (n=4) respectively of each group having done so. Also, non problem drug users were more likely than problem drug users to have accessed such services with more than two-fifths of the former having done so (44%, n=33) compared with less than a quarter of self-defined problem drug users (23%, n=7).

**Table 4.3.3 Use of All Hospital Based Out-Patient Services < 12 Months**

| | % |
|---|---|
| *Accident & Emergency + other* | **22** |
| *Accident & Emergency only* | **17** |
| *'Other' only* | **17** |
| *Neither* | **44** |
| | **100** |
| *N=* | **112** |

Combining the responses with respect to the use of Accident & Emergency services and other hospital based out-patient services (see Table 4.3.3), the findings suggest that more than half of the homeless people surveyed had made use of such provision in the previous 12 months (56%, n=63). A fifth had made use of both types of service (22%, n=25).

To put the above findings in context, in the 2003 Scottish Health Survey, 35% of men and 37% of women were found to have made use of Accident & Emergency facilities and other hospital based day-patient services in the previous 12 months (Scottish Executive, 2005). As such the present study suggests that homeless people make greater use of hospital based out-patient services than people in the general population.

Enquiries were then made about participants experience of in-patient stays in hospital in the previous 12 months.

As Table 4.3.4 shows, around a third of the homeless people surveyed had spent at least one night as a patient in hospital in the past year (30%, n=34). The most likely in-patient stay during this time was as a patient in a general hospital. Within the study group, it was found that self-defined non-problem drug users were more likely than problem drug users to have had an overnight stay in hospital in the previous 12 months, with 36% (n=27) and 16% (n=5) respectively of each group reporting this to be the case. No other systematic differences were found.

**Table 4.3.4 In-Patient Hospital Stays < 12 Months**

| | % |
|---|---|
| *No stays in hospital* | **70** |
| *General hospital* | **27** |
| *Psychiatric hospital* | **3** |
| | **100** |
| *N=* | **113** |

To put the above findings in context, in the 2003 Scottish Health Survey it was found that 9% of men and 13% of women had stayed in hospital for one night or more in the previous 12 months (Scottish Executive, 2005). Once again, the findings of the present study suggest that the health behaviours of homeless people differ from those of people in the general population and that homeless people make disproportionate use of in-patient hospital services.

## 4.4 Health related Services

Enquiries into the health behaviours of the homeless people surveyed closed by exploring their use of health related services. Participants were asked about their use, in the past six months, of a range of services including 'dedicated' general nursing services for homeless people, mental health services (including CPN services), specialist drug services and statutory and voluntary sector social work services. The following was found.

Overall, two-thirds of participants reported having used a health related service in the past 6 months (65%, n=73), with Aberdeen Cyrenians, Drugs Action and Pharmacists the most reported services used (see Table 4.4.1). Within the study group, no systematic differences were noted in the use of health related services.

**Table 4.4.1 Use of Health Related Services**

| Health related service used | Number* |
|---|---|
| *Aberdeen Cyrenians* | **24** |
| *Drugs Action* | **13** |
| *Pharmacist* | **12** |
| *GDENT/Dentist* | **10** |
| *Podiatrist/Chiropodist* | **6** |
| *Duty Social Work* | **4** |
| *Nurse/Homeless nurse* | **2** |
| *Physiotherapist/Occupational physiotherapist* | **2** |
| *Diabetic clinic* | **1** |
| *Fulton Clinic (SMS)* | **1** |
| *Rehab clinic* | **1** |
| **Total responses (n)** | **76** |

** the 'Number' includes multiple service use of those who specified a service*

# SECTION FIVE: EXPERIENCE OF HEALTH SERVICES

## 5.1 Introduction

The final part of the survey (and focus groups) into the health status and health behaviours of homeless people examined their subjective assessments of using NHS health services. In particular homeless people were invited to comment upon the ease of accessing NHS treatment, the usefulness of treatments and ways of improving services. The following was found.

## 5.2 Access to Treatment

To begin with enquiries were made about how easy it was to access NHS treatment for a range of illnesses and health related concerns (i.e. physical illness, mental illness, substance misuse etc.).

**Table 5.2.1 Ease of Access NHS Treatment for select conditions**

| *Condition* | *Very easy / easy* | *Not easy** | |
|---|---|---|---|
| | **%** | **%** | **Total N** |
| ***Physical illness*** | **73** | **27** | **69** |
| ***Accident*** | **75** | **25** | **74** |
| ***Mental Illness*** | **33** | **67** | **54** |
| ***Drugs*** | **21** | **79** | **43** |
| ***Alcohol*** | **39** | **61** | **33** |
| ***Smoking*** | **61** | **39** | **31** |
| ***Sexual Health*** | **61** | **39** | **33** |

** not easy referred to 'difficult',' very difficult' and' unsure'*

As table 5.2.1 shows, the homeless people surveyed had a differential experience of accessing NHS services linked to the particular type of condition for which treatment was sought. The conditions most likely to allow easy access to treatment were accidents, physical illness, smoking and sexual health. Between three-fifths and three-quarters of homeless people requiring NHS services for these conditions were able to access treatment. By contrast homeless people's access to NHS mental health services and substance misuse services was more problematic. Differences within the study group suggest that men were able to access treatment for an accident more easily than women, with 91% (n=23) and 57% (n=21) respectively reporting this to be the case. Also, men were more likely than women to be able to access treatment for an alcohol problem, with 57% (n=12) and 8% (n=1) of women respectively reporting this to be the case. Finally, self-defined non-problematic drug users were more likely than problem drug users to report ease of access to alcohol services, with just under half of the former doing so 46% (n=10), compared with none of the latter.

Follow up enquiries about ease of access to NHS treatment, examined a range of factors that were more or less enabling for the homeless people surveyed. Twelve areas were asked about that covered both individual experience and disposition, as well as service organisation and delivery. The following was found.

**Table 5.2.2 Factors more or less enabling access to NHS services**

| *Factor* | *Made it Easy* | *Made it Less Easy* | |
|---|---|---|---|
| | % | % | Total N |
| ***Own knowledge*** | 72 | 28 | 67 |
| ***Own attitude*** | 69 | 31 | 64 |
| ***Previous experience*** | 67 | 33 | 67 |
| ***Appointment system*** | 44 | 56 | 63 |
| ***Location of service*** | 68 | 32 | 65 |
| ***Attitude Medical Staff*** | 65 | 35 | 68 |
| ***Attitude Receptionists*** | 54 | 46 | 59 |
| ***Waiting lists*** | 28 | 72 | 52 |
| ***Opening Hours*** | 56 | 44 | 39 |
| ***Financial costs of using service*** | 51 | 49 | 39 |
| ***Advertising of service*** | 54 | 46 | 43 |
| ***Peer Pressure*** | 37 | 63 | 27 |

As table 5.2.2 shows, there were clear sets of enabling factors as well as potential barriers to NHS service use. Amongst the enabling factors, reported by two-thirds or more of participants, were homeless people's own knowledge, experience and attitude to using NHS services, as well as the disposition of medical staff. Knowing which services were available, a good previous experience and confidence in the staff providing the service facilitated engagement. Thus a 38 year old homeless man talked about his very positive experience of the sexual health clinic at Woolmanhill hospital in the city, highlighting the positive attitude and care of the Consultant who treated him, remarking '*Dr <name> at Woolmanhill listened and managed to write to the other doctors I was seeing, streamlining (things). Prior to this I was passing on the little bits of information I had. Dr (name> made the service more friendly and informative'*. On the other hand, a 46 year old homeless man highlighted the consequences of a previous bad experience of NHS services and a lack of confidence in medical staff, recalling an experience of using Accident & Emergency , '*I always sign myself out... I got stabbed and slashed on the leg and had 58 stitches. Once they put the stitches in I signed myself out. I was supposed to go back but I took the stitches out myself. I cleaned the wound with antiseptic wipes in here [drop-in centre for homeless people] and once it was healed up I took the stitches out myself .. I have bad memories of hospitals.'*

With respect to the potential barriers to service use, the most reported were waiting lists, peer pressure and the appointment systems in place. In addition, the financial costs of using services and the attitude of receptionists were highlighted. With respect to waiting lists and appointments, the problem of accessing drug treatment services was a particular concern. A 26 year old homeless man outlined his own experience, which resonated with many, explaining '*SMS service [Substance Misuse Service].... 3 or 4 months back it said in Evening Express that you don't have to wait more than a year but half the people I spoke to said that they've been waiting 2- 3 years to get on the methadone programme. There may be bigger priorities, but longer you're waiting, you <u>are</u> a priority, you're going more and more downhill. If the service wasn't like that, some people could maybe save themselves and might not be homeless, because drugs is a lot to blame with homelessness…you won't get your appointment until you're going to get the stuff (i.e. Methadone). My doctor referred me over two years ago and I've been clean in between, but I'm still on the waiting list. I had one letter a while ago saying your near top of list, nothing since…then your 2nd, 3rd, you jump up and down.'* A further criticism was made of the way in which appointments were organised through a local GP practice, specialising in helping homeless people, in terms of its system of 'block bookings'. A 26 year old man explained how '*I use Marywell surgery which is on a*

*bus route but I am only half-happy with it as you don't get a specific appointment time. So approximately seven people are given a block time to come in.'*

Elsewhere a 23 year old man identified financial barriers to service use, pointing out the costs of finding private dental care, in the absence of NHS provision, remarking '*Dentists are all private now. It's £17 per week and extra for treatments (but) homeless people can't afford this. If you're homeless you're struggling anyway and need to spend money on food. (Also) NHS dentists are so packed out you can't get access for months.'*

In terms of the attitudes of (medical) receptionists, there was a commonly shared unease about a lack of courtesy and respect shown by some receptionists. As such just under half of the homeless people surveyed reported that such staff made accessing services '*less easy',* variously reporting '*GP receptionists are sometimes belittling'* (female, 37 years), '*Receptionists in GP surgeries seem to think they have more authority than they do!'* (female, 28 years), *'They all need to listen more'* (male, 17 years), '*I often find receptionists are obstructive'* (female, 37 years) and '*They need to be more sympathetic'* (male, 38 years).

Differences within the study group suggest that factors inhibiting NHS service use are linked to sex and drug using status. As such, it was found that women were more likely than men to report 'opening hours' as a barrier to service use, with three-fifths of women doing so (60%, n=12) compared to a third of men (32%, n=10). With respect to drug using status, self-defined problem drug users were more likely than non-problem drug users to cite problems with appointments (problem drug users 77%, n=17 and non-problem drug users 46%, n=18), medical staff attitudes (problem drug users 52%, n=12 and non-problem drug users 27%, n=12) and waiting lists (problem drug users 90%, n=17 and non-problem drug users 63%, n=19).

## 5.3 Usefulness of Treatment

The second main interest in examining homeless people's experience of NHS health services was the usefulness of this provision. Accordingly, the homeless people surveyed were asked to assess the value of a range of services, including primary care, hospital based treatments and specialist services. Such assessments were based on the extent to which these services were able to meet their health needs in the past year. The following was found.

**Table 5.3.1 Usefulness of NHS Services**

| *Service* | *Useful* | *Unsure* | *Not useful* | |
|---|---|---|---|---|
| | % | % | % | Total N* |
| ***GP practice*** | **74** | **12** | **14** | **85** |
| ***Accident & Emergency*** | **69** | **12** | **19** | **48** |
| ***Hospital Out-Patients*** | **73** | **18** | **9** | **44** |
| ***Substance Related Outpatient Services (e.g. SMS)*** | **48** | **17** | **35** | **29** |
| ***General Hospital in-patient*** | **59** | **24** | **17** | **29** |
| ***Psychiatric Hospital in-patient*** | **67** | **27** | **6** | **15** |

** homeless people who had not used a service were excluded from the analysis*

As table 5.3.1 shows, with the exception of substance misuse services, homeless patients generally found a range of NHS services useful in meeting their health needs in the previous 12 months. GP services and hospital out-patient services were the most reported useful services, with three-quarters of homeless people regarding them in this way. Differences

within the study group suggest that older homeless people (aged 25 years+) found Accident & Emergency services more useful than younger homeless people (aged 16-24 years) over the previous year, with 79% (n=25) and 50% (n=8) of each group respectively reporting this to be the case.

With respect to substance misuse services (e.g. SMS), a third of homeless people who had used the service had not found it useful. Such a negative assessment related in part to the difficulty of accessing the service but also described the difficulty of complying with treatment once a place had been secured. In terms of the latter, one young homeless woman talked about the lack of sympathy for missed appointments within the Substance Misuse Service (SMS), suggesting that '*if you miss your appointment it is really problematic'*. Another 26 year old homeless man pointed out a further difficulty with the SMS, suggesting that he was not able to fully benefit from the service as it was unable to take account of his wider commitments to family and work. He explained '*The Fulton Clinic (SMS) wanted to take me in for a residential detox but I do jobs on the side and I needed the money to give my kids Christmas presents.'* He was unable to accept the offer of residential detoxification.

## 5.4 Improving NHS Services

The survey (and focus groups) closed by exploring ways of improving NHS health services for homeless people. In particular participants were asked about how attitudes, policies and practices might change within the NHS to better deliver health care. The following was found.

To begin with participants were invited to choose three factors from a list of nine that would have made a positive difference to their own experience of NHS health services in the previous 12 months. The factors described a range of organisational arrangements, staff attitudes, new types of service and new ways of accessing services.

**Table 5.4.1 Ways of Improving NHS services**

| *Factor** | *%* |
|---|---|
| *Shorter waiting lists* | **48** |
| *Better appointments system* | **42** |
| *Having own permanent address* | **27** |
| *Better medical staff attitudes* | **25** |
| *Better location of services* | **21** |
| *More 'female friendly' services* | **21** |
| *Better reception staff attitudes* | **21** |
| *Someone to accompany to service (i.e. 'buddy')* | **20** |
| *Services provided for homeless people only* | **15** |
| *Other (i.e. interpreter, information)* | **4** |
| | **100** |
| *N* | **118** |

***** *Participants were invited to state multiple choices*

As table 5.4.1 shows, the three most reported improvements called for were shorter waiting lists, better appointment systems and having a permanent address. Almost half of the homeless people surveyed called for shorter waiting lists and two-fifths for better appointment systems. The quarter who called for a permanent address touched upon the reality that health cannot be divorced from wider social issues. As previously, the need for better staff attitudes was highlighted, although few homeless people sought dedicated health

services for homeless people only. The latter request testifies to the desire by homeless people to be treated equally.

Differences within the study group suggest that older people (aged 25 years +) would more readily welcome a 'buddy' to accompany them to NHS appointments than younger people (aged 16-24 years), with 24% (n=21) and 7% (n=2) of each group respectively stating such a position. Women were more likely than men to call for better attitudes amongst reception staff (women 30%, n=14 and men 14%, n=10) and more 'female friendly' NHS services (women 41%, n=19 and men 9%, n=6). Finally, self-defined problem drug users were more likely than non-problem drug users to call for better attitudes amongst reception staff (problem drug users 38%, n=12 and non-problem drug users 16%, n=12) and the need for a permanent address (problem drug users 44%, n=14 and non-problem drug users 22%, n=17).

Next the homeless people surveyed were asked about the extent to which their views and opinions had been listened to as they underwent NHS treatment in the previous 12 months.

As table 5.4.2 shows, across a range of services the views and opinions of homeless people were more or less listened to as they underwent treatment through the NHS. GP services and hospital outpatient services (e.g. Aberdeen Royal Infirmary, Woolmanhill, Woodend hospitals) were the most reported settings in which homeless people felt that their voices were being heard, with more than half of homeless people using these services reporting that their views and opinions had been listened to. Just under half felt that their views and opinions were listened to as in-patients in general hospital. By contrast around a third of homeless patients felt that their views had not been listen to within substance related out-patient services (e.g. Substance Misuse Service) and around a quarter felt similarly ignored within Accident & Emergency services and general hospital in-patient services.

Differences within the study group suggest that women were more likely than men to have felt listened to within substance related out-patient services (e.g. Substance Misuse Service), with 53% (n=8) and 15% (n=2) respectively of each group reporting this to be the case. Elsewhere, older people (aged 25 years +) felt listened to as in-patients in general hospital more than younger people (16-24 years), with 60% (n=15) of the former reporting this to be the case and none of the latter. No other systematic differences were found.

**Table 5.4.2 Views & Opinions listened to <12 months**

| *NHS service* | *Listened to* | *Unsure* | *Not listened to* | |
|---|---|---|---|---|
| | **%** | **%** | **%** | **N** |
| *GP practice* | **59** | **21** | **20** | **81** |
| *Accident & Emergency* | **42** | **33** | **24** | **45** |
| *Hospital Out-Patients* | **55** | **33** | **12** | **42** |
| *Substance Related Outpatient Services (e.g. SMS)* | **36** | **29** | **36** | **28** |
| *General Hospital in-patient* | **48** | **29** | **23** | **31** |
| *Psychiatric Hospital in-patient* | **35** | **47** | **18** | **17** |

The study closed by inviting the homeless participants to consider ways in which the NHS might change to provide better services to homeless people in the future. In particular, participants were asked to identify improvements in three distinct areas: illness that ought to be prioritised; policies that need to change; and NHS staff attitudes that could improve. They

were invited to identify three illnesses, policies and groups of staff attitudes in each of these areas. The following was found.

**Table 5.4.3 Future Improvements Sought in NHS – Illnesses & Conditions to Prioritise**

| *Illness / Condition* | *%* |
|---|---|
| *Mental Illness* | **53** |
| *Physical Illness* | **42** |
| *Drug Problems* | **38** |
| *Alcohol Problems* | **36** |
| *Physical Disability* | **22** |
| *Other (e.g. chiropody)* | **9** |
| | **100** |
| *N=* | **118** |

With respect to illnesses that required prioritisation, the homeless people surveyed identified mental illness as the major illness requiring attention. In addition, they highlighted the need to address physical illness and substance misuse (i.e. drug and alcohol problems). Differences within the study group suggest that self-defined problem drug users were more likely than non problem drug users to wish for drug problems to be given priority by the NHS, with 78% (n=25) and 25% (n=19) respectively of each group advocating such a position. No other systematic differences were found.

**Table 5.4.4 Future Improvements Sought in NHS – Policies**

| *Policies* | *%* |
|---|---|
| *Easier access to Dentist* | **61** |
| *Easier registration with GP* | **50** |
| *Easier access to Substance Misuse Service* | **36** |
| *Better hospital discharge procedures* | **16** |
| *Other (e.g. cheaper prescriptions, interpreters)* | **9** |
| | **100** |
| *N=* | **118** |

In terms of policies needing attention, the most sought after changes were easier access to dentists and easier registration with GPs, with three-fifths and a half, respectively, of the homeless people surveyed stating such a wish. A third sought easier access to substance misuse services provided by the SMS itself. Few saw the need to prioritise hospital discharge procedures. Differences within the study group suggest that women wish to prioritise access to SMS services, with around half of women stating such a preference (48%, n=22), compared with around a third of men (30%, n=21). Similarly, more than two-thirds of self-defined problem drug users sought to prioritise access to the SMS (69%, n=22), compared with around a quarter of non-problem drug users (26%, n=20). No other systematic differences were found.

Finally, with respect to the need to change the attitudes of groups of NHS health workers, the staff seen as most requiring to change were receptionists in GP surgeries. Just under two-fifths of homeless people identified this group of staff. As previously noted, participants

called for more sympathy and courtesy from such NHS staff. Indeed, just under half found that such negative attitudes made accessing NHS services 'less easy' (see table 5.2.2).

**Table 5.4.5 Future Improvements Sought in NHS – Staff Attitudes**

| *Staff Group* | *%* |
|---|---|
| *Receptionist in GP surgeries* | **38** |
| *GPs* | **30** |
| *Nurses in hospital* | **17** |
| *Receptionists in hospital* | **16** |
| *Medical staff in hospital* | **15** |
| *Nurses in GP surgeries* | **13** |
| *Other (e.g. security staff in hospitals)* | **4** |
| | **100** |
| *N=* | **118** |

Also, just under a third of participants thought that a change in attitude by GPs themselves would improve homeless people's access to NHS services. Such a view derived from a shared perception that GPs sometimes did not understand or have sufficient time to give to patients. Thus, a 17 year old man suggested that '*GPs don't seem to listen'*, while a 19 year old woman observed that GPs '*could be more understanding'*. Elsewhere a 47 year old man explained '*On a recent visit .. my GP left me unsure of answers I needed. The GP did not take me seriously'* and a 44 year old woman complained, about GPs (and receptionists in GP surgeries), '*They have no time for you!'* By contrast both medical staff and receptionists in NHS hospitals were far less likely to attract such negative criticism.

Differences within the study group suggest that self-defined problem drug users were more likely than non problem drug users to seek a change in the attitudes of both GPs (44%, n=14 and 25%, n=19, respectively) and GPs' receptionists (56%, n=18 and 31%, n=24, respectively).

Finally, participants were asked how their views and opinions (about improvements in services) might best be represented. In focus group discussion, participants identified a number of ways through which their voices might be heard. Such ideas fell into two broad categories: self-advocacy and representation. With respect to the former, it was felt that homeless people themselves could make use of 'suggestion boxes' available in some surgeries and clinics. Also, it was felt that the commissioning of independent research would be a powerful way of having their views heard, as one 23 year old man explained '*It should go through independent bodies (e.g. researchers at university). An independent body hasn't anything to do with the NHS and they can put it in black and white the way it is.'*

In terms of representation, it was agreed that having an advocate who could work with other agencies on their behalf, was an important way of being recognised. As such, several participants spoke favourable of a local homeless charity, Aberdeen Cyrenians, which provided a support service in this respect. As one 28 year old man having difficulty with the Substance Misuse Service (SMS) explained, '.. the Cyrenians represent us, making phone calls, phone doctors. Without this place (drop-in centre run by Aberdeen Cyrenians), there'd be nothing .. they write letters for me and everything, phone doctors ..'

Asked lastly if they knew about the Scottish Health Council, only one woman was aware of the organisation, having heard about it on TV. She was unable to explain what it did.

# SECTION SIX: CONCLUSION

## 6.1 Introduction

The conclusion aims to highlight the main findings of the research by returning to the original research interests that guided the study. As such, it will attempt to answer the following five main questions:

1. What are the individual needs of homeless people, including young homeless people, regarding healthcare and treatment?
2. How should NHS services ensure that homeless people's individual needs are identified respected and responded to?
3. What are the barriers (i.e. structural, policy or attitudinal) to homeless people, including young homeless people, being involved in decisions about their care and treatment?
4. How should NHS services engage with homeless people, including young homeless people to capture their views and experiences of NHS services?
5. How should NHS services engage with homeless people, including young homeless people to plan changes and improvements in services?

In addition, the conclusion will reflect upon the findings of the study and suggest possibly policy implications which flow from the research.

## 6.2 Research Questions Answered

### 1. What are the individual needs of homeless people, including young homeless people, regarding healthcare and treatment ?

The study sought to understand the health needs of (young) homeless people in Aberdeen by adopting a multi-dimensional approach to health. Accordingly health was variously examined in the study through a combination of 'objective' and 'subjective' measures and the use of standardised and study specific questions, all of which were based on self-reporting by the survey participants. As such, no clinical assessments were used in the study. Although such an approach of necessity delimits the findings of the research it is important to acknowledge that any biomedical definition of health is in itself insufficient as health is essentially an amalgam of personal experience and the absence of more measurable abnormality or dysfunction. Further, the 'standardised' (self-report) items used in the study have attained a degree of validity and reliability sufficient to allow us to have confidence in their usefulness as indicators of personal well-being. In short therefore, the measures of health used in the present study were 'recognised', meaningful and practicable and clearly indicative of the health status of the homeless people surveyed. What do such measures tell us?

Based on standardised questions, the vast majority of the homeless people surveyed assessed their own general health as 'less than good' (83%). In addition, three-fifths reported a long-term illness or disability (61%), often related to drug, alcohol or mental health problems, which was limiting in some way for most sufferers (80%). Furthermore, asked about their experience of 20 commonly reported 'objective' diseases or conditions, respondents, on average, indicated experience of three such conditions at some stage in their lives, with over half reporting severe depression or nervous illness (54%), and just under half reported alcohol problems (47%). A third reported asthma (37%), back trouble (34%), 'other' chest trouble (i.e. not chronic bronchitis) (32%) and migraine (31%). Investigation into recent illness (i.e. the subjective experience of pain and discomfort) in the past month, suggested that almost all

of the homeless people surveyed had been 'ill' during this time (86%), often with colds/flu or headaches. Finally, enquiries about street drug use found that around a third of those surveyed had used street drugs in the past month (33%), while a quarter of respondents had injected street drugs in the four weeks prior to the survey (22%). Overall, two-fifths of those surveyed had injected street drugs at some time (41%) and a third of all respondents considered themselves to be problem drug users (32%).

To put these findings in context it is instructive to compare them with rates of morbidity in the general population.

**Table 6.1 Morbidity Amongst Homeless People and General Population**

| *Condition* | ***Homeless Study Group*** | ***General Population*** |
|---|---|---|
| *1. General Health – 'less than good'* | **83%** | **26-27%**[1] |
| *2. Long-term illness/ disability* | **61%** | **41-42%**[1] |
| *3. Limiting long-term illness/disability (among sufferers)* | **80%** | **c.60%**[1] |
| *4. Disease prevalence (ever)* | **85%** | **-** |
| *5. Disease average number of (20) specified conditions* | **3** | **-** |
| *6. Illness prevalence (< month)* | **86%** | **-** |
| *7. Illness average number of (12) specified symptoms* | **4** | **-** |
| *8. Street drug use past month* | **33** | **5**[2] |
| *9. Street drug injecting - past month* | **23%** | **-** |
| *10. Street drug injecting - ever* | **41%** | **-** |

*Key:1 = Scottish Health Survey 2003, men and women respectively; 2 = Scottish Crime Survey 2003, adults aged 16 – 59 years*

As Table 6.1 shows, homeless people appear to suffer higher levels of general ill-health and long-term and limiting illness or disability and to use street drugs more than people in the general population. In addition they are likely at some time to have experienced three (medically defined) diseases or conditions and more recently to have suffered from four illness symptoms. In short, the health profile of homeless people is distinctive and sets them apart from people who are not homeless. It is characterised by inflated levels of acute and chronic conditions, by a susceptibility to mental health, drug and alcohol problems, by functional consequences which undermine the ability to perform valued social roles and by the absence of a general sense of well-being.

Homeless people however are not a homogeneous group and differences were noted within the sample with respect to self-assessed general health, long-standing illness or disability, diseases or conditions, (recent) illness and drug use (see table 6.2). With respect to gender, women were more likely than men to report suffering from a range of diseases or conditions, including severe depression / nervous illness, chest trouble and varicose veins. In addition they suffered more illness, being more likely to report headaches and trouble with their eyes. In terms of age, young people (16-24 years) suffered more from colds / flu and were more likely to be recent drug users. By contrast, older people (aged 25 years +) had poorer general health, suffered more from long-term and limiting illness or disability, were more likely to have certain diseases (including epilepsy and arthritis), and suffer back pain. Finally, problem drug users suffered disproportionately from back pain, trouble with their teeth and (as expected) made greater use of drugs. By contrast homeless people who were (self-defined) as non-problem drug users were more likely to suffer alcohol problems and to be troubled by rheumatics and arthritis.

**Table 6.2 Health Profile of Homeless People**

| *Health Indices by Likely Sufferers* | | | | | | |
|---|---|---|---|---|---|---|
| ***Condition*** | **male** | **female** | **16-24 years** | **25 years+** | **problem** | **Not problem** |
| ***General Health*** | | | | **'not good'** | | |
| ***Long-standing (limiting) Illness / Disability*** | | | | **Long-term limiting illness**<br><br>**Alcohol problem** | | **Alcohol problem** |
| ***Likelihood of 20 specified diseases*** | | | | | | |
| ***Types of disease*** | | **Severe depression/ nervous illness**<br><br>**'other' chest trouble**<br><br>**Migraine**<br><br>**Chronic bronchitis**<br><br>**Varicose veins** | | **Epilepsy / fits**<br><br>**Rheumatic trouble / arthritis** | **Back trouble** | **Alcohol problem**<br><br>**Rheumatic trouble / arthritis** |
| ***Illness*** | | **Headaches**<br><br>**Eye trouble** | **Colds / Flu** | **Back pain** | **Trouble teeth** | |
| ***Drug use < month*** | | | **use** | | **use** | |
| ***Inject drugs < month*** | | | | | **inject** | |
| ***Inject drugs ever*** | | | | | **inject** | |

In sum, across the key dimensions of sex, age and drug status, sub-populations of homeless people emerged defined by the main health indices used in the study. However the spread of illness, disability, disease and substance misuse found, better served to differentiate the health status of homeless people as a group from people in the general population, rather than highlighting intra-group differences. As such it is being homeless that is associated with poor health, although other differences remain.

**2. How should NHS services ensure that that homeless people's individual needs are identified, respected and responded to ?**

To understand how the NHS ought to engage with homeless people, it is necessary to map out current patterns and levels of service use and to understand the usefulness of such health behaviours to homeless people themselves. The research sought to do both.

Accordingly, the study explored how (young) homeless people made use of a variety of NHS health services and health related services. As such it examined registration and use of GP services, use of Accident & Emergency services and other hospital based out-patient services. Also, it reported on the use of in-patient hospital services. Finally the use made of a range of

health related services (including community based 'dedicated' nursing services, mental health services (CPN), specialist drug services and statutory and voluntary sector social work services) was looked at. Where possible, the study sought to compare the use of services by homeless people with the use of services by people in the general population. Later, the study examined homeless people's assessments of such service engagement. The following was found.

With respect to primary care services the study found that the vast majority of the homeless people surveyed had registered with a GP (89%), a quarter of whom had done so through the dedicated homeless practice at Marywell Street. Only 11% had not registered with a GP. In the two weeks prior to the survey just under two-fifths of respondents had consulted a doctor (40%), women being more likely to have done so.

As noted earlier, in the general population as a whole 20% of women and 16% of men consulted a doctor in the previous two weeks. Such figures rise to 45% of women and 34% of men for those with acute sickness. The findings from the present study therefore suggest that homeless people make far greater use of GP services than people in the general population, a use that implies far greater levels of morbidity.

With respect to acute services, the study found that two-fifths of the homeless people surveyed had made use of hospital based Accident & Emergency services in the past year (40%), women being more likely to have done so. Also, two-fifths had made use of 'other' hospital out-patient services during this time (39%). In total more than half of all the homeless people surveyed had used some kind of hospital based out-patient facility in the last 12 months (56%), with older people (aged 25 years+) and self-defined problem drug users more likely to have done so, overall.

Once again it is possible to put such findings in context by comparing rates of usage of acute services among the study group with health behaviours in the general population. Accordingly among the population at large around a third of people (35% men, 37% women) have made use of Accident & Emergency facilities and other hospital based day-patient services in the previous 12 months. As such, the findings suggest that homeless people again make high and disproportionate use of health services[1]. Also, such high levels of acute service use are engaged in alongside heavy use of primary care services and do not appear to be pursued by way of compensating for a lack of access to primary (GP) care. Once again greater health need amongst homeless people is implied in such (acute) health (service) behaviours.

In terms of in-patient hospital stays, the study group found that around a third of the homeless people surveyed had spent at least one night as a patient in hospital in the past year (39%). Most had been patients in a general hospital during this time. In the general population 9% of men and 13% of women have spent time as a patient in hospital over the past year. The findings from the present study again draw attention to the high levels of service use amongst the homeless population, behaviour indicative of high levels of morbidity.

Finally, with respect to the use of health-related services, the study found that two-thirds of the homeless people surveyed had made use of such services, with Aberdeen Cyrenians, Drugs Action and Pharmacists the most reported services used.

[1] Interestingly the relatively high level of use of hospital based out-patient services among the study group (56%) were similar to the relatively high levels of out-patient services amongst people with cardiovascular conditions in the population (50% men, 47% women). However only 32% of the homeless sample report 'other chest trouble' and 15% report 'heart trouble'.

In terms of the value of engaging NHS health services, the study found that with the exception of substance misuse services, homeless patients generally found a range of NHS services useful in meeting their health needs in the previous 12 months. GP services and hospital out-patient services were the most reported useful services, with three-quarters of homeless people regarding them in this way. Differences within the study group suggest that older homeless people (aged 25 years+) found Accident & Emergency services more useful than younger homeless people (aged 16-24 years) over the previous year.

In sum therefore, the study suggests that homeless people make disproportionate use of primary care and secondary care services, including emergency services. The high levels of use of secondary care services are indicative of greater levels of morbidity amongst the homeless population rather than difficulties accessing primary care. Further, and notwithstanding the need for improvements (see below), the perceived usefulness of a range of NHS services testifies to the quality and effectiveness of the primary and secondary care offered to and used by homeless people in Aberdeen.

**3. What are the barriers (i.e. structural, policy or attitudinal) to homeless people, including young homeless people being involved in decisions about their care and treatment ?**

Given the exaggerated levels of morbidity found amongst the homeless people in the present study (and elsewhere), it was instructive to examine the extent to which homeless people enjoyed equitable access to a range of NHS health services. In particular the study sought to find out whether homeless people faced barriers to service use, either in terms of the ways in which services were organised (i.e. structural and policy factors) or the ways in which they were delivered.

The results of the study suggest that the homeless people surveyed had a differential experience of accessing NHS services linked to the particular type of condition for which treatment was sought. The conditions most likely to allow easy access to treatment were accidents, physical illness, smoking and sexual health. Between three-fifths and three-quarters of homeless people requiring NHS services for these conditions were able to access treatment. By contrast homeless people's access to NHS mental health services and substance misuse services was more problematic. Differences within the study group suggest that men were able to access certain treatments more easily than women, especially in relation to accidents and alcohol problems.

Asked about the factors which more or less enabled them to access such services, the study found clear sets of enabling factors as well as potential barriers to service use. Amongst the enabling factors found were homeless people's own knowledge, experience and attitude towards using NHS services, as well as the disposition of medical staff. Knowing which services were available, a good previous experience and confidence in the staff providing the service facilitated engagement

With respect to the potential barriers to service use, the most reported were waiting lists, peer pressure and the appointment systems in place. In addition, the financial costs of using services and the attitude of GP receptionists were highlighted. With respect to waiting lists and appointments, the problem of accessing drug treatment services was a particular concern. In terms of the attitudes of GP receptionists, there was a commonly shared unease about a lack of courtesy and respect shown by some receptionists. As such just under half of the homeless people surveyed reported that such staff made accessing services '*less easy'*.

In sum, therefore, the homeless people surveyed were generally able to access NHS services for certain conditions (i.e. physical illness, accidents, smoking and sexual health), although

access to services on account of mental health problems and substance misuse issues was perceived as more difficult. Information, previous experience and confidence in medical staff facilitated engagement, whilst waiting lists, appointment systems and staff attitudes (e.g. GP receptionists) could deter involvement.

**4. How should NHS services engage with homeless people, including young homeless people, to capture their views and experiences of NHS services ?**

To understand how the NHS might best engage with homeless people to capture their views and experiences about NHS services, it is important to understand how homeless people currently experience NHS services. Accordingly, the study sought to find out whether or not homeless people's views and opinions were already recognised within the NHS services they used.

Across a range of services, the views and opinions of homeless people were more or less listened to as they underwent treatment through the NHS, in the preceding 12 months. GP services and hospital outpatient services (e.g. Aberdeen Royal Infirmary, Woolmanhill, Woodend hospitals) were the most reported settings in which homeless people felt that their voices were being heard, with more than half of homeless people using these services reporting that their views and opinions had been listened to. Just under half felt that their views and opinions were listened to as in-patients in general hospital. Of significance was the role of senior medical staff in ensuring that effective communication took place between practitioner and patient and amongst other NHS staff, in order that better healthcare for homeless people came about. The role of a Consultant (in sexual health at Woolmanhill Hospital) highlighted how such intervention could 'streamline' services to the benefit of the patient.

By contrast around a third of homeless patients felt that their views had not been listen to within substance related out-patient services (e.g. Substance Misuse Service) and around a quarter felt similarly ignored within Accident & Emergency services and general hospital in-patient services.

Differences within the study group suggest that women were more likely than men to have felt listened to within substance related out-patient services (e.g. Substance Misuse Service), whilst older people (aged 25 years +) felt listened to as in-patients in general hospital more than younger people (16-24 years).

In sum therefore, if the responsiveness and interest found in certain GP surgeries and hospital out-patient services were replicated more widely across other NHS services, homeless people's views and opinions about health and healthcare would be better recognised within the NHS.

**5. How should NHS services engage with homeless people, including young homeless people, to plan changes and improvements in services ?**

The study closed by exploring how the NHS might engage with homeless people in order to improve future service provision. Participants were asked to identify improvements in three distinct areas: illness that ought to be prioritised; policies that need to change; and NHS staff attitudes that could improve. In addition, they were asked about the processes through which their views might best be represented.

In terms of the improvements required in NHS services, and with respect to illnesses requiring prioritisation, the homeless people surveyed identified mental illness as the major

condition requiring NHS attention. In addition, they highlighted the need to address physical illness and substance misuse (i.e. drug and alcohol problems). Differences within the study group suggest that self-defined problem drug users were more likely than non problem drug users to wish for drug problems to be given priority by the NHS.

In terms of policies needing attention, the most sought after changes were easier access to dentists and easier registration with GPs, with three-fifths and a half, respectively, of the homeless people surveyed stating such a wish. A third sought easier access to substance misuse services provided by the SMS itself. Differences within the study group suggest that women and self-defined problem drug users wished to prioritise access to SMS services.

With respect to the need to change the attitudes of groups of NHS health workers, the staff seen as most requiring to change were receptionists in GP surgeries. Just under two-fifths of homeless people identified this group of staff. Participants called for more sympathy and courtesy from such NHS staff. Also, just under a third of participants thought that a change in attitude by GPs themselves would improve homeless people's access to NHS services. Such a view derived from a shared perception that GPs sometimes did not understand or have sufficient time to give to patients. By contrast both medical staff and receptionists in NHS hospitals were far less likely to attract such negative criticism.

Differences within the study group suggest that self-defined problem drug users were more likely than non problem drug users to seek a change in the attitudes of both GPs and GPs' receptionists.

Finally, asked how their views and opinions (about improvements in services) might best be represented, participants identified a number of ways through which their voices might be heard. Such ideas fell into two broad categories: self-advocacy and representation. The former included the use of 'suggestion boxes' in GP surgeries and clinics, as well as participation in independent research. The latter involved the use of supportive voluntary sector agencies, such as Aberdeen Cyrenians.

## 6.3 Policy Implications

Research does not make health or social policy. However alongside resources and the political will to use them, research can inform decisions at both the strategic and operational levels. The findings from the present study should be understood in this way.

The present study examined the health status and health behaviours of homeless people in Aberdeen. It sought to find out how well NHS services engage with homeless people in the city and to explore how patient and public involvement could be developed meaningfully to ensure that the views of homeless people are actively sought, listened to and acted upon.

It was the intention that the information gathered and understandings achieved would inform the work of the NHS locally with respect to how best to engage with 'hard to reach' and 'seldom heard' groups. As such, in keeping with 'Health and Homelessness Standard 4' and NHS Grampian's Health and Homeless Action Plan 2004 – 2007, the research sought to explicate the structural, policy and attitudinal factors which may undermine the health needs of homeless people in Aberdeen. In addition the research sought to inform the Scottish Health Council about how best to support NHS Grampian as it seeks to identify, understand and address these issues, through for example, the development of guidance and standards.
What does the research imply ?

Firstly, the study found that homeless people suffered exaggerated levels of ill-health compared with people in the general population. Their general health is not as good and they suffer more long-term (and limiting) illness and disability. The latter is often related to drug, alcohol or mental health problems. **Accordingly, NHS Grampian should take account of such patterns of illness and disease in the planning and delivery of health services, the better to meet the requirements of a particularly needy group.**

Secondly and (consequently) the study found that homeless people made disproportionate use of NHS services. Compared with people in the general population, they consulted more with GPs, were more likely to attend Accident and Emergency services, made greater use of hospital out-patient services and were more likely to have been a patient in hospital overnight. **Accordingly, NHS Grampian should take account of such distinctive patterns of health service use in the planning and delivery of health services, the better to meet the requirements of a particularly needy group.**

Thirdly, the study found that homeless people's high levels of need and experience were, in general, met by an appropriate response from NHS services. As such the majority of homeless people surveyed felt that the NHS did meet their needs and wishes as patients. **Accordingly, NHS Grampian should build upon the high levels of satisfaction expressed by homeless people about NHS services to reinforce the valuable work done by staff.**

Fourthly the study found that homeless people's assessment of NHS healthcare however was both illness and service related. As such, treatments for accidents, physical illness, smoking and sexual health were more readily available than treatments for mental illness or substance misuse. **Accordingly, NHS Grampian should ensure that effective action is taken to improve services to homeless people where necessary. Attention should be focused, in particular, on providing additional mental health and substance misuse services.**

Fifthly, the study found clear sets of enabling factors as well as potential barriers to NHS service use. Amongst the enabling factors were homeless people's own knowledge, experience and attitude to using NHS services, as well as the disposition of medical staff. In short, the study found that the 'key' to homeless people's satisfaction with services lay in knowing which services were available, a good previous experience and confidence in an interested and caring staff. **Accordingly, NHS Grampian should publicise its services to homeless people, ensure that 'first contact' with services is positive and offer 'care' as well as treatment.**

Sixthly, with respect to the potential barriers to service use, amongst the most reported were waiting lists and the appointment systems in place. In addition, the financial costs of using services and the attitude of GP receptionists were highlighted. **Accordingly, NHS Grampian should look again at the organisation of both primary and secondary care services, with a view to developing better ways of managing queues. Alongside a reduction in waiting times, keeping patients informed about likely dates for treatment would be welcomed by homeless people. In addition, extra NHS dentists would promote greater equality amongst a needy and disadvantaged group of patients unable to access private and costly healthcare. Also, values training, as part of on-going CPD amongst support staff (e.g. GP receptionists), would make NHS services for homeless people more accessible.**

Finally, the study explored how the views and opinions of homeless people about the design and delivery of services could best be represented to NHS Grampian. Participants identified a number of ways through which their voices might be heard. Such ideas fell into two broad categories: self-advocacy and representation. With respect to the former, it was felt that homeless people themselves could make use of 'suggestion boxes' available in some surgeries and clinics. Also, it was felt that participation in independently commissioned research would be a powerful way of having their views heard. With respect to the

representation, the use of staff from voluntary sector agencies to advocate on their behalf was considered an important way of being recognised by homeless people. **Accordingly, NHS Grampian should proactively seek the views and opinions of homeless people by supporting the use of patient feedback forms in surgeries and clinics and other places where homeless people gather (i.e. drop-in centres), commissioning independent research and facilitating the use of non NHS agencies as advocates for homeless people.**

# Appendices

## Appendix A – Definition of Homelessness

The present study relied mainly on a self-completion questionnaire. As such participants defined themselves as homeless. However, the homeless people surveyed were assisted by a range of agencies to take part in the study. Agencies worked to the definition of homelessness provided by the Homelessness Task Force (Scottish Executive, 2005), as follows:

**Homeless People:**

1. Persons defined in current legislation as homeless persons and persons threatened with homelessness, i.e. those:

- Without any accommodation in which they can live with their families.
- Who cannot gain access to their accommodation or would risk domestic violence by living there.
- Whose accommodation is "unreasonable", or is overcrowded and a danger to health.
- Whose accommodation is a caravan or boat and they have nowhere to park it.

2. Those persons experiencing one or more of the following situations, even if these situations are not covered by the legislation:

- Roofless: those persons without shelter of any kind. This includes people who are sleeping rough, victims of fire and flood, and newly-arrived immigrants.
- Houseless: those persons living in emergency and temporary accommodation provided for homeless people. Examples of such accommodation are night shelters, hostels and refuges.
- Households residing in accommodation, such as Bed & Breakfast premises, which is unsuitable as long-stay accommodation because they have no where else to stay.
- Those persons staying in institutions only because they have nowhere else to stay.
- Insecure accommodation: those persons in accommodation that is insecure in reality rather than simply, or necessarily, held on an impermanent tenure. This group includes:
    - Tenants or owner-occupiers likely to be evicted (whether lawfully or unlawfully).
    - Persons with no legal rights or permission to remain in accommodation, such as squatters or young people asked to leave the family home.
    - Persons with only a short-term permission to stay, such as those moving around friends' and relatives' houses with no stable base.
    - Involuntary Sharing of Housing in Unreasonable Circumstances: those persons who are involuntarily sharing accommodation with another household on a long-term basis in housing circumstances deemed to be unreasonable.

## Appendix B – Homeless Medical Assessments Aberdeen City

**Table B.1 Medical Data Homeless Applicants Aberdeen City March 2006 – October 2006**

| *Medical Condition* | *Male N* | *Female N* | *Total N* | *% of Medical Conditions* |
|---|---|---|---|---|
| *Psychiatric* | 149 | 131 | 280 | 36 |
| *Respiratory* | 60 | 63 | 123 | 16 |
| *Connective Tissue, Joints & Bones* | 69 | 26 | 95 | 12 |
| *Drugs* | 48 | 35 | 83 | 11 |
| *Neurology* | 27 | 17 | 44 | 6 |
| *Cardiovascular* | 27 | 13 | 40 | 5 |
| *Endocrinal & Metabolic* | 17 | 11 | 28 | 4 |
| *Infectious Diseases* | 17 | 11 | 28 | 3 |
| *Gastroentestinal* | 9 | 10 | 19 | 2 |
| *Cancers* | 11 | 3 | 14 | 2 |
| *Dermatology* | 3 | 9 | 12 | 2 |
| *Other (e.g. eating disorders, learning difficulty, renal & genitourinary)* | 17 | 13 | 30 | 4 |
| *Total** | 444 | 334 | 778 | |

*Source: Dr Leela Gautham,Bucksburn Medical Practice, Aberdeen (2007).*
** 47 males and 35 females had multiple conditions.*

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