FOREWORD

Article 25 of the Universal Declaration of Human Rights states that *'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services…'*

This fundamental social human right - related to health and medical care - was not included in the European Convention on Human Rights (1951) which has subsequently been incorporated into UK law through the Human Rights Act (1998).

The right to health has however been identified as one of the areas in which a guarantee may be needed in the Bill of Rights for Northern Ireland. The Northern Ireland Human Rights Commission (NIHRC) are actively developing a Northern Ireland specific Bill of Rights to ensure, as stated in our Mission Statement, "that the human rights of everyone in Northern Ireland are fully and firmly protected in law, policy and practice".

In consulting and advising on a Bill of Rights, the NIHRC is particularly keen to gather the views of the most marginalised and disadvantaged people in Northern Ireland. This report will greatly assist in this process and add to our knowledge base in terms of understanding:

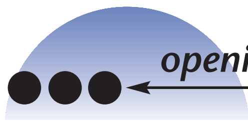
- The detrimental impact people's circumstances, housing (or lack of it) and living conditions have on their health;
- The barriers single homeless people encounter in accessing primary health care services, and the subsequent impact on their health and well-being;
- The barriers health professionals encounter in delivering primary health care services to such a socially excluded group.

I commend this research undertaken by the Health & Social Services Councils and the Simon Community Northern Ireland. Given the draft Programme for Government, and its references to *Working for a Healthier People*, and the work of the NIHRC this report is particularly timely in ensuring that single homeless people have a right to health.

Brice Dickson

Professor Brice Dickson
Chief Commissioner
Northern Ireland Human Rights Commission

December 2000



ACKNOWLEDGEMENTS

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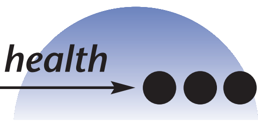
Particular thanks to all the residents of temporary accommodation who completed questionnaires and participated in focus group discussions. Thanks also to the health professionals who participated in in-depth interviews.

We would like to thank the Northern Ireland Housing Executive for providing statistical information and the Council for the Homeless for their assistance and advice.

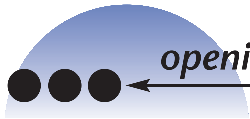
This research was commissioned and funded by the Northern Ireland Health and Social Services Councils and the Simon Community (Northern Ireland). The research was conducted by the Research and Development Department of the Simon Community (NI) and the Summary Report was written by the Southern Health and Social Services Council.

A full report of the research findings is available from the Simon Community (NI), Central Office, 57 Fitzroy Avenue, Belfast, BT7 1HT (Telephone 028 9023 2882).



CONTENTS

	Page No
INTRODUCTION	5
METHODOLOGY	7
FINDINGS - FOCUS GROUP DISCUSSIONS WITH SINGLE HOMELESS PEOPLE	10
FINDINGS - SURVEY OF SINGLE HOMELESS PEOPLE	18
FINDINGS - INTERVIEWS WITH HEALTH PROFESSIONALS	33
CONCLUSIONS	40
RECOMMENDATIONS	43
REFERENCES	45



INTRODUCTION

An individual's health is determined by a wide range of economic, social and environmental influences, as well as hereditary factors. Accommodation is perhaps one of the most important influences on health and wellbeing. Research indicates that homelessness and poor living conditions (or housing exclusion) are closely associated with ill health (Ambrose, 1999; Shelter, 1998). It is therefore not surprising to learn that the incidence of illness in homeless people has been shown to be higher than that of the general population.

The Charter for Patients and Clients (1992) states that *"Everyone has the right to be registered with a family doctor and to change your doctor easily if you wish".* Previous research has indicated that being registered with a GP is not always the case for single homeless people (North et al. 1996). Not only do homeless people experience more health problems than the general population they also have greater difficulties accessing health care services (Pleace & Quilgars, 1996; Shelter, 1998). The conditions associated with homelessness have been shown, not only, to have a profound effect on an individual's ability to maintain good health but also to get treatment when health is compromised and indeed to recover even after treatment is received. (Plant-Jackson & McSwane, 1992)

Extent of Homelessness

The Northern Ireland Housing Executive (NIHE) and Simon Community (NI) both record the number of people who present to them as being homeless[1]. The total number of single homeless presenters as recorded by NIHE in 1999-2000 totalled 5,455. Most of these were aged between 19 and 59 years and most were men.

Single Homeless Presenters to NIHE 1999-2000			
	Men	**Women**	**Total**
16-18 years	344	480	824
19-25 years	1,006	684	1,690
26-59 years	2,202	739	2,941
Total	**3,552**	**1,903**	**5,455**

1 There are some difficulties with the statistics in that they record the number of 'presenters' and an individual may present themselves as homeless on more than one occasion in the same year. However many instances of homelessness may also go unrecorded in official statistics.

During the same year, Simon Community (NI) recorded that 4,065 single homeless people throughout Northern Ireland contacted them for assistance. The highest proportion of these contacts occurred in the Eastern Health Board's area and the lowest number of contacts occurred in the Southern Health Board's area[2].

Single Homeless Presenters to Simon Community (NI) 1999-2000	
Health Board Area	
Northern	670
Southern	268
Eastern	2,695
Western	432
Total	**4,065**

Context

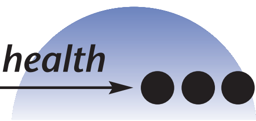
International and UK based studies exploring the health status of the homeless population are widespread (Grenier, 1996; Bines, 1994). Within Northern Ireland this area has received relatively little attention although some research has been conducted on the physical and mental health status of the homeless population. (McGilloway & Donnelly, 1996; Curran 1996). However, none has focused on access to and use of primary health care services[3].

In recent years social policy[4] in Northern Ireland has increasingly been orientated towards addressing inequalities in society. The homeless population has not been identified as a specific target group although research has indicated that many may experience inequalities in health and in accessing services generally.

2 The Simon Community provides 300 bed-spaces of temporary accommodation throughout Northern Ireland; 58 in the Northern Board, 21 in the Southern, 197 in the Eastern and 24 in the Western.

3 Primary health care services are defined as services primarily provided by GPs, nurses, social workers etc in community settings.

4 -'Well into 2000 - Regional Strategy for Health and Social Wellbeing 1997-2002.' DHSS (1997).
-'New TSN: An agenda for Targeting Social Need and Social Exclusion in Northern Ireland.' CCRU (1998).
-'Guide to the statutory duties- A guide to the implementation of the duties on public authorities arising from section 75 of the Northern Ireland Act 1998.' Equality Commission Northern Ireland (2000).



Current Study

Given that this group is not specifically mentioned in recent health and social services policy, coupled with a lack of research, the four Health and Social Services Councils and Simon Community (NI) worked jointly to investigate single homeless people's[5] access to primary health care services.

The objectives of the research were to:

- Compare and contrast the relationship between homelessness and access to primary health care provision.
- Determine the proportion of homeless people who do not have access to a GP.
- Examine the proximity of homeless people's current accommodation to their GP.
- Identify the barriers homeless people face in accessing primary health care.
- Identify the barriers which health care professionals face in treating homeless people.
- Describe homeless people's experiences of accessing primary care services.
- Describe the impact on the health status of homeless people in accessing primary care services.

METHODOLOGY

The research was conducted in three stages using quantitative and qualitative methods. These involved:

- Focus group discussions with single homeless people.
- Questionnaire survey of all single homeless people resident in hostels.
- Semi structured interviews with a selection of health care professionals.

5 For the purposes of this research, a single homeless person is defined as a single person without dependants living in temporary hostel accommodation. Other single homeless people such as those sleeping rough or staying temporarily with friends or relatives have not been included.

Focus Groups

A total of ten focus groups were held with single homeless people resident in hostel accommodation across Northern Ireland. Altogether, 60 residents of different ages, background and gender took part.

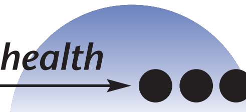
Location of Focus Group Discussions	
Health Board Area	
Northern	Larne Coleraine
Southern	Newry Portadown
Eastern	Belfast (3 Focus Groups) Bangor Downpatrick
Western	Derry

Questionnaire Survey

A questionnaire was developed based on the issues identified by focus group participants and this was piloted before distribution. A questionnaire was distributed to all single homeless people resident in hostel accommodation between 18 February and 19 March 2000.

Altogether, 671 questionnaires were distributed to single homeless people in 40 hostels of which 354 were returned equating to a response rate of 53%. The response rate varied by Health Board area with 33% responding in the Western area and 71 % in the Northern area.

		Response Rate		
Health Board Area	**Hostels**	**Questionnaires Distributed**	**Questionnaires Returned**	**% Response Rate**
Northern	6	85	60	71
Southern	3	46	32	70
Eastern	27	451	233	52
Western	4	89	29	33
TOTAL	**40**	**671**	**354**	**53**



A researcher distributed questionnaires to all hostels and on occasions either assisted residents in the completion of the questionnaire or advised staff on how to assist residents. To encourage a good response rate all participating hostels were visited on two occasions and respondents were entered into a prize draw.

Semi-structured Interviews

Thirteen semi-structured interviews were conducted with health care professionals. These included 4 GPs, 2 A&E consultants and an A&E nurse, 2 community nurses, 2 community psychiatric nurses, a health visitor and a dentist. The health professionals were interviewed about their experiences of providing healthcare to the homeless population and the potential barriers to treating them.

Interviews with Health Professionals by Health Board Area

Area	Health Professionals	Area	Health Professionals
Northern	General Practitioner Community Nurse Dentist	**Eastern**	General Practitioner Community Nurse 2 A&E Consultants Community Psychiatric Nurse
Southern	General Practitioner Health Visitor	**Western**	General Practitioner Community Psychiatric Nurse A&E Nurse

Selection of quotes

Quotes from the focus group discussions, interviews with health professionals and the open-ended questions from the survey are presented throughout this report. The number of quotes expressing a particular view should not be interpreted as being proportionate to the number of people holding such views. Each quote represents the views of one individual and is not intended to be representative of the majority viewpoint. Quotes have been selected to illustrate the range and variety of views, experiences and reasons why a certain opinion was held.

FINDINGS – Focus Group Discussions

The main issues and themes which emerged from the focus group discussions were as follows:

• Importance of Good Health

Focus group participants outlined a range of factors contributing to health and highlighted the importance of good health to carrying out normal day to day activities. A good diet, exercise, sleeping well and an absence of drugs, cigarettes and alcohol were mentioned by the majority of respondents as important to the maintenance of good health. Participants also recognised the importance of good mental health and emotional wellbeing.

> " … Being able to work, have energy and motivation."
>
> "Being content such as sleeping well, having no worries, being energetic, eating well."
>
> "Not smoking, drinking, taking drugs."
>
> "If you have poor health you are dysfunctional in all aspects of life."
>
> "If you're not healthy you feel discontent and depress others around you."

• Living Environment

Participants highlighted the implications for their physical and mental wellbeing of living in hostel accommodation. A small number of participants who had experienced rough sleeping, referred to the debilitating effects this had on their physical and mental wellbeing. Lack of food and heat, poor hygiene, no security and vulnerability to disease were identified as being detrimental to physical health. Some mentioned the *"devastation"* and *"humiliation"* of being on the streets.

"… If you are on the streets, pick up diseases… cold nights… eat food that is lying about…"

"A complete loss of self confidence, self respect and respect for others."

"You feel depressed because you are stuck in a rut and a mundane routine, you have a feeling of not going anywhere in life."

A small number of participants referred to the positive aspects of living in hostel accommodation. These included practical support/help to access services.

"It makes you realise to respect where you live a lot more and raises awareness of situation you are in."

"…Teaches you how to look after yourself and support yourself."

"Taught how to cook…and help you find a home."

"There is structure and support, always someone to talk to."

Most of the participants were smokers and there was agreement that smoking levels were higher in hostels than elsewhere. Some participants said smoking helped alleviate boredom and settled their nerves. A number of participants said the rules and curfews of the hostel controlled their intake of alcohol.

" …smoke more because of boredom and nerves."

"Cigarettes help my nervous disposition and relieve boredom."

" …don't drink at all, the restrictions here and staff are teaching me."

"I have lessened my intake of everything because of lack of money..."

• Stress, Self-esteem and Depression

A large proportion of participants referred to the stress of living in a hostel. Having to live with strangers, no privacy and a lack of autonomy increased levels of stress.

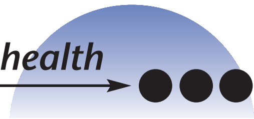
> "Environmental conditioning and staff trying to tell you how to run your life."
>
> "You're living with strangers from different backgrounds."
>
> "Living with other people – you have run-ins with them."
>
> "Living 24 hours a day, everyday with others – a lack of privacy."

Stress on occasions was exacerbated by feelings of alienation and isolation. This was attributed to estrangement from family, unemployment and financial worries. Many felt detached from the outside world and felt stigmatised.

> "You have to deal with the opinions from outsiders– the stigma of where you live – your address."
>
> " …society's perception of you is wrong – society holds you back."
>
> "Living in a hostel cuts off your contact with the outside world – you feel alienated from the wider community."

A large proportion of participants said they suffered from depression brought about by feelings of powerlessness to change their current situation.

> "You lack influence and control in your life – lose self esteem and dignity."
>
> "When you become homeless you have problems and no one is sorting them out. The problems escalate and you become depressed because of where you are – it's a vicious circle."



• Registering with a GP

Participants were, in general, aware of services available to them from health and social services and the majority said they were registered with a GP. Some said they had expereinced difficulties in registering with a new GP. Reasons were mainly attributed to the bureaucracy associated with the system. The length of time taken to transfer medical notes from one practice to another was also highlighted. Some however did not experience any difficulties in getting registered with a GP, in some instances this was due to the assistance provided by hostel staff.

"When you have no address you fall through the bureaucratic net, red tape system holds everything up."

"Because of homelessness you find it very hard to get registered with a doctor."

"I had moved from Tyrone to Belfast, had to go via system to get registered. I had no medical card or identification and meanwhile my health was deteriorating."

"When you are down in the system, you go further down and the walls get higher."

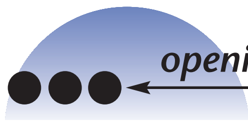
"People want to stay with their own doctor and travel to them because they know they can't get re-registered."

"Staff are good at sorting things out for you when you come to the hostel."

"Got registered straight away, permanently…"

• Stereotypes

Some focus group participants had a positive relationship with their GP but a large proportion perceived that GPs and receptionists discriminated against them because they were homeless. They considered that GPs held stereotypical views because they lived in hostel accommodation.



"…they are sympathetic to the needs of homeless, my doctor is obliging and would do anything to help me."

"GPs have preconceived ideas because you come from a hostel, their mindset is that you are looking for something, for example, DLA (Disability Living Allowance)."

"The doctor doesn't listen to my problems, he considers me wasting his time and sends me off to the AA (Alcoholics Anonymous)."

"Living in a hostel can affect a doctor's view of you…they can have pre-conceptions."

"They stigmatise and judge you on your appearance, they have no respect."

Receptionists were perceived as creating obstacles for homeless people in accessing GP services. Some participants mentioned that receptionists had treated them disrespectfully. The perceived reason for this was because of their homeless status.

"They are like a brick wall in getting to see your doctor."

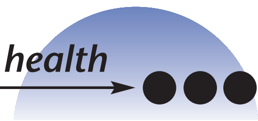
"They create deliberate obstacles, for example, refer you back to your previous doctor who is in a totally different location."

"They are arrogant, disrespectful and have an attitude problem, their non verbal communication and hostility sees you as hostel scum."

"They are too intrusive, ask questions they don't need to know."

However, not everyone held this view.

"Receptionists are OK, they are straight with you and just doing their job."



• Prescriptions

Most participants did not experience any difficulty in obtaining prescriptions or medication from their GP.

> "No problems with medication or prescriptions. Prescription is phoned through from doctor to chemist across the road."
>
> "Staff here (the hostel) can ring your old surgery and get your prescription faxed through…"

However, problems were encountered with repeat prescriptions. Some participants stated they had difficulty in obtaining one following a move from one area to another.

> "Problem with being on long-term medication when you're moving from place to place. You have to wait for your medical files to come from your previous practice, which can take a few weeks…Doctors can only give you tablets for a couple of days."
>
> "I was told by the receptionist I couldn't get a prescription until I saw the doctor."
>
> "Receptionists hinder you getting prescriptions by asking too many questions."

• Access to Information

Focus group participants said there was an inconsistency between hostels in the availability of information on health related issues. Variations also existed in the access to and relationships some hostels had with healthcare professionals in comparison to others and this was identified as a problem. The majority of participants said they would welcome more information being made available and the provision of more services within the hostel setting such as nursing, GP and counselling services.

"The policy in the hostel is to refer to outside agencies rather than bringing outside agencies in."

"Member of staff with trained medical experience to deal with an emergency."

"You have more chance of accessing services via liaison with hostel staff."

"Very little information in hostel about health issues, should be more available…the notice board should be full of health numbers such as helplines."

• Accident and Emergency

Some participants said they had used A&E services since becoming homeless. However they indicated their use was appropriate and was not an alternative to seeing their GP. Reasons quoted for attending A&E were overdoses, car accidents, broken limbs and other injuries. Some participants recounted positive experiences of using A&E, however, a number of participants reported negative experiences and considered staff stereotyped them because they were homeless.

"Stayed in hospital, staff checked I had somewhere to go on discharge."

"…treated brilliant… They got me a taxi straight to the hostel."

"Staff in A&E said I had taken an overdose to get a bed for the night."

"When you say you are from a hostel, staff think you are looking for a bed and that you are the scum of the earth, or you are labelled as an alcoholic."

"Accompanied friend who had overdosed. Staff ignorant. Nurses sent her out after 12.00am, she couldn't get back into the hostel at this time, so slept outside…"

"Night I left home, I was in hospital with an overdose. Social worker in hospital spoke to me. No-one really checked where I was going when discharged."

• Solutions

Focus group participants highlighted a number of ways in which they thought access to healthcare services could be improved for them. Some suggestions related to the provision of health information and in particular improvements to the transfer of medical information between practices.

> "There should be better dissemination of information on services available in the health service."
>
> "There should be more information and advice within hostels."
>
> "Medical files should be computerised so that once a resident moves from temporary accommodation they can be transferred and accessed automatically by GP practices and A&E departments."
>
> "Hostels should inform your doctor when you have moved on."

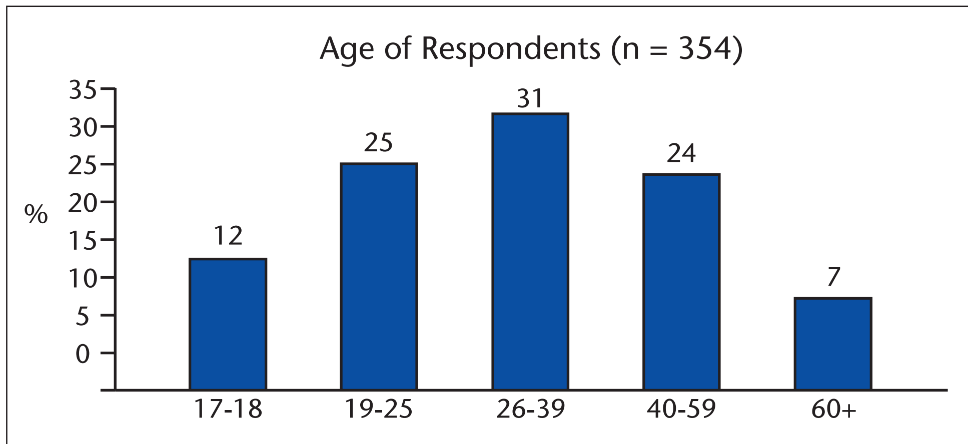
Other suggestions related to the provision of healthcare services within the hostel environment and a travel pass to facilitate attendance at the GP's surgery for those who had moved on to a different area.

> "It would be good to have healthcare professionals coming into the hostel every so often for a chat, in an informal setting where no appointment is needed."
>
> "Homeless people should be issued with a travel pass if their doctor is far away."

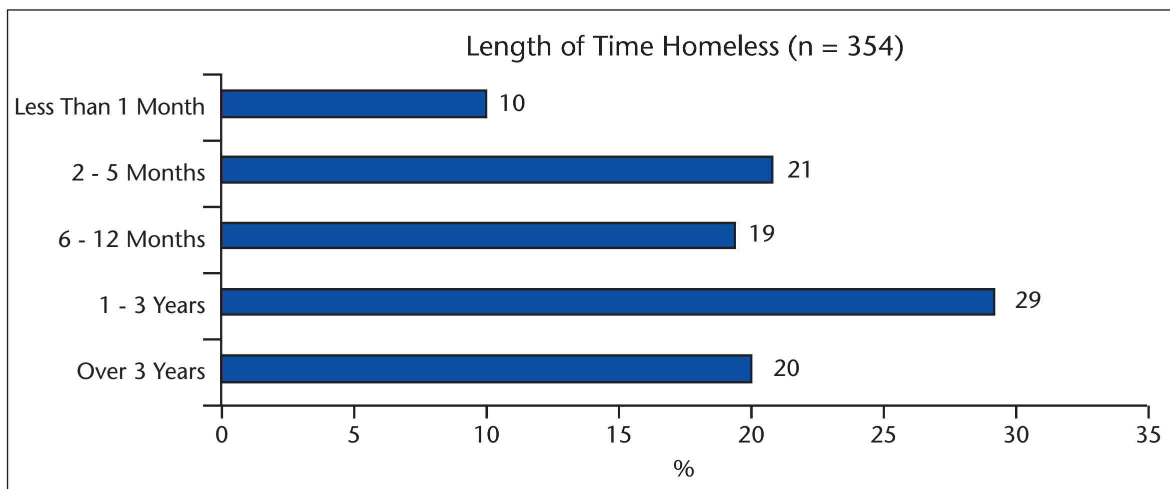
FINDINGS – Questionnaire Survey

Profile of Respondents

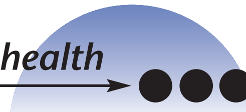
Altogether, 78% of the single homeless people who responded to the survey were male and 22% were female. Their ages ranged from 17 years to over 60 and the majority were aged between 19 and 59.

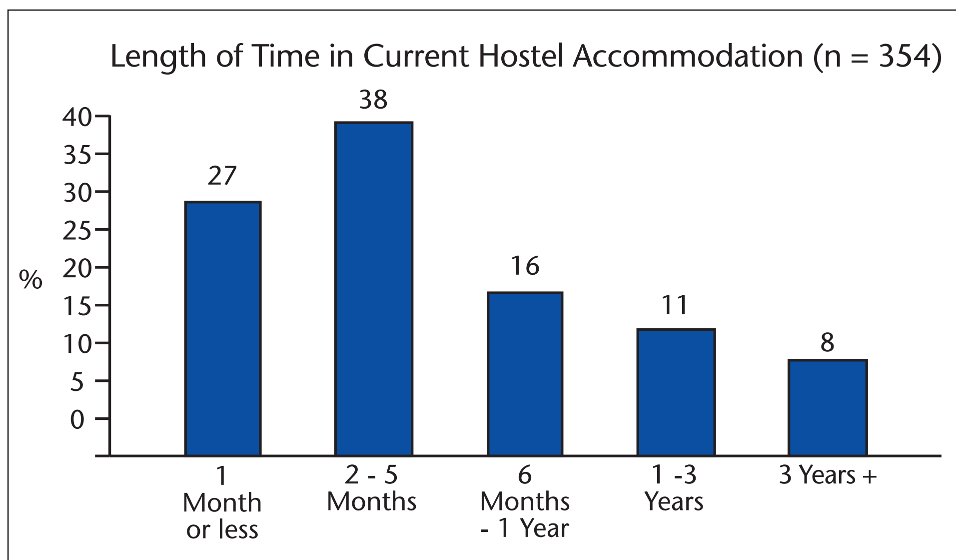


Nearly half (49%) had been homeless for more than a year and 20% for over 3 years. Half (50%) had become homeless in the previous year and 10% within the previous month.



The majority of respondents (65%) were resident in their current accommodation for between 1 week and 5 months. A further 27% were resident between 6 months and 3 years and 8% had been in the same hostel for over 3 years.





The three main reasons given for becoming homeless were family conflict, relationship breakdown and intimidation.

The vast majority (96%) of respondents were in receipt of benefits.

• Health Status

Over half (58%) considered their health good but 20% regarded themselves to be in poor health. However, nine in ten (90%) respondents said they encountered at least one health problem over the last six months. The most commonly reported problems included difficulty sleeping, depression, stress, panic attacks, and problems with digestion and breathing. Over a quarter (27%) had problems associated with alcohol.

Health Problems Identified by Respondents (n = 354)

Type of Illness	%	Type of Illness	%
Difficulty sleeping	64	Painful joints	23
Depression	59	Skin complaints	19
Stress	55	Problems with sight	16
Panic attacks	35	Other mental health problems	14
Digestive problems	33	Other illnesses	14
Chronic chest/breathing problems	30	Drug addiction	12
Alcohol related problems/addiction	27	No health problems	10
Dental problems	23	Tuberculosis	0.3

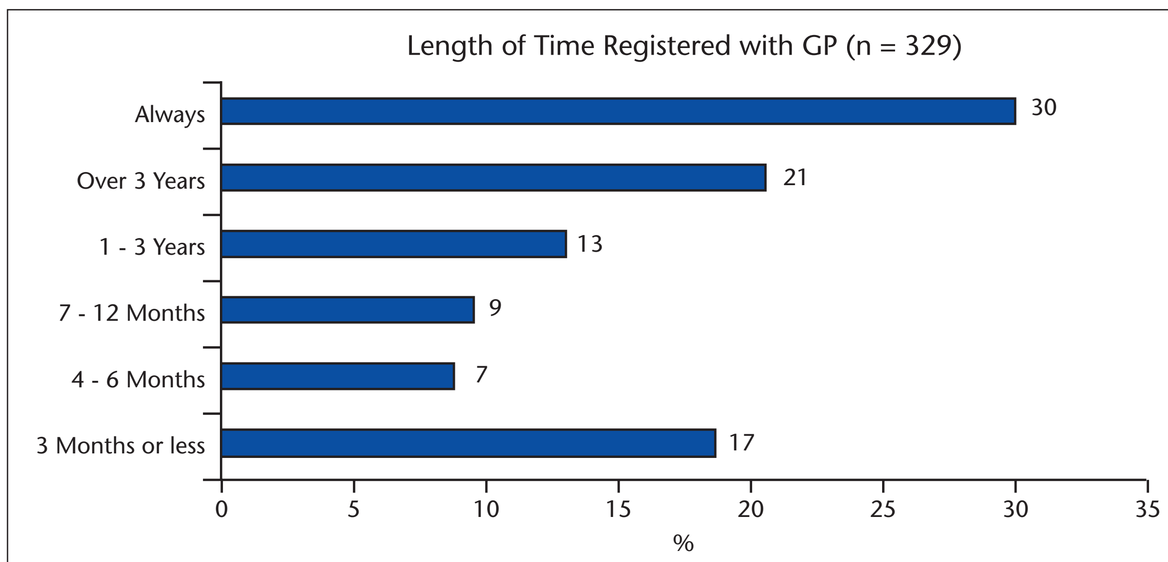
Nearly half (47%) reported they had a long-term health problem including chronic conditions such as asthma and manic depression. Other problems identified were dyslexia, suicidal tendencies and paranoia.

• Registering with a GP

The vast majority (93%) were registered with a GP. Registration varied between 84% in the Southern Board's area to 94% in the Eastern Board's area.

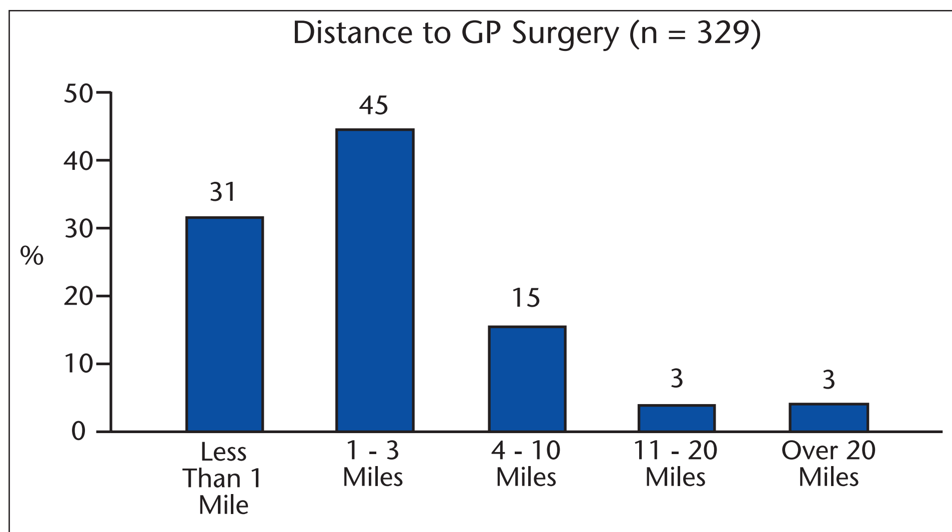
Registered with a GP (n = 354)	
Health Board Area	**% Registered**
Northern	88
Southern	84
Eastern	94
Western	90

Over three quarters (76%) said they were registered as permanent patients, 14% as temporary patients and 10% were unsure. The length of time respondents were registered with their current GP varied from less than 3 months to over 3 years or always.



• Accessibility to the GP Surgery

The distance respondents had to travel to visit their GP varied between less than one mile to over 20 miles. However, the majority (76%) lived within 3 miles of their GP surgery. Fifteen percent lived between 4 and 10 miles and a small proportion (3%) lived over 20 miles from the surgery.



Methods of travelling to the GP surgery varied. Over half (57%) walked, 27% travelled by bus, 16% by taxi, 6% by car and 3% by train. The vast majority (81%) either found it easy or fairly easy to get to and from the surgery. One in ten (10%) expressed difficulties in accessing the surgery.

"When I have to visit my GP and I don't have enough fare, no one can help me so I don't go and sometimes I am quite ill."

"Because my GP is out of the area I now live in, I can only make an appointment using my old address, and only when I have the money for the long bus fare."

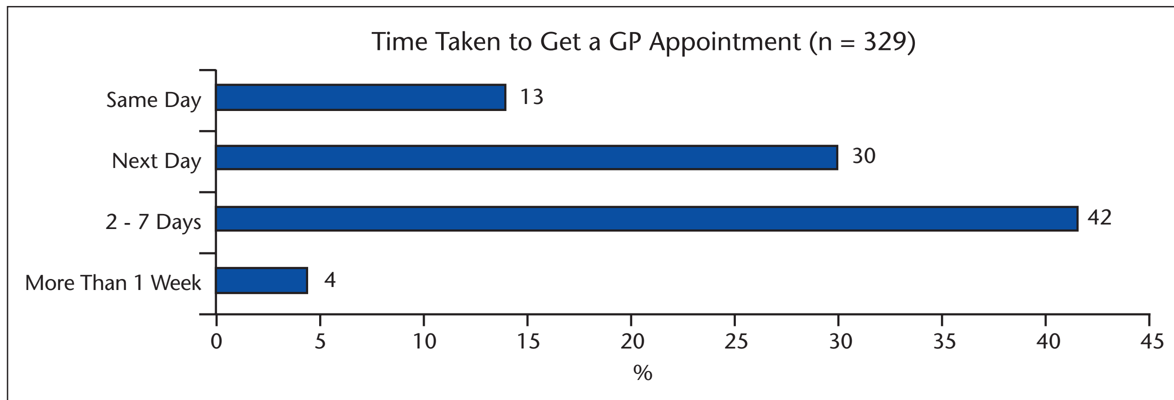
"I have a bad leg, need to take taxis, I have no money so it takes me an hour to walk to the surgery."

"I have to travel to Belfast to see my GP which is inconvenient."

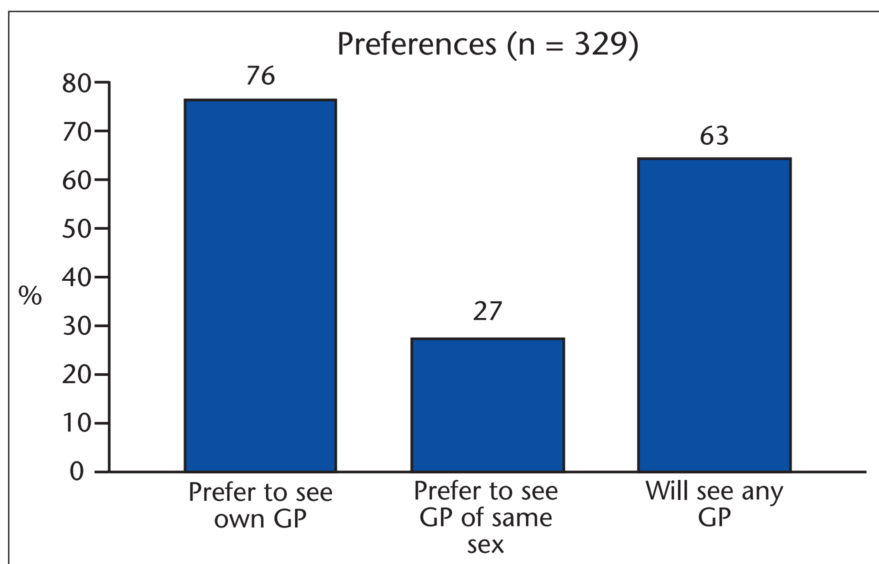
"Sometimes I have to wait until I can afford the travel costs."

• GP Appointments

Most (73%) called to the surgery or phoned to make an appointment. Just over one in ten (12%) were able to see their GP without an appointment and a similar proportion (12%) said hostel staff arranged their appointments. While 46% indicated they had to wait over 2 days for an appointment 43% were able to see a doctor by the next day.

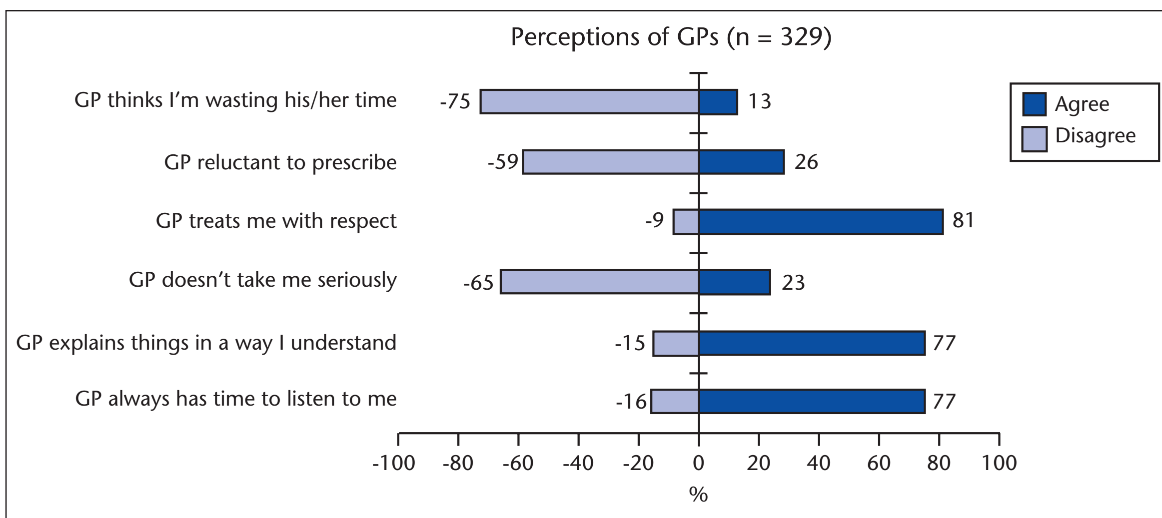


Over three quarters (76%) preferred to see their own GP and over a quarter (27%) preferred to see a GP of the same sex. However, 63% said they were willing to see any GP at the surgery provided they had seen them previously.



• Perceptions of GPs

The majority of respondents (81%) agreed that their GP treated them with respect and 77% said that their GP always explained things in a way they understood and that he/she always had time to listen to them.



On the other hand almost a quarter (23%) reported that their GP did not take their health problem seriously enough and a similar proportion (26%) said the GP was reluctant to prescribe them medication. Almost one in five (16%) did not think their GP had time to listen to them and 13% perceived that the GP thought they were wasting his/her time.

"Things have become different since I became homeless. I felt that the medical profession was against me. I felt that the medical profession would think I was lying in order to gain more points with the Housing Executive."

"Being homeless and in ill health, doctors who don't know my history don't take the time to fully treat my medical conditions."

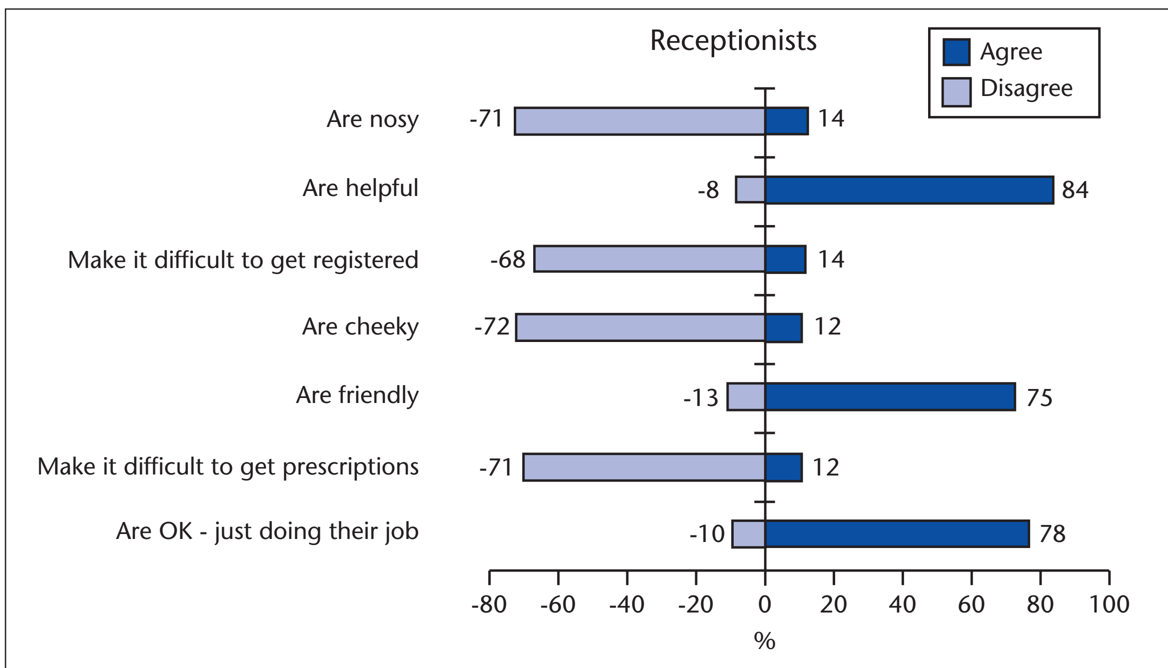
"Because I am homeless, the doctor doesn't know me, therefore he is not helpful and he looks down on me, rushes, doesn't listen to what I'm saying and the way I am feeling and I end up confused."

"My GP refuses to prescribe me Diazepam saying it is all in my head."

"My GP does not explain what I am suffering from, nothing is ever explained to me or any evidence given to me especially about cancer tests or women's stuff."

• Perceptions of Receptionists

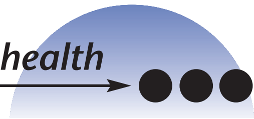
Most respondents encountered no difficulties with receptionists and 81% were satisfied with how they were treated when they visited their GP's surgery. The majority agreed receptionists were helpful (84%), friendly (75%) and were just doing their job (78%). However, some (14%) felt that receptionists had made it difficult for them to get registered with a GP and a similar percentage (12%) believed they made it difficult for them to get prescriptions.



• Obtaining Prescriptions

Almost all (97%) did not have to pay for prescriptions. Three quarters (75%) said they had experienced no problems getting a prescription but 9% did. Nearly a quarter (23%) did not know how to go about getting a repeat prescription and 7% had experienced difficulties in getting one. Amongst the problems highlighted were the reluctance of GPs to prescribe and having to see a GP before getting a prescription.

> "Receptionist said I could not get prescription unless seen by GP … Which means I have to see doctor again…Even though I suffer from depression and could not get a prescription until I saw the GP."
>
> "Required steroids, my GP refused to give them to me unless he has written notes… They said I was looking for an addictive drug."



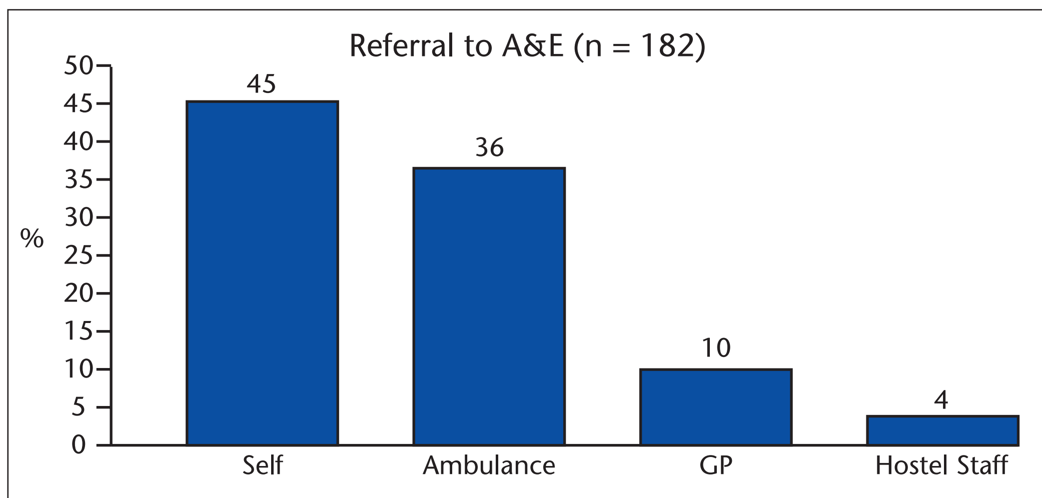
"Somewhere there seems to be a link missing between hostel, GP and Pharmacy."

"No fixed abode, doctors think you are lying to get tablets."

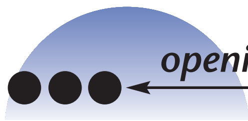
"Temporary registration had run out, had to travel to permanent GP – costly process."

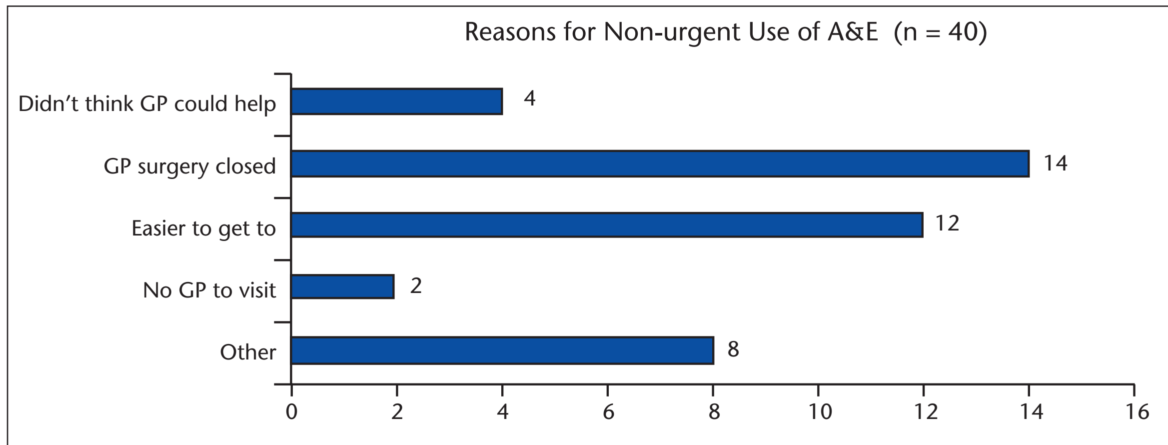
• Use of A&E

Over half (51%) had used A&E facilities since becoming homeless and most of these (83%) had used it less than 5 times. Nearly half (45%) went to A&E of their own accord, 36% were taken by ambulance and 14% were referred by a GP or hostel staff.

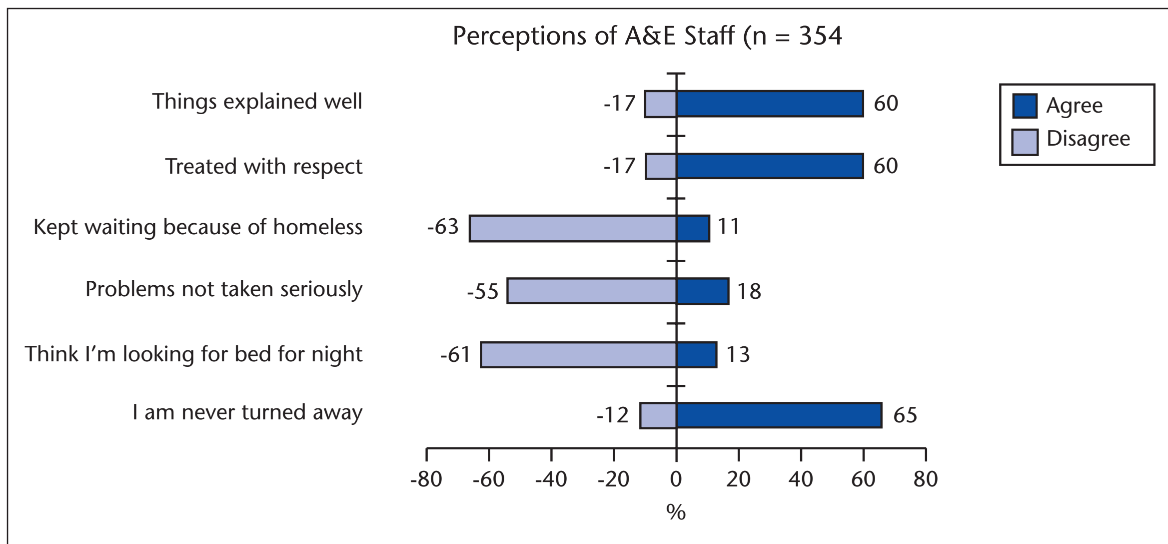


Forty respondents (11%) said they had attended A&E for a non-urgent illness. Fourteen had attended because the GP surgery was closed and 12 because A&E was easier to get to.





Almost one in five (17%) said their illness was not explained to them in a way they understood in A&E. A similar proportion (18%) agreed that staff did not take their problem seriously enough and 17% did not think staff had treated them with respect. A smaller proportion (11%) thought they had been kept waiting longer in A&E because they were homeless, 12% disagreed that they had never been turned away from A&E and 13% perceived that A&E staff thought they were looking for a bed for the night.

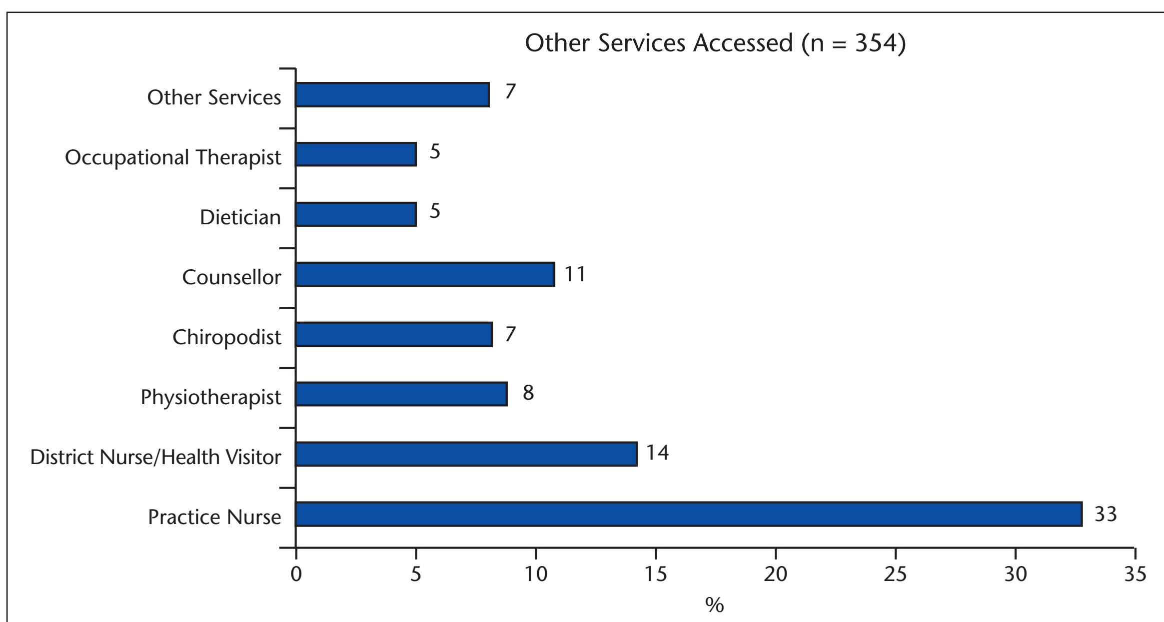


• Access to Dental Services

Six out of 10 respondents (60%) said they were registered with a dentist – nearly half of these (44%) visited their dentist at least once a year but 35% only did so in an emergency and 16% had not been at the dentist within the previous 15 months. A small proportion (5%) said they paid for their dental treatment.

• Access to Other Services

Nearly half (45%) of the respondents had not been in contact with any of the services outlined below since becoming homeless. The most commonly used service was nursing. A third (33%) had been in contact with a practice nurse and 14% had used district nursing / health visiting services. Just over one in 10 (11%) had used counselling services.



Nearly one in ten (7%) said they had difficulties in accessing one or more of these services. The difficulties experienced included having to be referred by a GP and communication problems.

> "Due to problems reading and writing, I have not been able to contact counsellor."
>
> "Find difficulties in communicating problem, they don't understand or don't want to."
>
> "My own GP was away and I found it very difficult to get a referral to a CPN."

In addition, 25% currently had a social worker. In a proportion of cases (28%) social workers referred the respondents to other services such as day centres and counselling. A quarter (25%) said it was difficult for them to meet with their social

worker from their current accommodation. The problems identified related to travel expenses and the lack of privacy.

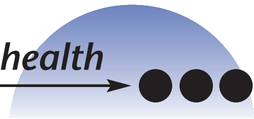
Over a third of respondents (38%) had been referred by their GP for other appointments. While most (80%) attended, 20% did not. The reasons why included not receiving their appointment details, sickness and deciding not to go.

> "I am awaiting an appointment."
>
> "The appointment has not come through yet."
>
> "Got referred to Shaftesbury Square Rehab, didn't go because I didn't want to give up drink with their help, do it myself."
>
> "Unable to get there on my own."
>
> "Too sick."

- **Barriers**

A fifth of respondents (20%) provided information on the main difficulties they experienced in accessing healthcare services. The barriers identified were similar to those discussed by focus group participants. The distance or difficulties associated with travelling were most frequently mentioned. Some respondents did not live in the same area as the GP with whom they were registered and others experienced difficulties in relation to travel expenses.

> "Having to travel 50 miles to attend GP."
>
> "Travel - being unable to attend doctor due to mobility."
>
> "Cost of travel."
>
> "Travelling if I needed to see a GP."
>
> "Travelling while injured due to knee operation, ie. Physiotherapy in…"



Other barriers identified included getting registered with a GP, the bureaucracy associated with registration and the necessity of having a medical card.

"Difficulty in finding regular permanent GP."

"They made it difficult for me to register with a doctor and they looked at me as if I was mad."

"Will only register me temporarily, some practices refuse."

"Administration - paperwork to get into the system - lengthy process…"

"Trying to get medical card/Lots of doctors will not take homeless people/Told to go to A&E and…have to wait."

"I find it difficult to fill in forms by myself."

Some respondents said that the difficulties they experienced were due to the attitudes of others and a lack of interest or understanding from health professionals.

"Social services no longer take an interest in me."

"Secretaries putting phone calls on hold without asking therefore you run out of money…secretaries' lack of empathy with homeless…"

"Health care don't want to know, don't understand the way I feel about my children."

"GP seems not to care."

"My GP thinks I am a junkie because I want Valium to help me sleep and cope with stress."

Other barriers also identified included; self-esteem of the homeless person, being homeless, lack of information, getting a prescription and waiting times.

"I am also fairly shy and feel very uncomfortable sitting in a surgery with the majority being women…"

"Finding somewhere to stay, low self-esteem/depression."

"Admitting to being homeless."

"The problems are getting repeat prescriptions without having to see a doctor."

"Time taken to get teeth braces is forever, waiting times in A&E."

• Solutions

Just over a quarter of the respondents (26%) suggested changes which they thought could improve access to health care services. Some of these suggestions were very general in nature such as additional staff and an increase in funds for the health service. However most were specific to the needs of the single homeless population. A third of the suggestions related to the services provided to single homeless people. Some respondents indicated that additional support and the provision of information on services available would improve their ability to access these services.

"I feel that homeless people require more structure, familiarity and support than anyone else, there should be a network of people they can trust including a GP they can get to know well."

"I would like to have a wee bit more help and support from social services."

"All homeless are given information/explained to them about services/help available."

"Need to be made more aware of available services…"

Other respondents suggested the provision of specific services including outreach services.

> "I think there should be a nurse or doctor to come round all the hostels one day a week. I think all people in hostels should get a check-up from a doctor as illnesses such as Tuberculosis is on the increase."
>
> "Regular visits to hostels by HSS, advising and informing occupants of services and benefits available…"
>
> "Dr coming in every month to check residents."
>
> "I think it would be helpful for people with other mental health problems such as panic attacks, if someone like a nurse could call once a month to make sure that person …(is) keeping contact with his/her doctor."
>
> "There should be all male surgeries especially because of the increase in depression among young males…"

Some others suggested that information on the needs of the homeless population should be provided to health professionals, that health professionals held stereotypical views about them or they were not treated with understanding and respect.

> "Information to staff about the health problems of homeless people."
>
> "…training for staff about the particular difficulties homeless people have."
>
> "Unprejudiced attitudes towards homeless people."
>
> "GP's attitude seems to have a bad first impression of homeless people. I feel that if they had more open contact with homeless situation their initial contact with homelessness might be better."
>
> "The staff in the doctor's surgery (receptionists) could be a bit nicer and polite to others."
>
> "If people would treat you with respect."

Other changes which were also commonly mentioned related to A&E including waiting times and the provision of locally accessible A&E services. Some respondents suggested changes to the administrative system in registering with a GP.

"Better waiting times in A&E."

"Shorter waiting times in A&E, should be easier to get new/replacement medical card, shorter waiting times for acceptance as new patient."

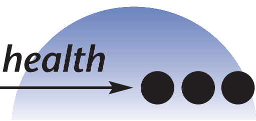
"Bringing a 24 hour casualty department back in…"

To open an A&E in…as…is too far away."

"Make it easier to register with a doctor, treat everyone with respect, non judgemental."

"Make changing doctor simpler."

"Legal obligation for doctors to take everyone."



FINDINGS – Interviews with Health Professionals

The 13 health professionals interviewed identified a number of barriers to treating single homeless people in the primary care setting.

• Transience/Mobility

Health care professionals said there were complications in providing ongoing care for homeless people because they had a tendency to move from one hostel to another. One of these complications was that they were reluctant to prescribe medication which required follow-up. As a result they had little opportunity to talk about health promotion or continuity of care.

> "There is no recall system. In other words if you say to someone you want to see them back and they don't turn up, you don't know if they are living, dead, worse or better off or whatever."
>
> "Lack of continuity of care, you don't know what their background is, you see them once and you never see them again."
>
> "You see people possibly once and you never see them again. You are not going to get involved in prescribing drugs that need follow up, because you are never going to see these people."
>
> "You don't really get the opportunity to get involved in the ongoing care of people who are homeless."
>
> "If somebody is moving around a lot it is very hard for a GP to know their history."

They also pointed to the complexity of the needs of single homeless people in that they often had multiple problems which tended to present at a crisis intervention stage.

> "Homeless people have a lot of demands, they often have multiple problems. You can have the dilemma of people arriving from X needing ten things sorted out and arriving on a Monday morning looking for all these things to be done."

• Self-esteem

Health care professionals said that in many cases homeless people did not feel confident in accessing health services. They indicated that they had low self-esteem because they were unemployed and homeless.

"They may have little self-esteem and poor literacy skills, all those things that prevent them from going to seek help. There are a lot of people who will not access any sort of service because they can't. They literally don't feel confident to do it."

"They are unsure of themselves, they're worried about coming to you and they maybe don't have a lot of money…"

"If you don't have a home and you don't have a job your self-esteem is low …"

• Value of Health

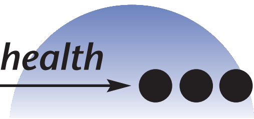
Health care professionals thought that homeless people did not give a high priority to their health needs because other factors were of greater importance at the particular time.

"I would say they probably have less perception of their health."

"People in hostels arrive obviously having had problems. So I wouldn't think their health is a priority."

"Hygiene problems or just that their teeth are a low priority for them, sometimes that can be a barrier for regular dental treatment."

"A lot of them have social problems or they have addictions and an awful lot of them don't want treatment, they just want you to give them what they want. That basically is the main barrier."



• Gender Issues

Health professionals said, as the majority of single homeless people were male they were less likely to look after their health needs or access services. They considered there was a major difference between this group and homeless women with dependants, in how they were targeted by health care providers. The latter group was less likely to be marginalised from mainstream services.

"Staff at the refuge are very good and get the women temporary registration with a GP. Health visitors are GP aligned; once a woman gets registered a health visitor is informed. Women's Aid are good at pointing ladies in the right direction."

"It's not macho for men to talk about their health. Men do not value their health and this is a major problem we have. We have the service, we can provide for them but it is how they accept it and how they prioritise it and to be honest they just don't."

• Registration with a GP

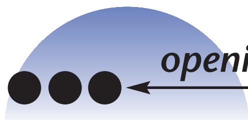
Health professionals emphasised the importance of homeless people being registered with a GP in order that they could access other services, for example, community nursing and mental health services. They also pointed to the importance of homeless people coming forward to request services.

"I think one of the problems is someone coming along and they don't have a GP, that is a very important thing."

"You are very dependent on a person coming forward and seeking help and by the very nature of the sub-group, they don't."

"Some of them don't have a GP and particularly there is an element of migrant population…"

"When people move to an area they have to sign on with a doctor and the doctor is the gateway to a lot of other services; you can't get some things without a doctor."



• Medical History

GPs said they were restricted in treating single homeless people by a lack of medical history and knowledge of the person. Health professionals considered this impacted on the treatment of homeless people particularly in relation to the prescribing of medication. The reasons highlighted included difficulty in monitoring progress, providing continuity of care and potential misuse of drugs.

"You have to be realistic. Although I suppose, to be critical of ourselves, we tend not to go into the health promotion aspect of consultations. The consultation tends to be very shallow, as if you are only scratching the surface."

"We rarely have notes, we rarely have a prescribing record, and we normally have no history to go on, so that automatically limits what you're prepared to enter into with the patient."

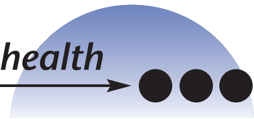
"Medical records tend to be empty apart from the out of hours. You don't know what their background is or if they have been to one of the other practices also as a temporary resident."

• Access to Information

Health professionals perceived that homeless people lacked sufficient information about the availability of local health services and what their rights and entitlements were. Consequently, they felt homeless people were dis-empowered and lacked confidence when in contact with health professionals.

" ...The homeless population, it is hard for them to know, for anybody to know whether they are entitled to free treatment."

"If they are in a hostel they are maybe not aware of our services (community nursing) particularly if they have not got a GP."



• Stereotypical Views

Some health professionals suggested that others within their professions often held stereotypical views of homeless people. This could possibly be attributed to their past experiences of working with this client group or was down to ignorance of the problems faced by single homeless people. This in some cases had an impact on the provision of prescriptions.

"You do get GPs who are very supportive of homeless people and there are others who don't want to know homeless people, who stereotype the homeless person and so are not prepared to take on anybody."

"Most of them aren't genuine health problems and I don't see that I should waste my time or waste appointments. The vast majority of them (homeless people) at least the ones we don't want to know, are smoking, abusing drugs and alcohol…"

"You are just doubly suspicious of what they are trying to get off you on prescription and you are trying not to prescribe controlled drugs that have addictive qualities."

"Homeless people tend to be more reliant on prescription medicines, it is something we keep tight control of."

• Changes in Primary Care

Health professionals commented that changes in primary care had resulted in increased demand and pressures which were impacting on all service users.

"There are problems in primary care because of more and more demand. Much more is happening and demands have risen in the last ten years."

"In the last month we have demanded that unless we get another doctor in and make the whole thing bigger then we are going to have to close the books, so generally speaking we will not be taking new registrations."

• Solutions

The healthcare professionals suggested a number of ways in which the barriers identified in treating single homeless people could be overcome. One main theme which emerged was partnership working. The health professionals interviewed thought it important for the various agencies to work together to develop a strategy to address the healthcare needs of single homeless people.

"…it has to be inter-agency, collaboration and negotiating some strategy. I don't think anybody doing it in isolation could work."

"Statutory, voluntary and charitable agencies tend to be quite fragmented, everybody has their own form of training but working in parallel. There is no sort of interagency approach to it."

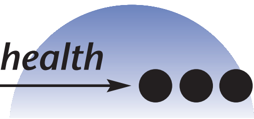
"Liaison with other professionals and good back-up would help…even to explain why somebody hasn't come in. I think that would help considerably."

"It must be in partnership and it must be multi-agency because everybody out there has so much to offer."

"To really improve standards and to improve the health of the homeless person, we need to be speaking to the right people, to more professional people, we need to be on more boards and committees. A holistic approach is important."

"Accessing those, maybe forming relationships with an identified, interested resource in the community that you can build on."

Another common theme related to the provision of information. This related to the information provided to single homeless people, the information held by social services and hostels and in particular the electronic transfer of information relating to an individual's medical history.



"Maybe a written proforma in hostels recording basic medical details of residents."

"Information sharing and also some input from social services as well. I think there should be a co-ordinated approach."

"Some sort of healthcare package…with advice on personal hygiene, first aid, medication, rules...with a charter of rights, should be given to residents in all hostels upon admission."

"Maybe if you had some kind of database or some kind of system whereby you can find out somebody's medical history, what medication they are on…"

"You are talking about a whole range and different set of problems there. I think the thing could be improved definitely to have better primary care. Somewhere whereby a homeless person could have a GP in every town or with electronic data nowadays, it should be relatively easy for a homeless person from Limavady staying in Belfast to be able to see a GP."

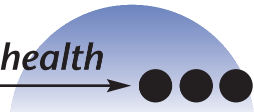
SUMMARY - Key Barriers

A range of barriers were identified in the research which make it difficult to access primary care services in Northern Ireland. A major barrier is that single homeless people and homelessness generally have been largely ignored in recent health and social services policy planning. This is despite a government commitment to target health and social need. Other barriers were identified by single homeless people and health care professionals. These barriers varied from stereotypical views held of homeless people to the difficulties associated with prescribing medication in the absence of medical notes. There was a degree of overlap in that many of the barriers identified by single homeless people were also mentioned by the health professionals. It also proved difficult to separate these because many were interconnected with each other. The following sections set out the key barriers identified by both groups.

Barriers identified by single homeless people[6]

Stereotypical views	• Homeless people perceived that GPs and other health professionals held stereotypical views of them. • Homeless people thought GPs were reluctant to prescribe them medication (26%) because they perceived them to abuse/be addicted to it. • They perceived that A&E staff thought they only attended A&E looking for a bed for the night (13%). • They thought A&E staff kept them waiting longer (11%).
Distance	• In some cases single homeless people lived in a different area to their GP practice (21% lived 4+ miles away). • The cost of travelling long distances restricted attendance. • The inconvenience of travelling long distances was highlighted.
Transport	• Homeless people were less likely to have access to private transport to visit their GP. • The cost of public transport restricted attendance at appointments.
Receptionists	• Homeless people thought receptionists prevented them from getting registered and/or seeing a doctor (14%). • They also considered that receptionists made it difficult for them to get a prescription (12%).

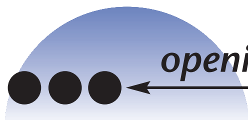
6 The barriers listed in this section have been identified in the focus group discussions and the questionnaire survey. Where possible the percentage of respondents to the survey who identified such a barrier have been included.



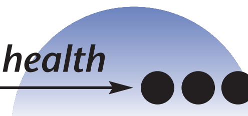
Lack of information	• Homeless people thought there was a lack of information on health related issues in some hostels.
Administration	• Temporary registration with a GP didn't allow for the transfer of medical records. • The need for GPs to have access to medical records made it difficult for temporary registered patients to get prescriptions including repeat prescriptions. • The time taken to transfer medical records from one practice to another caused delays in obtaining prescriptions including repeat prescriptions.

Barriers identified by health professionals

Transience	• Health professionals said that the transience of the single homeless population prevented them providing continuity of care. • Contact with them was usually at the crisis intervention stage. • They had limited opportunity to engage in health promotion with homeless people. • There was bureaucracy and delays associated with the transfer of medical records.
Complexity of need	• Health professionals viewed homeless people as having multiple health and social problems. • In some cases they had poor literacy skills.
Low self-esteem	• Health professionals viewed that low self-esteem prevented single homeless people seeking out services. • They also thought they lacked confidence when in contact with health professionals.
Value of health	• Health professionals regarded health and well being to have been placed low down on the homeless person's hierarchy of needs. • This leads to the individual not coming forward to seek out health services or information. • As such, contact is usually at crisis intervention stage.
Not being registered	• If the homeless person is not registered with a GP then access to GP services is limited. • The GP acts as a gatekeeper for referrals to other services such as; community psychiatric nurse, social worker etc…



Limited medical history	• Temporary registration with a GP didn't allow for the transfer of medical records. • Therefore, GPs and other health professionals often had limited knowledge of the person and/or their illness. • They were reluctant to prescribe medication in the absence of medical notes.
Access to information	• Health professionals thought single homeless people lacked sufficient information on the availability of services.
Stereotypical views	• Sometimes health professionals viewed single homeless people as drug abusers, alcoholics etc… • They were therefore reluctant to prescribe medication. • They considered them not to have genuine health problems.
Changes in primary care	• Changes in primary care have increased pressures on GPs. • Some practices have closed their lists to new patient registrations.
Gender issues	• Health professionals said that most single homeless people were male and less likely to avail of primary care services. • They also pointed out that the links between health professionals and some hostels was not as developed as those with Women's Aid hostels.



RECOMMENDATIONS

This section outlines a number of recommendations to address the barriers faced by single homeless people in accessing primary care services, as identified by this research. The overall aim of the recommendations is to facilitate the full integration of single homeless people into mainstream health and social services. However to some extent specialist measures are required in the short-term and this has been acknowledged in the content of some of the recommendations.

• Policy

1. Future health and social services policy / strategic documents produced by DHSSPS, Boards and Trusts should specifically target single homeless people alongside the other socially disadvantaged groups.

• Stereotypical Views

2. Training on the needs of homeless people should be provided to primary care and A&E staff, including administrative and clerical staff. Primary care commissioners and providers should seek to do this in association with the Council for the Homeless (NI) and / or other relevant organisations.

• Information

3. Primary health care providers should work with the Council for the Homeless (NI) in developing information packs targeted specifically at single homeless people. The packs should contain details of services available locally, how to access them and advice on promoting good health. These should be updated annually. The packs should be distributed to all new residents on admission to hostel accommodation.

4. The Council for the Homeless (NI) in association with its members should develop a pro-forma for use within hostels to record the basic medical details of residents. This should be used to provide relevant information to primary care providers.

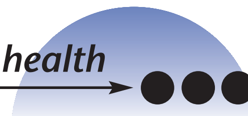
• Liaison with Primary Care Providers

5. Hostels should develop stronger links with local primary care providers. Outreach schemes should be developed whereby health professionals visit hostels to conduct regular health checks and offer advice on health promotion.

• **Administration**

6. Policies in respect of temporary registration with a GP, including the requirement for a medical card to register, should be reviewed. The review should also examine other issues including how essential medical information can be transferred effectively and efficiently between GP practices.

7. The Central Services Agency (CSA) should pilot/explore the feasibility of single homeless people carrying their own medical records which they can present to GPs with whom they are temporarily registered.



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Minicom: 028 3834 6488
E-Mail: admin.shssc@dnet.co.uk

Simon Community
Northern Ireland
57 Fitzroy Avenue
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Telephone: 028 9023 2882
E-Mail: simon-community@simon-community.freeserve.co.uk

Eastern Health and
Social Services Council
19 Bedford Street
Belfast, BT2 7EJ
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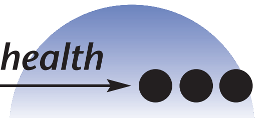
Minicom: 028 9032 1285
Freephone: 0800 3285420
E-Mail: ecouncil@ehssc.n-i.nhs.uk

Western Health and
Social Services Council
Hilltop, Tyrone and
Fermanagh Hospital
Omagh, BT79 0NS
Telephone: 028 8225 2555
E-Mail: lpreston@hilltop.n-i.nhs.uk



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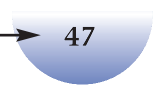

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