Cities Caring at the Margins Glasgow

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Aims of session

- Overview of targeted primary and secondary cares services in Glasgow for those who are Homelessness or seeking Asylum
- Principles of the service and links to local services in
- Tier 3 & 4 services - PD, Trauma and Liaison services
- Integration in NHS & HSCP from Health Perspective
- Current Systems – what needed?

History of Glasgow Homelessness

- Homelessness Taskforce Recommendations
- Early partnerships – Addictions & Homelessness Teams
- Homelessness Partnership – co-dependency, H&H Standards, choice…

Homelessness and Health in Glasgow's Hostels

- 70% of those aged 24 - 34 have a drug dependence
- 54% have hazardous drinking
- 58% had a long standing physical health problem
- 6% probable psychosis, 46% neurotic disorder
- 96% Unemployed , 63% No educational qualifications
- 80% registered with own GP, 65% of those who have a GP actually access them

(source ONS Survey 2000) (Updated October 2003)

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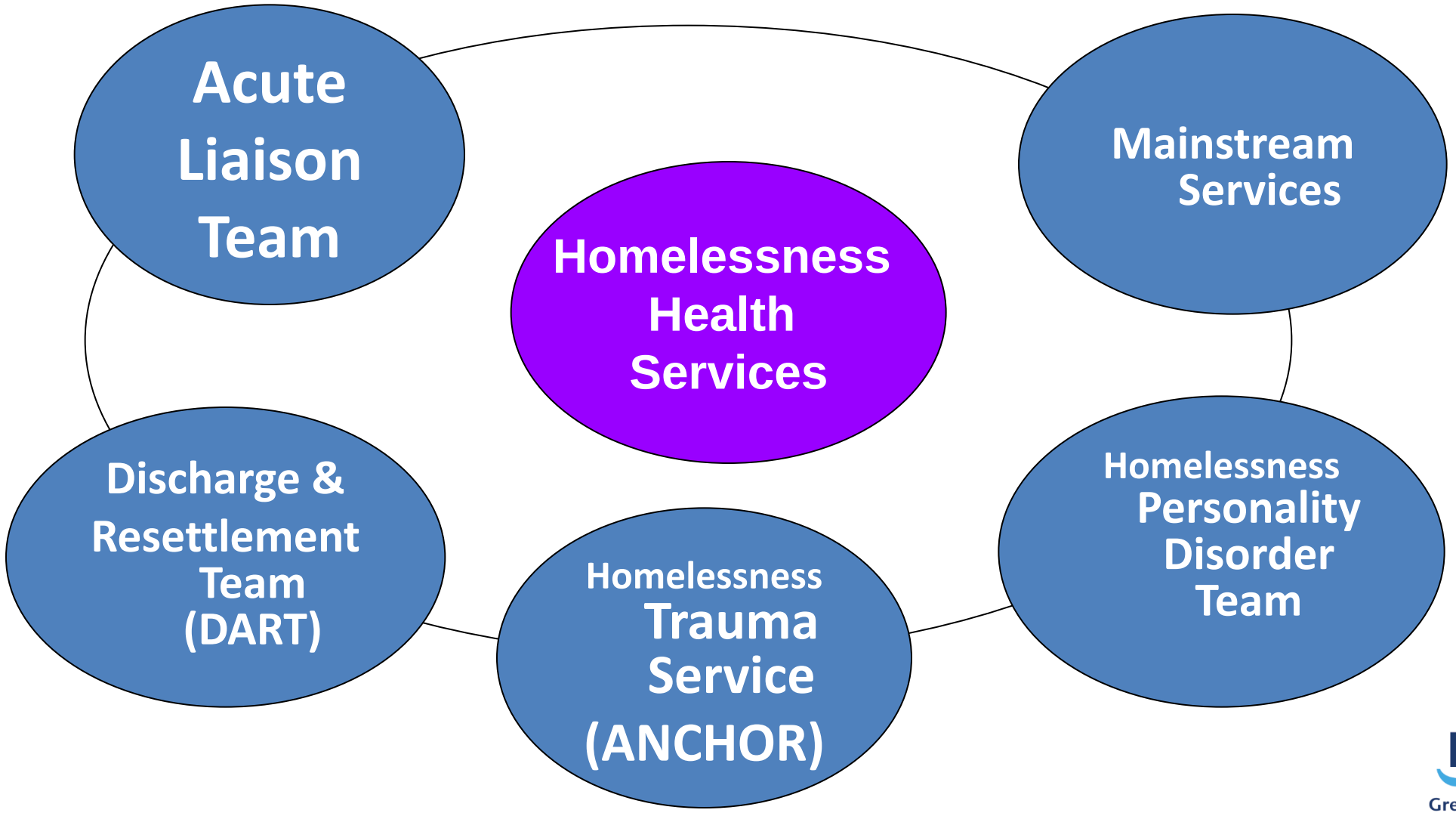
Health Opportunity & Response



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Why Homelessness Health Services (HHS)?

"Homeless people avoid services; services avoid homeless people" St Mungo's CEO, 2009

- Health is the last priority
- Unstructured lifestyles
- Distrust / Stigma
- High levels of alcohol consumption
- High risk injecting practices
- Unmet physical and mental health needs

Why Continue Targeted Health Services?

Costs

- Average age of death for a homeless male is 47 compared to 77 in general population. (Scot PHN)
  - Late marker of severe and complex disadvantage.
  - Risk of death by Drugs x 7, Chest infection x 3, circulatory conditions x 2
- Homelessness is an independent risk factor for mortality (David S. Morrison, 2009)
- Financial Cost i.e. secondary care x 8, A&E Attendance x 6, Admitted x 4 and stay twice as long
- Fife - Higher use blue light, younger, 30% DNA vs 10% gen pop.
- Public Health – HIV Outbreak & Public injecting

Hunter St Homelessness Services

- Improved access to health services for homeless people for most vulnerable, multi –excluded services users i.e. rough sleeping / emergency & TFF up to 3 months.
- Acute Services – Reduce inappropriate use of A&E, prevent inpatient admissions and reduce bed stay
- MDT Model – Provide a range of medical, health & Social care interventions to meet individual needs
- Approach – Stage response to complex or chaotic lifestyles to enable service users to sustain engagement with mainstream services.

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Approach & Focus

‘Hunter St is one stop shop that builds relationships, provides opportunistic intervention and reduces risk taking behaviours so that service users are more able to engage with Mainstream service and sustain accommodation’

- Right and entitlement to access mainstream
- Direct Access – open referral system
- Assertive outreach to initiate engagement
- Opportunistic interventions through relationship
- Reduce risk taking behaviours/ harm reduction
- Improve health outcomes and sustain accommodation
- Transfer to Mainstream / Local service

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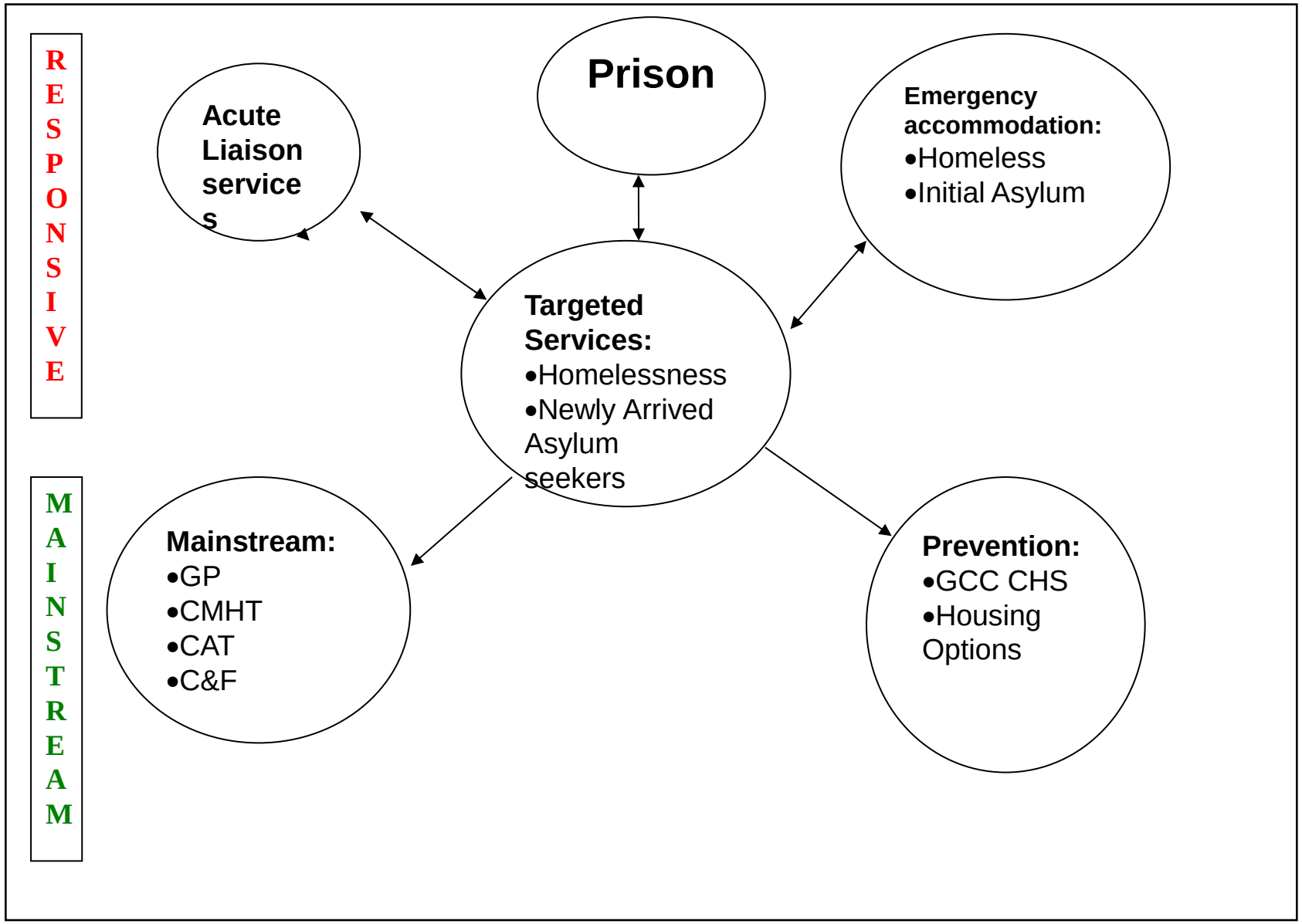
Integrated Health - Model

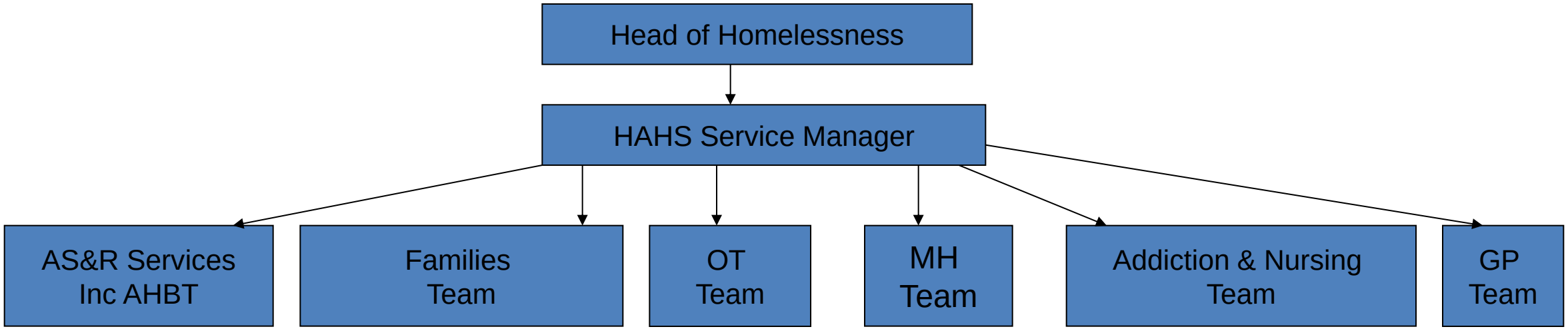


- Aim to reduce health inequalities through being responsive to the needs of the most excluded groups
- Opportunistic interventions for those who may not choose to engage with health services
- Focus on best practice i.e. multi agency services delivered in a flexible and responsive way from centralised resource
- Working proactively with local services through Housing Options to meet the needs of homeless people in their community
- Centralised resource which is accessible to those experiencing MECN and those living in emergency accommodation

Homelessness Recent Times

- Housing Options
- Refugee Community
- Local Initiatives – Housing First, CAN, Assertive Outreach
- Public Bodies (Joint Working) Scotland Act
- Multiple Exclusion and Complex Needs (MECN)

Homelessness & Asylum Health Structure



Visiting Service
- Maternity
- 0.3 wte Sexual Health
- 0.8 wte Dietetics
- 0.6 wte Podiatry
- 0.5 wte Oral health
- 0.3 wte Pharmacy
- GCU Vision Clinic

Mainstream targeted resources
Personality Disorder Team
Homelessness Trauma Team
COMPASS - Asylum
MH DART
Acute Homelessness Liaison

Why Whole Systems Approach?

Homelessness is both a consequence and cause of poverty, social and health inequalities

- Homelessness is a late marker of severe and complex disadvantage
- Relationship to early years and education
- Relationship to adulthood and response to presenting needs
- Relationships in late stages – homelessness and criminal justice

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Why Specialist Bridging Health Services?

Asylum health and wellbeing

- May not have accessed health care for a period of time
- Have conditions which are specific to the home country.
- Have been victims of rape/ torture/ physical violence.
- May have witnessed scenes of extreme distress and require mental and emotional support.
- When arrive in UK, they are very much unaware of what the NHS can offer them.
- Some health information has been translated into different languages. Interpreters are essential for those who are unable to speak English.

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Update & Trends

Asylum

- Highest numbers seeking Asylum in UK since 2004
- AHBT in last 4 years 45% increase
- GP allocations increased 56% during same period
- Remains predominately young single males
- IA model

Refugee's

- Presentations to GCC homelessness

NHSGGC Response

- Asylum Health Bridging Team – IHA and signposting
- Access to GP registration on dispersal across the GGC area which is co-ordinated from central point.
- Health Improvement activity targeted through joint initiatives – research, peer education.
- Development of information – interpreting, translated information.
- Capacity building within NHS services - training
- Network and Health pathway group.
- Inequality Sensitive Practice - inquiry

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Health Issues – AS&R

- Growing demand
- Introduction into NHS – GP registration & Repeat message
- Consultation Times – new ways working i.e. interpreting
- Use Health Care – distress, listening need for networks
- Understanding community – signposting to local support
- Peer education – Pilot embedded in integration
- Health behaviours - western

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Policy: NHSGGC Aims

- Ensure everyone how uses or works for NHS treated fairly
- All services responsible for meeting needs of marginalised groups to tackle inequalities.
- To ensure NHSGGC meet needs of asylum seekers and refugees in the local community and work in away to remove discrimination or prejudice response of marginalised groups.
- Ensure marginalised groups are able to engage by:
  - More accessible and user friendly, with staff aware of issues.
  - Open & honest as are with all service users
  - Staff should not make assumptions
  - Health response needs to be tailored to the individuals needs. Some people will require specialist services while most need equitable access to mainstream.

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Next Steps

- One Stop Shop
- Health & Social Care Integration
- Welfare Reforms
- Institutions – prisons
- World Events
- Westminster – Scottish Government
- Change in need?
- Choice?

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Summary

Inverse Care Law

"The availability of good medical care tends to vary inversely with the need for it in the population served."

"Those who need healthcare least use the services more, and more effectively, than those with the greatest need and those people in the worst health receive the least services."

Julian Tudor Hart 1971

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