Nurses for Homeless People Project

Introduction

Scottish Executive funding
In 2004, as part of the process of adjustment to the Arbuthnott Resource Allocation formula,1 the Scottish Executive awarded funding to three Health Boards: NHS Greater Glasgow; NHS Tayside; and NHS Argyll & Clyde. NHS Argyll & Clyde received £0.5 million in 2004/5 and £1 million in 2005/6.

Announcing the funding in 2004 the then Health Minister Malcolm Chisholm stated that adjustments to the resource allocation formula should ‘take account of unmet need in the most deprived areas. However, before we decide on this we need to examine how additional funding can be used to improve access to health services by people from the most deprived areas’ (Scottish Executive, 2004). Money was to be spent on pilot projects whose aim was both to highlight unmet need and pilot services that would address that need.

The Health of Homeless People is one of the five unmet needs pilot projects put into operation in (the former) NHS Argyll & Clyde.

NHS Argyll & Clyde
Since the Scottish Executive funding award and during the course of this project NHS Argyll & Clyde has been dissolved. In 2006 the health board area was divided geographically between NHS Greater Glasgow (now NHS Greater Glasgow & Clyde NHSGGC) and NHS Highland. NHS Argyll & Clyde staff was obliged to transfer to either NHS Greater Glasgow & Clyde or NHS Highland. It was agreed that the unmet needs pilot projects would respect their original brief and continue to operate over the two health board areas.

Context

Between 1997 and 2004 the number of households accepted by their local authorities as being homeless in the UK rose from 160,000 to 200,000 (Croft-White & Parry-Crooke, 2004). This figure refers exclusively to those who were either on or had applied to join local authority housing lists. It did not include

those living in hostels, bed and breakfast accommodation, squats or derelict buildings, or sleeping on the floors of family and friends: those referred to as the ‘hidden homeless’. In 2004 it was estimated that there were 380,000 hidden homeless in the UK (Crisis, 2004).

The estimated population of the Argyll & Clyde health board area in 2002 was 427,000 people. The average number of people (representing a household) making a housing application with their local authority taken over three years from 1998 to 2001 was approximately 2,640 (NHS Argyll & Clyde, 2002b). In 2002 NHS Argyll & Clyde undertook a health needs assessment amongst its homeless population. This was to inform actions taken from the Health and Homelessness Action Plan published the same year. This showed that, besides being homeless, 76% of the interviewees (n=119) had 2, 3 or 4 other serious well-being issues in their lives. (NHS Argyll & Clyde, 2002b).

Research suggests that homeless people, for a variety of reasons, have difficulty in accessing appropriate health care (Victor, 1997; Wright, 2002; Scottish Executive URL, 2006). In particular, homeless people often have multiple health needs that reinforce barriers to primary and secondary health services. In 2002 Homeless Link defined multiple needs as those having a combination of three or more of the following (Croft-White & Parry-Crooke, 2004):

- mental health problems
- misuse of various substances
- personality disorder or offending behaviour
- physical disability
- physical health problems
- challenging behaviours
- vulnerability because of age (not in effective contact with services).

Working with this definition it reported that over three quarters of homeless agencies worked with people with multiple needs (Croft-White & Parry-Crooke, 2004).

The NHS Argyll & Clyde Health and Homelessness Needs Assessment reinforced these findings at a local level (NHS Argyll & Clyde, 2002b). The implications of this health needs assessment revealed the complexity of needs of individuals in this category, and the overwhelming need to co-ordinate relevant services timeously in order to improve the overall well being of this vulnerable population. Although many of the required services were in place, they were very poorly co-ordinated (particularly the health services). This is reflected in guidance from the Scottish Executive and the Homeless Task Force (2004), and in many individual research publications (Victor, 1992: 1997).

Partnership for Care. Scotland’s Health White Paper (Scottish Executive, 2003) highlights the importance of partnership working as a cornerstone of health improvement. Partnership working is crucial if we are to address the complex and multiple needs of homeless people. All those concerned need to find ways of engaging with homeless people to ensure that services are appropriate and accessible. Unmet health needs can lead to trapping people in homelessness. In terms of inequalities, homeless people were identified by the Argyll and Clyde
Health Inequalities Steering Group as a key group for attention (NHS Argyll & Clyde, 2002a).

There are reports specifically on the findings amongst homeless dependent children (Amery, 1995; Riley, 2001). In surveys of the reasons for priority need in the partner local authorities in Argyll & Clyde area, having dependent children was the reason for receiving priority for between 30% (Argyll & Bute) and 47% (Renfrewshire) of all homeless households.

### Nurses for Homeless People Project

For the purposes of this proposed project, ‘homelessness’ is widely defined. The definition of ‘homelessness’ is based on that used in NHS Argyll & Clyde health and homelessness action plan document, *Improving Health and Homelessness in Partnership* (NHS Argyll & Clyde, 2002a). In addition to homeless people so defined, the project also works with people who are at risk of homelessness. This includes a considerable number of people who use voluntary services such as the George Street Drop-in, Paisley, and the HELP project in Dunoon and Rothesay.

### Aims and objectives

**Aims:**
The stated aim of the project was:
- to co-ordinate improved access to services needed for increased well-being by homeless people in the project area.

**Project objectives**
1. To have a dedicated homeless persons’ nurse working in conjunction with local authority homeless officers in the project area
2. To increase numbers accessing services*
3. To facilitate access to services* that is better (i.e. easier and/or more effective).

*Note: throughout this report, ‘services’ relates only to drug misuse services and mental health services
Research design

Project area:
The project was located across four local authority areas: Renfrewshire, East Renfrewshire, West Dunbartonshire, and Argyll & Bute. Within these areas nurses worked to project locality boundaries:

Table 1: geographical spread of project

<table>
<thead>
<tr>
<th>Local authority</th>
<th>Project locality</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renfrewshire</td>
<td>Renfrewshire</td>
<td>Renfrewshire local authority area</td>
</tr>
<tr>
<td>East Renfrewshire</td>
<td>East Renfrewshire</td>
<td>East Renfrewshire initially covered only the part that was in the Argyll &amp; Clyde health board area but after the dissolution of the health board included the whole of East Renfrewshire</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>Dumbarton</td>
<td>West Dunbartonshire local authority area</td>
</tr>
<tr>
<td>Argyll &amp; Bute</td>
<td>Lomond</td>
<td>Helensburgh, Cardross, Rhu, Garelochhead, Kilcreggan, and north to Arrochar</td>
</tr>
<tr>
<td>Argyll &amp; Bute</td>
<td>Cowal &amp; Bute</td>
<td>Cowal &amp; Bute</td>
</tr>
<tr>
<td>Argyll &amp; Bute</td>
<td>Mid-Argyll &amp; Kintyre</td>
<td>Including Islay, Jura &amp; Gigha</td>
</tr>
</tbody>
</table>

The remaining former Argyll & Clyde area, Inverclyde, was originally conceived as a control area. However this area already supported a Health Visitor undertaking similar duties to the project nurses and therefore was not suitable for control.
**Method:**
Six project nurses were employed and located across the project areas. They were located in a variety of settings including: offices of local authority Homeless Persons’ Officers; NHS offices (e.g. Ross House, Barrhead Health Centre); and voluntary sector offices (e.g. Cowal Council for Alcohol & Drugs.).

**Table 2: project staffing**

<table>
<thead>
<tr>
<th>Contract</th>
<th>Locality</th>
<th>No</th>
<th>Based at:</th>
<th>Referrals mainly from:</th>
</tr>
</thead>
<tbody>
<tr>
<td>W/t Nurse</td>
<td>Renfrewshire</td>
<td>2*</td>
<td>Ross House</td>
<td>George St Drop-in, Mount Royal (homeless), Renfrewshire Council, Homeless Persons’ Officers (HPOs)</td>
</tr>
<tr>
<td>P/t (25hrs) Nurse</td>
<td>East Renfrewshire</td>
<td>1</td>
<td>Barrhead HC</td>
<td>East Renfrewshire Council (HPOs), Overlee Lodge Staff</td>
</tr>
<tr>
<td>W/t Nurse</td>
<td>Mid-Argyll &amp; Kintyre</td>
<td>1</td>
<td>Ross House</td>
<td>Daily links with HPOs in Lochgilphead and Campbeltown (weekly travel to area)</td>
</tr>
<tr>
<td>W/t Nurse</td>
<td>Cowal &amp; Bute</td>
<td>1</td>
<td>Council projects offices, Dunoon</td>
<td>HPOs, Help Project</td>
</tr>
<tr>
<td>W/t Nurse</td>
<td>Dumbarton and Lomond</td>
<td>1</td>
<td>Housing Office</td>
<td>HPOs</td>
</tr>
<tr>
<td>W/t Project Manager</td>
<td>Entire project area</td>
<td>1</td>
<td>Ross House</td>
<td>All project staff</td>
</tr>
<tr>
<td>W/t Project administrator</td>
<td>Entire project area</td>
<td>1</td>
<td>Ross House</td>
<td>All project staff</td>
</tr>
</tbody>
</table>

*This was reduced to one when one of the nurses resigned to take up another post.

**Identification and recruitment:**
Eligible participants included all homeless people in the project area. The working definition of homeless conformed to that outlined in the health & homeless action plan *Improving Health and Homelessness in Partnership: The Way Forward* (NHS Argyll & Clyde, 2002a, pp.8-9) to include housed people who were particularly vulnerable and/or at risk of becoming homeless.

Eligible people were offered a referral to a project nurse. Nurses accepted all referrals but people were not under any obligation to participate. Referrals were made principally by Homeless Persons’ Officers but also from other related agencies (e.g. Jericho House, Special Needs for Homeless, CACTUS – Turning Point; Help Project, Blue Triangle, Causeway, Police; etc), and from individuals (e.g. B&B concierge staff). Self-referrals were also accepted.
**Health assessment:**

Those referred were invited to undergo a health assessment using the proforma devised for the project (Appendix 1). The health assessment was usually undertaken at the first meeting but in some cases it was delayed until subsequent meetings when trust between the nurse and the homeless person had been established. All referrals were seen by the nurse but only those who agreed to participate in the project, had their health assessment documented on the project proforma, and who signed consent, are considered to be participants.

The health assessment recorded a range of health details including general health/health history/use of services relating to drug misuse and mental health. Additional questions related to education, training, social and welfare issues were included. A summary and action plan was completed for each participant. Where appropriate, clients were directed to appropriate services, in particular, health care services for drug misuse and mental health. Initially, where referrals were made, follow-up work was undertaken to track whether clients accessed the service. This involved issuing a ‘did/did not attend’ pro-forma to services (to be returned to nurse), and/or follow-up phone calls to services. This system proved to be poorly used by the various services and time-consuming for nursing staff and was abandoned within the first few months of the project.

**Consent and confidentiality:**

Before completing the health assessment form, participants were given a verbal and written explanation of the project and were asked to sign a consent form. Consent forms were signed and stored with due regard for the Data Protection Act (1998). In the interests of client confidentiality, personal details were only available to project nursing staff, project administrative staff and project lead, for purposes directly related to clinical issues. Research staff accessed records via client identification numbers.

**Deprivation:**

Homeless people are by definition deprived. Use of Scottish Index of Multiple Deprivation (SIMD) data was impractical in most cases as homeless people have no permanent residential address. Temporary addresses can change frequently and so one person may have several different postcodes in a relatively short period of time. There was no affluent homeless group to act as a control.

**Measuring results:**

The original protocol discussed measuring project outcomes against information routinely collected through the SMR24 and SMR25 returns for drug misuse services and the SMR04 returns for mental health services. Reliance on this data source proved problematic. SMR data do not define homelessness comprehensively and in some cases homeless status is not accurately documented. In addition, access to these data was limited. Data other than that contained in formal SMR reporting could be collated by the NHS Information &

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2 There is no field on SMR04 returns which identifies whether a person is homeless other than that derived from the postcode field which would be noted as ‘no fixed abode’.
Statistics Division (ISD) in response to specific queries but may not be available when required.

In May 2006 ISD provided statistical data on new clients reported to the Drug Misuse Database who were noted as ‘roofless’ or in ‘temporary unsuitable accommodation’ for the years 2000-2005. Reference will be made to these figures in discussion of the project results where it is thought useful.

After some discussion, the project team agreed that the NHS Argyll & Clyde Health and Homelessness Needs Assessment, 2002 (HHNA) provided a more reliable point of reference in the analysis of project results. The HHNA outlined the level of need amongst homeless people in the Argyll & Clyde area in 2002. Findings of this project will refer to the 2002 level of need and assess how the work of Health & Homelessness Project nurses has addressed it.

A stated aim of the project is to ‘improve’ access to services. This implies a service that is more effective and qualitatively better for the client group. A series of interviews with project staff and the documenting of example cases was undertaken to provide a narrative context for the work of the project. To avoid positive bias by the selection of ‘good news’ stories, example cases were selected at random from the referral figures collated by each nurse. The character of each locality and the strategies employed by nurses are outlined and cases are presented by locality.
Findings

Presentation of findings

The findings are presented in three sections:

1. Total project area: general project information and characteristics of the participation
2. Project localities: brief narrative of project localities
3. Total project area: random sample of case studies

Argyll & Clyde: all project localities

The project area
The project area includes some of the most deprived urban communities of Scotland as well as a substantial and widespread rural/island population. Access to mainstream health services varies across the area. The major hospitals providing a comprehensive range of services are situated in the urban centres making it difficult for people in rural areas to access them without incurring cost, time and energy. Access to primary care services is also not equitable; e.g. dental practices and GP surgeries are fewer and less easily accessed in rural/island areas than in the larger towns and cities.

Project nurses worked in areas where boundaries corresponded to those of the local authority housing departments. The project nurse in West Dunbartonshire initially covered part of West Dunbartonshire Local Authority area plus the Helensburgh part of Argyll & Bute Local Authority area. After the dissolution of Argyll & Clyde Health Board, the Nurse’s area continued to include Helensburgh but expanded to take in the whole of West Dunbartonshire. The project nurse in East Renfrewshire initially covered only that part of it under Argyll & Clyde health board. After dissolution this area expanded to take in the whole of East Renfrewshire. (See map, p).

Drug addiction and mental health services
A range of services operates across the project area providing specialist treatment, support and advice in relation to mental health and addictions although these are concentrated more in some areas than others. For example, in urban areas such as Paisley or Renfrewshire services are more comprehensive and accessible. Argyll & Bute provides addiction services commensurate with the population figures but the wide geographical spread makes it difficult for many staff and clients to access them and use them effectively.
Reporting period
Health & Homelessness Project nurses took up their posts in January 2006. After an initial training period, engagement with clients had commenced fully by the beginning of February 2006. The ‘project period’ reported on here covered January 2006 to March 2007 representing a 13 month period of project activity with clients. Most of the Nurses continued their roles beyond the ‘project period’ until the Autumn of 2007, in some cases up to the end of the calendar year.

Exclusions
Lack of engagement with services is a feature of the homeless population and where resistance was encountered, project nurses were required to adopt a sensitive approach to build trust with clients over a period of time. In three of the five project localities, approximately one third of those who were referred, or self-referred, to the nurses did not want further involvement in the project and did not have a complete project health assessment documented. In East Renfrewshire and Mid-Argyll & Kintyre the participation rate was over 90%. Most patient/nurse encounters where there was no further involvement in the project were recorded by the nurses informally allowing an estimation of the total number of people seen by project nurses in the course of their work. In the project period this estimate was 578. A number of referrals were made by the nurses on behalf of these clients. These referrals were not included in the project and do not feature in the findings noted below.

Participant numbers
Across all localities the total number of people who completed a health assessment form with a project nurse in the project period was 356.\(^3\) Across all localities project nurses made 562 referrals to other health or social services.

Findings from the project period are reported with reference to the Argyll & Clyde HHNA 2002. The HHNA 2002 was based on a representative sample taken from the total number of homeless people across the five council areas of Argyll & Clyde 1999-2000.\(^4\) In contrast, figures from the Health & Homelessness Project represent all homeless people who have reported a health problem to one of the referring services across Argyll & Clyde (excluding Inverclyde). While the Health & Homelessness Project figures represent only one year and must be regarded to some extent as a snapshot, it can be argued that by including all homeless people with a health problem they reflect a more comprehensive picture of the health status of homeless people in Argyll & Clyde during that period than a sample where representativeness is formulaic.

\(^3\) Health assessment forms included space to record family members. Noted family members amounted to 166 people, 132 of whom were under 16 years of age. Family members are not included in the results.

Individual Localities

West Dunbartonshire: Dumbarton / Lomond Area

Project Nurse:
After a period as Combat Medical Technician in the army medical services the nurse worked as a civilian learning disability nurse before undertaking general nurse training and specialising in the field of neurology. The nurse then trained as a community nurse and worked for two years with asylum seekers and refugees before taking up the post on this project. For the duration of the project the nurse was based in West Dunbartonshire housing office.

Context:
Since the demise of the engineering industry in West Dunbartonshire in the 1960s there has been a surplus of housing stock in the area as people moved away for employment. Unlike Glasgow, West Dunbartonshire has never developed a system of homeless hostels but provided temporary accommodation to all homeless people from its ‘low demand stock’. Many homeless people have location preferences and feel personally insecure in areas that are less familiar to them. A proportion of homeless people display anti-social behaviour patterns that are often themselves rooted in other health and social problems. Responses by authorities and neighbours can often exacerbate feelings of insecurity. Many are caught in a continuous vicious circle of temporary accommodation, insecurity, anxiety and anti-social behaviour as they move, or are moved, from one location to another.

The three most common reasons for homelessness given by project participants in West Dunbartonshire were:
- family members and/or friends no longer willing or able to accommodate
- fleeing external or non-domestic violence/abuse
- discharge from prison

While West Dunbartonshire offers an extensive range of statutory and voluntary services in relation to general health, drug addiction and mental health problems, many homeless people do not find access to these services easy. Frequent changes of address result in appointment notices not being received and consequent missed appointments. This coupled with a generally chaotic lifestyle that often accompanies poor mental health and addiction problems, means that homeless people often find themselves removed from GP registers or health programmes due to non-attendance. By default then, the local housing office operates as a stable point of contact for homeless people whose housing needs remain ongoing. Housing officers become a familiar point of contact for clients with health problems.

Basically the clients come in here and they moan and groan at the reception staff, they’ll moan at the housing officers and support workers here

The response of housing officers to health problems is by nature a lay one but the project nurse was able to offer a professional response thereby providing clients with a better service and reducing the workload of housing officers.
Information sharing and co-operative working:
Trust between the project nurse and the housing staff developed quickly and the nurse was soon in a position to liaise with other services including social work, police, Assist teams, as well as GPs, community and acute health services. A feature of the project work in West Dunbartonshire is the improved communication, information sharing and joint working facilitated through the presence of the project nurse.

Table 3: Statistics for West Dunbartonshire

<table>
<thead>
<tr>
<th>West Dunbartonshire</th>
<th>Dumbarton &amp; Helensburgh</th>
<th>Lomond Area</th>
<th>Total</th>
<th>Number presenting recorded on SMR24 **</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of homeless presentations made to Council 2006/7</td>
<td>2,815</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of assessments completed</td>
<td>37</td>
<td>48</td>
<td>85</td>
<td></td>
</tr>
<tr>
<td>No of people noted on assessments</td>
<td>39</td>
<td>65</td>
<td>104</td>
<td></td>
</tr>
<tr>
<td>No of people whose main problem is mental health</td>
<td>13</td>
<td>24</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>No of people whose main problem is drug addiction</td>
<td>23</td>
<td>22</td>
<td>45</td>
<td>64</td>
</tr>
<tr>
<td>No of people on Methadone programme</td>
<td>5</td>
<td>2</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

** This figure refers to all those who presented for drug treatment in the year 2004-5 who were roofless or in temporary or unstable accommodation.

In the HHNA 2002 the total sample of homeless people from West Dunbartonshire was 22. Of these, over all age groups, 32% were female. The proportion of female clients seen by the Health & Homelessness project nurse in this locality in 2006-7 was 35% (n=30). [Fig.1]
Compared to the HHNA 2002 the Nurses for Homeless People project identified mental health problems in a higher proportion of clients. [Fig.2]

In the HHNA 2002 figures relate only to those who self-identified a mental health problem in answer to a direct question. Only 18 people answered this question. In the homeless nurse project, figures relate to all clients assessed by the nurse in this project locality (n=85) and who answered positively to 3 or more mental health conditions.

In the HHNA 2002 respondents were asked whether they required help or support in relation to mental health problems: half of those who had reported mental health problems (9%) replied that they did require help or support.
Fig. 3 also indicates that a proportion of people deemed to have a significant mental health problem had not been receiving support from the appropriate services in the last year.

**Renfrewshire**

**Project nurse**
The nurse in this area started as a treatment room nurse before completing District Nurse training. Prior to this post she had no direct experience working with the homeless although she was aware of the work of the homeless unit in Glasgow where a similar holistic approach to health was encouraged. During the project she was based in the CHP headquarters in Ross House, Paisley but rarely saw clients there.

**Context**
Renfrewshire covers an extensive area to the west of Glasgow with a large urban centre in Paisley and a number of surrounding towns. It has good transport links to Glasgow, and Renfrewshire council housing department uses Glasgow facilities as an overspill for its homeless population. Despite the fact that there is a considerable number of vacant houses in Renfrewshire at any one time, a number of people with housing applications in Renfrewshire are placed in temporary bed & breakfast accommodation in Glasgow. On numerous occasions housing officers have described some houses as being in need of ‘outstanding repairs’ and the uptake of tenancies is often delayed for this reason. Anecdotal evidence illustrates this in the case of one homeless young man who was offered a house but could not take up the tenancy because outstanding repairs were required. The offer of tenancy was eventually withdrawn by the council and another offer made. Again, outstanding repairs were required but slow to begin. The young man waited approximately eight months before being able to take up his tenancy.
The three most common reasons for homelessness given by project participants in Renfrewshire were:

- parents no longer willing or able to provide accommodation
- dispute with partner/family: violent/abusive
- other family members no longer willing or able to provide accommodation

**Information sharing and co-operative working**

It had been hoped that the nurse would be based in the local authority housing office but links with the housing department were not easily forged at the start of the project. This affected early referral patterns. It was anticipated that the majority of referrals would come from the housing office but these referrals were not forthcoming. Housing officers cited data protection issues as a barrier. Although housing officers did ask clients if they wanted to be referred to the nurse, clients agreed to this and consent from clients was documented, housing officers remained reluctant to actually make referrals. Links with housing were further hampered by the physical distance between the two services and the project nurse felt that this poor integration resulted in potential clients being overlooked. In face of poor communication and slow integration, the nurse sought out clients by visiting temporary accommodation and other service providers. These visits elicited numerous ad hoc self-referrals. A large proportion of referrals came from concierge staff at B&B accommodation.

It is standard practice for Renfrewshire council housing services to cancel automatically the temporary [supported] accommodation tenancies of anyone arrested for criminal behaviours, with immediate effect. As a result, and coupled with poor information sharing practices with council staff, the project nurse often had to track down clients herself as they moved in and out of temporary accommodation. She reported that the police were remarkably co-operative and helpful in this process and willing to confirm with her if clients were in police custody or not.

<table>
<thead>
<tr>
<th>Renfrewshire</th>
<th>Number presenting recorded on SMR24**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of homeless presentations made to Council</td>
<td>1,961</td>
</tr>
<tr>
<td>No of assessments completed</td>
<td>73</td>
</tr>
<tr>
<td>No of people noted on assessments</td>
<td>109</td>
</tr>
<tr>
<td>No of people whose main problem is mental health</td>
<td>21</td>
</tr>
<tr>
<td>No of people whose main problem is drug addiction</td>
<td>40</td>
</tr>
<tr>
<td>No of people on Methadone programme</td>
<td>11</td>
</tr>
</tbody>
</table>

** This figure refers to all those who presented for drug treatment in the year 2004-5 who were roofless or in temporary or unstable accommodation.
In the HHNA 2002 figures relate only to those who self-identified a mental health problem in answer to a direct question. Only 18 people answered this question. In the homeless nurse project, figures relate to all clients assessed by the nurse in this project locality (n=73) and who answered positively to 3 or more mental health conditions.
**East Renfrewshire**

The East Renfrewshire nurse came from a hospital setting and had no prior community nursing experience before taking up this part time post. The nurse was based in Barrhead Health Centre but used her office there as an administrative base only.

At the start of the project the East Renfrewshire project area extended to the south eastern border of NHS Argyll & Clyde where it met NHS Greater Glasgow. The East Renfrewshire local authority boundary encompassed parts of both health boards. Although the project nurse worked in close cooperation with the local authority housing office she covered only the NHS Argyll & Clyde section.

**Context**

There are good housing support and advisory services available. The Council offers a range of housing and support options for homeless young people, families, children who have been looked after and other client groups with complex needs. East Renfrewshire also uses some Glasgow based accommodation for homeless people. This results in some people being housed at a considerable distance from familiar support and health services (e.g. GP). Most referrals came from the homeless section of the council with others coming from a range of local services including Women’s Aid, Children 1st, and Throughcare. The nurse reported substance misuse as a prevalent problem amongst her homeless clients although they themselves often did not recognise the impact of their addiction. In common with other project nurses, she reported that, amongst her clients, health was commonly regarded as a secondary problematic feature of their lives.
The three most common reasons for homelessness given by project participants in East Renfrewshire were:

- parents no longer willing or able to provide accommodation
- dispute with partner/family: violent/abusive
- other family members no longer willing or able to provide accommodation

**Information sharing and co-operative working**

In recent years colleagues from both health boards have established good working relationships to ensure consistent approaches to the implementation of the health and homelessness action plans and to address cross boundary issues in relation to health and homelessness. Effective procedures have been established between homeless services, social work, health, education and the voluntary sector. From the outset the nurse established a very good working relationship with the local housing office and called the housing officers on a weekly basis. Throughout the area there was enthusiasm for the homelessness project nurse and she found it easy to establish working relationships with these agencies. The nurse reported no problems around information sharing or confidentiality with the exception of Women’s Aid who nevertheless invited the nurse to joint meetings and referred clients to the nursing service.

<table>
<thead>
<tr>
<th>Table 5: Statistics for East Renfrewshire</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>East Renfrewshire</strong></td>
</tr>
<tr>
<td>Number of homeless presentations made to Council</td>
</tr>
<tr>
<td>No of assessments completed</td>
</tr>
<tr>
<td>No of people noted on assessments</td>
</tr>
<tr>
<td>No of people whose main problem is mental health</td>
</tr>
<tr>
<td>No of people whose main problem is drug addiction</td>
</tr>
<tr>
<td>No of people on Methadone programme</td>
</tr>
</tbody>
</table>

**This figure refers to all those who presented for drug treatment in the year 2004-5 who were roofless or in temporary or unstable accommodation.**
Fig. 7: East Renfrewshire project clients by gender

<table>
<thead>
<tr>
<th>% Homeless Health Needs Assessment 2002 (n=25)</th>
<th>% Homeless nurse project 2006-7 (n=70)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% male</td>
<td>% female</td>
</tr>
<tr>
<td>28</td>
<td>46</td>
</tr>
<tr>
<td>72</td>
<td>54</td>
</tr>
</tbody>
</table>

Fig. 8: East Renfrewshire reported mental health problems

<table>
<thead>
<tr>
<th>East Renfrewshire reported mental health problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Homeless Health Needs Assessment 2002</td>
</tr>
<tr>
<td>% Homeless nurse project 2006-7</td>
</tr>
<tr>
<td>40</td>
</tr>
<tr>
<td>39</td>
</tr>
</tbody>
</table>

In the HHNA 2002 figures relate only to those who self-identified a mental health problem in answer to a direct question. Only 18 people answered this question. In the homeless nurse project, figures relate to all clients assessed by the nurse in this project locality (n=70) and who answered positively to 3 or more mental health conditions.
Argyll & Bute
Argyll & Bute supported two nursing areas: Mid Argyll & Kintyre (from Inveraray south to Mull of Kintyre and including Islay, Jura, Gigha and Colonsay) and Cowal & Bute.

Mid-Argyll & Kintyre
The Mid-Argyll & Kintyre project nurse was a Community Staff nurse in a Glasgow clinic before training as a District Nurse. The nurse was based in NHS Argyll & Clyde headquarters in Ross House, Paisley but travelled regularly across the area spending two nights per week in Ardrishaig and the islands. She was also given the use of a desk in the housing offices in Lochgilphead and in Campbeltown.

Context
Mid-Argyll & Kintyre extends from the south end of Mull of Kintyre some 85 miles north to Inveraray. Largely rural, it encompasses the towns of Lochgilphead, Campbeltown and the islands of Jura, Islay, Gigha, Colonsay and Oronsay. Mid-Argyll hospital is situated in Lochgilphead but access to a range of health services is poor and people are commonly referred to Glasgow for specialist services.

Islay has a surprisingly high level of homelessness due in part to the number of seasonal lets which are rented on short-term leases over the winter but given over to the tourist sector during the summer months. The nurse recognised a high level of need for the homelessness nursing service in Islay. There were no rough sleepers reported in the area as most people are housed in B&Bs, temporary accommodation or were ‘sofa-surfers’. A number of people utilise the rent deposit scheme to access private lets while remaining on the housing list.
Throughout the area social services are overstretched. The Mid-Argyll Council on Alcohol & Drugs (MACAD) and Kintyre Alcohol & Drugs Advisory Service (KADAS) provide support with alcohol and addictions and provide a range of alternative therapies. Ronachan House in the Mull of Kintyre is the only residential rehab facility in the area. However, it is oversubscribed and it is difficult to secure a place there. There are no other rehabilitation or detoxification facilities other than the drop-in centres. Anecdotal evidence suggests that GPs do not acknowledge the high level of substance abuse and are not involved in Methadone prescribing or rehab programmes. This is borne out by project figures (see Fig.21). Islay has a Healthy Living Centre.

Prior to the project nurse post, housing officers were called upon to make decision relating to clients’ health as noted on housing applications. A majority of applications showed a health issue. Referrals to the nurse came mainly from housing with others from social work, hospital and some from the local housing association, Argyll Community Housing Association (ACHA). Geographical scale and access issues meant that clients often had to wait for up to a week between referral and a visit from nurse.

**Information sharing and co-operative working**

Once in post the nurse developed a very close relationship with the local housing officers in the area and found them very willing to support her work.

**Cowal & Bute**

The Cowal & Bute nurse was originally trained as a psychiatric nurse and had previous experience as a CPN in a Community mental health team. When Glasgow began the process of closing their homeless hostels the nurse was invited to act as a community liaison nurse for the homeless. Previous posts also included working in a joint funding post with social work for one year.

The nurse worked from two principle bases: the offices of Cowal Council on Alcohol & Drugs (CCAD), Dunoon, and with the homeless team at the Housing Office or with the HELP project,\(^5\) in Bute. She also saw HELP clients in Dunoon on a regular basis. She worked 1-2 days per week in Bute and the other days in Dunoon.

**Context**

Bute and Dunoon present two different pictures. In Dunoon homeless people tend to be local and are accommodated in B&Bs or within a recently built dedicated bedsit unit housing six people. Services in the area are well integrated and people tend to be tied into them. In Bute, service provision is poor and those that exist are overloaded. This led to the nurse taking on a more active role than the post should have required. Where she was unable to refer to a CPN, due to lack of staff, she provided short-term input herself using her CPN experience and training. Throughout this, she kept the local CPNs and psychiatrist informed of what she was doing. If the case was ongoing for more than two months, she would then refer clients on.

---

\(^5\) The HELP project is a housing support project running in Dunoon and Bute for people aged 16-25 years.
The main health problems reported were related to addictions—usually drug addiction—and the nurse shared a lot of cases with the local drug addiction nurse. Alcohol addiction was less frequent or problematic. Mental health problems were also prevalent. These tended to be cases of anxiety, stress or depression rather than more severe and enduring conditions.

**Information sharing and co-operative working**

The Cowal & Bute nurse was initially based at the Dunoon housing office but felt that her post’s ‘health identity’ was lost. When she moved to the CCAD office she then found it difficult to establish working relationship with the housing office from a distance. Initial tension was soon resolved and she developed a very good relationship with the housing officers. Prior to the homelessness nursing project, housing officers did not make contact with CPNs and did not think to do so. The nurse was able to establish links and feels that all concerned now know more about the roles of others. Referrals came mostly from the area homeless officers, the HELP project and increasingly from addiction services. The nurse did not offer a drop-in service and there was no self-referral system. It is her opinion that when her post is closed, contact between the various agencies will be greatly reduced.

Across Argyll & Bute the three most common reasons for homelessness given by project participants were:

- parents no longer willing or able to provide accommodation
- loss of private tenancy
- other family members no longer willing or able to provide accommodation

**Table 6: Statistics for Argyll & Bute**

<table>
<thead>
<tr>
<th>Argyll &amp; Bute</th>
<th>Cowal &amp; Bute</th>
<th>Mid-Argyll &amp; Kintyre</th>
<th>Total</th>
<th>Number presenting recorded on SMR24**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of housing applications made to Council</td>
<td></td>
<td></td>
<td></td>
<td>1,276</td>
</tr>
<tr>
<td>No of assessments completed</td>
<td>65</td>
<td>63</td>
<td>128</td>
<td></td>
</tr>
<tr>
<td>No of people noted on assessments</td>
<td>89</td>
<td>103</td>
<td>192</td>
<td></td>
</tr>
<tr>
<td>No of people whose main problem is mental health</td>
<td>27</td>
<td>21</td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>No of people whose main problem is drug addiction</td>
<td>20</td>
<td>26</td>
<td>46</td>
<td>22 / 40</td>
</tr>
<tr>
<td>No of people on Methadone programme</td>
<td>5</td>
<td>0</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

**This figure refers to all those who presented for drug treatment in the year 2004-5 who were roofless or in temporary or unstable accommodation.**
In the HHNA 2002 figures relate only to those who self-identified a mental health problem in answer to a direct question. Only 18 people answered this question. In the homeless nurse project, figures relate to all clients assessed by the nurse in this project locality (n=128) and who answered positively to 3 or more mental health conditions.
Fig. 12: Argyll & Bute – mental health

Argyll & Bute: mental health

<table>
<thead>
<tr>
<th>Category</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support for mental health problems required as identified in HHNA 2002</td>
<td>29</td>
</tr>
<tr>
<td>Project clients whose main problem is mental health</td>
<td>37</td>
</tr>
<tr>
<td>Project clients who have been to psychology or psychiatric unit in year prior to project</td>
<td>9</td>
</tr>
<tr>
<td>Project clients who have been in contact with CMHT in year prior to project</td>
<td>12</td>
</tr>
</tbody>
</table>
Findings: general

Table 7 shows the HHNA 2002 sample size in comparison to the numbers of clients who participated in the Health & Homelessness Project. Percentages in Table 7 show that the proportion of homeless people reporting a health problem in the Argyll & Bute area was significantly higher in the Health & Homelessness Project period than the representative sample used in 2002.

<table>
<thead>
<tr>
<th>Locality</th>
<th>Health &amp; Homelessness Project</th>
<th>HHNA 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No of assessments (included in results)</td>
<td>% of total participants over all localities</td>
</tr>
<tr>
<td>Argyll &amp; Bute</td>
<td>128</td>
<td>36%</td>
</tr>
<tr>
<td>[Mid-Argyll &amp; Kintyre; Cowal &amp; Bute]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>85</td>
<td>24%</td>
</tr>
<tr>
<td>[Dumbarton &amp; Helensburgh; Lomond Area]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renfrewshire</td>
<td>73</td>
<td>20%</td>
</tr>
<tr>
<td>East Renfrewshire</td>
<td>70</td>
<td>20%</td>
</tr>
<tr>
<td>Inverclyde</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>356</td>
<td></td>
</tr>
</tbody>
</table>

Age and Gender of participants

The incidence of homeless people in the 16-34 age range reporting health problems was higher in the urban centres than in the rural localities (Fig 13).

A higher ratio of women to men was found in the urban localities.
People under the age of 16 are not included in the results. However, the number of under-16s noted on assessment forms suggests that a considerable number of participants were part of a homeless family. [Fig.14]
Fig. 15 shows the services participants approach if they are sick. This question was asked as part of the initial health assessment and therefore homelessness project nurses was not an optional answer.

Across all localities 295 (83%) of participants selected their GP as a current source of support but only 249 (70%) reported that they would go to their GP if they were sick. [Fig 15]

**Fig. 15: Use of services when sick**

![Pattern of use of services if sick - before project](Image)

**Referral / Linkage patterns**
Project nurses were asked to note all referrals and linkages made. A ‘referral’ in this context involved the nurse contacting a particular service on the patient’s behalf specifically to make an appointment. The nurse then provided related support to the patient at various levels including, if necessary, transporting the patient to the appointment and acting as advocate during the appointment. A linkage refers to instances when the nurse made contact with services to which the patient was already known, in order to help the patient re-engage with that service. Linkages did not necessarily entail arranging an appointment or accompanying the patient.

**Referrals**
Referral numbers were higher than numbers of people assessed in some areas. This suggests that multiple referrals were made for some clients.
Total referrals made by the project reached 147% of the total participant number. With the exception of the Lomond area, across all localities referrals were made for at least 50% of clients. This pattern of referrals suggests that, for the majority of homeless people in these areas the project nurses were addressing health/welfare needs that were not being met fully prior to the project health assessment, and that individual patients have more than one problem of sufficient severity/degree to warrant a referral.
**Mental Health**

Of all participants across all localities 133 (37%) reported 3 or more adverse mental health issues. This was taken as the working definition of poor mental health being a participant’s main problem.

Table 8 shows the number of people whose main problem related to poor mental health.

<table>
<thead>
<tr>
<th>Locality</th>
<th>Number of people assessed</th>
<th>* Number with 3 or more significant mental health issues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Argyll &amp; Bute</strong></td>
<td>128</td>
<td>48 (37%)</td>
</tr>
<tr>
<td>[Mid-Argyll &amp; Kintyre; Cowal &amp; Bute]</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>West Dunbartonshire</strong></td>
<td>85</td>
<td>37 (43%)</td>
</tr>
<tr>
<td>[Dumbarton &amp; Helensburgh; Lomond Area]</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Renfrewshire</strong></td>
<td>73</td>
<td>21 (29%)</td>
</tr>
<tr>
<td><strong>East Renfrewshire</strong></td>
<td>70</td>
<td>27 (39%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>356</td>
<td>133 (37%)</td>
</tr>
</tbody>
</table>

* Percentages are calculated in relation to the total number of people assessed in each area.

Fig. 17 shows the number of linkages and referrals made for those whose main problem related to their mental health.

**Fig. 17: Referrals & linkages for those whose main problem is mental health**

![Bar chart showing number of referrals and linkages for people with mental health issues.](chart.png)

- **People whose main problem was mental health: number of referrals and linkages**
  - No of cases: 133
  - No of linkages: 138
  - No of referrals: 191
Referrals
For 27 of the 133 people whose main problem was mental health, no referral was necessary. A further 6 people declined a referral. For the remaining 100 people, total of 191 referrals were made to a wide range of services.

Table 9: Referrals for those whose main problem is mental health

<table>
<thead>
<tr>
<th>Referral to</th>
<th>Number of people referred</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>23</td>
</tr>
<tr>
<td>CPN</td>
<td>20</td>
</tr>
<tr>
<td>Housing Assessment</td>
<td>18</td>
</tr>
<tr>
<td>Homeless Team</td>
<td>17</td>
</tr>
<tr>
<td>Dentist</td>
<td>12</td>
</tr>
<tr>
<td>Citizen’s Advice Bureau</td>
<td>9</td>
</tr>
<tr>
<td>Independent adviser on housing</td>
<td>10</td>
</tr>
<tr>
<td>Welfare rights</td>
<td>8</td>
</tr>
<tr>
<td>Hospital out-patient</td>
<td>7</td>
</tr>
<tr>
<td>Social work</td>
<td>6</td>
</tr>
<tr>
<td>Family planning</td>
<td>6</td>
</tr>
<tr>
<td>Counselling</td>
<td>5</td>
</tr>
<tr>
<td>Addiction services</td>
<td>4</td>
</tr>
<tr>
<td>Women’s Aid</td>
<td>3</td>
</tr>
<tr>
<td>Health Visitor</td>
<td>3</td>
</tr>
<tr>
<td>Shelter</td>
<td>3</td>
</tr>
<tr>
<td>Islay Healthy Living</td>
<td>3</td>
</tr>
<tr>
<td>Hospital admission</td>
<td>3</td>
</tr>
<tr>
<td>Adult literacy</td>
<td>2</td>
</tr>
<tr>
<td>Anger management</td>
<td>2</td>
</tr>
<tr>
<td>Optician</td>
<td>2</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>2</td>
</tr>
<tr>
<td>Bereavement counselling</td>
<td>2</td>
</tr>
<tr>
<td>Blue Triangle</td>
<td>2</td>
</tr>
<tr>
<td>Causeway</td>
<td>2</td>
</tr>
<tr>
<td>Quarriers Project</td>
<td>2</td>
</tr>
<tr>
<td>Debt counsellor</td>
<td>2</td>
</tr>
<tr>
<td>BBV</td>
<td>1</td>
</tr>
<tr>
<td>Chiropodist</td>
<td>1</td>
</tr>
<tr>
<td>Consultant Public Health</td>
<td>1</td>
</tr>
<tr>
<td>Practice Nurse</td>
<td>1</td>
</tr>
<tr>
<td>Police</td>
<td>1</td>
</tr>
<tr>
<td>Physiotherapy department</td>
<td>1</td>
</tr>
<tr>
<td>Mother &amp; Baby clinic</td>
<td>1</td>
</tr>
<tr>
<td>Help Project</td>
<td>1</td>
</tr>
<tr>
<td>Healthy Living Initiative</td>
<td>1</td>
</tr>
<tr>
<td>District Nurse</td>
<td>1</td>
</tr>
<tr>
<td>Voluntary work</td>
<td>1</td>
</tr>
<tr>
<td>Education department</td>
<td>1</td>
</tr>
<tr>
<td>Family Matters Project</td>
<td>1</td>
</tr>
</tbody>
</table>

Total no of referrals made 191
48% of people referred required more than one referral. The highest number of referrals made for any one person was 9. These included a referral to each of the following: addiction services, Citizens Advice Bureau, counselling, CPN, GP, hospital admission, hospital outpatient, housing assessment, and Shelter.

The most frequently made referrals were to GPs, Community Psychiatric Nurses, housing assessment and to the homeless team.

**Linkages**

Of the 133 people whose main problem was mental health, linkages were made for 78 people. Of these, 40 (51%) required more than one linkage. A total of 138 linkages were made.

The highest number of linkages made for any one person whose main problem was mental health was 6. These included links to: the community mental health team, social services, maternity services, psychiatrist, hospital, and relatives. The most frequent linkages made were to: the community mental health team, housing, social work, and GP.

<table>
<thead>
<tr>
<th>Linkage with</th>
<th>Number of people linked</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHMT</td>
<td>27</td>
</tr>
<tr>
<td>Housing</td>
<td>26</td>
</tr>
<tr>
<td>Social Work</td>
<td>17</td>
</tr>
<tr>
<td>GP</td>
<td>13</td>
</tr>
<tr>
<td>Hospital</td>
<td>8</td>
</tr>
<tr>
<td>Health Visitor</td>
<td>8</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>7</td>
</tr>
<tr>
<td>Addiction services</td>
<td>5</td>
</tr>
<tr>
<td>Maternity services</td>
<td>5</td>
</tr>
<tr>
<td>Help Project</td>
<td>5</td>
</tr>
<tr>
<td>Counselling</td>
<td>2</td>
</tr>
<tr>
<td>Paisley Threads</td>
<td>2</td>
</tr>
<tr>
<td>Police</td>
<td>2</td>
</tr>
<tr>
<td>Relatives</td>
<td>2</td>
</tr>
<tr>
<td>Women’s Aid</td>
<td>2</td>
</tr>
<tr>
<td>Bereavement Counselling</td>
<td>1</td>
</tr>
<tr>
<td>Blue Triangle</td>
<td>1</td>
</tr>
<tr>
<td>Harm reduction</td>
<td>1</td>
</tr>
<tr>
<td>Housing Dept B&amp;B Project</td>
<td>1</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>1</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>1</td>
</tr>
<tr>
<td>Quarriers</td>
<td>1</td>
</tr>
</tbody>
</table>

**Total no of linkages made** 138
Mental health: addictions

Given the prevalence of mental health issues, chaotic lifestyle, and the high level of alcohol and drug misuse amongst homeless people it was difficult to assess the level of drug addiction amongst the participants. 161 people (45% of all participants) reported a mental health problem relating to addiction (this figure includes those whose main problem was mental health and included addiction issues). Fig. 18 shows how this was spread across localities and by gender.

Fig.18: Number reporting a mental health problem relating to addiction

![Number reporting addictions as a mental health problem](image)

Of the 161 participants who reported a mental health problem related to addiction, 134 required referrals. 66 required more than one referral. 17 declined referrals. 265 separate referrals were made.

118 required linkages. 61 people required more than one linkage.

While the main focus of this report relating to addictions is drug addiction, addiction to alcohol also presented a problem for many. Fig.19 shows the number of people who answered positively to 3 or more questions on their drinking suggesting that it was problematic.

Fig.19: Number reporting problematic alcohol use
Answered positively to 3 or more questions on alcohol; % over whole project area
Drug misuse
Participants were asked to report which illegal drugs they had taken over the last three months. Cannabis was the most commonly used drug across all localities (109 users), followed by heroin (50), cocaine (41) and amphetamines (41). The urban areas show a higher incidence of drug use with a wider range of drugs being used. [Fig 20]

Fig.20: Range of drugs used across localities

Other drugs reported to be used across all localities included ‘Special K’ [Ketamine] (1 user), Ecstasy (1) and Diazepam (22).
The pattern of recent drug use across localities suggests a higher level of illegal drug use than the figure for those who were noted as having addiction issues in the mental health assessment (161). Recent use of a drug does not necessarily imply problematic addiction and the pattern of drug taking can be varied across all participants and on an individual basis. For example, one participant reported using 6 different substances at one time or another.

**People who have ever injected drugs: referrals**
A total of 41 people reported that they had injected illegal drugs at one time. For 8 of them no referral was thought necessary. 66 referrals were offered; 3 were declined. Table 11 shows the range of referrals made for those who had ever injected drugs.
### Table 11: Pattern of referrals – people who have ever injected drugs

<table>
<thead>
<tr>
<th>Referral to</th>
<th>Number of people referred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals offered but declined</td>
<td>3</td>
</tr>
<tr>
<td>GP</td>
<td>7</td>
</tr>
<tr>
<td>Addiction services</td>
<td>7</td>
</tr>
<tr>
<td>Dentist</td>
<td>6</td>
</tr>
<tr>
<td>Housing Assessment</td>
<td>5</td>
</tr>
<tr>
<td>CPN</td>
<td>4</td>
</tr>
<tr>
<td>Family Planning</td>
<td>4</td>
</tr>
<tr>
<td>Hospital</td>
<td>4</td>
</tr>
<tr>
<td>Homeless Team</td>
<td>3</td>
</tr>
<tr>
<td>Anger management</td>
<td>2</td>
</tr>
<tr>
<td>Causeway</td>
<td>2</td>
</tr>
<tr>
<td>Citizen’s Advice Bureau</td>
<td>2</td>
</tr>
<tr>
<td>Blood Borne Virus testing</td>
<td>2</td>
</tr>
<tr>
<td>Women’s Aid</td>
<td>2</td>
</tr>
<tr>
<td>Welfare rights</td>
<td>2</td>
</tr>
<tr>
<td>Practice Nurse</td>
<td>1</td>
</tr>
<tr>
<td>Link club</td>
<td>1</td>
</tr>
<tr>
<td>Smoking cessation</td>
<td>1</td>
</tr>
<tr>
<td>Debent counseling</td>
<td>1</td>
</tr>
<tr>
<td>Chiropodist</td>
<td>1</td>
</tr>
<tr>
<td>Independent housing</td>
<td>1</td>
</tr>
<tr>
<td>Child</td>
<td>1</td>
</tr>
<tr>
<td>Social work</td>
<td>1</td>
</tr>
<tr>
<td>GUM Clinic</td>
<td>1</td>
</tr>
<tr>
<td>Adult literacy</td>
<td>1</td>
</tr>
<tr>
<td>P2W</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total referrals offered/made</strong></td>
<td><strong>66</strong></td>
</tr>
</tbody>
</table>

15 (37%) of those who had ever injected drugs required more than one referral. Two participants required 5 referrals each (Table 12)

### Table 12: referral patter for those with 5 or more

<table>
<thead>
<tr>
<th>Referral to</th>
<th>Addiction service</th>
<th>Housing</th>
<th>Anger Management</th>
<th>Smoking</th>
<th>Family planning</th>
<th>CPN</th>
<th>GP</th>
<th>Causeway</th>
<th>Social work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant 1</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participant 2</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
People who had ever injected drugs: linkages

Of the 41 people who had ever injected drugs, 29 required linkages. 59 separate linkages were made for people who had ever injected drugs. 20 people required more than one linkage. One person required 6 separate linkages. These included links to: relatives, community mental health team, maternity services, psychiatrist, social work and addiction services.

Table 13 shows the range of linkages made for those who had ever injected drugs

<table>
<thead>
<tr>
<th>Linkage to</th>
<th>Number of people linked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addiction services</td>
<td>20</td>
</tr>
<tr>
<td>CMHT</td>
<td>7</td>
</tr>
<tr>
<td>Housing Services</td>
<td>6</td>
</tr>
<tr>
<td>Social work</td>
<td>6</td>
</tr>
<tr>
<td>Children 1st</td>
<td>2</td>
</tr>
<tr>
<td>Harm reduction</td>
<td>2</td>
</tr>
<tr>
<td>GP</td>
<td>2</td>
</tr>
<tr>
<td>Maternity services</td>
<td>2</td>
</tr>
<tr>
<td>Hospital</td>
<td>2</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>2</td>
</tr>
<tr>
<td>Quarriers</td>
<td>2</td>
</tr>
<tr>
<td>RAMH</td>
<td>2</td>
</tr>
<tr>
<td>Health Visitor</td>
<td>1</td>
</tr>
<tr>
<td>Relatives</td>
<td>1</td>
</tr>
<tr>
<td>Women’s Aid</td>
<td>1</td>
</tr>
<tr>
<td>Housing Dept B&amp;B project</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>59</strong></td>
</tr>
</tbody>
</table>

People who currently inject drugs: referrals

18 participants reported currently injecting illegal drugs. A total of 32 separate referrals were made. 15 people required at least one referral and 7 required more than one referral. Referrals were made to GP (6), addiction services (4), dentist (4), family planning (3), BBV testing (2) and one each to Blue Triangle, housing services, Causeway, Citizens Advice Bureau, CPN, GUM clinic, and welfare rights. Two people declined a referral. Three participants required 4 referrals each. [Table 14]
For those currently injecting drugs (n=18), a total of 15 linkages were made for 11 different people. 10 linkages were to addiction services. The remaining 5 were to social work (2), harm reduction (1), housing (1) and psychiatrist (1).

**Drug use / harm reduction**

Of these 41 people who had ever injected drugs, 19 had attended harm reduction services.

![Fig.22: Those who have injected drugs and harm reduction](image-url)
Of those currently injecting drugs (n=18), 13 reported attending harm reduction services. [Fig.23]

Fig.23: Those who currently inject drugs and harm reduction

Figures show that in West Dunbartonshire & Helensburgh a relatively high percentage of homeless people have at one time shared drug injection needles but have not been tested for blood borne viruses (BBV) such as HIV and Hepatitis C.[Fig.24] Despite its relatively high level of injecting drug users and needle sharing practices, no referrals in relation to BBV were made by project nurses in Dunbartonshire & Helensburgh.
Fig. 24: Drug use and BBV testing

Drug users have used other’s works
Drug users currently injecting
Drug users BBV testing
Case studies

The following case studies were taken from the notes of project nurses. They were selected at random from case notes by the project nurses or the project administrator.

Argyll & Bute

Case 1.

Aged 49 this man was homeless due to marriage breakdown and was referred by the Homeless Persons Officer in Campbeltown. His long-term health problems included anxiety/depression, addictions and panic attacks. He also indulged in relatively problematic alcohol use.

He had a GP and was receiving medication at the time of his assessment. He smoked cigarettes and cannabis. He also received support from family, addictions counsellor, money advice and Blue Triangle.

The project nurse referred him to the CPN and addiction services. In addition, health advice and support from the project nurse remains ongoing. This is mainly in the form of dietary advice but the nurse has also referred him on to the voluntary sector to do voluntary work.

The nurse held his case with regular visits for 14 months until he got a secure tenancy after which the nurse’s role was over.

Case 2

Aged 56 this man had been homeless for 12 months when he was referred by a Housing Officer.

He had come to the area to live with sister after being involved in a house fire where he suffered serious burns. He has 80% burns, keloid scars and a skin graft site. He also suffered significant lung damage from the fire. He has regular medication including inhalers. He also suffers long-standing addiction and anxiety problems. Although a trained nurse, he can no longer work.

He has now moved from his sister’s house into temporary accommodation but is very anxious about living alone. He has good domestic skills and has family support.

He attended the burns unit at Glasgow Royal Infirmary regularly and is supported financially by the NHS to fly regularly from his town of residence to Glasgow for appointments. The nurse referred him to the Clinical Psychologist attached to the burns unit in relation to Post Traumatic Stress. The nurse also linked him into smoking cessation, a computer course and into pension advice. The nurse continues to visit him and he is doing well.
Case 3

This man is aged 50. He is divorced with 2 non-resident children. He was referred by the nurse by ACHA.

He had previously lived in the Middle East (for 15 years) but now lives in the Argyll & Bute area in a rented caravan. The caravan was being sold making him homeless.

His health problems included high blood pressure and a sore back. He was receiving no medication. He has a good diet. He smokes 20 a day but does not take or drink alcohol. He is a teacher and working.

He was in debt through credit card use. The nurse referred him on to debt management and Islay HLI for his back, smoking cessation and relaxation.

Nurse involvement is ongoing until he gets a secure tenancy.

Renfrewshire

Case 4

This woman, aged 27 has been homeless for 8 months because family members are no longer able or willing to put her up. She was referred by Renfrewshire Council Housing Department Support Officer.

She has significant mental health problems including a personality disorder; addictions and suicidal thoughts. She has no significant physical problems. She was being prescribed tranquillisers and anti-depressants. She smokes more than 30 a day.

She was already linked into community addictions nurse at Renfrewshire drug service. The project nurse made no referrals but did provide support over several visits to help her engage more fully with services.

Case 5

This man was 28. Homeless since the age of 19 because his parents were no longer willing or able to support him. He has lived rough on and off since the age of 15. He was living in a B&B and was referred by Renfrewshire Housing Department.

He had a long-standing history of addictions and depression but was on no regular medication. He smokes cigarettes and heroin. He had a GP but hadn’t seen a dentist in over 1 year. He is dyslexic.

He was in debt to a drug dealer and had a pending court appearance. When he saw the nurse he declined any offer of help and didn’t want to address drug issues. However, one week later came back to project and asked to speak to the
nurse he first saw, who was not there at that time. When the nurses tried to contact him in the following days, he could not be found. No word since.

West Dunbartonshire

Case 5

This single man took timeout of university to travel before coming back to the council area of his birth looking for accommodation. He had some health issues and was happy to be referred to the nurse. He presented with strange health issues. Although everything was seemingly straightforward at first, it turned out that he had been in jail both while abroad and in Britain. His crime related to the possession of drugs but he had ended up in a forensic psychiatry unit. Homeless officer thought it best for the nurse to be accompanied when seeing him. Hospital records confirmed that he had been very violent in prison which had led to his transfer to forensic psychiatry unit.

He wanted his mental health taken into account in his housing application. He got a house but further info given to the nurse from a hospital abroad suggested that he had a persecution complex and was a regular drug user.

Case 6

This woman was originally from the islands but was now living in army housing in Helensburgh. Her husband ended the marriage and left and she became depressed. The nurse tied her in with her GP but continued to see her. It transpired that there were issues of child abuse involved and the woman was offered counselling through her GP which she accepted. She was re-housed within the area.

Case 7

This man in his late 40s had had a successful working career at one time. His marriage fell apart due to his drinking. Financial problems ensued. He lost his house and his health deteriorated considerably. He now has number of alcohol related illnesses. He is living in supported accommodation but presents problems as he is prone to violence and has assaulted staff. If he is evicted from there he will be on the streets. The state of his personal hygiene is such that he is unwelcome anywhere. His physical health is in great jeopardy and the prospect of his being evicted from supported accommodation causes the nurse concern. This case is ongoing.

Case 8

This man was a businessman some years ago but developed problems with alcohol when his marriage broke up. He was described by the nurse as ‘drinking himself to death’. He has a history of physical abuse to his children and so his family now keep distant from him. He himself is subject to a lot of violence from people in his area, exacerbated by his problematic drinking. He keeps moving address but continues to be in the line of violent abuse and has suffered a number of serious head injuries as a result. He is under the care of the community addiction team. The nurse has strengthened this link and works
hand-in-glove with the social work to support the man as and when he becomes homeless.

*Case 9*
This man in his mid-30s started using drugs and alcohol at the age of eight. He eventually became homeless and threatened to kill himself by jumping off into a local quarry. The nurse reconnected him with the local addiction team and he got into rehab. He was there for a year but when he came out for a couple of days he drank vodka and ended up in intensive care. He takes seizures and his health is such that if he drinks or takes drugs any longer it is likely to kill him. He has now been resettled in supported accommodation. The nurse expects to see him only a couple more times as he is now coping well with living independently. It is hoped he will be given a secure tenancy in the near future. The nurse, along with social work and housing officers, has tried to discourage him from returning to his home area where his connections are mainly through illegal drug-related practices.

*Case 10*
This woman in late-30s to early 40s was very badly physically abused by her stepfather as a child as were her mother and siblings. By the age of 15 she had attempted suicide 15 times. Her life is now chaotic. She had social work, drug service, and CPN input but was involved with a partner who was heavily involved in heroin use and distribution. He is currently in jail. The woman is also a serious heroin user. She drops in to see the nurse quite regularly. Suicide is a constant possibility. The nurse continues to speak with her regularly.
Discussion

The findings of the Nurses for Homeless People Project suggest that the work of the project nurses successfully addressed health needs that were hitherto unmet. While the numbers of participants was small in relation to the total number of homeless presentations made to the local authorities, for those with health problems the project nurse played a crucial role in facilitating access to health and social services needed for increased well-being. The value of the nurse’s activities was demonstrated in the high number of referrals and linkages required by participants.

Prior to the nursing posts, local authority housing officers were often the first, main, and sometimes only, points of contact utilised by homeless people with a health problem. It was often incumbent upon them to assess a person’s state of health and make decisions about appropriate referrals. This they had to do from a lay perspective. Under these circumstances, many homeless people did not previously receive health advice that was underpinned by professional training and experience. Nor did they benefit from the advocacy work that was integral to the nurses’ approach.

As more than one nurse explained, homelessness often impacts on priorities to the point where health and welfare are diminished in importance compared to the keenly felt need for stable accommodation. For most homeless people, the focus on being homeless is uppermost and poor health is given low priority: in some cases it is barely recognised at all. Hence, the chaotic lifestyle associated with addiction or poor mental health is often perceived by those who live it to be a result of their homelessness rather than a contributory factor to it. This may have contributed to the discrepancy between the perceived high level of mental health and addiction problems reported by nurses anecdotally and the level reflected in the results. The former perception could be formed over time and after developing more in-depth relationships with clients; the latter reflects self-reporting by clients and/or judgements made in response to particular health assessment questions which may not have captured the complexity of people’s lives or their specific health needs.

The list of referrals, linkages and the case studies illustrate that nurses saw the need for clients to access services beyond those directly related to health in order to address extant health issues. This underlines the complex nature of health problems experienced by the homeless.

Results show that in all localities mental health was reported as being the main problem for around one third of participants and addiction as the main problem for around one third to one half of participants. In West Dunbartonshire there was a considerably higher proportion of people with mental health problems reported than in the 2002 Homeless HNA, in Renfrewshire and East Renfrewshire the proportion was almost the same as in the HNA, and in Argyll & Bute it was considerably lower. While this may well reflect a realistic picture of the areas, it may be that the reporting of mental health issues in this project was
skewed to some extent by the experience and practice of the nurses. For example, the nurse in Cowal & Bute was an experienced CPN and, in the absence of adequate psychiatric services in the area, took on a considerable amount of clinical nursing work in relation to homeless clients with mental health problems. In cases where poor mental health was mild or moderate she offered initial counselling as an alternative to referral to local psychiatric services. Hence, many of these people were not represented in referral or linkage statistics despite having mental health needs.

Across the whole project area, referrals and linkages for people with mental health problems exceeded the number of clients seen by nurses indicating that homeless people with mental health problems were not accessing services appropriately prior to the project. 80% required a referral and almost one half (48%) required more than one referral across a wide range of services. Around 40% required encouragement to re-engage with services they had used in the past. The wide range of health and welfare services implicated in referrals and linkages indicates that homeless people with mental health problems who participated in this project had multiple needs relating to both health and social welfare. The fact that they required active support from the nurse to enable them to access services upholds the assertion that the route to services is not always appropriate to their needs.

Of those who were reported as having an addiction problem 83% required a referral and 73% required linkages. While for some of these people, addiction defined their poor mental health, for others it was one of a number of issues affecting mental health ranging from anxiety to complex personality disorders or severe mental illness. The fact remains that each required the services of the nurse to enable them not only to recognise their need for professional services but also to actively support them in accessing them successfully.

Drug use over the whole project area was widespread with cannabis being the most widely and commonly used drug. Heroin was used across all localities but was most prevalent in the urban areas. However, total numbers of people who reported injecting drugs were surprisingly low. Anecdotal evidence from nurses suggested a very high proportion of problematic drug use (usually associated with heroin) across the whole project that is not reflected in the figures. It is difficult to assess why this is the case. As suggested above, it may be that nurses gained a truer insight into the lives of their clients after the initial assessment and that the figures, taken from the assessments, do not then reflect the actual activities required of the nurses. That said, and with the figures available, this report focussed only on injecting drug use on the basis that it is most likely to be of greatest risk to health, not least because of needle use and sharing practices. Amongst the rural localities, Mid-Argyll & Kintyre had the highest number of injecting heroin users yet recorded a nil score for people on Methadone programmes. A small number in this locality who had ever injected drugs were reported as having attending harm reduction services and current injectors did not attend harm reduction services at all. In interviews nurses commented on the fact that GPs in this area are resistant to involvement in Methadone prescribing and rehabilitation places are few and difficult to secure. This lack of mainstream drug addiction services suggests that a homelessness nursing service providing advice and referrals to services outwith the area if required fills a gap for a vulnerable group of drug users.
The particular character of the homelessness nurse was her unique identity as both health professional and advocate for the homeless on a range of issues. Whether physically based in a housing office or not, all nurses built strong links with housing officers that facilitated reciprocal access amongst homeless clients and nurses. When this was less successful (e.g. in the early stages in Renfrewshire) referrals were not forthcoming and potential benefit to homeless people missed. The complex nature of the needs of homeless people who experience ill health also necessitated close links with a range of other agencies. Shared working of this kind underpinned the nurses’ work and is reflected in the spread of referrals and linkages made by them. Co-operative working was key to improving access to services for homeless people. Findings reported here suggest that project nurses exploited their unique position to encourage co-operative working of this kind.

Conclusions.

This project has allowed nurses dedicated to one group in society with multiple and complex needs, namely homeless people, very largely referred to them by non-health service staff, to meet the unmet needs of this group by improved access to health care. Health care service was regarded very broadly as any service which could improve the homeless individual’s well-being, as health and well-being are indivisible. They have achieved this by first agreeing on the problems with their clients/patients, and then achieving the support, advocacy and co-operation with an enormous range of services, required to meet those needs.

To that extent, it may be deemed to have been a success. Whether it is a cost-effective method of meeting the needs of people whose problems are multiple and complex, this study had neither the capacity nor the objective of deciding.

However, it is clear that homeless people, besides the stigma from which they may suffer, not least from services, have their ambitions for their health and well-being adversely skewed by their circumstances. Some of the very necessary advocacy needs to be directed at themselves to build self-esteem, as well as at any of the agencies with some of the skills to meet some of their needs. A vital part of this is the development of trust between client and nurse. There are examples throughout this project where a fuller appreciation of the individual’s circumstances was not reached until some long time after initial contact. And at least one example of an individual lost to follow-up, because the nurse was not there when he decided to come back. Developing such trust takes a long time and consistent input from the worker.

An equally vital part of this was the skilful co-ordinating role to provide all the appropriate interventions timeously.

It is without doubt that an important factor in this work was the characteristics and personalities of the nurses involved, and this was a specific piece of time-limited work, so it may not be wise to place too much reliance on its reproducibility.
But it is very important to bear in mind that homeless people are but one, fairly small, group of people with multiple and complex needs in our society. Others include those who experience any one of a number of discriminations, sufferers of domestic violence, prisoners on discharge, the unemployed, and the rapidly growing group of the very elderly, to mention but a very few of such groups.

It is unlikely that the statutory or voluntary services will be able to reproduce specialist, but comprehensive, services for each of these, and all the other similar, client groups, whether in inner cities or in remote, rural or island locations. If that is the conclusion, then the implications for the way services, especially for that majority group amongst clients who experience multiple and complex needs, are planned and provided, are very profound. Meeting these sorts of needs is much more complex, difficult and challenging than providing a mono-specialist service for the fairly small numbers of people who have only one thing wrong at a time.

**Recommendations**

1. That to meet the multiple needs of people who have several serious problems at once, not all of them strictly medical, it is necessary to assess those needs comprehensively, which takes trust, time and continuity, and to link the individual to all the Services appropriate in a timeous fashion.

2. That to determine whether or not such co-ordination is better performed by (yet another) team of specialist workers, is beyond the scope of this study. All that can be said is that in this context, using such a team, it is possible.

3. This study has shown that the degree of beneficial joint working engendered was very much appreciated by partners and, in particular, the Homeless Persons’ Officers of Local Authorities, who were able to refer direct to, and build relationships with, the Nurses.

4. This work, with a clientele possessing Multiple and Complex Needs, may be better done by co-ordinating existing Services, rather than establishing a specialist team with that as its remit. However, such is the resistance of existing specialist services, each performing its own function, and showing commitment to “its” patients/clients, that that would require a very major cultural shift in all statutory services, and in most voluntary sector services. The difficulties of changing services to do this well should not be underestimated.

5. Much more research is needed, if there is to be a firm “evidence base” here. The resources (particularly economic expertise) need to be devoted to establishing robust cost/effectiveness and cost/benefit trials over a period long enough to establish trust with these clients, and to allow outcomes to be evaluated properly in the health field. Simply achieving a tenancy certainly does not mean the well-being needs of these people have been met. If at all possible, such trials should have properly designed control groups. Some of this could, with benefit, be action research.
References


NHS Argyll and Clyde (2002b) Health and Homelessness Needs Assessment

Scottish Executive (2003), 'Partnership for Care': Scotland's Health White Paper


Appendix 1

Health Assessment Form

CONFIDENTIALITY

The information you give to the nurses, and recorded here will remain confidential within the Health Service. We will not share or disclose any of this information to anyone else without your written consent, unless we are legally obliged to (as for instance, where the welfare of children may be at risk.)

SECTION 1 - Personal details

1.1 Date referred

1.2 Source of referral

1.3 Client’s name

1.4 Date of Birth

1.5 National Insurance No.

1.6 Address (if relevant) include NFA & Rough sleeping & c/o
1.7 Postcode

1.8 Gender

1.8.1 [ ] Male 1.8.2 [ ] Female

1.9 Family composition

1.9.1 Number in homeless family unit 

1.9.2

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age</th>
<th>Nurseries / schools attended</th>
<th>Relationship</th>
<th>Due date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Partner

- Children under 6
- Children 6 -16
- Dependent elderly (60+)
- Non-dependent elderly (60+)
- Non-family carer
- Anyone under 21 who has been ‘looked after’
- Other family members in group
- No of children <16
- No of children not with household
- Member of household pregnant

1.10 Ethnicity & Nationality - What is your ethnic origin?

1.10.1 [ ] White
1.10.2 [ ] Indian, Pakistani or Bangaladeshi
1.10.3 [ ] Black or Afro-Carribean
1.10.4 [ ] Chinese
1.10.5 [ ] Mixed
1.10.6 [ ] Other
1.10.7 [ ] No answer

1.11 What is your nationality?

1.11.1 [ ] Scottish
1.11.2 [ ] Other British
1.11.3 [ ] Other (specify)
1.11.4 [ ] No answer
1.11.5 If your preferred language is not English, please specify another:

SECTION 2 - Homelessness situation

2.1 How long have you been homeless?  

2.2 Have you applied to any Council/Local authority as homeless in the past 3 years?  
   2.2.1 Yes ☐  2.2.2 No ☐

2.3 How many times?  

2.4 What was your last settled address?  
   [including postcode]  

2.5 Dates from  
   ....../....../....  to  ....../....../....

2.6 Which towns have you stayed in or near in the last 3 months?  
   [start with most recent]  

2.7 Have you yourself ever been of residential looked-after status (‘in care’)?  
   2.7.1 ☐ Yes  2.7.2 ☐ No

2.8 Immediate reasons for homelessness [tick all that apply].
   2.8.1 ☐ parents no longer able or willing
   2.8.2 ☐ other family members no longer able or willing
   2.8.3 ☐ friends no longer able or willing
2.8.4 dispute with partner – violent/abusive
2.8.5 dispute with partner – non-violent/abusive
2.8.6 dispute with parents/family - violent/abusive
2.8.7 young person affected by domestic abuse
2.8.8 loss of Council tenancy – arrears
2.8.9 loss of Council tenancy – ASB
2.8.10 loss of Council tenancy – other
2.8.11 loss of RSL tenancy – arrears
2.8.12 loss of RSL tenancy – ASB
2.8.13 loss of RSL tenancy – other
2.8.14 loss of private tenancy – arrears
2.8.15 loss of private tenancy – ASB
2.8.16 loss of private tenancy – other
2.8.17 mortgage default
2.8.18 other debt
2.8.19 forced division – sale of house
2.8.20 loss of service tenancy (‘tied house’)
2.8.21 expiry of short assured tenancy
2.8.22 emergency – fire, flood, storm, etc.
2.8.23 accommodation BTS
2.8.24 discharge from prison
2.8.25 discharge from hospital
2.8.26 discharge from armed forces or merchant navy
2.8.27 left residential ‘looked after’ status
2.8.28 loss of hostel/lodgings
2.8.29 gave up secure accommodation
2.8.30 overcrowding
2.8.31 harassment – racial
2.8.32 harassment – other
2.8.33 fleeing external, non-domestic violence/abuse
2.8.34 not reasonable to occupy
2.8.35 asylum seeker/refugee
2.8.36 choice
2.8.37 other (specify)
SECTION 3 - Health

3.1 Do you have an illness or disability which is:

3.1.1 longstanding (over 3 months)
3.1.2 short term (under 3 months)
3.1.3 none

3.2 If you have significant mental health problems, are they:

3.2.1 anxiety
3.2.2 bi-polar disorder
3.2.3 depression
3.2.4 psychosis or schizophrenia
3.2.5 addictions
3.2.6 self-harming
3.2.7 ever felt suicidal
3.2.8 other (specify) [ ]

Physical health

3.3 If you have significant physical health problems, are they:

3.3.1 asthma
3.3.2 allergies
3.3.3 diabetes on tablets
3.3.4 diabetes on insulin
3.3.5 bronchitis (recurring chest infections)
3.3.6 tuberculosis (TB)
3.3.7 epilepsy or fits
3.3.8 Hepatitis
3.3.9 Hep B
3.3.10 Hep C
3.3.11 HIV
3.3.12 persistent headaches
3.3.13 foot problems
3.3.14 skin bladder, kidney or urinary problems
3.3.15 persistent problems, wounds or sores
3.3.16 high blood pressure - state figure
3.3.17 angina
3.3.18 other heart problems
3.3.19 eye problems
3.3.20 deafness
3.3.21 problems with teeth or gums
3.3.22 problems with periods, including menopausal problems
3.3.23 stroke (‘shock’)
3.3.24 joint, muscular or skeletal problems
3.3.25 limb amputation
3.3.26 bowel problems
3.3.27 stomach ulcers
3.3.28 others (specify)

3.4. Prescribed medicines
If you take these do they include:
3.4.1 blood pressure tablets
3.4.2 angina spray
3.4.3 pain killers
3.4.4 aspirin
3.4.5 sleeping pills
3.4.6 tranquillisers
3.4.7 prescribed methadone and
3.4.8 is your methadone dispensed daily
3.4.9 antidepressants
3.4.10 inhalers for chest problems
3.4.11 List any others

3.5 Health service attendance
In the last year have
3.5.1 been to casualty or A&E
3.5.2 been to a general outpatient clinic
3.5.3 spent 1 or more night in a general hospital
3.5.4 been to a psychiatric or psychology outpatient clinic
3.5.5 spent 1 or more night in a psychiatric unit
3.5.6 been in contact with a community mental health team
3.5.7 been in contact with drug agencies
3.5.8 been in contact with alcohol agencies
3.5.9 been in touch with services for sexually transmitted diseases
3.5.10 General practitioner
3.5.11 Practice nurse

3.6 Do you smoke?

3.6.1 Yes ☐ (go to 3.8) 3.6.2 No ☐ (go to 3.7)

3.7 Have you ever smoked?

3.7.1 Yes ☐ 3.7.2 No ☐

3.8 How many cigarettes daily?

3.9 Do you normally smoke other ways, e.g. pipe, cigars, etc.?

3.9.1 Yes ☐ 3.9.2 No ☐

3.10 Do you drink alcohol?

3.10.1 Yes ☐ 3.10.2 No ☐

If yes, have:
- you ever been advised to cut down?

3.10.3 Yes ☐ 3.10.4 No ☐

- people ever annoyed you by criticising your drinking?

3.10.5 Yes ☐ 3.10.6 No ☐

- you ever felt bad or guilty about your drinking?

☐
3.10.7 Yes ☐ 3.10.8 No ☐
- you ever had a drink to steady your nerves, get rid of a hangover?

3.10.9 Yes ☐ 3.10.10 No ☐
- you ever had a drink first thing in the morning?

3.10.11 Yes ☐ 3.10.12 No ☐

3.11 If over the last 3 months you have used illicit drugs, which drugs and by what route?

<table>
<thead>
<tr>
<th>Drug</th>
<th>Oral</th>
<th>Smoke</th>
<th>Inject</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>3.11.1 ☐</td>
<td>3.11.2 ☐</td>
<td>3.11.3 ☐</td>
</tr>
<tr>
<td>Other opiates (e.g. Tems/DFS)</td>
<td>3.11.4 ☐</td>
<td>3.11.5 ☐</td>
<td>3.11.6 ☐</td>
</tr>
<tr>
<td>Methadone (not prescribed)</td>
<td>3.11.7 ☐</td>
<td>3.11.8 ☐</td>
<td>3.11.9 ☐</td>
</tr>
<tr>
<td>Cocaine</td>
<td>3.11.10 ☐</td>
<td>3.11.11 ☐</td>
<td>3.11.12 ☐</td>
</tr>
<tr>
<td>Amphetamines (e.g. speed/ecstacy)</td>
<td>3.11.13 ☐</td>
<td>3.11.14 ☐</td>
<td>3.11.15 ☐</td>
</tr>
<tr>
<td>Cannabis</td>
<td>3.11.16 ☐</td>
<td>3.11.17 ☐</td>
<td>3.11.18 ☐</td>
</tr>
<tr>
<td>Others (specify)</td>
<td>3.11.19 ☐</td>
<td>3.11.20 ☐</td>
<td>3.11.21 ☐</td>
</tr>
</tbody>
</table>

3.12 Do you currently inject drugs?

3.12.1 Yes ☐ 3.12.2 No ☐

Have you ever injected drugs?

3.12.3 Yes ☐ 3.12.4 No ☐
Have you ever used someone else’s ‘works’?

3.12.5 Yes ☐ 3.12.6 No ☐

Do you attend a harm reduction service (needle & syringe exchange)?

3.12.7 Yes ☐ 3.12.8 No ☐

SECTION 4 – Social

4.1 Work. Are you:

4.1.1 ☐ in paid work or self-employed – full time
4.1.2 ☐ in paid work or self-employed – part time (less than 30 hours)
4.1.3 ☐ unemployed and seeking work
4.1.4 ☐ temporarily sick or injured but otherwise intending to seek work
4.1.5 ☐ permanently sick or disabled
4.1.6 ☐ retired
4.1.7 ☐ looking after family full time
4.1.8 ☐ going to school, college or university
4.1.9 ☐ on another training course or apprenticeship
4.1.10 ☐ doing something else

4.2 Qualifications?

4.2.1 ☐ none
4.2.2 ☐ school leaving certificate
4.2.3 ☐ Standard Grades/GCSEs
4.2.4 ☐ Highers / A Levels
4.2.5 ☐ SVQ etc
4.2.6 ☐ professional diploma
4.2.7 ☐ time-served apprentice
4.2.8 ☐ university degree or diploma

4.3 Literacy and language.
Do you have problems with:
4.3.1 □ reading
4.3.2 □ writing
4.3.3 □ numbers
4.3.4 □ Do you need a translator. If so, which language?

4.4 Status. Are you:
4.4.1 □ single or never married
4.4.2 □ cohabiting, living with partner
4.4.3 □ married
4.4.4 □ separated
4.4.5 □ widow/widower
4.4.6 □ divorced
4.4.7 □ Other (specify)

4.5 Sexual health
Are you sexually active?
4.5.1 Yes □ 4.5.2 No □

How many sexual partners have you had in the past month:
4.5.3 □ None
4.5.4 □ One or more (please specify)

Do you use contraception (family planning)?
4.5.7 Yes □ 4.5.8 No □

If so, do you use:
4.5.9 □ the pill
4.5.10 □ condom (sheath)
4.5.11 depot injection
4.5.12 coil
4.5.13 other (specify)

Where do you get contraceptive advice or supplies?

4.5.14 GP/Practice nurse
4.5.15 chemist
4.5.16 slot machines
4.5.17 NHS family planning clinic
4.5.18 private clinic (e.g. Brook)
4.5.19 other (specify)

Do you have problems accessing contraceptives? If so is it because of:

4.5.20 money
4.5.21 staff attitudes
4.5.22 embarrassment
4.5.23 other (specify)

4.6 Women only. Have you had a smear test:

4.6.1 never
4.6.2 less than 3 years ago
4.6.3 more than 3 years ago

4.7 Debts
Do you have problems managing money?

4.7.1 Yes 
4.7.2 No 

4.7.3 Do you owe money, are you in debt? If so, how much
Is this due to:
4.7.4 Mortgage
4.7.5 Council
4.7.6 Other RSL
4.7.7 Private landlord
4.7.8 Gambling debt
4.7.9 Money lender
4.7.10 Drug dealer
4.7.11 Other (specify)

4.8 Pets
Do you have a dog?
4.8.1 Yes
4.8.2 No

4.8.3 Any other pets? If so, please specify:

4.9 Legal issues
Do you have:
4.9.1 a lawyer
4.9.2 a probation order
4.9.3 a criminal justice social worker
4.9.4 a pending court appearance
4.9.5 a community service order
4.9.6 a deferred sentence
4.9.7 any outstanding fines

If you have children, are any under:
4.9.8 any restraints under a court order
4.9.9 subject to a children’s hearing
4.9.10 subject to supervised access
4.9.11 subject to residential access with you
4.9.12 the Child Protection Register, now or in the past

4.10 Eating
Have you eaten today?
4.10.1 Yes
4.10.2 No
How would you describe your diet:

4.10.3 □ very good
4.10.4 □ adequate
4.10.5 □ poor
4.10.6 □ not sure

How often do you eat the following (tick appropriate box):

<table>
<thead>
<tr>
<th>Food Type</th>
<th>Never</th>
<th>Once / week</th>
<th>2-6 / week</th>
<th>Once or more a day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fruit</td>
<td>4.10.7</td>
<td>4.10.8</td>
<td>4.10.9</td>
<td>4.10.10</td>
</tr>
<tr>
<td>Vegetables (fresh, frozen or tinned)</td>
<td>4.10.11</td>
<td>4.10.12</td>
<td>4.10.13</td>
<td>4.10.14</td>
</tr>
<tr>
<td>Bread, pasta, rice, potatoes (not chips)</td>
<td>4.10.15</td>
<td>4.10.16</td>
<td>4.10.17</td>
<td>4.10.18</td>
</tr>
<tr>
<td>Meat, chicken, fish</td>
<td>4.10.19</td>
<td>4.10.20</td>
<td>4.10.21</td>
<td>4.10.22</td>
</tr>
<tr>
<td>Fried food (inc chips)</td>
<td>4.10.23</td>
<td>4.10.24</td>
<td>4.10.25</td>
<td>4.10.26</td>
</tr>
<tr>
<td>Convenience foods (e.g. microwaveable)</td>
<td>4.10.27</td>
<td>4.10.28</td>
<td>4.10.29</td>
<td>4.10.30</td>
</tr>
<tr>
<td>Other (e.g sandwiches, etc.)</td>
<td>4.10.31</td>
<td>4.10.32</td>
<td>4.10.33</td>
<td>4.10.34</td>
</tr>
</tbody>
</table>

4.11 Household facilities
Can you cook a hot meal where you are now?

4.11.1 Yes □ 4.11.2 No □

Do you have access to the following (tick appropriate box):

<table>
<thead>
<tr>
<th>Facility</th>
<th>Yes / shared</th>
<th>Yes / personal use</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fridge</td>
<td>4.11.3</td>
<td>4.11.4</td>
<td>4.11.5</td>
</tr>
<tr>
<td>Kettle</td>
<td>4.11.6</td>
<td>4.11.7</td>
<td>4.11.8</td>
</tr>
<tr>
<td>Gas or electric cooker</td>
<td>4.11.9</td>
<td>4.11.10</td>
<td>4.11.11</td>
</tr>
<tr>
<td>Oven</td>
<td>4.11.12</td>
<td>4.11.13</td>
<td>4.11.14</td>
</tr>
<tr>
<td>Microwave</td>
<td>4.11.15</td>
<td>4.11.16</td>
<td>4.11.17</td>
</tr>
</tbody>
</table>
4.12 Children

Do any children in the family have:

4.12.1 □ physical disabilities

4.12.2 □ behavioural problems

4.12.3 Do you have any concern about any of your children. If so specify:

Do any children in the family have, at the moment, somewhere quiet and suitable to do homework?

4.12.4 Yes □ 4.12.5 No □

4.13 Current support

4.13.1 □ next of kin
4.13.2 □ family support
4.13.3 □ General Practitioner (please give contact details):

4.13.4 □ District Nurse
4.13.5 □ named nurse
If you do not have a GP is it because:

4.13.32 [ ] just moved to the area
4.13.33 [ ] not tried to register
4.13.34 [ ] do not need one
4.13.35 [ ] no one will take me on
4.13.36 [ ] waiting to be allocated one
If you were sick, where would you go?

4.13.37 ☐ other (specify)
4.13.38 ☐ A&E
4.13.39 ☐ homeless project
4.13.40 ☐ GP
4.13.41 ☐ Practice Nurse
4.13.42 ☐ harm reduction clinic
4.13.43 ☐ nowhere
4.13.44 ☐ other (Specify)

When did you last see a dentist?

4.13.45 ☐ never
4.13.46 ☐ within last 6 months
4.13.47 ☐ within last year
4.13.48 ☐ more than a year ago

SECTION 5 – Support
5. Current needs for support (not being met at present).
5.1 Is support needed for any of the following:

5.1.1 ☐ budgeting
5.1.2 ☐ maximise DWP
5.1.3 ☐ homelessness advice
5.1.4 ☐ health advice & support
5.1.5 ☐ GP
5.1.6 ☐ CMHT
5.1.7 ☐ addictions
5.1.8 ☐ Health Visitor
5.1.9 ☐ District Nurse
5.1.10 ☐ dentist
5.1.11 ☐ chiropodist
5.1.12 ☐ family planning
5.1.13 ☐ furniture storage
5.1.14 ☐ respite
5.1.15 cooking
5.1.16 nursery/creche
5.1.17 welfare rights
5.1.18 family mediation
5.1.19 counselling
5.1.20 training
5.1.21 employability
5.1.22 other (specify)

6. **Actions**

**Referrals**

6.1 Independent medical advisor on housing
6.2 Police
6.3 Housing Assessment
6.4 Homeless team
6.5 Child protection/welfare, to social work
6.6 Women’s Aid
6.7 other (Specify)

7 **Linkages**

7.1 Addictions services
7.2 HV
7.3 Harm reduction
7.4 CMHT
7.5 Maternity services
7.6 Hospital
7.7 other (specify)
8. Summary of unmet needs and action plan (Who is doing what with client. Who is Care Manager?)

7. Evaluation of Action Plan
<table>
<thead>
<tr>
<th>Paragraph numbers from points 6 above</th>
<th>Date completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>