Section B The Homeless Health learning pathway
Module 3/6: Needs assessment

Learning outcomes:
- To understand and be able to identify the key risks for homeless families
- To understand and be aware of the key risks for single homeless people and to understand the difference in risk factors between the two groups
- To know how to use the Common Assessment Framework and other clinical assessment tools in assessing homeless people’s needs
- To understand the importance for both practitioners and clients of multi-agency working in needs assessment.
Brief overview of the content

Welcome to Module 3. In Module 2 you looked at the specific health problems many homeless people experience. In this module we look at how to assess the often complex needs of your client groups, in order to tailor service provision appropriately. In particular, we will cover the following topics:

- Assessing homeless families’ health needs
- Assessing the health needs of single homeless adults.

How to use this module

First read carefully through the learning outcomes below, and consider your starting point. You may be relatively new to this field, or you may be more experienced, seeking to underpin your practice with additional learning and the sharing of innovation and good practice.

Whatever your starting point, think in advance about what you want to get from the module and make a note of any additional learning outcomes. Then read through the material. It has various learning points along the way. Some of them will simply ask you to think about your perceptions of a particular issue before going on to read the theory. Others will require you to go away and talk to colleagues or to reflect on your own practice or experience. The exercises are intended to strengthen and underpin the written material, making it relevant and meaningful to your practice and working circumstances.

On completing the module, you will be invited
to return to the learning outcomes, and consider whether they have been met and what it means for your practice as a result.

**Learning outcomes**
By the time you have worked through this module and completed the self-assessment exercises, you should be able to:

- understand and be able to identify the key risks for homeless families
- understand and be aware of the key risks for single homeless people and to understand the difference in risk factors between the two groups
- know how to use the Common Assessment Framework and other clinical assessment tools in assessing homeless people’s health needs
- understand the importance for both practitioners and clients of multi-agency working in needs assessment.

**Part 1: Assessing homeless families’ health needs**
In Part 1 of this module we will focus on the health needs of homeless children, young people and their parents. By the end of Part 1 you should be able to:

- understand and be able to identify the key risks for homeless families
- know how to use the Common Assessment Framework and other clinical assessment tools to assess homeless families’ health needs
- understand the importance for both practitioners and clients of multi-agency working in needs assessment.

**Severe and complex needs**
Homeless children and their families are very vulnerable, are likely to experience severe and complex needs, which creates major issues in assessing those needs and in safeguarding children and families from harm. Many nurses, health visitors and midwives offer support but frequently find they need improved knowledge to be effective. This module will outline the issues affecting homeless families and the practitioners working with them, and signpost practitioners to the key tools and guidance to enable good practice in assessing their needs.

Homeless families require the same assessment tools as other families but due to the multiple, complex, and extra risks and needs that they face, a structured approach is needed to reduce or eliminate risks, to support them, advocate for them and empower them in building a better and more secure future.

There are many homeless families in England, including an estimated 116,000 children. Rough sleeping is a visible, extreme aspect of homelessness. However, the vast majority of homeless people live in hostels, squats, bed and breakfasts or stay temporarily with friends or family.

Homeless families should not be sleeping rough due to the Housing (Homeless Persons) Act 1977, housing authorities have a duty to house unintentionally homeless people with a local connection in priority need, including pregnant women and families with dependent children. However, temporary accommodation presents many challenges, affecting children’s health and safety. Homeless families require the same assessment tools as other families, but due to the multiple, complex and extra risks and needs they

‘There are many homeless families in England, including an estimated 116,000 children.’
face, close and special attention needs to be given to assessing their needs.

Safeguarding vulnerable children – and also, on many occasion, vulnerable adults – is a key concern when assessing the needs of homeless families. Practitioners need to consider the additional risks, pressures and needs that homeless families face and plan to meet those challenges, including through multi-agency working.

The Common Assessment Framework (CAF) remains, at the time of writing, the key tool for assessing homeless children’s/families’ needs. Note, however, that this may change due to the election of a new government in May 2010 and subsequent review of health and social policy. This part of the module will aim to make you aware of the risk factors specific to homeless families, enabling you to use the CAF (and adapt it where necessary) to meet homeless families’ particular needs.

First of all, let’s consider the key points to bear in mind when making an assessment:

• Assessment is not an end in itself but a means of ensuring more effective interventions – with practical outcomes in mind.

• Assessment should be done with the family (in partnership) not to the family, involving both parents and children.

• Who is being assessed? It may not just be the person whose needs originally triggered the request for an assessment. Particularly with homeless families, who often have multiple needs, each child in a family may need to be assessed individually as will the needs of the parents, who may often be vulnerable themselves.

• How will you assess multiple needs in a holistic way?

• How you will involve other agencies?

• How will you build on the strengths, not just the difficulties, of the children and parents?

Risk factors faced by homeless families

Before reading further, think about what the key risks for homeless families might be and note them down now.

Your list might contain some of the 11 key risk factors:

• significant harm
• having no fixed abode and/or experiencing frequent house moves
• domestic abuse/violence
• gender or sexuality/sexual orientation
• mental health problems of children and parents
• physical health problems, including the risk of accidents and fire
• substance misuse
• not registered with a GP
• no school place or irregular attendance
• lack of information sharing and coordination between agencies
• combination of needs in families.

Risk of significant harm

This item is placed first to highlight the seriousness of this concern. Significant harm – either through abuse or neglect – can take place in the original home and lead to homelessness, or it can take place in temporary accommodation, such as friends’/families’ homes or homeless hostels.
Significant harm can include:

• physical abuse

• sexual abuse

• emotional abuse

• neglect

• self-harm (as distinct from suicide/suicide attempts)

• death by harm from others or via suicide (suicide is the second most common cause of death in people aged 15-24, behind accidental death).

Note that accidents and suicide are two of the highest causes of death in young people, with homeless young people more at risk of suicide, according to the Samaritans.

Every local Children’s Safeguarding Board has guidance for practitioners on recognising and responding to the abuse and neglect of children.

Are you familiar with your own local guidance? Ensure you have a copy readily available. Further guidance, listed in Section D (Learning Resources), is available to help you recognise these forms of abuse and harm and to respond appropriately.

The list above indicates common issues but is not exhaustive. There may be other risks of significant harm that you have encountered or are aware of.

No fixed abode and/or frequent house moves

The mobility of homeless families creates serious challenges in terms of keeping well. The stressful experiences involved include lack of security, and the causes of family homelessness themselves, such as domestic abuse.

It also creates serious challenges for professionals in safeguarding and monitoring vulnerable children’s and adults’ safety and wellbeing. Housing status was noted in an intensive sample of Serious Case Reviews (carried out where a child dies or is seriously ill or harmed as a result of abuse or neglect) – 36% had frequent house moves, 15% had conflict with neighbours, and 15% had poor housing. Living temporarily with friends or family or being in temporary hostels or bed and breakfasts all count as having no fixed abode. According to the London Children’s Safeguarding Board (2007), ‘Frequent movers can find it difficult to access the services they need. For those already socially excluded, moving frequently can worsen the effects of their exclusion.’

Homeless families may move more than once before they can settle permanently. For example, on becoming homeless due to domestic violence, they are be placed in temporary accommodation before being permanently housed – and may move again in between. The placement of families into temporary accommodation which may be at some distance from previous support may lead to families becoming disengaged from services and losing their support networks. Particular attention may need to be given to safeguarding issues when families are moving frequently.

Domestic abuse

The causes of homelessness highlight the specific risks families face. Most families become homeless because of domestic violence and, to a lesser extent, harassment from neighbours. Domestic violence was present in about two thirds of a sample of serious case reviews carried out by the then Department of Children, Schools and Families. In addition it is estimated that 30-66% of children are directly abused by

‘Most families become homeless because of domestic violence.’
the same violent man who abuses their mother. Witnessing domestic violence also damages children. Thus the existence of domestic abuse is a serious risk factor for parents and children for both ill health and homelessness.

Domestic violence may also be linked with bullying at school. Children from families that experience domestic violence may become victims of bullying at school or become bullies themselves.

**Risks related to gender or sexuality/sexual orientation**

Domestic violence, discussed above, predominantly affects women. There are other specific risks that have higher proportions for specific genders or people of a particular sexual orientation. These may be more likely or more evident in homeless people.

Think about what these risks might be. Think about cases of abuse among homeless people, linked to gender or sexuality, that you have come across in your practice. They could be either the cause of homelessness or the result of homelessness. Note them down now.

The risks you thought of may have included the following:

- prostitution
- forced marriage
- other sexual abuse – rape or sexual assault
- self-harm – adolescents, particularly females, are at higher risk of self-harm, and people who have self-harmed are more likely to commit suicide
- suicide – a higher risk for young males than young females and the second highest cause of death in men aged 15 – 34; while women aged 15 – 19 are more likely to attempt suicide, young men are more likely to succeed; lesbian, gay, bisexual and transgender (LGBT) young people are more likely to attempt suicide
- difficulties within families regarding relationships or sexual orientation – young people who have relationships that their families do not accept, or who become pregnant; LGBT young people may be bullied at school; such problems
could lead to homelessness, either through running away or being evicted by parents

- female genital mutilation (FGM).

**Mental health problems of both children and parents**

Homeless children are up to four times more likely to experience mental health problems. They also have six times as many speech and stammering problems as non-homeless children. Being uprooted, losing toys and social networks, and living in cramped accommodation can be very difficult for children, leading to depression, anxiety and behavioural problems. Homeless children may also experience bullying. The issues that caused the homelessness – domestic violence or harassment by neighbours, which children may have witnessed – will frequently have been traumatic.

Homeless parents are also more likely to experience mental health problems, which in turn can impact on the children. Research by the Royal College of Psychiatrists (2002) found that homeless mothers had a 49% prevalence rate of psychopathology and an 11% rate of contact with mental health services, with children demonstrating 30% prevalence rates and a 3% rate of contact with child and adolescent mental health services (CAMHS). Given these issues, it is important for health and other services working with homeless families and children to find ways to improve equity of access to mental health services. As with all the risks identified, ensuring that all assessments of homeless families include considering whether there are any mental health needs is very important.

Mental ill health was present in over half of the sample of cases leading to serious case reviews mentioned above. However, the report warns against exaggerating the contribution of parental mental ill health to child death, instead urging professionals to ‘…understand whether or how this type of ill health in parents poses a risk to children’s healthy development and increases the risk of maltreatment and neglect’ (DCSF 2008).

**Physical health problems including risk of accidents**

Physical health issues of homeless children also highlight safeguarding issues, including a higher likelihood of accidents, injuries and burns; delayed immunisations, and lower birth weight.

The nature of accommodation could increase the risk of accidents, injuries and burns, for example through cramped and overcrowded rooms or unsafe appliances.

People who do not have a permanent home and who have vulnerabilities such as substance misuse, mental health problems, smoking, chaotic lives or multiple occupancy are more at risk of fires starting and more likely to be injured or killed if a fire does start.

![Have you made a link with your local Fire Service? It can provide a free home safety visit for clients moving into temporary or permanent accommodation, to discuss fire risks and fit free smoke alarms. They can also give you a simple checklist on when clients are a priority for a home visit.

Be alert yourself when carrying out home or hostel visits to any potential risks such as blocked fire exits, and refer these to the local authorities. You should also follow up any home fire safety visits to assess whether the person is following the safety advice given.

‘Children from families that experience domestic violence may become victims of bullying at school or become bullies themselves.’
Substance misuse
Substance misuse problems were present in 57% of serious case reviews. Young people who are deemed at particular risk of misusing substances include homeless young people, those who have been in care and those whose parents have misused substances. Homeless parents too may be misusing substances. Young people may become homeless partly due to substance misuse – fragile family relationships can also be a factor in this.

Not registered with a GP
Overall, homeless people are less likely to be registered with a GP, often because they have changed address frequently and/or urgently. As a result, homeless families tend to rely on accident and emergency departments for medical treatment and they have high rates of hospital admissions.

If a family on your client list is not registered with a GP, this should be considered an indication of mobility and possibly chaotic circumstances. It will create barriers to:

- accessing primary and secondary healthcare
- monitoring children’s and parents’ needs
- accessing other support services.

Take some time to think about the clients on your caseload. Do you know what percentage are registered with a GP? If not, take some time to find out. Of those that are not registered, list the particular problems this causes. For example, if one of your clients is pregnant, is she able to access regular antenatal care?

Homeless families’ GP registration should always be checked and they made need help to ensure that they continue to be registered throughout the various house moves they may undergo. Many GP practices require identification and proof of address, which homeless people may not always have.

Lack of a school place or irregular attendance
This is a common issue with homeless children. Those in temporary accommodation may need to move school twice within a short space of time – once on entering temporary accommodation and again if and when they are permanently housed.

Irregular attendance can in itself be a possible indication of mobility and/or chaotic circumstances and is also a barrier to monitoring children’s and parents’ needs.

What particular risks does a child not regularly attending school face? Think about them and note them down.

You may have included the following:

- impact on level of attainment
- loss of opportunity to monitor the child and family
- impact on patterns of behaviour
- risk of significant harm, e.g. abuse through prostitution.

Lack of information sharing and co-ordination between agencies
There are serious risks when several different agencies are holding information about the child or family, when the information is not coordinated or does not follow the child or family to a new address or a new service. Authorities are not able to properly monitor children in these circumstances.

Combination of needs in families
Homeless families can present with multiple problems (usually more than five issues) and this means increased vulnerability, risks and exclusion. Risks such as domestic abuse or lack of a GP, homelessness and poor physical and mental health all compound each other.

Many of the above key risks and predictors were
identified by the Department of Health’s Child Health Promotion Programme (2009). Families at risk of experiencing multiple problems include those who live in social housing, have a young mother/father, where the mother’s main language is not English, where the parents are not co-resident and where one or both parents grew up in care.

The predictors identified in pregnancy as putting particular families/parents most at risk include many which will apply to homeless families, such as unsatisfactory accommodation, poverty, parents with mental health problems, partner abuse and stress in pregnancy.

In addition, the following risk factors in pregnancy may also apply to homeless families such as: young parents, educational problems or parents not in education, employment or training, parents with history of anti-social/offending behaviour, unstable partner relationships, low social capital, ambivalence about becoming a parent, low self-esteem/low self-reliance, history of abuse, mental illness or alcoholism in mother’s family, underlying medical/developmental disorder, low birth weight and prematurity, obesity in parents, poor attachment and cold, inconsistent care and smoking in pregnancy or smoking by partners.

When assessing needs, it is important to be aware of the effect of not just each risk but of the accumulation and multiplicity of risks, and how the risks affect each other.

The needs of children of different ages

What are the risks facing children at different ages?

Note down the key risks that you might expect to be faced by children and young people at different stages:

- under five
- aged 5 – 16
- aged 16 and above

Overall, children under 16 will be more at risk of becoming homeless together with their families (this may often be without the father). Where the risks are particularly severe, they may be placed in care, which predisposes them to a higher risk of homelessness at a later stage.

The needs of children during the early years are paramount, and health visitors in many areas may often concentrate on children under five. This is particularly useful as the early years are so crucial to later health. One example is in ensuring access to immunisations, which homeless children may often miss out on in the early years, affecting their later health.

While this focus is extremely important, however, it can mean that some families with children aged 5-16 may not be visited by a health professional and some may not be registered with a local GP (a risk factor noted above). Given their mobility, many homeless children may not be in school, so would not necessarily be picked up by school nurses or the education authorities. This can deepen the effects of falling through the net.

Young people close to 16 or over may be more at risk of becoming homeless alone if they are from a family experiencing domestic violence, abuse or family problems. They are at particular risk of either sleeping rough or staying at the home of a stranger, physical harm, sexual assault, emotional distress and isolation and the difficulty of patching up family relationships afterwards.

They can then need significant support to rebuild family relationships (where feasible) or successfully initiate independent living – or they can be at risk of repeat homelessness.

‘Lack of a school place or irregular attendance ... is a common issue with homeless children.’
The needs of homeless parents
The risk factors quoted above apply to homeless parents as well as their children. While safeguarding children is, rightly, a very high priority, homeless parents will often be very vulnerable themselves and their needs must also be taken into account.

Most will have experienced domestic abuse or harassment. Many will be single parents. In addition, many will themselves have experienced difficult childhoods. They may be young parents who have had little continuity or stability in their lives. Care leavers, for example, are well known as a group which experience homelessness.

Mental health and substance misuse problems in particular may be present in homeless parents. For them as well as for their children, poor access to healthcare, and appropriate support and a lack of financial support can compound their difficulties. It is important for practitioners to be aware of local referral procedures for mental health, substance misuse and advice (e.g. benefits and debt advice) services.

Remember that many women reported as being ‘single’ homeless may actually have children who are not currently with them. Nearly a third of the women interviewed by Crisis had children living elsewhere. Many hoped to reunite with their children in the future but were being assessed by service providers as single women, without their potential family status taken into account. This highlights the crucial importance of fully understanding the histories of homeless people.

Women who are pregnant will have a variety of needs but it is worth noting that domestic abuse can often start in pregnancy. Homeless women may become pregnant while in single homeless accommodation. Homeless women may have experienced their child being taken from them after birth.

Imprisonment can also be a cause of homelessness. Prisoners can lose their rights to accommodation or female prisoners separated from their children. The Fawcett Society estimates that sending women to prison separates nearly 18,000 children from their mothers each year, with 95% moved from the family home.

To sum up, professionals must assess the experiences, histories and needs of homeless parents (including pregnant women) alongside those of their children. Giving parents the right support to enable them to be the best parent they can may be the means of keeping that family.
together – the best option for the children.

Part 2 of this module will consider the needs of single homeless adults, which you may find relevant to homeless parents.

**Issues for practitioners, providers and commissioners**

Before beginning this section, identify the resources in your local area for assessing and meeting the health needs of homeless families. How many are in your team? Are you specialists in homeless healthcare? How large are your caseloads? Do you worry that families are slipping through the net?

If you are, you are not alone in that concern. Isolation, lone working and a lack of resources are key issues for practitioners assessing homeless families’ needs. An HHI survey found that 74% of HHI members were lone workers always, often or sometimes.

While there are some multidisciplinary teams, in other places the health of homeless families (and possibly other vulnerable groups) in a whole borough, town or even county is the responsibility of a single health visitor. A team of more than two health practitioners working with homeless families is rare, tending to be found only in the larger cities. Health professionals working with homeless families report high caseloads.

The existence of specialist health practitioners for homeless families is patchy, meaning that the proper assessment of the needs of homeless families could be missed – an issue compounded by the mobility, lack of registration with a GP and erratic school attendance demonstrated by many homeless families, meaning that they lack the links with the agencies and services which could highlight their needs.

To overcome these barriers, the needs of homeless people as a population group should be assessed and included in local strategic planning and services should be delivered based on those needs. These issues are considered in more detail in Module 5, Planning, commissioning and delivering services for homeless people.

HHI and its network offers free support to any nurse, midwife or health visitor who offers care to homeless people. Read the case study below to see how access to information from HHI helped one practitioner access the multi-agency support she needed and thus coordinate the care needs of a homeless family.

**In Practice**

**Case study: assessing and supporting a homeless family**

**Before:** This was a chaotic, homeless family with seven children under 12, repeated homelessness and multiple unmet health needs.

**The help I gave:** I used knowledge from a (HHI) child protection presentation to work with a variety of agencies and complete assessments for all the children. Feeling confident helped break down each problem into an action that has helped each individual in the family. For example, the three-year-old is now registered with a GP and therefore can see an orthopaedic surgeon to have the pain in her leg treated. All the children have seen a dentist. I have stayed involved to positively encourage all agencies to complete a Common Assessment Framework for each child. There was a danger that the focus could have remained on the housing situation and the needs of the adult while missing the health needs of the children.

‘Homeless parents will often be very vulnerable themselves and their needs must also be taken into account.’
Reflect on the case study above. Identify a case in your practice where you really feel you made a difference to the health needs of a family through a care and considered, multidisciplinary assessment of their needs. What worked well and what worked less well? What would you do differently next time? What difference did the presence or absence of an effective support network make?

Tools and guidance used in assessing needs

Common Assessment Framework (CAF):
At the time of writing, the CAF remained the key tool for assessing children's and families' needs, and should be used for any child which the practitioner identifies may need support with the five key outcomes identified in Every Child Matters (DCSF 2009):

- stay safe
- enjoy and achieve
- make a positive contribution
- achieve economic wellbeing.

Other factors that can trigger the use of the CAF include:

- a request from the child, young person, family, school, GP etc
- noticing a significant change in the child or young person.

Other useful tools and guidance are listed in Section D.

Conclusion to Part 1
In Part 1 we reviewed all the risks and problems that a homeless family – parents, children and pregnant women - can face. We discussed how these can both be caused by or can in themselves lead to homelessness, how they are complex, overlapping and multi-layered, one often impacting on the other. We discussed the importance of multi-agency support in assessing and attempting to meet these needs and we referenced the Common Assessment Framework and other useful tools and guidance in helping to do so.

In Part 1 you aimed to:

- understand and be able to identify the key risks for homeless families
- know how to use the Common Assessment Framework and other clinical assessment tools to assess homeless families' health needs
- understand the importance for both practitioners and clients of multi-agency working in needs assessment

Before we proceed to Part 2 of this module, take some time to reflect on
what you have learned or been reminded of so far. Consider the following point:

- Do you feel confident that you have an awareness of the full range of risk factors faced by homeless parents, children and families?

Remember to look at the further resources and web links on this topic listed in Section D of this learning pack, and on the QNI Homeless Health Initiative web pages.

Part 2: Assessing the health needs of single homeless adults

In Part 2 of this module we will focus on the particular health needs of single homeless adults. By the end of Part 2 you should be able to:

- understand and be aware of the key risks for single homeless people
- know how to use clinical assessment tools in assessing homeless people’s health needs
- understand the importance for both practitioners and clients of multi-agency working in needs assessment.

There is considerable evidence to demonstrate the poor health outcomes of homeless persons. For example, two studies for Crisis during the 1990s demonstrated high mortality rates for rough sleepers living in London, the second concluding that rough sleepers have an average age of death of 42 (Keyes and Kennedy 1992, Grenier 1996). Similar mortality ratios are found in other countries.

Although the reasons for high mortality include assault and accident, high physical and mental health morbidity also plays a huge role. As described in previous modules, homeless people have a wide variety of serious health problems, and while some are similar to those experienced by the general population, others are a feature of the homeless environment and/or addictive behaviours.

There is much evidence to support the existence of tri-morbidity – the concurrent existence of physical health, mental health, and addiction problem. For example, a survey of homeless people in London aged 50 and over identified that 56% were alcohol dependent, 48% had mental health problems, and 47% had physical health problems (St Mungo’s 2004). Other studies found that homeless people suffer more chronic chest and breathing problems and more frequent headaches than the general population, especially those sleeping rough.

Rough sleeping is the most visible and extreme aspect of homelessness, but most homeless people live in hostels, squats, bed and breakfasts or insecure conditions with friends or family. Overall, they suffer from significant health inequalities in comparison with people in more secure accommodation, in terms of both health status and ability to access health services. High morbidity and complex presentation make the effective clinical assessment of homeless persons a challenge, but specialist clinical tools can help ensure a thorough and safe process for clinicians and clients alike.

What should be included?

Not all community nurses will feel it necessary to design a detailed routine assessment. Merely obtaining a history of homelessness and undertaking a risk assessment may be appropriate.

‘Rough sleeping is the most visible and extreme aspect of homelessness, but most ... live in hostels, squats, bed and breakfasts or insecure conditions with friends or family.’
for some nurses. This will identify the homeless client, and ensure prompt and safe referral to a more specialist clinician. Our intention here is to present ideas that you can use to develop locally appropriate protocols. Note that there is no substitute for local needs assessment. Local populations may show localised epidemiological factors that should be seen as a priority.

You could consider the following areas useful to include in your assessment.

**Personal and demographic information**

Standard personal and demographic information should be included. Useful additional data might be:

- Sleeping site / squat address – sites and addresses should be specified wherever possible, rather than documenting 'no fixed abode' (NFA). This helps identify common areas of rough sleeping, and helps outreach workers find clients.
- Mobile phone number – a surprising number of homeless people have mobile phones, and this mode of contact can be invaluable.
- Secondary contact – the contact details of a key worker or friend whom the homeless person sees regularly.
- Ethnicity – in addition to the standard 16+1 ethnic stratification system, it may be appropriate to collect other ethnicity/language demographics, that may be used to argue for funding for targeted services. For example, a recent report showed that 18% of all rough sleepers in London came from Central and Eastern Europe.
- Residency status – referral for legal and/or other specialist advice will be indicated if the homeless person is a migrant without legal status.
- Next of Kin – when homeless people die on the streets, it is often found that their NOK have not been logged.
- Literacy levels – school exclusion is a risk factor for homelessness, and some homeless people cannot
read and/or write. This will affect, for example, the way in which health information is given or consent obtained.

Consent
Homeless people are often in contact with many agencies. The intention to do one referral can result in the person being ‘sent round the houses’ to variety of agencies. It is important to establish at the outset that the homeless person is happy for you to gather and share information about them.

Accommodation history
An attempt should be made to establish the client’s history of rough sleeping and other forms of homelessness, and current and past contact with street outreach teams and the Health Protection Unit. ‘Length of time homeless’ is a major risk factor for worsening health. A limited history of local rough sleeping may identify a person who has come from outside the area, while repeated abandonment of hostels can indicate a chaotic lifestyle.

Risk assessment
A risk assessment should ideally be conducted from the outset, in order to maintain the safety of both the client and the clinician. Nonetheless a client may perceive a risk assessment with suspicion, even when conducted entirely appropriately. Thus training in risk assessment may be needed.

Apart from the general risks to physical and mental health, think about the particular risks a homeless person might face that you might want to consider in a risk assessment. Make a list of these now.

Did you think of the following? All have been identified as particular risks to homeless people:

- suicide
- drug and alcohol poisoning
- unintended injuries and accidents
- being a victim of crime.

Clinician safety
The Crisis survey cited above identified that half of all interviewees had been in prison at least once, and a third reported being involved in serious crime. In addition, risk factors for homelessness include a history of addiction, a mental health problem, a history of physical or sexual abuse, and having been in care. People with these backgrounds are more prone to aggressive or volatile behaviour.

A simple risk assessment could take the form of a short checklist (see Box 3.1).

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<td>Criminal convictions</td>
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<td>Social isolation/lack of contact with family</td>
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‘A surprising number of homeless people have mobile phones, and this mode of contact can be invaluable.’
**GP registration**
If a homeless person is not registered with a GP, this should be a priority. GP registration levels are generally low among homeless people. They are often registered only temporarily. They can be permanently registered at a GP practice with an NFA or ‘care of’ address if they intend to stay in the area for more than three months. Many homeless people have had numerous prior investigations and referrals, and it benefits the NHS and the client if their notes follow them.

**Hospital attendance**
Ask about recent A&E attendances and inpatient admissions, because this will flag up clients with greater need for NHS services. There may be better ways of managing their healthcare needs, while reducing demand on secondary care services is a key target for homeless health service providers.

**Medical history**
Many homeless people do not understand the term ‘past medical history’. It is therefore useful to ask whether the client has ever been in hospital for any reason. Also ask general questions about their ability to carry out standard activities of daily living, and whether they have any concerns about their general health.

It may also be appropriate routinely to ask specific screening questions on conditions commonly affecting homeless people, e.g. tuberculosis (TB), which is recognised to be much more prevalent than in the general population. Homeless people are also more at risk of delayed diagnosis and infectious and drug-resistant forms of disease.

TB is often missed as many of the symptoms, such as sweating, coughing, weight loss and fatigue, are common to people experiencing homelessness for many reasons. A TB assessment is a specialist assessment – the QNI website has an example of a TB assessment form. Other common conditions to enquire about include foot problems, eyesight, dental and liver problems, and chronic respiratory disease.

**Family history**
Taking a family history may identify genetic disease trends.

**Drug history**
Ask about prescribed and over-the-counter medicines. Many homeless people have an impressive knowledge of over-the-counter drugs, and can treat themselves for a variety of conditions.

**Fire safety**
People who do not have a permanent home, and have vulnerabilities such as substance misuse, mental health problems, smoking, chaotic lives and multiple occupancy, are more at risk from fires starting and more likely to be injured or die in a fire.

The fire and rescue service can provide a free Home Fire Safety Visit to clients moving into accommodation or in temporary accommodation. They can discuss fire risks, fit free smoke alarms, and provide nurses with a simple checklist on when to prioritise clients for a Home Fire Safety Visit. When professionals identify fire-related concerns with any premises while visiting clients, e.g. blocked fire exits, they should alert their local fire service so that appropriate action can be taken.

Areas to consider around fire safety and homeless people are:

- Whether the person is sleeping rough – if so, can they protect themselves by keeping flammable substances out of sight? (Rough sleepers are occasionally attacked in this way.)
- Whether the person would like a free Home Fire Safety Visit.
- Following any Home Fire Safety Visit, whether the person is following the safety advice they were given.

**Allergies**
Allergy history is a routine part of clinical
Mental health
The incidence of mental health problems is estimated to be eight times higher in hostel dwelling homeless people, and 11 times higher in rough sleepers, than in the general population (Bines 1994). Thorough screening to identify mental health problems is therefore essential.

It is often best to address physical health issues first in order to build rapport, before addressing the often sensitive area of mental health. Areas to consider when screening around mental health issues include:

• any mental health problems (including anxiety and depression)
• any mental health diagnosis
• previous experience of seeing a mental health professional
• previous hospitalisations for mental health
• suicide attempts
• self-harm episodes
• problems with memory
• current help needed with mental or emotional health.

Alcohol
Alcoholism is rife in homeless people, leading to gastrointestinal, hepatobiliary, neurological, cardiovascular and metabolic conditions.

Areas to consider when screening around alcohol issues include:

• units of alcohol drunk per week
• any withdrawal symptoms or withdrawal fits
• any liver problems
• last time bloods were taken to test liver function
• thiamine and other medications taken
• usage of alcohol services
• referral for alcohol support.

Drugs
Substance misuse is common in homeless people, with the use of illicit intravenous drugs resulting in a high incidence of viral hepatitis (B and C), HIV infection, deep vein thrombosis, pulmonary embolism, septicaemia, encephalitis, endocarditis, cellulitis and abscesses.

Areas to consider when screening around drugs issues include:

• current use or history of taking illegal drugs
• spending per day
• current or past history of injecting drugs - if yes, does the person have access to needle exchange?
• sharing of injecting paraphernalia (including sharing filters, spoons, water)

‘It is often best to address physical health issues first in order to build rapport, before addressing the often sensitive area of mental health.’
• resulting health problems (e.g. abscesses, blood clots)

• accidental overdose(s)

• screening for blood-borne viruses (discussed further below)

• current engagement with drug services

• referral for drug misuse support.

Blood-borne viruses
Judd et al. (2005) note a Hepatitis C prevalence of 44%, and an HIV prevalence of over 4% in injecting drug users in London, although anecdotal evidence and professional experience suggest that rates of Hepatitis C are probably much higher. Hepatitis A exposure is common in street homeless people.

A brief question regarding possible past exposure to Hepatitis A, B, C and HIV, and dates of last testing, should be documented. Testing should be offered when risk factors are identified.

Smoking
Ask about smoking status, and signpost smoking cessation services.

Women’s health
A survey for Crisis (Gorton 2000) at 31 London homeless hostels showed that 24% of young women residents had been pregnant in the past year, and 76% had gone through with the pregnancy. Some homeless women see pregnancy as a way out.

Several studies show high incidences of sexually transmitted infections in homeless populations, e.g. chlamydia, trachomatis and syphilis, in addition to a high prevalence of blood-borne viruses. Casual sexual encounters, prostitution, substance misuse, and lack of access to condoms and sexual education are all contributory factors.

Studies have shown high levels of awareness of breast and cervical cancer screening services in homeless women, but levels of uptake are significantly lower than in the general population.

List the areas you might want to consider or ask about in relation to sexual health issues for women.

You may have included some or all of the following:
• currently sexually active/sexual history
• safe sex practice e.g. using a condom every time
• contraception
• date of last menstrual period
• screening for sexually transmitted diseases
• date of last smear test
• breast self-examination/breast screening
• experience of violence or other abuse in relationships.

Men’s health
Studies show that homeless men are less likely to have had a prostate examination and more likely to engage in more risky sexual behaviours, such as a higher number of partners and unprotected sex.

You may have included some or all of the following:
• currently sexually active/sexual history
• safe sex practice, e.g. using a condom every time
• screening for sexually transmitted diseases
• whether they examine their testicles (younger men)
• whether they have had a prostate check (older men)
• experience of violence or other abuse in relationships.

Vaccination history
A history of vaccination against hepatitis A and B, tetanus and influenza should be taken, and vaccinations offered. Providing vaccinations such as meningitis C (under 25s), Pneumovac and measles may also be appropriate.

Social history
The social histories of homeless clients are often very complicated. Key points to establish are whether the client has any children (including access details), and any contact with their family.

Other agency involvement
Duplication of work can be common when many professionals are involved. Make contact with key workers already involved if the client agrees.

Observations
Standard observations – blood pressure, body mass index (BMI) and urine - should be made. Particular attention should be paid to BMI, as malnutrition is common. Ask about recent weight loss. A baseline peak flow measure is also useful, given the high incidence of respiratory disease.

Health education checklist
As discussed in Module 2, Part 1, the health education and health promotion needs of homeless people are often not met, owing to lack of will, lack of training and inappropriate materials. Refer back to the work you did in

‘The social histories of homeless clients are often very complicated. Key points to establish are whether the client has any children and any contact with their family.’
Module 2 when assessing the health promotion needs of your client.

Now, together with your colleagues if possible, take the opportunity to review your own procedures for assessing the health needs of your homeless clients. Use the points above as a checklist to ensure all areas are covered. There may be areas HHI has not thought of, and we welcome feedback on your practice.

**Conclusion to Part 2**

In Part 2 of this module we worked through the background information required to help you develop or improve the assessment of homeless people’s health needs. Examples of clinical assessment tools developed by specialist homeless health teams can be found on the QNI/HHI website.

**Conclusion**

In this module we considered needs assessment of children, families and single adults who are homeless. You should now have a better awareness of the specific assessment needs of these groups, and in particular how the risks differ at different ages and between families, children and young people and single people.

In particular we focused on thinking about how you tackle these challenges in your work, and what you might do differently now that you have thought further about the issues and looked at some examples of good practice.

You have now completed the module. Section D lists the references used in this module, and further resources for you to consult as you strive to improve care and services for homeless people. If you are not already a member, you would benefit from joining the QNI Homeless Health Initiative’s network of homeless health professionals. You can sign up and access many other relevant resources free at http://www.qni.org.uk/for_nurses/learning_zone/homeless_health_initiative

**SELF-ASSESSMENT EXERCISE**

Now take time to reflect on what you have learned when working through this module and how it relates to your practice. Go back to the learning outcomes at the beginning and reflect on whether you have met them. Then answer the following questions.

Try to think of at least three points, as practical as possible, in response to each:

- What will I start doing as a result of completing this module?
- What will I stop doing as a result of completing this module?
- What will I do differently as a result of completing this module?

Make a note of the action points you decide on, and set a target to review them on a specific date in, say, three months’ time.

This completes Module 3. We hope you found it valuable. The next module in this learning pack, Module 4, looks at quality improvement in homeless healthcare.