A Health Needs Assessment of children experiencing homelessness in Lanarkshire

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Executive Summary

Introduction

Previous work looking at the needs of adults experiencing homelessness in Lanarkshire identified that they are a vulnerable group, experiencing health inequalities. This needs assessment was commissioned to identify the health and social needs of children under the age of 16 years affected by homelessness in Lanarkshire and make recommendations for service improvement.

Methodology

Mixed methods were employed to explore the needs of children in Lanarkshire experiencing homelessness:

- A literature review of the published and grey literature was conducted
- Scottish Government HL1 return data were obtained from South Lanarkshire for the period 2016-2017, giving a breakdown of numbers of applicants with children, numbers of children in these households and the reasons for application
- A data linkage exercise was undertaken by ISD List analysts to link North Lanarkshire HL1 data to health service data
- Three interviews with parents experiencing homelessness and seven focus groups with a range of professionals working with children and families experiencing homelessness were undertaken

Results

In South Lanarkshire, 40% of applications in 2016-17 were from households with children, with 71% headed up by a single parent. Of all households with children 51% had one child, 32% had two children, 13% had three children, less than 5% had between four to seven children. From the reasons for homelessness, 46% of these children could be considered to have experienced an Adverse Childhood Experience (ACE), 25% of reasons specifically included violence.

Data from North Lanarkshire indicates that the HL1 group had a higher proportion of children under 5 than the North Lanarkshire (NLan) comparator group, indicating a younger age profile than would be expected. The HL1 group were more likely to present or contact emergency or out of hours services due to respiratory issues or conditions and attend A&E for viral or bacterial infections than the NLan group. The HL1 cohort were less likely to take up preventative services and less likely to attend appointments for an already identified health issue e.g. the DNA rate for outpatient appointments in the HL1 cohort was 2.5 times that of the NLan cohort. The HL1 group were less likely to be registered with a dentist, and for the 5-11 year age band more likely to have had a tooth filled or extracted.

With regards to mental health, children in the HL1 cohort had twice the rate of referral to the Child and Adolescent Mental Health Service (CAMHS) than the NLan cohort, but were also less likely to attend the appointment. At the 27-30 month review conducted by health visitors, the HL1 cohort had significantly higher rates of any concern including speech/language/communication and emotional/behavioural than the NLan cohort.

Themes which were identified from all the data are:

- Homelessness in childhood is a traumatic event. Experience of other ACEs is more likely in this group of children
• Mental health, stress and anxiety issues are higher in parents and children experiencing homelessness. There is also evidence that behavioural and emotional issues are higher in children experiencing homelessness.
• Attendance at school and attainment are affected by homelessness. Developing and maintaining friendships can be challenging and the likelihood of experiencing bullying is believed to be higher.
• There are inequalities in a range of health outcomes for children experiencing homelessness compared with their peers.
• Issues regarding poorer access to health services may be due to the cost and distance of travel, being unable to register with health professionals due to being in temporary accommodation and not receiving appointments due to frequent moves or change of address.
• There is no assessment of children experiencing homelessness conducted as standard, only when potential issues are identified. There is therefore concern that issues are not identified at an early stage or when preventative measures could be employed.
• There is a lack of a co-ordinated approach to supporting children experiencing homelessness.
• There is a lack of support available for children experiencing homelessness, and a perception of inequity in provision between North Lanarkshire and South Lanarkshire.

Recommendations

1. Recognise that homelessness is an Adverse Childhood Event and that children experiencing homelessness are at increased risk of experiencing other ACEs, with the potential to have long term impacts on a child’s health, wellbeing and attainment.
2. Homelessness should be raised in priority to the same level as Child Protection, with the same obligation for multi-disciplinary engagement.
3. Agree a single assessment tool based on the SHANARRI indicators that is undertaken directly with every child experiencing homelessness, treating them as a client in their own right, with their own needs. This would allow early detection of potential issues, ensure more of a preventative approach and put supports in place early.
4. One agency should be responsible for the completion of the recommended assessment (point 3) and initiating and co-ordinating a multi-disciplinary group to review the needs, agree a care plan if required and monitor progress.
5. There should be an expansion of services which can offer intensive, longer term (when needed), outreach support through one point of contact for children and families experiencing homelessness. Support specifically for children, perhaps play therapy based, must be incorporated into these services. A holistic approach to family support should be adopted.
6. Develop and establish formal referral pathways, defining the roles and responsibilities of all services or agencies involved in supporting children and families experiencing homelessness. Use of the LOCATOR tools should be highlighted and useful improvements identified.
7. Bring together all staff and agencies involved in child and family homelessness to improve understanding of one another’s roles and responsibilities, improve networks and increase awareness of supports available.

8. The service provision across North and South Lanarkshire should be reviewed to ensure the needs of children and families are met.

9. Funding should be increased to support these recommendations and not have an expectation that these developments should be incorporated into current workloads.

10. Review the support for children experiencing homelessness in a school setting, especially for mental health and wellbeing support.

11. A needs assessment should be undertaken of young people aged over 16 years who become homeless in their own right, as their needs are likely to be different from children and young people experiencing homelessness as part of a family.
1. **Aim and Objectives**

**Aim:** To identify the health and social needs of children under the age of 16 years affected by homelessness across Lanarkshire and make recommendations for service improvement.

**Objectives:**
- Describe the impact of homelessness on the health and wellbeing of children affected by homelessness
- Describe the differences in health presentations and NHS service utilisation between children experiencing homelessness and the wider equivalent population in North Lanarkshire
- Describe the resources and services in place to support children experiencing homelessness and how their needs are assessed
- Describe service provider and users views as to whether current service provision meets the needs of children experiencing homelessness
- Describe the barriers to accessing services experienced by children and their families
- Make recommendations for improvement

2. **Background**

In 2017, a rapid Homelessness Health Needs Assessment (HNA) was undertaken to assess the health needs of the people experiencing homelessness across North Lanarkshire using 2014/15 service data available through North Lanarkshire Council Housing Service and NHS Lanarkshire. An exercise was undertaken to link client data from homelessness (HL1) applications with NHS Lanarkshire service usage data and compare this cohort with the wider North Lanarkshire (NLan) adult population.

At this point, information on the whole family was not collected as part of the HL1 process and although the number of homeless families could be identified, there was no information to allow a data match with anyone other than the main applicant. This has since changed and North Lanarkshire Council now collect and submit information on the whole family as part of the HL1 and SOURCE dataset, permitting the assessment of the health and wellbeing needs of children and young people affected by homelessness. South Lanarkshire do not have the same data sharing agreement set up with NHS Lanarkshire which would allow the linkage of their applicants’ data, hence why only data from North Lanarkshire is presented in Section 5. However, a breakdown of data of families making homelessness applications in South Lanarkshire was available and is presented in Section 4.

As part of the development and implementation of the Health and Social Care (HSCP) Health and Homelessness Action Plans, partners have suggested that there is a substantial level of unmet need across this population and they are often an under recognised group of children and young people, and this has been supported by national evidence.

This health needs assessment aims to develop local evidence on the impact of homelessness on this vulnerable group and consider whether the services available meet their needs.

This health needs assessment is identified in the Children Health Services Improvement Plan and the Lanarkshire HSCP Health and Homelessness Action Plans and progress will be monitored through the reporting structure for these action plans.
3. Literature Review

3.1 Methodology

A search of relevant published literature was undertaken in the databases Embase and Ovid Medline using the search terms “homeless*” AND “child*”; “homeless*” AND “famil*”; “homeless*” AND “young people”. The search was restricted to papers in the English language, 2008 to current day, and search terms present in the title, due to volume of papers. A search of the grey literature was also undertaken using the above terms in Google search engine and searching the websites of voluntary organisations working with the homeless for information and publications. Some locally undertaken research papers were identified through members of the needs assessment steering group.

Titles and abstracts were scanned for relevance and full papers obtained and read if identified as relevant.

3.2 Children

The impact of homelessness on children can be extensive and reach into every area of their lives. There is evidence that these impacts can be long term and affect the individual into adulthood. Key brain and physical development occurs in these early years\(^1,2\) which can determine emotional, behavioural, cognitive, psychological and physical outcomes across the life course\(^3,4\).

The experience of homelessness introduces instability, insecurity and uncertainty into a child’s life. When children describe their experiences of homelessness, the dominant themes are loss, anxiety and fear\(^5-10\). Their experience of loss can encompass loss of a stable home, relationship loss due to family break-up, loss of friends, family, toys and pets. Fear can be caused by fleeing violence or abuse and also moving into temporary accommodation in an area which is unfamiliar and may feel unsafe. Within the literature there were descriptions of being moved into areas with high drug use, violence and noise disturbance\(^5,7-10\).

3.2.1 Physical health

Studies show that children experiencing homelessness tend to have poorer health than children who are housed. Homeless children are documented as having higher rates of infectious, respiratory, gastrointestinal and dermatological diseases, diarrhoea, bronchitis, scabies, lice, dental decay\(^11,12\) and less likely to have received vaccinations\(^4,12\). Children experiencing homelessness are at higher risk of abuse and neglect\(^5,11\).

There are higher rates and severity of asthma\(^11\), with estimates of prevalence in homeless children living within emergency shelters ranging between 21% to 40%\(^13,14\), compared with the average rate in US children of 8%\(^13\). Potential causes of this increased prevalence could be living in overcrowded conditions, exposure to risk factors such as dampness, mould or environmental tobacco smoke\(^4,14\).

Nutrition can often be poorer in this client group, with challenges to purchasing healthier food and more reliance on take-away food due to lack of or poor cooking facilities\(^6-8,11,15,16\). In a couple of consultations undertaken with children experiencing homelessness, including one in South Lanarkshire, it was clear that participating children were hungry\(^7,10\) indicating food insecurity within the family.

Having no outside space or being too fearful to play outside, can restrict physical activity opportunities\(^7,12\). Having no access to a car can also limit the access to wider leisure
opportunities\textsuperscript{4,7}. Important developmental stages in early childhood can be impacted e.g. limited space can affect ‘tummy time’ and therefore the development of crawling or allowing toddlers space to practice walking safely\textsuperscript{3,17}. Higher developmental delay in general is reported within this group\textsuperscript{11,18} and higher childhood accidents and injuries are recorded in children experiencing homelessness\textsuperscript{4,11}.

Living conditions can have an impact on health for example, limited or unhygienic facilities make it difficult to properly prepare and sterilise bottles for feeding a baby, increasing the risk of infection\textsuperscript{3,8,17}. With limited living space, there may not be room for a cot, increasing the likelihood of babies co-sleeping with a parent, increasing the risk of Sudden Infant Death\textsuperscript{3}. Many families in homelessness are struggling financially and are unable to afford to heat their accommodation, leading to increased likelihood of damp and potentially mould, with increased risk of respiratory infections\textsuperscript{3,4,8}.

Families facing homelessness may move in with friends or family, or move into smaller accommodation than required, leading to overcrowded conditions. Overcrowding increases the risk of a number of conditions such as meningitis, tuberculosis and respiratory problems\textsuperscript{4}. Noise and shared sleeping arrangements can also impact on patterns and quality of sleep\textsuperscript{3,4,17}. Lack of privacy was also described as an issue for older children\textsuperscript{5,7}.

3.2.2 Mental health

Children experiencing homelessness are significantly more likely to have mental health issues than other children\textsuperscript{19,20}. Bassuk et al\textsuperscript{21} estimated in their systematic review that 10-26\% of pre-school age children experiencing homelessness had mental health issues needing clinical evaluation, with this rising to between 24-40\% in school age children: two to four times higher than equivalent aged poor but housed children in USA. This review also estimated that homeless school age children were twice as likely to suffer from internalising problems, such as depression, anxiety and social withdrawal, compared to housed low income children. Most available quantitative data on mental health was from the USA, which has different health and social care systems, and therefore caution should be used in its direct comparability to the UK. A large scale survey of people experiencing homelessness conducted by Shelter\textsuperscript{8}, stated that over two fifths of parents said that their child was ‘often unhappy or depressed’.

The insecurity and instability of homelessness, the fear and loss are all likely to contribute to the mental health issues that children experience. Within the literature, anxiety, sadness, anger, stress and worry are all described by children experiencing homelessness\textsuperscript{5,7,9,10,12}, with one study reporting an increase in bedwetting in school age children, indicating increased anxiety\textsuperscript{5}. Moving to a new area potentially away from friends and family, changing schools and experiencing bullying impacted on wellbeing, affected self-esteem and increased the likelihood of isolation\textsuperscript{5,8,10,22}. Children also described concern for their parents which added to their anxiety and some also took on caring roles, with added responsibility likely contributing to mental health issues\textsuperscript{5,7}.

3.2.3 Behaviour

In the literature, it has been identified that children experiencing homelessness have higher levels of emotional and behavioural difficulties\textsuperscript{4,7,8,21,23,24}. Bassuk et al\textsuperscript{21} identified a significant difference in externalising problems, such as aggression or disruption, in homeless school age children compared to low income peers. Jetelina et al\textsuperscript{25} also identified that even brief periods of homelessness increased the likelihood of aggression or both victim and aggressor in children. Kirkman et al\textsuperscript{26} describe a number of children they interviewed as being ‘chronically angry’ with other descriptions in the literature of children being combative,
antagonistic and prone to lashing out\textsuperscript{12}. Some children were also described as showing regressive behaviour such as using ‘baby talk’ and playing at a level that was younger than their chronological age\textsuperscript{7}.

3.2.4 School, education and social development

In a survey of people experiencing homelessness, 68% of respondents stated that their children had experienced problems at school\textsuperscript{8}. Problems included struggling to make and keep friends, being bullied, assessed as having Special Educational Needs, playing truant or being suspended, being expelled or excluded from school.

Many children miss periods of school due to frequent moves or the requirement to travel long distances if temporary accommodation is in a different area from the school and the associated cost and inconvenience\textsuperscript{4,7,8,12}. Frequent moves and the instability of homelessness can also impact on the parent’s ability to enrol their child into nursery\textsuperscript{26} which can impact on the child’s early cognitive and social development\textsuperscript{27}. The requirement to travel long distances to school, in addition to perhaps poor sleep due to noise or overcrowded sleeping conditions, can lead to children being extremely tired when at school and not able to perform their best\textsuperscript{8,12}. Often being late and sometimes appearing unkempt were other issues identified by teachers\textsuperscript{12}.

There is some suggestion within the literature that children who experience homelessness have lower academic achievement compared to their peers\textsuperscript{4,28,29}, however, one paper identified that under-achievement was due to co-occurring risks linked to poverty\textsuperscript{27}. A systematic review of young people who have experienced homelessness, foster care and poverty\textsuperscript{30}, found that cognitive performance was lower in all three groups compared with peers and general cognitive functioning, attention and executive function shortfalls were common to homeless and poverty experienced young people.

In addition to absence, having space and equipment (e.g. Wi-Fi) to complete homework were issues which could contribute to children experiencing homelessness falling behind at school\textsuperscript{8,12,17}.

Homelessness can adversely impact social connections in children and young people. As already mentioned, bullying is a common experience for these children, with descriptions of exclusion, loneliness, isolation and difficulties in making and maintaining friendships\textsuperscript{5,7,10,12,22} and experiences of racism and serious physical assault\textsuperscript{7}. A homeless child’s experience of bullying is associated with an increased risk of emotional and behavioural difficulties\textsuperscript{24}. Abilities to engage in extra-curricular activities or clubs are limited by cost and also potentially distance\textsuperscript{7,22}. Young people may feel ashamed and embarrassed by their home situation and have a sense of being different from other people, leading to withdrawal, increased self-consciousness and reduced self-esteem\textsuperscript{8,10,12}.

3.3 Parents

3.3.1 Mental health, stress and anxiety

Within the literature, it was identified that it was not uncommon for parents experiencing homelessness to have personal histories of trauma with personal childhood adversity, abusive relationships and experience of violence common, broken family relationships, absent or dysfunctional support systems and generational housing instability\textsuperscript{1,3,15,31}.

Becoming homeless is a major stressful event, often caused by the breakdown of a relationship, fleeing domestic abuse or other violence, being evicted or unable to pay rent. It is no surprise that many parents experiencing homelessness experience stress, depression
and anxiety\(^8,15,17\). Almost half of parents in a large survey conducted by Shelter reported being depressed, with rates higher in those who had recently become homeless and those living in temporary accommodation for long periods of time\(^8\). There is some evidence that maternal depressive symptoms or suicidality are associated with increased likelihood of emotional and behavioural problems in children who experience homelessness\(^{24,32}\).

Parents experience concerns about the immediate housing situation but in addition there is the stress of relying on the goodwill of others for support, family disharmony from being ‘cooped up’ if doubling up with family or friends or strain from living in someone else’s space\(^{17,20}\). Parents reported putting on a ‘brave face’ or trying to stay strong for their children but were also concerned about the impact homelessness might have on their children, leading to stress and anxiety, physical and mental exhaustion, and issues with eating and sleeping\(^{15}\). There was a desire to protect their children but a lack of sense of control of the situation, perpetuating the stress\(^1\). Some described shame and embarrassment at their situation, also feeling bullied and discriminated against, and were more likely to be experiencing low self-efficacy, self-worth and self-esteem\(^3,15\). Due to lack of support networks, many parents feel isolated, alone and sometimes scared\(^8,15\).

Facing such challenges, some parents report experiencing suicidal thoughts, drug or substance use or relapse\(^8,15\).

### 3.3.2 Pregnancy

Being pregnant and homeless challenges the ability to have a healthy pregnancy and can impact on the health of both mother and baby\(^3\). Higher levels of stress, reduced support networks, higher personal experiences of adversity such as mental health issues or domestic abuse, challenges to accessing a healthy diet and lower likelihood of attending maternity appointments can all lead to poorer outcomes\(^3\). There is increased risk of pre-term birth, low birth weight, post-neonatal hospitalisation, poor mental health in the infant or child and developmental delays\(^1,3,18\). Babyhood is a critical life stage and more vulnerable to the impacts of stress\(^1,3\).

### 3.3.3 Parenting

As already described, many parents experiencing homelessness had experience of homelessness in their own childhood and history of trauma, both as children and as adults. In Gültekin et al’s\(^{15}\) exploration of homelessness, a number of the mothers interviewed had poor relationships with their own families, often having felt unloved or not protected by their own mothers. In order for children to grow and develop both physically and emotionally, they require a caregiver to be sensitive and responsive to their needs and provide consistent care\(^1,3\). This ability can be challenged by the history of the mother and how she was parented i.e. if she was not nurtured or adequately cared for in infancy, she is less likely to be able to respond sensitively or connect emotionally with her own child\(^1,3\). The stress, anxiety, insecurity, increased mental health issues and substance use associated with homelessness will also add to the challenges of responding sensitively to infants or children in a time when they need it most\(^1,3,33\).

Park et al\(^{33}\) examined the risk of adverse parenting in families with experience of homelessness. Mothers who had experience of homelessness reported levels of physical aggression towards their children that were more than double those of the housed group (29% vs 13%). They also reported almost double the levels of psychological aggression than the housed group (39% vs 22%). Maternal depression increased the odds of psychological aggression by 39% and parental stress was associated with increased odds of 37% for physical aggression and 31% for psychological aggression. The frequency of physical...
aggression decreased as the child increased in age, but psychological aggression increased or remained at similar levels over time. The caveat for this work is that aggression was self-reported and thus there may have been some social desirability bias at play in the results between different groups.

Homelessness is an adverse event with the potential to cause trauma in both adults and children. Stressful experiences cause the brain to react in a ‘fight or flight’ mode, with the release of various hormones which cause a physiological response: raised heart rate, blood flow to the muscles, heightened state of alertness etc. Repeated or cumulative adverse events in childhood (commonly referred to as Adverse Childhood Experiences or ACEs) can lead to hyper-vigilance, where the child is always in a heightened state of fear or anxiety i.e. in constant ‘fight or flight’ mode. The constant or repetitive stimulation of the more primitive parts of the brain involved in ‘fight or flight’, in the absence of repetitive stimulation of other parts of the brain involved in promoting attachment, such as consistent emotional care, responsiveness, love and nurturing by a care giver, can lead to under-development of the higher functioning, more complex parts of the brain. This can result in long term issues with behaviour, emotional and physiological development.

Herbers et al. identified within a sample of children aged between four and six years old living in emergency shelters in the USA, that on average the children had experienced 3.05 (range 0-10) stressful events (e.g. had a parent in prison, witnessed violence, divorced/separated parents, had a parent with a mental health problem or serious drug/alcohol problem) and on average were experiencing 1.05 trauma symptoms (e.g. talk repeatedly about the event, worry something bad is going to happen, easily startled, nightmares). They identified that experience of adversity was a significant predictor of trauma symptoms, emotional and behavioural issues. However, these symptoms and issues were attenuated by positive parenting practices such as positive structure, responsiveness and direction (positive co-regulation) and the association was stronger in children who had experienced more adversity. Labella et al. also found that positive parenting was associated with children experiencing better social relationships with peers and attenuating the impacts of adversity on internalising symptoms. However, the ability to be responsive and nurturing, provide structure and other positive parenting practices are severely challenged by the circumstances of homelessness.

3.4 Service utilisation and access

Clark et al. identified that for homeless family members in Massachusetts, USA, A&E use and hospital admissions increased in the run up to them becoming homeless, with higher rates for infants, pregnant women and individuals with depression, anxiety or substance use. These rates declined after entering a homeless shelter. As already mentioned, the health system within the USA is quite different to the UK which makes patterns of health service use difficult to compare. However, a similar pattern was recently reported for the adult homeless population within Scotland and therefore, is likely to be similar for Scottish families experiencing homelessness. This increased health service utilisation potentially represent opportunities for early intervention to prevent family homelessness or initiate support at an earlier stage.

Access to appropriate healthcare support was described as challenging for those experiencing homelessness. Experiences of health services in a Leicester cohort of families was mixed: some positive, some negative. Negative experiences included descriptions of not feeling listened to and not having the time to explain themselves. Becoming homeless may result in being moved into temporary accommodation out-with the catchment area for a family’s GP, affecting the continuity of relationship with primary care services that might have
been built up over time. Without a permanent address, registering with a new GP can be challenging and travelling to a former GP can be difficult without money or transport. With anxiety, low confidence and the potential to face stigma, accessing services can be off-putting. Suggested changes to improve the accessibility of healthcare services include same day appointments, more flexibility, drop in services and a reach out model as opposed to expecting people to come to services. With so many services over and above health included in supporting families experiencing homelessness, a need for a co-ordinated response was identified. An advocate who could work with the family to support them access services would provide a central contact, able to offer the intensive support and time that is needed for families experiencing homelessness.

The response to families in homelessness often focuses on the housing and financial needs, and less on the emotional and physical needs. All services (not just health) supporting families would benefit from being trauma informed and offering understanding and empathy. In addition, Parry et al. identified that in Australian homeless services, the needs of the parent, as applicant, are often identified but the needs of the child within the homeless family are not. The authors suggest that without a more child centred approach, services are failing to meet the requirements of the International Rights of the Child in terms of ‘best practice standards of assessment, case management and referrals to appropriate services’.
4. South Lanarkshire profile of families making applications for homelessness 2016-2017

4.1 Methodology

In order to explore the profile of families making an application for homelessness, data were sought from the South Lanarkshire housing team for the period 2016-17. In addition, data were provided regarding time spent in temporary accommodation at a point in time (June 2018).

4.2 Results

Of 2016 applications for homelessness, 40% were from households with children, with 71% headed by a single parent, 14% were couples with children and 15% were single people with access to a child (n.b. these proportions should be treated with caution as there may be cross over between recording of custody and access). The composition of these households is displayed in Table 1A.

Table 1A: Proportion of the numbers of children within households making a homelessness application in 2016-17 in South Lanarkshire

<table>
<thead>
<tr>
<th>Number of children</th>
<th>% of total households with children</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>51%</td>
</tr>
<tr>
<td>2</td>
<td>32%</td>
</tr>
<tr>
<td>3</td>
<td>13%</td>
</tr>
<tr>
<td>4</td>
<td>3%</td>
</tr>
<tr>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td>6</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>7</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

In total, 1415 children were within the households making an application for homelessness. Examining the reasons for homelessness, 46% of these children had potentially experienced what would be considered an Adverse Childhood Experience (e.g. family breakdown, a parent who had been in prison, exposure to domestic abuse) and 25% had potentially experienced something specifically violent.

Data from a snapshot in June 2018 shows that households with children experienced longer periods of time in temporary accommodation than the overall average (193 vs 164 days), longer in Women’s Aid accommodation (249 vs 221 days), longer in private sector leased accommodation (214 vs 191 days) and less time in hostel accommodation (4 vs 25 days).
5. North Lanarkshire HL1 and ISD Data Linkage

In order to identify the health needs of children experiencing homelessness, a data linkage exercise was undertaken by ISD List Analysts. This process linked the health records of children under 16 years whose parents or guardians made an application for homelessness in the financial year 2016/17. A number of different data sources have been drawn from, with the key aim of identifying differences between this group and the rest of the North Lanarkshire child population, in terms of health service access and usage.

5.1 Methodology

5.1.1 Defining Cohorts

HL1 cohort (HL1): The HL1 cohort is children aged under 16 years old on 30/09/16, whose guardian made an application for homelessness in North Lanarkshire in the financial year 2016/17. This cohort has 1478 people and was followed across the financial year 2016/17.

North Lanarkshire cohort (NLan): This is the comparator group used when comparing the HL1 cohort in this report. This cohort consists of the population of North Lanarkshire, aged under 16 years on 30/09/16, excluding the HL1 cohort and has 61,821 people.

People aged 16 years or over on 30/09/16 were excluded, as they are included in a review of adult data.

5.1.2 CHI Seeding

The HL1 dataset was CHI seeded using a probability matching algorithm. The fields used in this process were: Surname, Forename, Date of Birth, Gender, and Postcode. This process is 98% accurate.

5.1.3 Information Governance

- The NSS ISD analysts completed an application to NHS Lanarkshire Caldicott Guardian for approval for use of patient identifiable data.
- The NSS ISD analysts completed an application to NHS NSS Caldicott Guardian for approval for use of patient identifiable data.
- The data were transferred and stored securely on the NSS network where they could only be accessed by (ISD) analysts involved in analysis.
- One section (CAMHS) required access to NHS Lanarkshire data as NSS does not have access to patient level data for this service. Caldicott Guardian approval was granted to share the list of HL1 CHI numbers with an ISD analyst working in the CAMHS team in NHS Lanarkshire, who provided analysis for this data source.

5.1.4 Analysis

- Rates per 1,000 population are based on dividing outputs by appropriate population size and multiplying the result by 1000. This allows for a comparison of rates.
- Where appropriate, percentages have been used for comparison purposes. This has mainly been used to compare rates of non-attendance or non-uptake of services.
- % Difference – It is possible to calculate the difference between different % results in multiple ways (percentage point increase/decrease, percentage increase, percentage decrease). In this paper, the percentage increase from a NLan result to an HL1 result is used to highlight where differences between the two groups are highest. This is done through the following formula – (HL1 result-NLan result)/NLan Result.
• For outputs where categories are included for completeness, but numbers are too small for publication, a ‘*’ has been put in place of actual numbers.
• If more information is required regarding data output or sources, this is available from the Lanarkshire LIST team nss.list-lanarkshire@nhs.net
5.2 Results

5.2.1 Demographics

As can be seen in Figure and Table 2A, the HL1 group has a higher proportion of children under 5 and a lower proportion of 12-15 olds than the NLan group. The proportion of males and females in both cohorts was close to identical.

Table 2A: HL1/NLan Population Count by Age Band

<table>
<thead>
<tr>
<th>Age Band</th>
<th>Population</th>
<th>%</th>
<th>Population</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5</td>
<td>571</td>
<td>38.6%</td>
<td>18,460</td>
<td>29.9%</td>
</tr>
<tr>
<td>5-11</td>
<td>651</td>
<td>44.0%</td>
<td>28,045</td>
<td>45.4%</td>
</tr>
<tr>
<td>12-15</td>
<td>256</td>
<td>17.3%</td>
<td>15,316</td>
<td>24.8%</td>
</tr>
<tr>
<td>Total:</td>
<td>1,478</td>
<td></td>
<td>61,821</td>
<td></td>
</tr>
</tbody>
</table>

Table 2B: HL1/NLan Population Count by Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Population</th>
<th>%</th>
<th>Population</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>753</td>
<td>51.0%</td>
<td>31,617</td>
<td>51.1%</td>
</tr>
<tr>
<td>Female</td>
<td>725</td>
<td>49.0%</td>
<td>30,204</td>
<td>48.9%</td>
</tr>
<tr>
<td>Total:</td>
<td>1,478</td>
<td></td>
<td>61,821</td>
<td></td>
</tr>
</tbody>
</table>
5.2.2 Breathing and respiratory conditions and reasons for A&E attendance

As can be seen in Table 3A, the HL1 group experienced higher rates of presentations for respiratory issues and conditions compared to the NLan group (all significant differences except acute bronchiolitis). It should be noted that these data are for total number of presentations and could represent some of the same children presenting on more than one occasion.

Table 3A: Breathing Conditions: Rates per 1000 Comparison between NLan and HL1 Cohort (greyed out boxes: no significant difference)

<table>
<thead>
<tr>
<th>Category</th>
<th>Output</th>
<th>HL1 Rate</th>
<th>NLan Rate</th>
<th>% difference btwn NLan &amp; HL1 Cohort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident &amp; Emergency</td>
<td>Breathing Abnormalities</td>
<td>6.1</td>
<td>2.3</td>
<td>165%</td>
</tr>
<tr>
<td>Accident &amp; Emergency</td>
<td>Upper Respiratory Infection</td>
<td>16.2</td>
<td>6.9</td>
<td>135%</td>
</tr>
<tr>
<td>Emergency Admissions</td>
<td>Breathing Abnormalities</td>
<td>16.9</td>
<td>7.7</td>
<td>119%</td>
</tr>
<tr>
<td>Emergency Admissions</td>
<td>Acute Bronchiolitis</td>
<td>10.1</td>
<td>6.5</td>
<td>55%</td>
</tr>
<tr>
<td>NHS 24</td>
<td>Breathing Related Condition</td>
<td>50.1</td>
<td>32.9</td>
<td>52%</td>
</tr>
<tr>
<td>Out of Hours</td>
<td>Breathing Related Condition</td>
<td>69.0</td>
<td>48.4</td>
<td>43%</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>Asthma</td>
<td>528.4</td>
<td>472.4</td>
<td>12%</td>
</tr>
</tbody>
</table>

Table 3B breaks down the reasons for attendance at Accident and Emergency and identifies that children in the HL1 group were significantly more likely to attend A&E because of viral or bacterial infections than the NLan group (range from 109% to 151% more likely). It should be noted that 33% of HL1 and 31% of NLan attendances did not have the ICD10 code recorded, so results should be interpreted with caution. There were no significant differences in rates for injuries between the two cohorts.

The HL1 group attended A&E for counselling at a rate 110% higher than the NLan group. The majority of the presentations under ICD-10 code Z71 (‘Counselling’) were for Z71.1 ‘Person with feared health complaint in whom no diagnosis is made’.
<table>
<thead>
<tr>
<th>ICD10 Code</th>
<th>Condition</th>
<th>NLan No. Attendances</th>
<th>Rate</th>
<th>HL1 No. Attendances</th>
<th>Rate</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>A09</td>
<td>Infectious Gastroenteritis Colitis</td>
<td>183</td>
<td>3.0</td>
<td>11</td>
<td>7.4</td>
<td>151%</td>
</tr>
<tr>
<td>J06</td>
<td>Upper Respiratory Infection</td>
<td>425</td>
<td>6.9</td>
<td>24</td>
<td>16.2</td>
<td>136%</td>
</tr>
<tr>
<td>J21</td>
<td>Bronchiolitis</td>
<td>190</td>
<td>3.1</td>
<td>10</td>
<td>6.8</td>
<td>120%</td>
</tr>
<tr>
<td>Z71</td>
<td>Counselling</td>
<td>477</td>
<td>7.7</td>
<td>24</td>
<td>16.2</td>
<td>110%</td>
</tr>
<tr>
<td>B34</td>
<td>Viral Infection</td>
<td>260</td>
<td>4.2</td>
<td>13</td>
<td>8.8</td>
<td>109%</td>
</tr>
<tr>
<td>M79</td>
<td>Other Soft Tissue</td>
<td>320</td>
<td>5.2</td>
<td>12</td>
<td>8.1</td>
<td>57%</td>
</tr>
<tr>
<td>S00-S09</td>
<td>Head Injury</td>
<td>2,136</td>
<td>34.6</td>
<td>58</td>
<td>39.2</td>
<td>14%</td>
</tr>
<tr>
<td>S60-S69</td>
<td>Wrist Hand Finger Injury</td>
<td>1,718</td>
<td>27.8</td>
<td>44</td>
<td>29.8</td>
<td>7%</td>
</tr>
<tr>
<td>S50-S59</td>
<td>Elbow Forearm Injury</td>
<td>774</td>
<td>12.5</td>
<td>17</td>
<td>11.5</td>
<td>-8%</td>
</tr>
<tr>
<td>S80-S89</td>
<td>Knee Lower Leg Injury</td>
<td>602</td>
<td>9.7</td>
<td>13</td>
<td>8.8</td>
<td>-10%</td>
</tr>
<tr>
<td>S90-S99</td>
<td>Ankle Foot Injury</td>
<td>1,442</td>
<td>23.3</td>
<td>25</td>
<td>16.9</td>
<td>-27%</td>
</tr>
</tbody>
</table>
5.2.3 Did not attend rates and uptake of services

The HL1 cohort were less likely to take up preventative services and less likely to attend for appointments where a health issue has been identified (See Table and Figure 4A). Outpatient DNAs saw the greatest difference between the HL1 and NLan groups, where in each age group, DNA rates were at least 2.5 times higher in the HL1 group, and were over 3 times higher in the 12-15 year old category.

Table 4A: DNA/No Participation - % difference between NLan and HL1 Cohort (greyed out boxes: no significant difference)

<table>
<thead>
<tr>
<th>Category</th>
<th>Outcome</th>
<th>HL1 Rate</th>
<th>NLan Rate</th>
<th>% difference NLan to HL1 Cohort</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Outpatient Appointments</td>
<td>Did Not Attend</td>
<td>28.1%</td>
<td>10.7%</td>
<td>162%</td>
</tr>
<tr>
<td>Teenage Booster Vaccine</td>
<td>Did not receive</td>
<td>54.7%</td>
<td>26.7%</td>
<td>105%</td>
</tr>
<tr>
<td>5+1 Vaccine</td>
<td>Did not receive</td>
<td>9.0%</td>
<td>4.7%</td>
<td>93%</td>
</tr>
<tr>
<td>Dental Registration</td>
<td>Not Registered</td>
<td>21.7%</td>
<td>12.2%</td>
<td>78%</td>
</tr>
<tr>
<td>CAMHS Appointments</td>
<td>Did Not Attend</td>
<td>18.9%</td>
<td>11.7%</td>
<td>62%</td>
</tr>
<tr>
<td>27-30 Month Review</td>
<td>Did not receive</td>
<td>11.2%</td>
<td>7.4%</td>
<td>52%</td>
</tr>
</tbody>
</table>

Figure 4A: DNA/No Participation % difference between NLan and HL1 Cohort
5.2.4 A&E attendance

Overall, the A&E attendance rate for the HL1 group is 32.4% greater than the NLan group with the largest differences in attendance between the two groups for the Under 5s (HL1 31.9% greater) and for males (HL1 37.4% greater). Referral sources were broadly similar for the two groups, although the HL1 group was more likely to be referred via 999 Emergency Services (11.3% compared to 8.8% for NLan). It should be noted that these data are for total number of presentations and could represent some of the same children presenting on more than one occasion.

Table 5A: A&E attendance count by age band

<table>
<thead>
<tr>
<th>Age Band</th>
<th>HL1 Number of Attendances</th>
<th>Rate</th>
<th>NLan Number of Attendances</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5</td>
<td>325</td>
<td>569.2</td>
<td>7,967</td>
<td>431.6</td>
</tr>
<tr>
<td>5-11</td>
<td>216</td>
<td>331.8</td>
<td>7,086</td>
<td>252.7</td>
</tr>
<tr>
<td>12-15</td>
<td>89</td>
<td>347.7</td>
<td>4,852</td>
<td>316.8</td>
</tr>
</tbody>
</table>

Table 5B: A&E attendance count by gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>HL1 Number of Attendances</th>
<th>Rate</th>
<th>NLan Number of Attendances</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>360</td>
<td>478.1</td>
<td>11,000</td>
<td>347.9</td>
</tr>
<tr>
<td>Female</td>
<td>270</td>
<td>372.4</td>
<td>8,905</td>
<td>294.8</td>
</tr>
</tbody>
</table>
5.2.5 Hospital Admission (Acute)

Emergency admissions overall had a higher rate in the HL1 group, although 5-11 year olds saw a slightly lower rate than the equivalent age group in the NLan group. It should be noted that these data are for total number of admissions and could represent some of the same children being admitted on more than one occasion.

Table 6A: Emergency admission rate per 1000 by Age Band

<table>
<thead>
<tr>
<th>Age Band</th>
<th>HL1 Emergency Admissions</th>
<th>Rate</th>
<th>NLan Emergency Admissions</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5</td>
<td>99</td>
<td>173.4</td>
<td>3,021</td>
<td>163.7</td>
</tr>
<tr>
<td>5-11</td>
<td>26</td>
<td>39.9</td>
<td>1,177</td>
<td>42.0</td>
</tr>
<tr>
<td>12-16</td>
<td>13</td>
<td>50.8</td>
<td>684</td>
<td>44.7</td>
</tr>
<tr>
<td>All Ages</td>
<td>138</td>
<td>92.8</td>
<td>4,882</td>
<td>74.4</td>
</tr>
</tbody>
</table>

5.2.6 GP Out of Hours and NHS24

The HL1 group had a slightly higher overall rate of NHS24 consultations than the NLan group, but no significant difference in rate of OOH consultations.

Table 7A: OOH Patient rate per 1000 by Age Band

<table>
<thead>
<tr>
<th>Age Band</th>
<th>HL1 Number of Patients</th>
<th>Rate</th>
<th>NLan Number of Patients</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5</td>
<td>152</td>
<td>266.2</td>
<td>5,149</td>
<td>278.9</td>
</tr>
<tr>
<td>5-11</td>
<td>60</td>
<td>92.2</td>
<td>2,389</td>
<td>85.2</td>
</tr>
<tr>
<td>12-15</td>
<td>15</td>
<td>58.6</td>
<td>1,098</td>
<td>71.7</td>
</tr>
<tr>
<td>Total:</td>
<td>227</td>
<td>153.6</td>
<td>8,636</td>
<td>139.7</td>
</tr>
</tbody>
</table>

Table 7B: NHS 24 Calls rate per 1000 by age band

<table>
<thead>
<tr>
<th>Age Band</th>
<th>HL1 Number of Patients</th>
<th>Rate</th>
<th>NL Number of Patients</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5</td>
<td>244</td>
<td>427.3</td>
<td>7,660</td>
<td>415.0</td>
</tr>
<tr>
<td>5-11</td>
<td>120</td>
<td>184.3</td>
<td>4,116</td>
<td>146.8</td>
</tr>
<tr>
<td>12-15</td>
<td>22</td>
<td>156.3</td>
<td>1,496</td>
<td>97.7</td>
</tr>
<tr>
<td>Total:</td>
<td>386</td>
<td>261.2</td>
<td>13,272</td>
<td>214.7</td>
</tr>
</tbody>
</table>
5.2.7 Child and Adolescent Mental Health Services (CAMHS)

As can be seen in Figures 8A and B, children in all age groups of the HL1 group were significantly more likely to be referred to CAMHS and less likely to attend. The referral rate for the HL1 group was over double that of the NLan group and males, under 5s and 5-11 year olds had a rate three times that of the NLan group.

Figure 8A: 2016/17 Total CAMHS Referrals per 1,000 population

Figure 8B: All CAMHS Appointment DNA Rate 01/04/16 to 31/05/18
5.2.8 27-30 month health review

In the three review categories where numbers were large enough to compare (Any concern, Speech, Language & Communication concern and Emotional/Behavioural concern), the HL1 group had significantly higher rates than the NLan group.

In terms of non-participation, HL1 Females saw the highest rate (16.9% vs 6.6%), although it should be noted that this is based on only 10 out of a possible 59 children.

Figure 9A: 27-30 Month Review Results
### 5.2.9 Dental health

Lower registration with a dentist was seen across all age groups in the HL1 group compared to the NLan group (Table 10A) and also lower participation by those registered, with the biggest gap in 12-15 year olds (Table 10B). In the 5-11 year age band, those in the HL1 group were 30% more likely to have had a filling and 57% more likely to have had a tooth extracted than the equivalent age in the NLan group (both significant differences).

#### Table 10A: % Registered Dental Patients by Age Band

<table>
<thead>
<tr>
<th>Age Band</th>
<th>HL1 No. Registered Patients</th>
<th>%</th>
<th>NLan No. Registered Patients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>1,157</td>
<td>78%</td>
<td>54,296</td>
<td>88%</td>
</tr>
<tr>
<td>&lt;5</td>
<td>312</td>
<td>55%</td>
<td>12,098</td>
<td>66%</td>
</tr>
<tr>
<td>5-11</td>
<td>611</td>
<td>94%</td>
<td>27,018</td>
<td>96%</td>
</tr>
<tr>
<td>12-15</td>
<td>234</td>
<td>91%</td>
<td>15,180</td>
<td>99%</td>
</tr>
</tbody>
</table>

#### Table 10B % Registered Patients who have Participated by Age Band

<table>
<thead>
<tr>
<th>Age Band</th>
<th>HL1 No. Registered Patients who have Participated</th>
<th>%</th>
<th>NLan No. Registered Patients who have Participated</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>497</td>
<td>43%</td>
<td>24,659</td>
<td>45%</td>
</tr>
<tr>
<td>&lt;5</td>
<td>173</td>
<td>55%</td>
<td>7,263</td>
<td>60%</td>
</tr>
<tr>
<td>5-11</td>
<td>241</td>
<td>39%</td>
<td>10,692</td>
<td>40%</td>
</tr>
<tr>
<td>12-15</td>
<td>83</td>
<td>35%</td>
<td>6,704</td>
<td>44%</td>
</tr>
</tbody>
</table>

#### Table 10D: % Patients who have had a tooth extraction by Age Band

<table>
<thead>
<tr>
<th>Age Band</th>
<th>HL1 No. Patients who have had a tooth extraction</th>
<th>%</th>
<th>NLan No. Patients who have had a tooth extraction</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>89</td>
<td>8%</td>
<td>3,346</td>
<td>6%</td>
</tr>
<tr>
<td>&lt;5</td>
<td>*</td>
<td>*</td>
<td>106</td>
<td>1%</td>
</tr>
<tr>
<td>5-11</td>
<td>69</td>
<td>11%</td>
<td>1,904</td>
<td>7%</td>
</tr>
</tbody>
</table>
Across all age groups and both genders, rates of prescriptions to treat asthma were higher amongst the HL1 group (Figure 11A). Conversely, prescription rates of antibiotics were higher within the NLan group (Figure 11B), although the difference was only significant for 12-15 year olds. Five other categories of prescription were analysed, but within the HL1 group, results were too low to provide comparisons.

### Table 10C: % Patients who have had a filling by Age Band

<table>
<thead>
<tr>
<th>Age Band</th>
<th>HL1</th>
<th></th>
<th>NLan</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. Patients who have had a filling</td>
<td>%</td>
<td>No. Patients who have had a filling</td>
<td>%</td>
</tr>
<tr>
<td>All</td>
<td>210</td>
<td>18%</td>
<td>9,040</td>
<td>17%</td>
</tr>
<tr>
<td>&lt;5</td>
<td>*</td>
<td>*</td>
<td>295</td>
<td>2%</td>
</tr>
<tr>
<td>5-11</td>
<td>156</td>
<td>26%</td>
<td>5,368</td>
<td>20%</td>
</tr>
<tr>
<td>12-15</td>
<td>54</td>
<td>23%</td>
<td>3,377</td>
<td>22%</td>
</tr>
</tbody>
</table>

### 5.2.10 Prescribing

Across all age groups and both genders, rates of prescriptions to treat asthma were higher amongst the HL1 group (Figure 11A). Conversely, prescription rates of antibiotics were higher within the NLan group (Figure 11B), although the difference was only significant for 12-15 year olds. Five other categories of prescription were analysed, but within the HL1 group, results were too low to provide comparisons.
5.2.11 Primary 1 BMI data

There was no significant difference between the HL1 and NLan group in terms of those in the healthy weight, risk of overweight or risk of obesity categories at the Primary 1 stage.
6. Views of parents and those working with children and families experiencing homelessness

The aim of the needs assessment is to identify the health and social needs of children and families affected by homelessness across Lanarkshire and make recommendations for service improvement. An essential component of this assessment was therefore to gather qualitative data from families with lived experience of homelessness and also those working closely with them.

6.1 Methodology

Three interviews were carried out with parents who are currently experiencing homelessness. The decision was made not to undertake exploratory work with children, as it was felt this could cause unnecessary negative emotional impact and distress at a time that is already likely to be difficult. Recruitment of parents was through staff who already have established relationships with families experiencing homelessness in Lanarkshire. Staff spoke with potential participants explaining the aim of the work and giving a copy of the information sheet. The staff member then contacted the lead for the work and arranged a mutually convenient time for interview with the staff member present for the duration. As a thank you for participation, those who were interviewed received a £10 supermarket voucher. Interviews ranged in length between 25 and 35 minutes.

It is acknowledged that having only three interviewees and not speaking directly with children is a limitation. Although the ideal would be to only interview those with direct experience of homelessness, this can be a challenging group to engage with and the pragmatic approach was taken to also seek the views of those working closely with those experiencing homelessness. Bias could be a concern with those providing a service assessing the needs of those using their service. However, the majority of those who took part in the focus groups use a standard assessment tool to gather data from participants of their service, therefore making their assessment of need more robust. In addition, upon analysis, the findings from the focus groups aligned well with findings from interviews and the literature.

Seven focus groups were run with groups of professionals working in various parts of Lanarkshire: NHS Health and Homelessness Team, Shelter Scotland Support Service (South Lanarkshire), Local Authority Housing/Homeless staff, support teachers, school nurses and Community Alternatives (a team in North Lanarkshire who offer support to young people aged 11-16 years old). These groups were approached via team leaders who were asked to speak with team members to ask for voluntary participation, passing on an information sheet explaining the purpose of the work and what would be involved. At the focus groups, all participants received a copy of the information sheet and were asked to sign a consent form. In total, there were 32 participants across the focus groups and they ranged in length between 50 and 95 minutes.

Focus groups and interviews followed a semi-structured format, using questions which would allow exploration of the aims and objectives of the needs assessment. All sessions were digitally recorded and these data were transferred on conclusion of the session onto the interviewer’s encrypted computer. Once the recordings had been transferred on to the encrypted computer, they were deleted from the digital recording device. Transcription was undertaken by a professional transcription agency and recordings were uploaded to their secure website. Once transcripts were completed, they were also stored on the interviewer’s encrypted computer. Signed consent forms were stored in a locked filing cabinet, accessible only by the interviewer, within a secure NHS building. On transcription, all person identifiable
details (names of people and other identifying features) were removed. Where this has been done in the results section, it is highlighted in italics.

The transcripts were analysed by identifying themes which were matched against the main questions this piece of work aims to address and results are presented under the relevant headings. Direct quotes from focus groups and interviews are presented throughout, to evidence points made within the narrative.

6.2 Resources and services for children experiencing homelessness in Lanarkshire

6.2.1 Health and Homelessness Service (Lanarkshire wide)

The health and homelessness service was identified within a number of focus groups as a valuable resource to support the needs of people experiencing homelessness. This team work across the whole of Lanarkshire and receive referrals from housing, Health and Social Care Partnerships, Third Sector Organisations and self-referrals. It is a small team made up of: 1.0 wte Team Leader, 2.6 wte mental health and addiction nurses, 1.6 wte health visitors, 1.0 wte sexual health nurse, 0.5 wte podiatrist and 1.0 wte health care support worker. The service predominantly offers an outreach service with home visits for those who are not engaged with services.

With regards to children and young people affected by homelessness, the aim of the service is to assess and meet the immediate needs and refer onwards to the Named Person and / or mainstream services. To assist this process, there are two systems of notification: i) GIRFEC notification process (currently operating in North Lanarkshire) to notify the Named person in education and health when a child presents with their family as homeless, within the locality they originate from.

Notifications for children 0-5 years are sent direct to the Health & Homelessness (H&H) service. The H&H Health Visitor contacts the Health Visitor currently linked to the family to advise of their change of circumstances. Notifications for children older than five go directly from housing to the Named Person in education.

ii) A referral process is in place for children and young people who are disconnected from local health services as a result of their homelessness e.g. moving to/from a new locality, local authority or country. The child /young person receives a wellbeing assessment, their health needs are identified, a care plan is put in place to ensure continuity of healthcare and links are made with local services. The outcome of H&H team involvement is referral onwards to mainstream services or the Named Person in health and education.

From the focus groups and interviews it was clear that this team had the expertise to offer an intensive support for families and individuals, and although ultimately the aim is to refer on to and link with other services and support, the team build trusted relationships with people at a point of vulnerability and often crisis, offer practical and compassionate support, act in an advocacy role between those in need and services which can be challenging to access. The team described having the ability to persevere with people, an important asset for a service working with those experiencing homelessness. ‘Not giving up’ was described as an essential part of building a trusted relationship, which could enable effective support to be given. Making initial contact and offering very practical support such as helping with furniture, gas and electricity and food was described as often being the first step in supporting homeless individuals and families. Reflecting on Maslow’s hierarchy of need, basic requirements of food, shelter and warmth were described as needing to be fulfilled before moving on to looking at other needs such as health, improving self-esteem etc. and
this work takes time which many other services do not have. However, this team are a limited resource and are currently stretched in their capacity.

6.2.2 Shelter Scotland Support Service (South Lanarkshire)

Shelter Scotland is a registered charity with a service based in South Lanarkshire, which is commissioned by South Lanarkshire Council. This service offers practical and emotional support for families living within the South Lanarkshire Council area who are homeless or at risk of homelessness. Each family is allocated a support worker who offers direct support with the parent/s and indirect support for children and young people within that family. Referrals can be from any agency and also self-referral, and tend to be for families who are identified as having high support needs. The team of three support workers work with approximately 30 families in the South Lanarkshire area, which includes approximately 60 children.

The service was described across various focus groups and interviews as highly valued, similarly to the H&H team, offering intensive and practical support via an outreach service. The support workers are able to work with families long term, sometimes up to three years, to help them through all stages of homelessness and onto supporting them to maintain a tenancy long term. Building a trusted relationship was again a key part of enabling support for the families. Many of the families were described as having a suspicion of statutory services, and were more often open to a third sector organisation being involved in their support. This enables Shelter workers to work with families who typically do not engage well with statutory services and start the process of breaking down barriers and making links with the supports that these families are often needing. Similarly to the H&H team, Shelter often offer very practical support especially in the early stages of the relationship. Examples include supporting families to attend appointments (including driving them to appointments), being an advocate, working closely with other agencies, encouraging and enabling parents to develop confidence and life skills.

The Shelter Families team previously had a children’s support worker who specifically worked with the children within the family, assessing each child’s needs, offering needs led play therapy and counselling. However, funding for this post ceased several years ago due to financial savings required to be met by the Local Authority. Although the current support workers are able to monitor the needs of the whole family, they work predominantly with the adult and have identified the lack of dedicated support for children as a concern within their service.

6.2.3 Breaking the Cycle (South Lanarkshire)

This Local Authority service, available in South Lanarkshire, provides outreach support to families who are homeless or at risk of homelessness who have a history of anti-social behaviour, domestic abuse and various other vulnerabilities. Referral can come from various agencies, predominantly housing and social work, and would then be assessed via a multi-agency panel.

This service was identified within some of the focus groups, although some who worked within the South Lanarkshire area had not heard of the service and there was some confusion as to whether the service was available across all of the Local Authority area. The service works intensively with families on an outreach basis, linking with various other agencies as required to improve the family situation. It was identified as a good example of multi-agency working and case management approaches. Homeless families will frequently be working with a large number of agencies concurrently and an identified strength of this service was their ability to coordinate the response of such agencies by bringing them
together to collectively agree the direction of travel with the family. Focus group participants acknowledged this would be a useful approach for all families experiencing homelessness.

Before the financial crisis, there had also been a dedicated Family Support Team within the South Lanarkshire Housing Team, who would contact and visit every family that was experiencing homelessness. Participants saw the value of this approach and felt without such dedicated focus on children within the families, the needs of the children were not being identified and met increasing the potential for problems multiplying instead of being addressed early.

6.2.4 Community Alternatives (North Lanarkshire)

This service aims to work with disengaged young people aged 11 to 16 with a view to retaining them with their families in their own communities, working in partnership with other social work staff, education, psychological services and the children's hearing system. Referrals are from social work and the young people have a range of difficulties including issues with school behaviour, family breakdown, offending, drugs / alcohol misuse and social exclusion. The service can offer support for young people and their families and often work with those experiencing homelessness. Much of the experience of the team related to young people who were homeless in their own right, often due to family breakdown or leaving care and is not explored further in this needs assessment. However, when working with families experiencing homelessness, this service, similar to others, has the ability to offer intensive outreach support, often offering very practical support and persevering, developing a trusted relationship and offering a linking and enabling role with other services, often acting as an advocate for young people and their families.

6.2.5 Support within schools

The experience of those who were involved within the focus groups was that support for children of school age experiencing homelessness is limited. There was a sense that children experiencing such issues was on the increase, but the support services for them were diminishing, with the sense that schools were being left on their own to try to support the needs of these children. The schools described a multi-agency approach to trying to address the support needs of children within the school in a holistic manner, the Health and Wellbeing Review Team. However, where this had functioned well historically, in recent years due to pressures on other agencies and funding cutbacks, attendance was poor. Links between schools and social work were described as particularly poor and also links with health, were described as limited.

Some schools run weekly food and clothing banks for families, children and staff connected with the school, and in addition, often provide toiletries and underwear for young people. Within a school setting, a lot of time was being spent trying to sort out support for young people experiencing homelessness including arranging travel to school, assisting them with seeking financial support and providing emotional support. Previous supports such as attendance officers who were able to visit homes and provide a link with schools to identify potential issues and work with families to address issues that might be preventing attendance, had been lost due to funding cuts, with this role now falling to staff within the school setting, with limited time and without the ability to conduct home visits. The expertise of school nurses had been greatly appreciated when they were more present within the school, but this too had decreased, with a shift in focus of the school nurse role to child protection cases and looked after children.

Some schools have reported the use of Pupil Equity Funding (PEF) to recruit family support workers, offering outreach support for families who are experiencing difficulties, including
those experiencing homelessness. This role was seen as very valuable in developing relationships and giving practical support to families who were struggling, but is time limited funding which was causing concern that this post would be lost in the future, as other valuable support roles had been lost.

Although counsellors and educational psychologists within the school setting were highlighted as supports available for school age children in a number of focus groups, their availability was described as limited – in one school, the waiting list for the psychologist was 18 weeks and the counsellor could only have three children on their case load at any one time, attending the school on one day a week for three hours. A need for emotional support with many children experiencing homelessness was described, with many looking for someone to listen, and support teachers often taking on this role. Within the focus groups, professionals in a school setting described trying their best to help, but sometimes feeling out their depth, concerned that their support was inadequate for the young person’s needs but being unable to offer anything else. There was discussion regarding the proposed roll out of Low Intensity Anxiety Management (LIAM) training for professionals in a school setting, with an expectation that this would be delivered within existing roles. There was concern that this kind of support needed to be done well to ensure that children were being effectively supported, and there was a concern that without being trained psychologists, there was a risk this could do more harm than good. In addition, being already stretched beyond capacity, this would be challenging to undertake within current roles. It was also highlighted that there were criteria for children to access LIAM support and that children experiencing homelessness would often not meet these criteria. E.g. children on the child protection register could not access this support.

From the focus groups and interviews, what the Health and Homelessness service, Shelter Scotland Support Service, Breaking the Cycle, Community Alternatives, housing staff, teachers and school nurses all have in common is that they all go above and beyond what would be expected from their official roles. There were stories of people going out of their way to support families experiencing homelessness, putting their hands in their own pockets to help people meet basic needs and demonstrating high levels of compassion for those in desperate need.

“I just find it hard, that wee boy sat in my office yesterday and it’s like…you just wanted to take him home, take him home with me, go and have a bath, go and have a shower, I’ll make you something to eat.”

Focus Group 7 Participant

6.2.6 Travel fund (Lanarkshire wide)

It was identified in a number of focus groups that funding was available through the Local Authority school transport fund to enable families who have been placed out-with the area of the school or nursery to access funds for buses or taxis. However, there seemed to be variable awareness of this service.

6.2.7 Child and Adolescent Mental Health Service (CAMHS) (Lanarkshire Wide)

There was high awareness of the CAMHS service and an awareness that this service is for children and young people with moderate to severe behavioural, emotional or mental health difficulties. It was believed that CAMHS would only accept referrals when the home life was seen as stable and calm, which was felt to exclude many children who are experiencing homelessness due to a potentially more chaotic home set up or frequent moves. In addition, the long waiting times for an appointment were a barrier due to issues often being acute and
also the risk of appointment letters going to wrong addresses due to temporary accommodation or frequent moves.

6.2.8 Other Services

Other services mentioned within the focus groups which could offer support to children or young people were Women’s Aid, if a child or young person has experience of domestic abuse. Barnardo’s Axis, for a child or young person who has or whose parent has an addiction issue. Community Volunteers Enabling You (COVEY) befriending and mentoring support for young people in South Lanarkshire and some parts of North Lanarkshire, although the waiting list was believed to be one year. The Family Nurse Partnership (FNP) was also mentioned, which is an intensive support service for first time mums under the age of 20 years old, delivered in the home by specialist Family Nurses, from pregnancy through to when the child is two years old. This service was expanded for 20-24 years if the woman met specific criteria, which included being homeless. Data from FNP indicates that women who are pregnant and experiencing homelessness are accessing this service, with a three year average of 6% of women declaring homelessness at enrolment. First Steps workers also work across Lanarkshire to support first time mothers who are identified by midwives or health visitors as requiring additional support.

6.2.9 Service Cuts

All the professionals within the focus groups expressed a strong desire to be doing more for families and children experiencing homelessness but being curtailed by lack of support and funding cuts. Services which were in existence but which had been cut were perceived to have left a significant gap in support available for children and young people experiencing homelessness (as well as children with other vulnerabilities). There was an agreement that there was very little in terms of support for children and young people experiencing homelessness and that short term thinking was setting up concerning issues for the future. Although health visiting remains in place for all children aged 0 to 5 years, there was a noticeable gap in support for children of school age and within a school setting. Supports such as Active Breaks workers, offering lunchtime clubs for children who are struggling with inclusion were noted as another loss, in addition to cuts already mentioned.

| P1: | Basically there’s…do you know what I mean, it’s…there’s just no money in the pot to basically have the services that they used to have. Education’s budget’s been cut. |
| I: | Do you think we’re failing children in these situations? |
| All: | Yes. [General agreement]. |
| P2: | Every way. |
| P1: | Yes, in every way. This generation especially, isn’t it, ‘cause there’s so many cuts. |
| P2: | Absolutely. Setting ourselves up for a massive time bomb. |
| P1: | ‘Cause they’ll be the parents in the future. |
| P2: | Absolutely. They’re not coping with their emotional…they’re not coping with their health, they’re not coping with social… |

Two Focus Group 5 Participants and interviewer
6.3 How do professionals working with children assess the needs of those affected by homelessness?

Homelessness does not trigger an automatic assessment of a child or young person’s wellbeing and there is no standard form of assessment that is used by all agencies. This was raised within a number of the focus groups as a priority issue which needs to be addressed. It was suggested that homelessness should be as important as child protection issues and should be flagged with an alert to bring agencies together to identify and support the needs of the child.

P1: “And I think like we've said before, one of the main problems we have is that homelessness is not an automatic trigger for a wellbeing assessment. So in terms of getting that prioritised that is a big deal in terms of where everybody...social work, education, health needs to go. Because then automatically agencies should be aware that there's going to be extra needs for that set of children in that school who are homeless, and a system whereby they're alerted to the fact that those children are homeless, so that they can be aware of that. Because there's not one single child that's homeless that will not have any additional issues, because the fact that they're homeless in the first place. What's led to the homelessness will then inform the next part of that.”

Focus Group 2 Participant

The assessments used within various teams are highlighted below.

6.3.1 Health and Homelessness Service

This team will conduct a wellbeing assessment directly with the child, which is based on the wellbeing assessment used by universal health services. The assessment is based on the SHANARRI indicators.

6.3.2 Shelter Scotland Support Service

This team will conduct a wellbeing checklist with the parent about the children, based on the SHANARRI indicators (Safe Healthy Achieving Nurtured Active Respected Responsible Included).

6.3.3 Housing Services

When an application is made for homelessness, an assessment of support needs is conducted with the main applicant, but covers all the people within that application. This would cover such things as medical conditions, mental health issues etc. Permission is also sought at this point for the housing team to contact other agencies if they feel this would support the applicant and family e.g. health, education etc.

6.3.4 School nursing

If the child was on the child protection register, the school nurse would complete a health needs assessment which is based on the SHANARRI indicators. Two assessments were mentioned within the focus groups: a wellbeing assessment and a single agency assessment. It was not clear what the criteria for completion of these different assessments was.
6.3.5 Schools

Within a school setting, a number of assessments were mentioned: a ‘Getting It Right For Me’ plan; ‘All about me’ questionnaire based on the SHANARRI indicators which would be completed if a referral was being made to the Health and Wellbeing Review Team (HART); some would use a round robin to all staff working with the child based on the SHANARRI indicators in order to gain a more rounded picture of the potential issues.

6.4 What impact does homelessness have on the health and wellbeing of children affected?

6.4.1 Reasons for homelessness

A range of reasons for homelessness were described which included relationship breakdown, domestic abuse, fleeing violence (either in the family or community), mental health or addiction issues, anti-social behaviour, rent arrears, eviction and liberation from prison. Poverty, unemployment and financial insecurity were raised as being the root of many of the issues seen.

Repeat homelessness and generational homelessness were described as common, in all focus groups and within the service user interviews, two participants had histories in both childhood and adulthood of previous homelessness.

“I stayed with my dad more than my mum but anyway, when I stayed with my mum I can remember that she was evicted from a house because the guy didn’t want her staying there anymore. She had to uplift the full family and go to another homeless house and then moved from there to another house. So, I can remember that. So, I don’t know, maybe just with growing up like that maybe just, kind of, carried on for myself, I don’t know, but I’m hoping this next house is going to be settled.”

Interview Participant

“Because a lot of the times, when we’re dealing with some of the families, they could present as homeless, two, three, four, five times. They’ll be well known to the services, well known to the localities, there may be other issues.”

Focus Group 4 Participant

“We do have a client just now and she’s got her own children…and I knew her grandparents and their problems and then I knew her mum, and all her mum’s siblings, and now I’ve got her. And I know they’re siblings. And that’s really quite concerning when sometimes the cycle just perpetuates and it’s quite bad.”

Focus Group 6 Participant

Within one focus group, there were descriptions of some children for whom regular moving was perceived to be ‘normal’ and the children seemed to accept that as a way of life and appeared almost resilient to those changes. However, it was acknowledged that they may appear fine but issues may arise later in life.
“But the constant house move, it doesn’t seem to have had a detrimental effect on them and, you know, a lot of kids are very resilient if this is what they’re, kind of, living with. And sometimes that can be more of a worry, I suppose, ‘cause you don’t know…you know, later on in life, how’s that going to affect them? But this particular family, you know, kids seem to be jolling along and no issues. They’ve got friends that they go out and about with and they go to clubs and things and…the house is just chaotic. Absolutely chaotic."

Focus Group 5 Participant

6.4.2 Mental Health

Stress and anxiety were the two main issues identified through the focus groups and interviews. Many of the reasons for homelessness are traumatic in and of themselves and then the upheaval, insecurity, instability and worry of being homeless adds to the stress that is experienced by both parents and children.

In terms of parental mental health, it was felt that there were few who did not experience mental health issues, especially stress and anxiety, and two of the three parents interviewed were suffering with mental health issues. Feeling lonely, isolated and powerless were also commonly described.

“I don’t remember visiting any family where the parents haven’t described themselves as being stressed, feeling anxious, crying over their situation. They’ve got no control, they’ve lost everything, they’ve no control, they don’t know where… the control’s out with their control, so they don’t know when the end is going to come, they don’t know when…they’re waiting on money, they don’t know when that’s coming, they don’t know…they’re just in limbo, or as long as they’re in limbo for, they’re still…so that would cause stress and anxiety in anybody.”

Focus Group 3 Participant

“All three of the parents described trying to protect their children from the stress or emotional upset of the situation and trying to stay strong for their children. However, this was difficult and often seemed to feel beyond their control.

Within the focus groups and interviews, there were descriptions of children witnessing traumatic events which have led to fear, distress and anxiety. In addition, there was acknowledgement that the stress and anxiety of the parent, despite their efforts to protect, could filter down to the children. Some children were described as taking on a caring role for a parent or a sibling.
“I think all of the things that we highlighted with the parent or parents or care giver, obviously all of that is impacting on the child. All of it.”

Focus Group 2 Participant

P1: “Mental health I think, probably see that more with the parents. Mental health may be an issue before homelessness, but becoming homeless, I mean, that’s going to make you feel down and low and depressed. And if you have underlying mental health issues, then very often they can be exacerbated.

P2: Which will affect the whole family, which will affect the behaviours of the children and this vicious circle just, kind of, starts. The behaviours of the children affecting the parents’ mental health but they’re all interlinked completely.”

Two Focus Group 5 Participants

“Behavioural and emotional kind of behaviours in children, the young children, there’s usually something led up to the homelessness, whether that’s been domestic violence or stress within the household, parents are stressed, and children will pick up on that, and their behaviour can be challenging, while already the parents are coping with everything else they’re coping with, so it’s seen as a bigger problem, and it’s difficult to contain that, because you can’t promise them that this house is forever. They’re getting moved out from where their friends are, where their family may be, where their pets are, everything, and then they’re moving somewhere new that’s not theirs, their own furniture might not be in it, there might not be transport and all the things, so they’re in a new place to get used to that, but that…there’s still that uncertainty that how long’s it for, they don’t know, they might not be at the same nursery, might not be the same school, it might take a while for them to get linked into services, so they’re really disrupted. But the people caring for them are equally as disrupted emotionally, so it’s difficult for the whole family, it can cause even more stress.”

Focus Group 3 Participant

Behaviours such as anger, lashing out, agitation and frustration were described as more common in older children. Also negative and challenging behaviours which were described as possibly coming from a desire for someone to pay some attention to them, or an inability to express the emotions they’re feeling in any other way.

“I now, like with [name] constantly moving and stuff like just her behaviour and the way she acts and stuff is different because she used to be… Maybe if she just stayed in the one place because she has moved a few times and she seems to be acting differently. Whether that’s due to us moving and just unsettled life I don’t really know but I definitely notice a change in her with the way that she acts. Actually, the teacher’s phoned me about her behaviour and stuff at school which she never ever used to be like but I don’t know because she never really says that’s what’s causing it.”

Interview Participant

There was also description of poor mental health and self-harm. Potential shame and embarrassment at their home situation was also raised, impacting on self-esteem.
“And that's another thing that's horrific for them, it's the embarrassment. Kids were maybe getting moved… I had one girl that had 28 moves in one year. And I was constantly having to move her in bin bags. And that's…I know it's only a small thing, but it's the shame for her as well. That's my life all wrapped up in bin bags.”

Focus Group 1 Participant

For younger children, separation anxiety, being more clingy and anxious in new situations were more commonly described.

6.4.3 Health issues

In addition to stress and anxiety, there were few other commonly seen health issues consistently raised in the focus groups. There were some descriptions of children with asthma and breathing issues, which for one family experiencing homelessness, was felt to relate to mould and damp within a previous property and another parent thought the breathing issues in her child were related to the stress of frequent house moves, as they were sofa surfing.

There was some description of potentially psychosomatic symptoms in some children, brought on by anxiety and emotional distress.

“And the health and the emotional can be related. So it's a bit psychosomatic sometimes with children if they're so desperately unhappy that, one, they've maybe came from a bad environment, they're now homeless. They’re very stressed. They're emotionally upset. That can relate to…like I say, psychosomatic stuff like, I've got a sore tummy, so that means mum and dad keep them off school and that leads to attendance. Then they’ve no, kind of, socialisation with their peers and it can just be roll on effect from it all. There's a lot. There’s definitely a lot.”

Focus Group 5 Participant

“She’s had a lot of sore heads, and sore stomachs, and she's been off school.”

Interview Participant

In one focus group, poor dental health was mentioned and in two focus groups, there was mention of potentially lower uptake of immunisations.

6.4.4 School issues

Absence from school was the most commonly mentioned issue related to homelessness in every focus group and interview. Sometimes this was related to circumstances such as being placed out-with the area in which the children were currently attending school or nursery or sometimes to do with the traumatic events, chaotic households or behaviour.

“And the family I'm thinking in particular, they would go out on a temporary accommodation, and then something would happen and they wanted moved again. So, they've actually, within our locality, moved three times. So, their children missed a lot of school, and a lot of nursery, always unwell. And that was probably a good ten months of instability. Now, they're settled and they've got stability, and they've now got a nursery. But the wee boy missed a full year of primary, and a lot of that is down to the parents.”

Focus Group 4 Participant
“Quite often the scatter flat is not in the area, so then we’ve got first of all to get them transport which then takes time to get organised, to get approved, so there’s always a delay, and when a young person goes to a sort of sheltered accommodation, we’ve got to get things put in place quickly, so then they start missing school, and that can have that sort of a tumbleweed effect of…then they get into a habit of not attending, and it certainly significantly affects their attendance.”

Focus Group 7 Participant

And with lack of attendance, there was felt to be impact on attainment and future prospects. There were issues raised in terms of tiredness from having to travel further to school and ability to do homework due to lack of access to Wi-Fi or tiredness. Some behavioural issues within the school environment were also linked to the instability and uncertainty of their home situation.

“One of the families that I had, I mean, basically the…they were housed in [Area 1] do you know what I mean, temporarily. But they were still going to a school down in [Area 2]. And basically what their mum did was basically…she had got a whole load of their stuff but it was basically in this flat in [Area 1]. But she knew somebody who stayed in [Area 2], so they were temporarily living with them so that she could get them to school easier. So there was more behavioural issues noticed because these children…all of a sudden they were behaving quite, kind of…displaying quite bad behaviour in school. And the teacher was like, I wonder what’s going on here. And that’s what it was to do with, the fact that they didn’t know where they were, do you know what I mean. They were sometimes in [Area 1]. They were sometimes in [Area 2] and there was just this constant shift.

And that was a lot to do with their behaviours, because they didn’t have access to any of their belongings, do you know what I mean. And mum was just taking a wee bag to wherever she was going. But again, she was doing that with the best intentions, because it was too costly, didn’t have enough money to travel up and down because they’d…and she didn’t want to change their schools because they were not long at that school.”

Focus Group 5 Participant

Issues with making and maintaining friendships were described, sometimes due to being out-with the area of the school and therefore unable to socialise with friends, but also sometimes due to frequent moves. Older children were sometimes described as being withdrawn and in a couple of cases, children appeared not to want to be in busy places or large groups.

“So, it is because it’s basically like she’s getting settled and she’s making a group of pals then she’s been uplifted from that group of pals and then moved back somewhere else because while she was up here, she was going to [name of school]. She was getting up early and we were taking her away down there but it was a lot of hassle because she was having to get up so early and trying to get her down to school and stuff like that was horrendous. Then it's like dragging all the kids down to get her from school and stuff. It just wasn't really practical because I thought we would get a house up here but obviously it’s just not worked out like that.”

Interview Participant
“Yeah, it’s like they’ll go for the quiet places, so it’s real anxiety that I’ve seen with it, they don’t like loads of people, and they also find it hard to keep friends. I think a lot of the time they fall out with friends and stuff like that, you know they change friendship groups, and whoever’ll talk to them for that week, they quite struggle with that.”

Focus Group 7 Participant

P1: “Social bullying sometimes at school.
P2: Got that just now.
P1: We deal with that. And emotional...
Int: Because they're homeless?
P1: Sometimes. Because they've moved schools and they've just had to go to a new school and start out again. Or they've stayed at the same school but things have been declining and they've been turning up dirty, unkempt, no glasses, no jotter, no school books, no nothing, because they're homeless and things have went from there. Homework might not be getting done, and they become a target because their head's down in the classroom. So social and emotional is a big one that can lead to mental health issues. We've all dealt with people…they might have children sometimes with mental health issues, self-harming, teenagers sometimes.”

Two Focus Group 2 Participants

6.4.5 Living conditions

Temporary accommodation was described as having improved over the years and processes in place to avoid the use of bed and breakfast accommodation, especially for families. Staff described the efforts being made to accommodate families within their current location, but they acknowledged that this was not always possible due to lack of housing stock available in the area. Temporary accommodation was described as very basic and stark. With pressure to put families into accommodation as soon as possible, often there was very little within the accommodation, perhaps strengthening the perception of living somewhere that is not home, having limited options and feeling powerless within the system.

“The thing with the community care grant is, they’re not awarding carpets.* So even if you’ve got a young family, with kids that are crawling, they’re not gonna award carpets. And I’m like, well, you know, first of all, you need to try and create a safe environment for the children, how are you supposed to, especially at this time of year, retain the heat in a house without any flooring down?”

Focus Group 4 Participant

*At the time of the focus groups the CCG did not fund carpets, however, this is now not the case.
“A lot of the temporary accommodations have nothing, you’re going in and there’s nothing to look at, you’ve got four bare walls, you’ve got a bed, you might not have the full bedding, you might not have any of the utensils for your kitchen. I mean, they’re classed as furnished temporary accommodation, but there’s nothing in those temporary accommodations, nothing.”

Focus Group 3 Participant

Many of the families facing homelessness have limited income and financial insecurities, and rent arrears are a major issue. There were descriptions of families relying on food banks and charities for basics, but having very little to live on. Within temporary accommodation, electricity and gas were predominantly described as being provided through card meters, which tend to be more expensive and this perpetuates fuel poverty.

P1: “Gas and electric, everything’s done on a card, so people put their card in, they’re already in arrears, so their money’s getting taken and they’re still not getting any electricity and gas. I mean, the poverty’s terrible.

P2: And it’s higher with a card, the rate for your watts is higher with your card.

P1: Get their basic needs before they can even look at their other needs, like attending clubs, they can’t afford it, but free access would be great, but there’s a basic need, it’s right down to warmth, shelter, food.

P3: They’ve left everything behind, they’ve got nothing if they’ve fled.”

Three Focus Group 3 Participants

The introduction of Universal Credit was raised in a number of focus groups as a real concern in terms of increasing poverty and directly impacting on families, potentially increasing debt and stress and pushing already vulnerable families further into vulnerability.

“I mean you could get sanctioned and you’ve still got children. And your child… The new UC system unfortunately doesn't protect like the old system. Child tax credit would protect you, the child tax credit system, because it’s a standalone system. The children always get their money even if mum and dad fail to go to the Job Centre, the children always get their money. Not so much the case in some regards with the UC system.

If they mess up your real-time wage, say for example you’re a working family and your employer messes up your real-time wage, and then doubles it one month, but doesn’t put in the next month, but doubles it the next month. Then DWP respond to that on a monthly basis and stop all the benefits on the premise that you are exceeding the wage for that assessed period. So, the child tax credits go.”

Focus Group 2 Participant

In a number of focus groups, the link was made between homeless families and child protection issues. Some of the families experiencing homelessness were also on the child protection register, predominantly due to neglect. As already outlined, addiction issues were raised as a common reason for homelessness, and many households with whom workers were engaged were described as chaotic. Bearing in mind that groups such as Shelter Scotland Support Service, Community Alternatives, Health and Homelessness Team and School Nurses work specifically with those children and families who have complex and multiple needs or are disengaged from services, and where concerns have been identified. However, those working within Local Authority housing / homeless services and schools also
identified that this was a widespread issue and concern with families experiencing homelessness.

As already described, use of food banks by homeless families was described as common, however, restrictions on the number of times these could be used and only being available at certain times and on certain days were highlighted as barriers. Low budgets were felt to limit opportunities for nutritious food and there were two accounts of families not having access to milk tokens to feed babies, leading to weight concerns.

“I think we can really underestimate the impact of the welfare system as well, that very often from a [job role] point of view, if you’re speaking to families, you’re talking about health promotion and healthy eating, and quite often they don’t have a lot of money, and with the universal credit, I mean, that’s hugely impacting on people, so it’s really quite difficult, it does impact on sort of health and wellbeing, even in the most basic form in the fact people are using food banks and subsidies from charities to help them sustain a proper diet, if in fact it is a proper diet.”

Focus Group 3 Participant

Even where benefits existed which could support secondary school age children to access free school meals, the desire to be with friends and go out of the school at lunch time was described as being preferable to the perceived stigma of eating in the canteen.

6.4.6 Older young people: homeless in their own right

Various issues were raised in some of the focus groups which were specific to young people, predominantly under 20 years old, who were homeless in their own right. For various reasons, these young people had left their family home and were presenting as homeless or were perhaps being released from a Young Offenders Institute. Many of their issues are unique and different from those that face children or young people who are experiencing homelessness as part of a family. It was felt that this was a very vulnerable group, often experiencing poor family relationships and previous trauma. Presenting as single homeless people often meant that they were being put into homeless units where they were at risk of exploitation and exposure to substance misuse. It was felt that this group were not being well protected in a homeless situation and their prospects and aspirations were being severely limited. These issues are not explored in this needs assessment, however, would merit further exploration as a unique and vulnerable group whose needs should be identified and addressed.

6.5 What specific barriers are experienced by this group?

6.5.1 Access

One of the main issues regarding access to healthcare services was the lack of a permanent address when in temporary accommodation, leading to several issues. Whilst in temporary accommodation, you can be moved at any point if a suitable permanent tenancy becomes available and yet one interviewee described GP practices wanting assurance that they would be at their address for three months in order to register.

“And the doctors are asking, you’ve got to be here for three months. We've not got a clue how long we’re here for, we can't lie, do you know what I mean?”

Interview Participant
Being moved into temporary accommodation often meant moving out-with the catchment area of families’ current GP practice. Registering with new practices could be problematic due to the unknown length of time they might be within the new area and also the requirement for forms of identification which they often didn’t have access to, perhaps because they have moved frequently or have fled. Some people remained with their GP but the move made it a potential challenge to get there due to the distance and cost of travel.

“But for health needs for some of the wee children, as I said, sometimes they’ve missed appointments because…this happens all the time. They’ve missed appointments because they’ve moved house. They don’t tell the GP to change their address. And just as they moved house that appointment they're waiting for, for six months came through and now they've missed it. And guess what? You've missed the last one, so scrap you off the list. Have to go back to the GP. And guess what? You're not registered with the GP yet. Have to go down and get you registered with the GP first. Oh, have you got a birth certificate? No. You need to go and buy your birth certificate. You cannot register your child without a birth certificate.”

Focus Group 2 Participant

Appointment letters were described as often going missing due to change of addresses, leading to missed appointments. A low tolerance of missed appointments within the NHS was described with a ‘one strike and you’re out’ attitude, with little perceived leeway or understanding to a family’s situation.

“…they’re missing appointments because they’re at different addresses and systems don’t get updated, so perhaps they miss one appointment, then they’re not sent another one, some agencies wouldn’t…if you do any once, then it’s one strike and you’re out, or they might get another letter to the old address to say, if we don’t hear from you for seven days, then we presume you no longer want this appointment, so they’re out the loop again, and then they need to get back into services to be re-referred to the specialist and it’s months and months and months that they’re missing out on trying to get in.”

Focus Group 3 Participant

Once registered, there was description of delay in transfer of notes from former practices to the new practice, with a perception they were not ‘on the system’ for the new practice with resulting implications if their child became ill.

“When I registered all them, I had to get all the paperwork and then they weren’t going to go on the system for like a week and a half or something. So, I said, what would happen if one of the kids weren’t well? They said, oh, you could just like phone up the appointments in the morning but I’d have to wait until they go on the system.”

Interview Participant

One participant had been pregnant and had issues with previous pregnancies. She described having to explain at every appointment her previous experiences as the maternity notes had not been transferred, which she described as distressing. There were also descriptions of some people not able to access prescriptions for ongoing medications due to moving out of the area.

Accessing appointments in primary care was an issue raised within focus groups and interviews. With one family, this appears to be linked to a local shortage of GPs, not related to their homeless situation. However, it was raised within a number of discussions that
primary care appointment systems moving to telephone or online booking only and various automated systems has increased the difficulty for many people on limited incomes to make appointments. There were descriptions of people not having the credit to make phone calls or not having access to the internet and therefore limiting access to those in need. There was a feeling that GP practices could be inflexible and lack understanding in terms of being able to access appointments. Because of the difficulties in accessing appointments, NHS 24 and out of hours was seen as an option which was potentially more easily accessible for one of the participants.

“Even like if you phone for a repeat prescription, you can’t even do it. You have to go on the computer so if you don’t have a computer how are you supposed to go online? If you don’t have a phone, how are you supposed to phone an appointment? You have to drag all your kids to just stand at a doctors and use the phone.”

Interview participant

P1: Some of the practices, if you don’t have a phone and you just walk in, they won’t give you an appointment because you’ve got to phone. Honestly. We do advocate on their behalf a lot and just let them use our phones, work phones, but it doesn’t always work. We’re not always there when they need an appointment.

P2: That’s health. That’s a worry.

Two Focus Group 3 Participants

Travel was highlighted as a barrier to accessing healthcare on a number of occasions. As already mentioned, if the family have remained with their former GP or are having to attend hospital appointments, the cost of travel can be prohibitive. One family had a number of hospital appointments in Glasgow for more than one child and these were often scheduled on different times and days, leading to a number of trips being required in the one week. Trying to get to these appointments with more than one child by public transport was expensive, time consuming and the timings of appointments could be an issue when trying to get other children to and from school. Another parent described the challenges of trying to co-ordinate various appointments for them, one of their children and also trying to work.

I: Okay. And you’ve mentioned about various different appointments and things like that for the children, how easy have they been to get to?

P: A nightmare, because I’ve been juggling it with work, I’ve been juggling it with my own appointments, with kids appointments, I just feel like… everything’s just been chaotic, and I think it’s more the fact that I’m going between houses, you know what it’s like in your own home, you can be organised the night before, you can have everything done, everything set out for you getting up in the morning. I still do that, right you are, but it’s not the same, it’s just a complete rush everywhere. Sometimes I’m unable to make my appointments and I’m having to cancel, just out of the fact that if I’ve got an appointment, my son has, well, my priority’s him, so I take him and I cancel mine.

Interviewer and Interview Participant

As previously described, mental health and behavioural issues are a common concern in children and young people experiencing homelessness. The Child and Adolescent Mental Health Service (CAMHS) in Lanarkshire was believed not to take referrals if the home life
was not stable, with the perception that homelessness limited the ability of these children to access this service. CAMHS was described as having long waiting lists, with the potential for delaying the help and support for the child, but also increasing the likelihood of a move of location for the family during that waiting period and potentially missing an appointment letter.

6.5.2 Parental Self-esteem/ Self-confidence

Homelessness has an impact on the mental health of a parent but also affects their self-esteem and confidence to deal with the many challenges that the situation presents. One of the interview participants described feeling ‘beat down’ and not having the energy to deal with the various challenges that were facing them. The landscape for support in homelessness was described as involving a number of agencies, lots of appointments and could be overwhelming for people who may already be struggling with the trauma of events leading up to becoming homeless.

Perceived stigma and judgement within a healthcare setting were described on a number of occasions, with a lack of understanding and compassion for those experiencing homelessness.

…”if they hear that they're homeless, they don't really...aren't keen to take them on. They kind of make excuses about, you'll need to try somewhere else, you'll need to phone at eight in the morning, so it is really difficult.”

Focus Group 3 Participant

Low self-confidence was described as potentially affecting a parent's ability to raise concerns over their child's health, perhaps feeling that the issue was not an ‘emergency’, struggling to assert themselves and perhaps not wanting to draw attention.

“So, if somebody says 'is it an emergency', they might look at the child and go well, it's not really an emergency. I mean they're not dying or anything like that because they don't understand that... I would class it as an emergency because I'm going, I class it as an emergency, your child's not eating.

… And I think she was looking more at the barriers to getting there, than thinking of the child. She was thinking I've not got a babysitter, who's going to look after the kids? I've not got any money. She's looking at all the barriers…”

Focus Group 2 Participant

These issues could be compounded by the lack of continuous relationships with healthcare practitioners and other service providers, often due to having to move for temporary accommodation. Having a trusted relationship, developed through continuity, was identified as an important factor in supporting people effectively through the challenges faced from experiencing homelessness. Two interview participants described having to constantly repeat their story to many different people, which added to their trauma.

It was identified that some people experiencing homelessness have had negative experiences with service providers and statutory agencies in the past and will often avoid engagement with such agencies and view them with suspicion, adding further barriers to accessing appropriate support.
6.5.3 Hidden Issues

There is no standard assessment of a child’s wellbeing when a family present as homeless. The process of identifying issues relies on a parent raising concerns with housing or other agencies and a major barrier described in the focus groups was the fear that raising issues would potentially cause social work involvement, which increased the perceived risk of their children being removed. With those who work with families experiencing homelessness, there was a consequent concern that this fear inhibited parents from asking for help, potentially leading to people ‘suffering in silence’ and issues with children not being picked up until they had become more extreme.

“And we might not be fully aware of all the issues. Because the thing is, with the [word removed] support assessment is, you’re relying on that person telling a complete stranger all their problems.”

Focus Group 4 Participant

“I don’t think people like the word social work. You know, if you were offering somebody other supports, you know; you’re trying to link them in with people or services that are going to help them and social work is always…they’ve got this great fear that they’ll take their children away rather than support them to live a better life, you know; I think they fear…they don’t want social work.”

Focus Group 6 Participant

P1: “…we try to help families engage with social services, to take the stigma and the fear away and say actually, social services are there to support, not to take your child. The end game isn’t to remove your child. It’s to help you keep your child in your care.

I: Is that quite a big fear?

P1: Huge. That's what they ultimately believe.”

Focus Group 2 Participant and Interviewer

It was identified that if there were no child protection concerns or antisocial behaviour issues, that children did not appear to be officially linked in to any support. Within the focus groups, it was felt that homelessness used to be a higher priority concern with children, but other issues such as child protection, now dominated the case load for a number of teams. If specific issues were not highlighted, many homeless children appeared to be going under the radar.

“And I suppose if it’s not child protection then you don’t have social work going in and if everything seems to be okay on the surface then perhaps it’s not picked up by support and they say, well actually they’re doing okay because mum’s doing what she needs to do but in actual fact they can be in real crisis.”

Focus Group 6 Participant

Within the teachers’ focus group, only one teacher could recall receiving a GIRFEC notification that a child was homeless. They occasionally received a police alert or direct
contact if there was social work involvement. More often than not, the child would tell a teacher or some aspect of their attendance, behaviour or appearance might change and would alert a teacher to a potential problem. Similarly, school nurses indicated they usually found out homelessness status indirectly as a result of another issue and not official notification.
7. Discussion

7.1 Homelessness as an Adverse Childhood Experience

Homelessness is a traumatic event in a child’s life. It can be seen within the literature that the experience is defined by loss, often accompanied by fear, anxiety and insecurity. An Adverse Childhood Experience (ACE) is defined as a stressful event in childhood and although the traditional list of ACEs does not include homelessness, the experience is described in the literature and the qualitative aspect of this report as having all the hallmarks of a traumatic experience for children and young people. The data from South Lanarkshire, the literature and qualitative data in this report identifies that many of the reasons a family become homeless are also considered ACEs, such as parental relationship breakdown, poor parental mental health, incarceration of a parent, parental substance misuse and their mother treated violently. Homelessness may also increase the risk of experiencing other ACEs, such as neglect or abuse.

Data shows that within North Lanarkshire, we have a significantly higher proportion of children aged 0-5 years in the HL1 cohort than the North Lanarkshire population. Pregnancy and the transition to parenthood are both associated with increased relationship breakdown and domestic abuse, both recorded as common reasons for homelessness. It could be, therefore, that the higher proportion of under 5s in the HL1 group could be connected to these factors. These early years are also a critical stage in brain development and are particularly vulnerable to the impact of stress.

ACEs have been found to be linked to poorer long term health and outcomes across the life course. For example, a survey conducted in Wales identified that those with four or more ACEs were more likely to develop heart disease, cancer, Type 2 diabetes, have had underage sex, have been in prison, have health harming behaviours such as high risk drinking, smoking or drug use, have committed violence against another person in the previous 12 months and been a victim of violence. There is evidence that many people experiencing homelessness have a history of multiple ACEs, and that the ACEs led to other behaviours which increased the likelihood of homelessness. The impacts of ACEs are not inevitable, with evidence that a positive relationship with one trusted adult in childhood can mitigate the effects. However, as highlighted in the literature and qualitative data, parents experiencing homelessness are often struggling with their own stress and mental health, making supporting their children more challenging. Children are more likely to be dislocated from wider family, be experiencing absence from school and not able to access extra-curricular clubs reducing access to other potential trusted adults.

Children and young people experiencing homelessness are therefore experiencing multiple disadvantage due to this experience: homelessness being an ACE, reasons for homelessness likely to be an ACE, homelessness increasing the likelihood of further ACEs, likely to be a younger cohort and therefore more vulnerable to the effects of ACEs and less likely to have consistent support from their parents or other trusted adults.

7.2 Mental Health and wellbeing

Mental and emotional health and wellbeing were identified as prominent concerns in the literature and qualitative data for children and young people experiencing homelessness. In the focus groups and interviews, some children were described as having anxiety, a tendency to be withdrawn, and exhibiting behaviours such as anger or lashing out.

At the 27-30 month appointment, there was a significant difference in an emotional or behavioural concern being identified in children in the HL1 cohort compared to the NLan
group (17.5% vs 7.1% respectively). Referrals to CAMHS for the HL1 cohort were over double the number in the NLan comparator group. Both these data sets indicate that the HL1 group is experiencing a range of poorer emotional, behavioural and mental health outcomes, starting to manifest in the early years. And yet there is very little to support them. As previously described, CAMHS is a service for young people with moderate to severe behavioural, emotional or mental health difficulties, therefore not suitable for those with what could be considered lower level issues or those in the early stages of manifestation. Within the school setting, the capacity of educational psychologists and counsellors was not felt to be meeting the demand. Although there are plans to roll out Low Intensity Anxiety Management (LIAM) training to teachers and school nurses, these professionals felt they did not have the capacity to be delivering this support in the way it has been designed, alongside the demands of their current workload. Within the school setting, support for young people’s mental health, at all levels, is severely lacking.

In a number of the focus groups and one of the interviews, it was identified that children were not necessarily felt to require formal counselling if they are experiencing homelessness. What children perhaps require more is someone to talk to (independent of the parent), in an informal way, someone who will listen and check they are doing ok. One of the parents felt that there was support for her in this process through the Health and Homelessness Service, but nothing for her children. Play therapy was mentioned as a valuable support offered by the Children’s Support Worker, formerly in the Shelter Families team in South Lanarkshire and literature identifies that this can be beneficial specifically for children experiencing homelessness, demonstrating improvements in self-concept, mood, self-esteem and anxiety. There cannot be an assumption that if a parent is receiving support for their mental health or anxiety issues, that this will replace direct support for children. Instead of treating the downstream issues in children and young people, once they have developed to a moderate or severe level, there should be meaningful focus on preventing the development and progression of low level symptoms, which from the evidence, are likely to be present in many children and young people experiencing homelessness.

7.3 Inequalities in health outcomes

The data from North Lanarkshire identifies a number of disparities in health between the HL1 and NLan groups.

Respiratory infections and breathing conditions were significantly higher in the HL1 group, with more than double the rate of A&E attendances and emergency admissions for breathing abnormalities and more than double the rate of A&E attendances for upper respiratory infection. In reasons for A&E attendance, four out of the five with the highest differences between the HL1 and NLan groups were due to viral or bacterial infections, with the HL1 group again having double the rate for each one.

As outlined in the literature review, gastrointestinal infections, respiratory infections and conditions (including asthma) are more common in children experiencing homelessness. Risk factors for viral and bacterial infections include living in overcrowded conditions, poor hygiene and poor living conditions (e.g. damp and mould). Although there are no data from this piece of work, we know that breastfeeding is lower in areas of deprivation and therefore, it is likely that women experiencing homelessness are less likely to breastfeed which offers protection from various infections. Specifically for respiratory infections and exacerbation of respiratory conditions, risk factors include exposure to second-hand smoke. Although there are no data in this piece of work regarding exposure to second-hand smoke,
data from the adult cohort of HL1 applicants shows that 54% of women in the HL1 cohort smoked during pregnancy compared to 17% in the NLan cohort. The 2016 Scottish Health Survey also highlights that second-hand smoke exposure is 15 times higher in the most deprived communities in Scotland compared to the least deprived\textsuperscript{48}. This suggests that it is more likely that children in the HL1 cohort are exposed to second-hand smoke.

The lower uptake of two vaccinations is noted within the data. The teenage booster vaccine is administered in third year at school, within the school setting. In order to be included on this list, the child must be registered with a GP and receiving the vaccine also relies on school attendance – both situations which we know are affected by homelessness. This booster includes tetanus, diphtheria, polio and meningococcal types ACWY. Teenage years are a life stage of increased risk of contracting meningitis and, therefore, 54.7% of young people (n=29) experiencing homelessness not receiving this vaccine is concerning.

The 5 in 1 vaccine (now 6 in 1) begins at 8 weeks and includes diphtheria, tetanus, whooping cough (pertussis), polio and Haemophilus influenzae type b. Other vaccines, although not within the 5 in 1 vaccine that we have data for, are given at the same appointments (rotavirus, pneumococcal and meningococcal type B) and it is therefore likely that these vaccines have also been missed. The 9% missing these vaccines represent 109 children who have lower protection from common childhood illnesses.

These data identify potential issues which put the HL1 group at higher risk of viral and bacterial infections and respiratory issues, with higher likelihood of exposure to risk factors such as overcrowding, poorer living conditions, potentially second-hand smoke exposure and lower uptake of protective factors such as vaccinations and potentially breast-feeding.

Dental health was another area where there was a difference identified between the two groups. Although overall the differences in those with filled or extracted teeth were small, there was a significant difference in the 5-11 age band with the HL1 group having a 30% increased risk of a filled tooth and 57% increased likelihood of an extraction. Not being registered with a dentist reduces the opportunity for oral health advice, early detection and prevention of issues. (Barriers to registration with health services is discussed below). Through the child smile project, children should be provided with toothbrushes, toothpaste and offered fluoride varnishing through nursery and primary school, however, children and young people experiencing homelessness are more likely to have attendance issues at both nursery and school, reducing the likelihood of accessing these initiatives. Another consideration could be a higher consumption of sugar or less frequent toothbrushing within the HL1 group, however, we have no data through this piece of work to evidence that.

7.4 Access to health services

Attendance at A&E and emergency admissions for the HL1 group were significantly higher than the NLan comparator group. It is important to bear in mind that these figures were based on total presentations/admissions and could therefore represent the same people presenting a number of times. There are a number of other possible reasons for the differences. From the qualitative data, we know that registering with a GP and booking appointments can be challenging, perhaps resulting in issues being left until they are more serious before healthcare help is sought. Leaving issues until they are more serious could also be a result of lower self-confidence in assessing how ill a child might be, as raised within the focus groups. There may be issues with getting to primary care or outpatient appointments due to lack of funds, and again help may only be sought when more serious. A final possible contributing factor could be that poorer access to primary care could make
A&E a more accessible option, although this would not explain the higher emergency admissions.

Not attending appointments, such as CAMHS and outpatients were higher in the HL1 group and registration with a dentist was lower. Barriers regarding attendance and also registration with healthcare professionals such as GPs and dentists, were explored in the focus groups and interviews. It is likely that the cost and distance of travel to healthcare sites, multiple appointments at different times, dates and locations, difficulties registering with healthcare when in temporary accommodation and not receiving appointment letters due to frequent moves, could explain some of these trends. There was no significant difference seen between the two cohorts for the uptake of the 27-30 month review and it could be hypothesised that being a home-visiting appointment, this reduces the barriers to attendance experienced in the other services.

Through the focus groups and interviews, it was identified that those experiencing homelessness sometimes faced attitudinal barriers from staff within the NHS, although there were also examples of supportive and empathic care from various healthcare professionals. There was a feeling that there can be a lack of flexibility and understanding regarding circumstances when experiencing homelessness and improving this, could improve access to healthcare for this group. An evaluation of health services amongst homeless families in Leicester identified that same day appointments were the most commonly cited desired service improvement, followed by flexible services (although there is no more detail on what this means) and drop in services. With the interview participants, suggestions were similar with an expressed desire for more accessible appointments in primary care, but also where there were children within the family under the care of different teams in acute care, that there could be co-ordination of appointments to make access easier.

### 7.5 Support for children and families

From the data identified there appear to be limited supports available for children and families experiencing homelessness in Lanarkshire. More supports were identified in South Lanarkshire compared with North, indicating there may be an inequity between the two HSCPs or at least variation in awareness of what was available.

For children under 5 years, health visiting offers a universal service which maintains contact through the early years, and should be a mechanism to identify potential issues at their early stages and offer some level of support if required. However, there is an identifiable gap for children once they reach school age. Although systems were described to be in place in North Lanarkshire using a GIRFEC referral to notify the child’s named person within a school setting, it is not clear what is being done with the notification once it is received, what the expectations are following the notification and there is currently no follow up to assess the impact of the notification. This process had been in place in South Lanarkshire but had stopped being completed, however there are plans to resume.

The Health and Homelessness Service appeared to be the only Lanarkshire wide service with a focus specifically on homelessness and the ability to work with children and parents experiencing homelessness, although their role is predominantly to link people with other services. Services such as Shelter Scotland and Breaking the Cycle are based only in South Lanarkshire and have specific criteria for referral (e.g. multiple complex needs or anti-social behaviour). Community Alternatives based in North Lanarkshire work specifically with young people who are between 11 and 16 years old and already experiencing difficulties such as exclusion. Agencies which had previously had teams dedicated to specifically supporting
children and families had been cut, with professional participants identifying this as a concerning gap.

Within the school setting there was a lot of willingness but very little resource to be able to support children experiencing homelessness. There was a sense that teachers felt left on their own with very little support from external agencies and with resource cuts, such as the loss of attendance officers and active breaks workers, impacting on support that was previously offered.

One of the big issues identified throughout this report has been the mental and emotional health and wellbeing of children experiencing homelessness. The gap in available support was identified as a great concern for many of the professionals who participated in the focus groups. Capacity of existing supports in school were described as lacking and other services such as CAMHS are stretched and not appropriate for all levels of need. There seems to be a particular gap in provision for low level anxiety or other concerns. There can sometimes be a tendency to want a ‘service’ to deal with these kinds of issues, but from the focus groups and interviews with parents, sometimes what children may need is an environment which offers play, fun, development of friendships and an opportunity to chat to someone should they desire it. In addition to child focused support, encouraging and enabling the relationship building between parent and child is also vitally important. This kind of support would not be appropriate in the form of structured parenting classes, but in an environment of trust and support, where fun and connection with their child/ren can be modelled and nurtured.

What is clear, is that support for children and families experiencing homelessness in many cases will not be a quick fix. Homelessness, in general, follows a build-up of issues over a period of time and is inextricably linked with issues of poverty. There are some cases where a family will not have many issues and they require a new tenancy, with this being a one-off event. However, as identified through this work, there are many families where this is not a one-off but will have been an issue in their own childhood and may be a recurring event for their own family. What is required for these families is intensive and practical support in the early stages and the option for support over the longer term. The needs of the child as well as the parent and family as a whole need to be identified and services which can work with them should be available, no matter the level of need or location. Aspects of services which seem to work best with families experiencing homelessness include: outreach, home-visiting model, able to offer continuity of relationship and build trust, offer practical support and advocate on behalf of the client.

It was identified that there are other services or resources which are not necessarily just for people experiencing homelessness but which would be helpful in building up parenting skills, social connections and potentially leisure opportunities. A number of professionals in the focus groups highlighted that groups such as mother and baby groups or free leisure opportunities were not well publicised or easy to find information about. It was suggested that an easy to access tool should be available to help staff guide clients to available support or resources. The LOCATOR tool which provides this kind of information is available for both North and South Lanarkshire, which indicates there is perhaps a lack of knowledge of this tool or there are perhaps gaps in the information it provides.

7.6 Assessment: identifying needs

As identified within the qualitative aspect of this report, there is no standard assessment of the needs of children experiencing homelessness. The process relies on the parent identifying the needs of the child at their homeless presentation or with another professional, which can be hampered by fear of the consequences of disclosing problems or lack of
awareness. On the whole, assessments are only initiated when an issue becomes noticeable, which could be argued is too late e.g. refusal to go to school, behavioural issues. The child is not at the centre of this process, and there are currently no robust mechanisms to support children in the early stages of experiencing homelessness. Without a standard assessment for every child experiencing homelessness, there can be no effective early identification and therefore effective prevention of potential issues. It is clear that whether children appear to be ‘coping’, many will have experienced a number of ACEs, including homelessness itself, and mechanisms should be put in place to protect these children and ensure supports are in place to mitigate the potential effects, and this starts with effective early identification. Children should be seen as clients in their own right and assumed they are in need of support, until proven otherwise.

Services which did use an assessment were all based around the SHANARRI indicators, although there appeared to be a number of different variations in use. The ideal would be to have one assessment conducted with all children who are within families experiencing homelessness. As outlined, there are a number of agencies which will complete an assessment with some children, some are completed with the parent about the child. There is likely to be an element of duplication occurring and therefore it may be more straightforward to have one assessment completed by one agency. However, who this lead agency would be and how the results of this assessment are taken forward would need to be agreed. It would seem most appropriate that this assessment is completed once and have a mechanism established to develop a co-ordinated response to the needs identified.

7.7 Joint working

When a family become homeless, there are often a number of agencies involved in working with them, many appointments and a lot of processes to follow. One participant described feeling passed from pillar to post and two described having to tell their story repeatedly, which was upsetting for them. The different agencies involved do not seem to be well linked in a number of cases, with official referral routes lacking and a reliance on a contact they have made informally. Sometimes frustration was expressed at the lack of formal referral routes and some descriptions of passing the buck. A number of different professional groups described feeling left on their own dealing with issues they felt should be dealt with by other professional groups and not being given adequate support by others.

Each professional group which was involved in the focus groups was clear on what their role was within the homeless process, however, there was a feeling that there was a lack of understanding of their role and scope by other professionals and also they felt they did not have a good understanding of other profession’s roles and limitations. A number of staff recalled an event with social work, housing, health and some other professionals which had discussed roles and responsibilities. This had been found to be a useful exercise, with suggestion that it would be beneficial to repeat this, with invitation extended to wider sectors such as education. Having roles and responsibilities clearly defined and agreed referral processes came out as other suggestions for improvements.

A recurring theme in the focus groups was the benefits of multi-disciplinary working. A number of examples of positive multi-disciplinary working were identified, such as with Child Protection cases, when all agencies were obliged to engage regarding the care and protection of a child. Within the focus groups, there was a perception that homelessness was previously a higher priority issue, seen at the same level as child protection, but that this had slipped in recent years. There were suggestions that children experiencing homelessness should be the same level of priority as Child Protection cases and that multi-disciplinary meetings including all key agencies should be conducted to develop a plan, establish what
supports were required, if any for that child, and monitor on an ongoing basis. It was felt that this would improve the co-ordination and overview of the child’s wellbeing.

The question, however, remains as to who would take the responsibility for the co-ordination of the meetings and be the lead contact for the child and family? The immediate suggestion might be for the named person to lead on this (Health Visitor for Under 5s and Head Teacher for school age). However, the practicalities of this would need to be discussed and whether another model may fit better, with another agency taking the lead for all homeless children and families (including completing the initial assessment), but linking closely with the named person. Other practicalities to consider would be the capacity of agencies and professionals already stretched dealing with Child Protection, and asking them to add homeless children as an equal priority.

Barriers identified to better joined-up working were: already stretched capacity and caseloads; IT systems which are not linked up; some agencies unable or unwilling to send information to voluntary organisations; lack of official referral routes or contacts; willingness to engage.

8. Conclusions and Recommendations

It is clear from the data contained within this report that children experiencing homelessness in Lanarkshire are potentially experiencing disadvantage in multiple ways. We do not know the full extent of the issues they may be facing due to not treating them as a client in their own right, and relying on others to identify potential issues. In not completing an assessment with each child, we are missing a key stage to be able to intervene, potentially averting additional trauma and preventing issues escalating to the point that they need more intensive intervention. There are also a lack of support services specifically for children if issues are identified, especially low level anxiety and stress. The experience of homelessness can be frightening and is punctuated by uncertainty and loss for the child, therefore, supports which enable the child to feel safe, secure and experience fun, whilst supporting and nurturing the family unit need to be put in place. In some cases, homelessness is a one-off event for a family, but in many cases this is a repeated cycle driven by poverty and social issues. Solutions need to be co-ordinated, long term and intensive in order to break the homelessness cycle. To prevent the cycle continuing into the next generation, children need to be at the centre of the support we provide.

1. Recognise that homelessness is an Adverse Childhood Event and that children experiencing homelessness are at increased risk of experiencing other ACEs, with the potential to have long term impacts on a child’s health, wellbeing and attainment.

2. Homelessness should be raised in priority to the same level as Child Protection, with the same obligation for multi-disciplinary engagement.

3. Agree a single assessment tool based on the SHANARRI indicators that is undertaken directly with every child experiencing homelessness, treating them as a client in their own right, with their own needs. This would allow early detection of potential issues, ensure more of a preventative approach and put early supports in place.

4. One agency should be responsible for the completion of the recommended assessment (point 3) and initiating and co-ordinating a multi-disciplinary group to review the needs, agree a care plan if required and monitor progress.
5. There should be an expansion of services which can offer intensive, longer term (when needed), outreach support through one point of contact for children and families experiencing homelessness. Support specifically for children, perhaps play therapy based, must be incorporated into these services. A holistic approach to family support should be adopted.

6. Develop and establish formal referral pathways, defining the roles and responsibilities of all services or agencies involved in supporting children and families experiencing homelessness. Use of the LOCATOR tools should be highlighted and useful improvements identified.

7. Bring together all staff and agencies involved in child and family homelessness to improve understanding of one another’s roles and responsibilities, improve networks and increase awareness of supports available.

8. The service provision across North and South Lanarkshire should be reviewed to ensure the needs of children and families are met.

9. Funding should be increased to support these recommendations and not have an expectation that these developments should be incorporated into current workloads.

10. Review the support for children experiencing homelessness in a school setting, especially for mental health and wellbeing support.

11. A needs assessment should be undertaken of young people aged over 16 years who become homeless in their own right, as their needs are likely to be different from children and young people experiencing homelessness as part of a family.
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