

Bridging the Gap

**Understanding the health care
support and training needs of
frontline workers supporting people
experiencing homelessness**



Homeless Link

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Contents

Introduction	3
Mapping existing training	4
Health and support plans	5
Findings from the workshops	6
Types of health conversation	7
Initiating health conversations	8
Barriers to engagement	11
Conclusion	12

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Introduction

People experiencing homelessness face some of the worst health outcomes. This is driven by a combination of social determinants and poor access to services. Diagnoses of physical and mental health conditions are much more prevalent than the general population and many of those experiencing homelessness face early onset frailty.¹ Further, the average age of death of someone experiencing homelessness is around 30 years lower than that of the general population.²

Homelessness services are often at the frontline of this, supporting, advocating for and observing individuals experiencing a range of health care needs. Health conversations are embedded within the wider homelessness support system, with discussions around physical and mental health and substance misuse core elements of support planning. Therefore, frontline workers often play a vital role in signposting people to relevant services, advocating on their behalf, and even enabling and encouraging people to engage with preventative healthcare initiatives.

During the COVID-19 pandemic, the integral role homelessness services play in connecting those they support to health services came to the fore. In the initial stages of the pandemic, when the Everyone In initiative was at its height there was a surge in partnership working in local areas. This brought health services into spaces where they hadn't previously operated, proactively reaching out to individuals accommodated in hotels and other emergency or temporary accommodation, rather than waiting for these individuals to come to them.³

However, it was during the vaccine rollout that the importance of homelessness workers as a link into health and social care really shone through. Homelessness services have played a critical role in engaging those they support with COVID-19 testing and vaccination, encouraging vaccine uptake, raising awareness of the benefits and understanding vaccine hesitancy. Crucial to this was working with local vaccine rollout teams to create accessible vaccination clinics for people experiencing homelessness.

¹ Pathway, 2020, Premature frailty, geriatric conditions and multimorbidity among people experiencing homelessness: a cross-sectional observational study in a London hostel. Available at:

<https://www.pathway.org.uk/wp-content/uploads/Frailty-research-paper.pdf>

² ONS, 2020, Deaths of homeless people in England and Wales: 2019 registrations. Available at:

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deaths-of-homeless-people-in-england-and-wales/2019-registrations>

³ Homeless Link, 2021, Working Together: the sector's path beyond COVID-19. Available at:

<https://www.homeless.org.uk/sites/default/files/site-attachments/Homeless%20Link%20-%20Working%20together%20v5.pdf>; National Housing Federation, 2021, Partnership Working Around Homelessness: Lessons Learnt and Action for the Future. Available from:

<https://www.housing.org.uk/globalassets/files/lga-event-report-final.pdf>.

The conversations frontline homelessness workers are having with the people they support, encouraging use of primary health and social care services, are vital. People experiencing homelessness are disproportionately more likely to access emergency healthcare, and have extremely poor health outcomes and mortality rates. There are wider systemic barriers that contribute to this, however it is clear that frontline homelessness workers can, and often already do, play a key role in encouraging the people they support to engage with more upstream health care.

This paper sets out the findings of a consultation with frontline homelessness workers and people experiencing homelessness. It explores the barriers to and opportunities for more effective health and social care conversations and what training and wider support mechanisms are already available to frontline workers to help them facilitate health-related conversations, with a view to understanding what gaps there are in the current offer.

The work was carried out by the Homeless Health Consortium (HHC), part of the wider VCSE Health and Wellbeing Alliance. Increasing access to health care services for inclusion health populations is an important element of the work of the HHC within the Alliance.

Mapping existing training

As part of this scoping work, it was necessary to consider the existing health resources and training available to frontline homelessness workers and a recent [Inclusion Health Education mapping](#) study provided much of the required insight.⁴ As a result, we were able to compile an inclusion health educational resource map by exploring the quality, relevance, and utility of the existing inclusion health training for health and care staff. We also sought to identify any gaps or barriers to access. In addition, the mapping process allowed us to highlight training that has relevance for allied professionals and other frontline workers.

The top 10 resources for allied professionals and other frontline workers identified in the mapping are:

1. Aneemo - Rough Sleeper Mental Health Awareness (free)
2. E Learning for Healthcare - Suicide prevention (free)
3. Fairhealth – Adverse Childhood Experiences (free)
4. Aneemo - Working with Women with Complex Needs (£36)
5. E Learning for Health - Alcohol and tobacco brief interventions (free)
6. Homeless Link - Autism and homelessness toolkit (free)
7. Migrant Health website (free)

⁴Available at:

<https://www.hee.nhs.uk/sites/default/files/documents/Inclusion%20Health%20Education%20Mapping%20and%20Review%20-%20Full%20Report.pdf>

8. Friends, Families and Travellers – Online Cultural Awareness Training (£35)
9. National Homelessness Advice Service - Understanding Homelessness Vulnerability (free)
10. National Homelessness Advice Service - Introduction to Housing Eligibility for Housing Assistance (free)

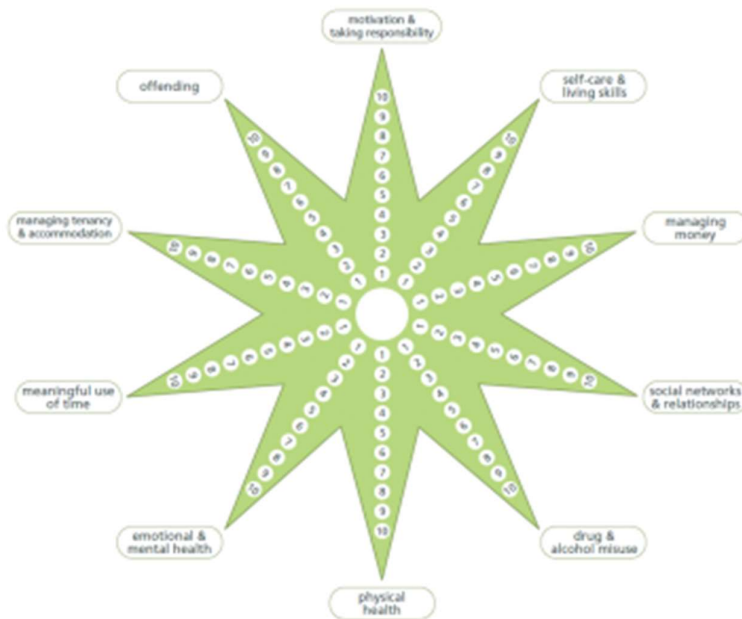
What this mapping shows us is that health-related capacity building training for homelessness professionals does exist. However, the available training tends to be issue-specific, for example, rough sleeping and mental health. Such training is commonly sought across the sector so there is a clear need for it. That being said, during the consultation frontline workers spoke to the vast range of health needs they are confronted with during their support work. It is perhaps unfeasible to imagine individualised training to cover every health need they encounter, but what the consultations drew out was a need for general capacity building training to allow workers to confidently broach a range of health needs with those they support.

Health and support plans

It is not only healthcare workers who speak to people experiencing homelessness about their health and such conversations don't only take place within a healthcare setting. In supported accommodation and, in fact, anywhere a person on their recovery journey has a key worker, support plans are integral to working successfully with individuals. The structure and format of support plans can vary hugely and person-centred support, trauma informed care, and asset-based approaches are used to shape individual plans. Nevertheless, there remain significant commonalities across the sector in terms of what these support plans typically cover.

A support tool widely used by homelessness services is the Homelessness Outcome Star™ (HOS).⁵ The HOS, which is designed to “both support and measure change when working with [homeless] people” (MacKeith, 2011) is made up of 10 elements each of which are rated on a 10 point scale (Figure 1). Of the 10 elements, three directly relate to health, and by definition require health-focused conversations. These three areas are: physical health, emotional and mental health, drug & alcohol misuse. When completing a star, individuals assess themselves on the scale, and then discuss this with their support worker. An associated support and action plan is then developed and the scores reviewed over time to measure progress and ongoing support needs

⁵ Joy MacKeith , (2014), "Assessing the reliability of the Outcomes Star in research and practice", Housing, Care and Support, Vol. 17 Iss 4 pp. 188 - 197

Figure 1: Homelessness Outcome Star

Completing a support plan using models such as the HOS will automatically open the door to conversations around health. However, the training related to HOS completion focusses predominately on the mechanisms of the tool and the skills needed to build effective support plans. There is little on the skills required to use the HOS as a springboard for meaningful conversations about health. Some services and associated frontline workers build their own experience in this space, however this is not consistent across homelessness provision. Indeed, the consultation revealed that those frontline workers who did feel confident in initiating health conversations put it down to experience not training and felt that new colleagues received limited support in this area.

Findings from the workshops

Between January and March 2022, a series of workshops and focus groups were held with people with lived experience of homelessness, and with frontline workers working within homelessness services. The workers were from a range of homelessness services across England and held a variety of roles.

Two frontline worker sessions were held in March 2022, each with seven participants. The frontline worker sessions explored their experiences in supporting individuals with health care needs, the opportunities and barriers to proactive health conversations, and the wider challenges related to supporting people with their health needs.

One workshop was held with the #HealthNow Peer Network, a group of volunteers all with direct experience of homelessness from across England. The group was asked about their experiences of how health needs are addressed within services, and anything they thought could be done to improve engagement.

Types of health conversations

Across all frontline workers there was a sense that a significant proportion of the time they spend supporting and talking to people experiencing homelessness concerned health and health-related issues. Participants in the workshops highlighted that this can be as much as 75% of their time. In this context, health conversations covered physical health, mental health and substance misuse.

Frontline workers highlighted the range and depth of conversations they have: helping people to register for GPs; encouraging engagement with sexual health clinics; supporting and advocating for them in accessing correct and timely prescriptions; discussing chronic conditions such as COPD; through to critical, emergency need such as infected injection sites.

Further, these top-level health-related conversations are a fundamental part of the wider support work done by frontline workers. This is because discussions around mental health and substance misuse, in particular, are typically core elements of support planning. However, the depth of these conversation and associated actions can vary greatly and the urgency around actions can also be dictated by other support needs. For example, a need to rectify incorrect benefit payments may be considered more urgent than GP registration.

Nevertheless, the embedded nature of health within wider support plans speaks to the ubiquitous nature of health needs within a homelessness setting and of the vital role that frontline homelessness workers can play as a result.

Outside of ongoing support plan-related discussions, most health-related conversations are typically seen as being reactive and responding to pressing and immediate need. In many cases participants stated that the people they are supporting often don't come to them for help until their health care needs are critical and people need to be urgently encouraged to attend A&E.

Alongside conversations, a significant amount of the work of frontline workers within the context of their broad-spectrum support focuses on health, mental health, and drug and alcohol-related advocacy and signposting. Frontline worker participants highlighted a range of typical support-related activities:

- Accompanying people to appointments including GP appointments
- Taking people to A&E and sitting with them whilst they're waiting to be seen to try and encourage them to stay and receive treatment

- Chasing up and keeping track of referrals and appointments
- Chasing up prescriptions
- Advocating for people who are being dropped from services due to missed appointments
- Challenging and advocating when poor service is received

Participants spoke about how many of the people they support will only go to hospital if they have a companion or advocate to accompany them. For some homelessness services they don't have the capacity to provide this support which can create delays and ultimately barriers to engagement. In this context, trusted peer advocates or volunteers were highlighted as making a significant difference.

Peers in the lived experience workshop also highlighted the challenges of capacity on support workers as a result of initiatives to help people access healthcare, but reflected that lots could be achieved without expending a great deal of extra time or resources, by simply signposting to relevant services during inductions.

"This is the ideal point, you don't need a crisis. When someone has suffered homelessness, or for whatever reason they arrive at a hostel, that should be part of the induction procedure.

They should probably have a checklist form, at least to say, you know, can we refer you to a local dentist? These are the doctors in this area, you ought to get registered. Have you any outstanding health issues? Do you have medication needs? Are you on any medication? Are you going to need a repeat prescription soon? Do you have your medication? Things like that. Would you need to have a bathroom nearby? Do you have incontinence issues or whatever it happens to be?

And that's the ideal point to get some of their narrative and show some compassion and actually provide some help. A small number of hostels, from some research I saw fairly recently, actually are a lot more psychologically informed, and they will actually support residents and engage and signpost them to nearby agencies and, phone Crisis, Shelter or whoever. And maybe check with them after a few days. Have you managed to register with a doctor? Do you need some help filling out the paperwork. Would you like somebody to advocate for you and come along with you and make sure that you do get registered."

Initiating health conversations

Participants in the frontline worker sessions were asked about their experiences of proactively initiating health conversations outside of standard support planning processes. We explored whether participants proactively approach individuals they support when they see their health deteriorating, particularly in the context of participants highlighting the level of critical care required. The responses to these

questions foregrounded the complexity of the decisions that workers are facing in this space.

Participants were divided as to the appropriateness of proactively initiating health conversations, and questions of balancing the personal choice of the individual against the workers responsibility to act strongly resonated. It was evident in discussion that the ethical weight of these considerations impacted on workers and that it was often left to individual workers and their personal choice.

Some participants felt strongly that initiating or forcing health care-related conversations risked undermining wider person-centred approaches. Such approaches are client-led, with each individual dictating what is prioritised in their support. Participants expressed how important the process of building trust is to a supportive relationship, and said they had concerns that pushing health conversations that weren't wanted at the time might be detrimental to the wider work being done.

Conversely, other participants reflected on what they felt was their responsibility to act where an individual has a recognised health care need but is disengaged from health services, or they observe a person's health visibly deteriorating. While it was acknowledged that any action needed to be balanced against an individual's personal choice, participants nonetheless felt that certain health care concerns should override this, even if the conversations were likely to be difficult.

The need to support people on their terms and to be responsive to when they express a desire to engage was also identified by the peers in the lived experience workshops when discussing good practice examples:

"What they do is, because I was talking to the guy that ran the hostel, and he said "We make a point of the fact that we want to do this early on so we can get it all out of the way, and it all benefits them. And if they don't want to do it straight away, we don't make them do it straight away. If they want to go away and come back later, we just give them a quick overview on a sheet of paper. There you go. That's what we'll cover if you want to do it later, fine."

One particular concern participants highlighted with initiating these conversations was their lack of knowledge of many health conditions. Participants discussed how hard it is to talk through the implications of not accessing support because they do not have the medical training to do so. A lack of confidence in what they're asking and speaking to individuals about can create barriers to initiating such conversations.

All participants in the frontline worker sessions discussed the challenge of knowing when mental capacity and safeguarding concerns overrode personal choice and there was a need to intervene. Participants discussed how confident they felt in their understanding of the Mental Capacity Act and their role within it. Again, participants

highlighted the responsibility they feel in this space and their acute awareness of what could happen if they make the wrong decision.

Concerns about workload capacity and how this impacts the ability to have effective and meaningful conversations were common to the broader conversations around initiating proactive health conversations. In most services, participants reported very high caseloads, and that being on top of everyone's immediate needs can make initiating conversations extremely difficult. There was a notable difference for those working in services like Housing First, or projects with smaller caseloads. Participants from these types of provision acknowledged that they were in a much better position to be able to have proactive conversations and to take the time to build the trust needed for positive engagement.

The variation between services, and individual workers, was reflected by the peers in the lived experience workshops who had differing experiences of healthcare engagement initiatives within services. As one respondent highlighted, successful engagement was often attributable to individual staff members with a passion for their role, rather than being part of a wider culture of healthcare focus within services themselves.

"I've found that, in the hostels I've been in, that it's not part of the hostel regime or rule, it's just been one worker who's had a passion for it and maybe trying to do a bit of work around health. But it's always very been very hit and miss. It's not been part of the process."

Participants discussed how to create spaces that might be more conducive to initiating health conversations. In most cases, there was a sense that, with the exception of specialist services such as Housing First, this was often best facilitated via specialist roles dedicated to health advocacy and engagement. An example given of successful models of this was Groundswell's [Homeless Health Peer Advocacy \(HHPA\) programme](#).

Alternative models looked at creating dedicated spaces that brought health care providers to people and allowed them to initiate conversations on their own terms. An example of this was a 'ladies night' service where female sex workers can come along to a very informal drop in, with a wide range of specialist services present. There is no expectation of health discussions and they can come just for the social aspect of the service but the providers have found it has been very successful in building trust and engaging the women in particular with sexual health services.

Nevertheless, participants did highlight examples of where attempts to create spaces that were more conducive to initiating health conversations could have unintended consequences. One example given related to a service that looked to use a needle exchange, which they also run, as an opportunity to have conversations around broader health. However, it became apparent that soon after injecting is not the right time to try and engage individuals in such discussions, in fact, it led to disengagement.

Likewise, having a specialist role is seen to only work if that facilitates pathways into services. One participant discussed having an in-house nurse attached to their service but engagement can be viewed by clients as a waste of time as the nurse is not able to make referrals and can often only signpost individuals to their GP or other known services. Ultimately, it was felt that this role just created another layer to access.

Barriers to engagement

Participants reflected on what they perceived to be some of the barriers to having health conversations for the people they're supporting.

The importance of trust as being integral to people being willing to engage in health conversations featured strongly across both frontline worker workshops. If trust isn't there then people will not be willing to disclose or share health needs beyond immediate crisis support. There was wide acknowledgement that establishing trust takes time but is nonetheless fundamental to the relationship building at the core of most support work in homelessness settings.

Lack of trust and faith in the healthcare system to adequately respond to their needs creates additional barriers to health conversations as people don't see any benefit in discussing health needs with their support workers. Participants talked about the range of experiences they have observed that lead to such hesitancy in individuals they are supporting. These included negative experiences such as individuals feeling like they've been unfairly denied appropriate health care, delays in accessing support, and having been previously discharged from hospital to no fixed abode, often with continuing health care needs. This was reported as being particularly true in relation to conversations encouraging GP registration and engagement as poor experiences are common.

Timing, in the context of supporting people to access health care, was a key theme raised throughout the discussion. Missed opportunities for engagement can lead to long-term disengagement. When someone is ready to talk and reach out to health care services the window of opportunity can often be narrow and if they're not able to have a productive appointment with a health care professional quickly, the opportunity can be lost. Participants in the frontline worker sessions talked about the challenges they face translating the work they have done in encouraging someone to reach out to health services into actual access to services that are not able to immediately see someone, or services that are not equipped to deal with the complexity of needs (particularly in the context of dual diagnosis: co-occurring mental health needs and substance misuse), via hard to navigate pathways.

A notable distinction was made here by participants who felt conversations around COVID-19 and vaccine take-up were more productive than general health care conversations due to the vaccine infrastructure being so well established and proactive in reaching out to people. The amount of effort put into meeting people in place, through outreach and accessible vaccine clinics, means the risk of encouraging and

supporting someone to get a dose of the vaccine and them not being able to receive it is minimised. This is not true for the wider health system, which can lead to breakdown in trust that can take significant time to rebuild.

Participants also discussed experiences of people they were supporting being in denial about their health condition(s) and therefore did not want to start the process of asking for help. This was further related to a perceived fear of a negative outcome from testing. One participant gave an example of someone who was extremely anxious to go for cancer tests as they knew if they had cancer they had no support network to help them through the treatment. These personal anxieties are likely to only be disclosed once there is a strong relationship with the frontline worker which takes time to establish. Likewise, turning a disclosure around health anxieties into engagement with health care services may also be a lengthy process, particularly when considering the limited capacity many frontline workers have for meaningful conversations in this space.

Additionally, frontline workers across both groups highlighted an observation that the people they're supporting had a tendency to compare their health to that of their peers, as opposed to expected health for someone of a similar age and profile who was not experiencing homelessness. As the health determinants for people experiencing homelessness are so poor compared to the general population, this means people are often comparing poor health to poor health. This can lead to underestimating the severity of their needs, or dismissing milder health concerns.

Conclusion

Frontline homelessness workers currently spend a significant proportion of their time supporting people with health and social care needs. Whilst much of this is active support advocating for or accompanying people to appointments, the conversations initiated are typically focussed around emergency health care needs.

Reluctance on the part of support workers to initiate conversations was tied to concerns that this conflicted with other approaches and did not fit in with person-led care. Workers felt concerned that they would be jeopardising trust they had built up by forcing conversations. There was a clear sense that an ethical conflict exists between the responsibility to act when individuals have observable healthcare needs, and individuals' personal choice. This was linked to lack of understanding and confidence in their role when it comes to Safeguarding and the Mental Capacity Act.

Frontline workers need to feel confident that by initiating conversations they are able to do this in a supportive way, and that it would not detract from user-led approaches to support. They also need guidance on how to hold these conversations in a way that contributes to trusting, effective relationships and does not detract. Based on the learning from the lived experience workshop there is a suggestion that this concern

around breaking trust may be more related to being confident in how to frame the conversation rather than the outcome of the conversation itself.

The learning from the mapping exercise suggests that there are gaps in existing training that would enable workers to develop these skills. Any work looking at needs going forward should focus on building this sense of confidence, helping workers to puzzle the ethical responsibilities they hold and to build their capacity to frame such conversations.

However, this can't be done in isolation. A significant part of the challenge in building momentum with health conversations is ensuring they lead to positive outcomes with health engagement. If health and social care services are not able to respond, enabling effective pathways, easy referrals, and meaningful appointments then there will continue to be significant systemic barriers preventing frontline workers from encouraging the effective health conversations which ultimately lead to improved health outcomes.

What We Do

Homeless Link is the national membership charity for frontline homelessness services. We work to improve services through research, guidance and learning, and campaign for policy change that will ensure everyone has a place to call home and the support they need to keep it.

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**Let's End Homelessness
Together**

